EVERY YOUNG
HEART AND MIND:

SCHOOLS AS CENTERS OF WELLNESS

MHSOAC

Mental Health Services
Oversight & Accountability Commission

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HEART AND MIND:

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About the Commission

The Mental Health Services Oversight and Accountability Commission is an independent state agency created in 2004 by voter-approved Proposition 63, the Mental Health Services Act. The 16-member Commission is composed of one Senator, one Assemblymember, the State Attorney General, the State Superintendent of Public Instruction, and 12 public members appointed by the Governor. By law, the gubernatorial appointees represent different sectors of society, including individuals with mental health needs, their family members, law enforcement, education, labor, business, and the mental health profession.

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This report represents a culmination of this collective effort. Special acknowledgements are given to the Commission's Subcommittee, leadership and staff, and specifically to Anna Naify, Katherine Elliot, and Melissa Huerta for their contributions to this report. A special acknowledgement is also given to Jim Mayer, Chief of Innovation Incubation, who provided expert guidance and was instrumental in editing and bringing this report to fruition.

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This report is dedicated to every student whose trauma and mental health needs have been unmet, misunderstood, stigmatized or punished. We lift them up with the hope that this ongoing work will bring healing to their lives, families, schools, and communities.

STATE OF CALIFORNIA
GAVIN NEWSOM, Governor

MHSOAC
Mental Health Services
Oversight & Accountability Commission

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TOBY EWING
Executive Director

October 7, 2020

Dear Governor Newsom and members of the Legislature, county and school officials, and the people of California,

The Commission in 2016 began to explore the mental health needs of California's K-12 students, with the knowledge that mental health is integral to academic success and lifelong prosperity and wellbeing. We discovered both a growing need and a growing response from professionals and community members. During this time, the State also responded, in part due to this very public process, by investing in partnerships between schools and county behavioral health departments, which is the essential infrastructure for durable and effective strategies.

As the Commission was finalizing this report, the COVID-19 pandemic hit, then the economic recession, and then the series of events that elevated for everyone the tragically enduring inequities in our communities.

The pre-existing student mental health crisis has grown deeper and more widespread – and at the same time less visible to schools and communities. Remote learning and social distancing have increased isolation and reduced student access to peer and adult support. Unemployment and economic uncertainty are straining families and raising concerns about an unseen surge of domestic violence and child abuse.

These impacts are compounded for children of color and their families, for whom long-standing inequities worsened as COVID-19 and the job losses hit them harder, and conflicts with police and other racial injustices inflicted more stress, trauma and anxiety.

Amid this multitude of crises, the wellbeing and resilience of students and their families are more important than ever. The Commission's report *Every Young Heart and Mind: Schools as Centers of Wellness* proposes a way to bring healing to our students, families, and schools in 2021 and beyond.

Now is the time to build upon the many local collaborations between health and education agencies to establish schools as centers of wellness and healing – where social and emotional learning is a core mission; youth are engaged as mental health champions and leaders; and families, including younger children, have access to mental health supports.

MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION
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To achieve this vision, the Commission offers the following recommendations:

- The State should establish collaborative leadership among its agencies, local governments, and local educational agencies to develop a statewide strategy for making schools centers of wellness and healing, with a clear focus on prevention and intervention as early as possible for those birth to five years old.
- The State should make a multi-year foundational investment that increases services while also building the necessary infrastructure of programming, data management, workforce and sustainable funding models so all schools are centers of wellness and healing regardless of the economic cycle.
- The State should provide technical assistance to schools, health agencies, and other community partners to strengthen capacity to integrate local resources and service systems, adapt proven practices and drive continuous improvement.

While the State has many urgent needs, the mental health crisis, if unaddressed, will have implications for a generation. The consequences – trauma and anxiety, diminished health and wellbeing, lost wages and economic security, and higher demands on social and health care systems – will continue and could even grow long after a vaccine vanquishes COVID-19 and the economy recovers.

In these times, meeting the mental health needs of children and families is not a discretionary act, but rather an essential one. At the same time, we know what to do. Emerging local models, partnerships, and entrepreneurial community leaders are showing us the way. If we find the courage and the commitment as a State, we will find the resources.

The Commission will do all it can, in partnership with others, to advance the vision, principles and recommendations in this report.

Sincerely,

David W. Gordon
Superintendent of the Sacramento (CA) County Office of Education & Commissioner
Chair, MHSOAC Subcommittee on School Mental Health

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Executive Summary

The wellbeing of California's children is vital to the future of the state. Yet across California's schools and communities, a sobering crisis burdens the young. Trauma and adversity are undermining the ability of many students to learn.[1] Bullying and harassment are common.[2] Anxiety, depression, and suicidal behavior are on the rise.[3]

Amid this crisis, there is cause for hope, even confidence. School districts and counties are working together to promote awareness, provide training, increase staffing, and leverage community partnerships. Social-emotional learning is being elevated as key to academic success. Youth are courageously stepping up to guide mental health programming and provide support to their peers. The State has buoyed this optimism with additional financial investments before COVID hit.

But the pandemic has increased the risk factors, the recession is shrinking revenues, and the spotlight on racial inequities and social justice has amplified the urgency.

Student Wellness in California

Depression Symptoms	1 in 3 high school students report feeling chronically sad and hopeless.
	More than half of all LGBT students report feeling chronically sad and hopeless.
Suicide Ideation	1 in 6 high school students report having considered suicide in the past year.
	1 in 3 LGBT students report having considered suicide in the past year.

The State must act decisively to establish the leadership structure to support these local efforts and provide the technical assistance required to make schools "centers of wellness and healing." This school-based approach will allow communities to connect to families with mental health needs, reach younger children at home before they start school, and further empower youth to develop the resilience required in these times. This strategic state support also is needed to build financially sustainable local partnerships designed to become more effective over time.

The Mental Health Services Oversight and Accountability Commission reached these conclusions after more than three years of engagement with parents, youth, teachers, providers and community members, which produced a deep understanding of the mental health needs of students, and the promising efforts already underway in schools and communities. The Commission was inspired by the tireless efforts of professionals and community members who recognize the needs of the "whole child" and realize that mental, social, and emotional health are integral to school success.

To advance this shared vision – and in recognition that communities throughout California are entrepreneurially working to meet these needs – the Commission developed principles to inform and align the actions of everyone working to develop healthy children. The Commission also developed specific recommendations, detailed below, for how the State can exercise its leadership obligations to develop a coherent and durable infrastructure for school mental health.

A Comprehensive Look at an Unfolding Tragedy – and a Concern for All Californians

Mental health needs can begin long before children enter school. Early exposure to trauma and chronic stress derails healthy development, and without proper intervention can lead to lifelong learning and mental health struggles.[4]

Students of color are at heightened risk. They disproportionately carry to school the burden of poverty, racism and discrimination, parental incarceration, exposure to violence and intergenerational trauma.[5]

Nationwide incidents of hate, racial injustice, and religious intolerance are deepening that burden. Federal immigration policies have spread fear of deportation among immigrant families and created ongoing anxiety for the one-in-eight students with an undocumented parent.[6,7]

Students are manifesting symptoms in ways that can be misunderstood by adults—distraction, disobedience, and disengagement. Exclusionary discipline practices disproportionately affect African American and Native American students, and students in foster care who are being pushed out of school at alarming rates for behavior that often reflects underlying trauma and mental health needs.[8]

These unmet mental health needs are a major barrier for learning for many of California's 6.2 million K-12 students.

These considerations elevate the importance of schools as a prime venue for promoting healthy development through prevention and early intervention to achieve equity. Schools are central to the lives of children – not just their education, but their lives – and central to promoting wellness, and accurately identifying and quickly responding to trauma and emerging mental health needs.

Schools also are the bedrock of the community and the place where children spend most of their time outside of their homes. And families look to educators to be role models for their children and provide nurturing care, guidance and support. But teachers and other school staff can only do so in the context of family trust, strong partnerships and adequate training and support. School-based mental health professionals—school psychologists, counselors, social workers and nurses—provide that training and support, and are the bedrock of the school mental health team. But there are not enough of these professionals to respond to the student mental health crisis.

The needs are great and require collaboration across sectors, engaging the health care system and community providers. Through collaboration schools can become centers of wellness and healing where more mental health services can be provided on school campuses and where families can be empowered through continued learning and support. Schools can also become safe spaces where children can thrive and reach their full potential, a vision that youth and families strongly urged the Commission to support.

The Governor and the Legislature have incentivized stronger partnerships between local education agencies and county behavioral health departments.[9] Trainings and workshops on student mental health and wellness are widespread, and thousands gather for annual state conferences to learn and share information.[10,11] At the local level, schools and community partners have created integrated solutions to local challenges.

Momentum is building for involving youth leadership in designing youth-centered programs and systems.[12,13] This energy, excitement and momentum can be harnessed by schools and communities, provided youth engagement is based on active participation and decision-making.

These impressive efforts should be focused on a common, overarching goal – **to promote the wellbeing and success of every child, regardless of where they start.**

This goal prioritizes the imperative to reduce disparities and to explicitly address the implicit bias in institutions, policies and practices that have limited the potential of some Californians generation upon generation.

The following recommendations, detailed in Chapter VII, are essential to achieving this overarching goal. All Californians can contribute to their advancement—lawmakers, educators, mental health providers, youth, parents, and concerned citizens.

Recommendations

1. ***State Leadership.*** The Governor and the Legislature should establish a leadership structure dedicated to the development of schools as centers for wellness and healing. The Governor's office should lead this effort, in partnership with the State Board of Education and Superintendent of Public Instruction, with operational leadership from the Department of Health Care Services, the California Department of Education and other agencies that can make a contribution. The leadership structure should work closely with the K-12 Statewide System of Support.[14] The operational leadership should have dedicated staff charged with developing and implementing a state-level strategy to support community-level partnerships.

2. ***State Investment.*** The State should make a significant investment to establish schools as centers for wellness and healing. This foundational investment will require a multi-year commitment to developing the model programs, the data and management systems and the workforce. It will require allocating more funding for services, and developing a sustainable funding strategy that links and leverages related funding and existing services, as described below.

Schools also are the bedrock of the community and the place where children spend most of their time outside of their homes.

3. ***State-supported Capacity Building.*** The state leadership structure must help counties and school districts develop the capacities required to integrate resources, adapt evidence-based practices and manage for continuous improvement. The capacity building efforts should include these elements:

   a. Model / program development. The K-12 System of Support should be expanded and funded to provide this technical expertise to schools, and find ways to enhance preventive support to early learning programs that serve children ages birth to five.

   b. Data and management. The K-12 System of Support should facilitate the local capacity for data and cross-system management with education and mental health systems, and facilitate ongoing policy evaluation at the state level.

   c. Workforce. OSHPD should be directed to work with county behavioral health and the K-12 System of Support to identify specific school-based workforce needs and allocate future fiscal year funding to students and educational providers.

   d. Sustainability. The Governor and the Legislature should make a multi-year funding commitment for services, while also investing in system capacity and system sustainability. Among the considerations:

   - Structure one-time funds to ramp up spending and then be reduced as ongoing funds are incorporated or created.
   - The State and K-12 System of Support should work together to develop and test options for braiding existing funds. The State and communities must share the objective of achieving financial sustainability and pursue opportunities to create more flexibility from existing funds or to develop new funding sources.

Guiding Principles

To guide the system-level changes that are underway – and need to be accelerated – the Commission developed principles that distill the knowledge, wisdom and experience that are needed to fortify school mental health. These guiding principles are intended to inspire and inform the myriad of decisions being made by state and community leaders.

Guiding Principle 1. Each Child Should be Emotionally and Intellectually Nourished
A commitment to equity and reducing disparities is central to a school mental health strategy.

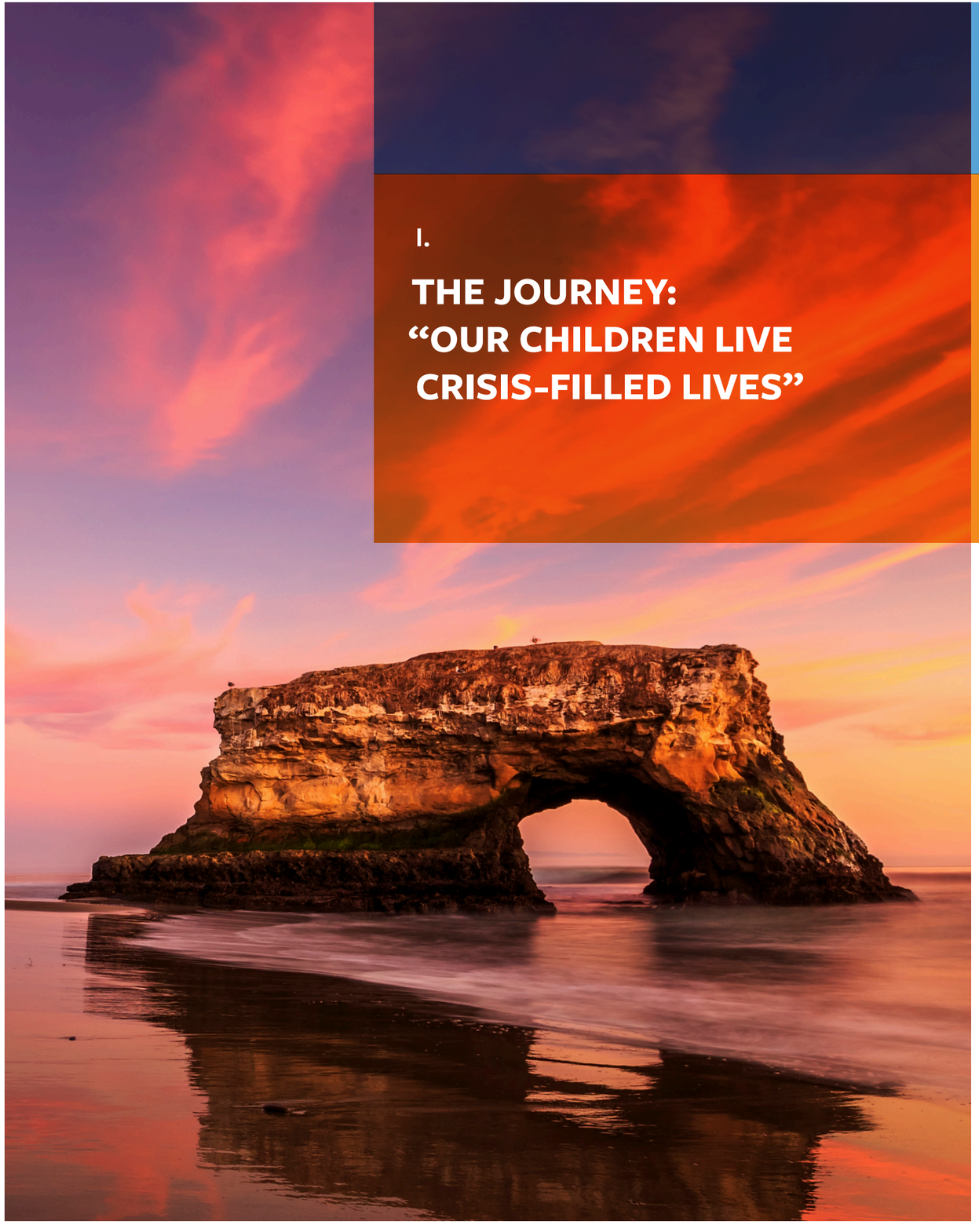
Guiding Principle 2. Schools Should Be Centers of Wellness and Healing
Students feel safe, valued, and respected, and have positive, healthy relationships with adults and students.

Guiding Principle 3. Health and Education Must Join Together
School-community-health system collaboration is essential to support student and family wellness.

Guiding Principle 4. Prevention and Early Intervention Must Be Prioritized
Healthy mental, emotional, and behavioral development in early childhood is foundational for school readiness and success.

Guiding Principle 5. All Youth and Families Must Be Engaged and Have Ownership
Youth and families have leadership roles at all levels of decision-making and service delivery.

Guiding Principle 6. Sustainable Funding, Continuity and Collaborative Leadership
State leaders are responsible for aligning policies, funding, training and technical assistance to local communities and schools.



I.

THE JOURNEY: "OUR CHILDREN LIVE CRISIS-FILLED LIVES"

The Mental Health Services Act (MHSA), through its Prevention and Early Intervention (PEI) component, promotes strategies to reduce the negative outcomes that may result from untreated mental health needs—suicide, unemployment, incarceration, homelessness, school failure or dropout, removal of children from their homes, and prolonged suffering. The Act also calls for the Commission to support the positive educational outcomes that can result from tailored mental health interventions.

In response to this charge, the Commission embarked on the Schools and Mental Health Project with the recognition that mental wellness is necessary for children to succeed in school. The project is directed by a subcommittee chaired by Commissioner and Sacramento County Schools Superintendent Dave Gordon. Through this project, the Commission set out to promote student wellness, encourage early identification, and support access to a continuum of school-based mental health services and supports.

The project began with a subcommittee meeting in December 2016 hosted by the Greater Sacramento Urban League in a neighborhood where approximately 28 percent of residents live in poverty and more than 50 percent speak a language other than English at home. The Commission chose this location to better understand the challenges of raising and educating children in communities struggling with poverty, unemployment, and other societal problems. A diverse group of parents and educators came together to discuss children's mental health and how schools can better support wellness and school success in their neighborhood. Participants emphasized the importance of engaging families and supporting students, especially in low-income, diverse communities – through education and empowerment, destigmatizing mental health, building family-school partnerships, and providing family advocates to assist families in need. Stakeholders specifically spoke to the "vulnerability of children of color" and poor mental health outcomes as a result of school disciplinary practices, cultural insensitivity and a host of environmental factors that place these children at risk.

On the same day, the Commission visited a neighborhood elementary school that was responding to the mental health needs of young students with a dedicated school social worker and a school climate initiative. Many of the students were exposed to poverty, housing and food instability, and neighborhood and family violence. They often arrived at school unable or unprepared to learn. Laura Lystrup, an educator and executive director of a Special Education Local Plan Area (SELPA), observed that an increasing number of children in her district were struggling and appear to have been exposed to trauma. "Our children live crisis-filled lives," she said.

Faced with significant adversity, children may disengage or act out in the classroom. However, Lystrup noted, children who are academically on-target do not qualify for state-funded Educationally Related Mental Health Services (ERMHS) through Special Education. Therefore, schools are less able and likely to intervene.

Following that first meeting and school visit, the Commission conducted extensive outreach through public hearings, meetings, site visits, and focus groups. (Appendix A inventories these activities.) The Commission made a concerted effort to reach as many constituencies as possible and deliberately sought different perspectives to understand how school settings can be better used to meet the mental health and wellness needs of children, youth and families.

An increasing number of children... were struggling and appear to have been exposed to trauma.

Listening to Families and Community Members

The Commission talked to youth, educators, school administrators, school and community mental health providers, cultural brokers, and community leaders. The engagement strategy was designed to connect to the racial-ethnic diversity of California's K-12 students. Thus, the Commission hosted several parent meetings in Spanish. Two of these meetings were near California's southern border and were facilitated by Commissioner and Subcommittee Member Mara Madrigal-Weiss to understand the unique challenges of families living in immigrant communities.

The Commission concentrated attention on student groups that were more likely to have poor educational outcomes. Community forums and focus groups explored the needs of African American, Asian American, and gender diverse students. Commission staff also worked closely with cultural brokers in the Native American community, who generously shared the results of their engagement with Native families regarding children's mental health. This project also tapped the expertise of a diverse group of youth who comprise the Commission's Youth Innovation Project Planning Committee. The committee members represent 12 counties and are developing youth-led solutions to the mental health challenges facing their peers.

Seizing Opportunities

In the course of this journey, the Commission seized emerging opportunities to advance a school mental health agenda. In 2013, the Legislature enacted SB 82 and entrusted the Commission to administer Triage grants.[15] The Commission allocated the grants to incentivize school-county partnerships to provide a continuum of services and supports on school campuses. More recently, the 2019-20 budget established the Mental Health Student Services Act (MHSSA) to fund partnerships between education and county mental health departments through a competitive grant program.[16] The Commission also partnered with the California Department of Education (CDE) to promote school mental health activities. That partnership is developing a school mental health toolkit and a statewide learning community to encourage its use.

In addition, the Commission's project has been informed by other statewide entities providing leadership in school mental health training, technical assistance and policy. These entities include the California Department of Education's Student Mental Health Policy Workgroup, Breaking Barriers, the California County Superintendents Educational Services Association (CCSESA), the California School-Based Health Alliance (CSBHA), the California PBIS Coalition Network, the Sacramento County Social and Emotional Learning Community of Practice, and CalMHSA to name a few. Many others such as the California Children's Trust are working on children's mental health policy to bring about systems change.

The Collective Wisdom

The bedrock for this report is the lived experience of children, youth and families; their teachers, health and mental health providers; and, other practitioners and community leaders seeking to reduce risk and increase resiliency for vulnerable Californians. From their thoughtful insight and candid guidance, six themes emerged:

1. Childhood Adversity Clouds the Future of Many Young Californians

Across stakeholder groups, Californians were concerned about the pervasiveness of adversity in their communities, and its impact on child wellbeing and the increased risk of mental health needs. This concern is understandably strongest in communities of color dealing with disproportionate poverty, violence, housing and food instability, and intergenerational and immigration-related trauma, including deprivation or violence during migration or border crossings and the fear of family separation.

Here's how one mother described her experience at an African American Community Forum in February 2019:

"My son had severe trauma and many transitions. An absent father, instability in the home, homeless from ages 1 to 6...moving frequently, house to house, city to city. He would cry a lot. He lacked social skills and did not understand his peers. What calmed him down was one teacher that took the time to understand my son. And she would hug him when he needed it."

Stakeholders from different backgrounds and professions all agreed on one aspect – the need for greater prevention and early intervention services...

The impact on child wellbeing is evident to educators who described being overwhelmed by student behavior in the classroom – including impulsivity and acting out, and their limited ability to effectively respond given the lack of time, resources and support. As one educator said, "It feels like we are putting a Band-Aid on students and not getting to the core issues."

2. It is Never Too Early to Intervene

The Commission frequently heard that the signs and symptoms of mental health needs were evident early in development and expressed by children in different ways, such as acting out, impulsivity, emotional dysregulation ("meltdowns"), or difficulty getting along with peers. However, these behaviors were not always recognized as an expression of an underlying mental health need or appropriately addressed. As Commissioner Gordon noted, too often schools operate under a "fail first paradigm," in which "children must get worse before they can get better."

The education system in California has no mandates or incentives to provide universal mental health/wellness supports to all children through a comprehensive strategy. The default of a "fail first" approach in the school system is referral for special education services. In the mental health system, children can be required to meet "medical necessity" to be eligible for services. In other words, they must exhibit signs and symptoms and meet criteria for a mental health diagnosis to receive help. In each system, mental health service delivery traditionally has been individually focused and deficit-based.

Parents and family members told personal accounts of how their children's mental health needs did not receive enough attention until worsening symptoms led to a crisis. One mother shared her agonizing experience of receiving a call from her 7-year-old son's elementary school telling her that police were taking him to the hospital to be placed on suicide watch. Another mother said her child had been "hauled out" of their house by police in the middle of a violent fit to be taken to the hospital. This mother described the incident as a horribly traumatic experience, but also beneficial. "It opened a lot of doors (to services)," she said. "But why did it get to this point before those doors were open?" Some stories were less dramatic but had serious implications for a child's future success, including failing grades, disengagement from school, being suspended or expelled, and eventually dropping out of school – all of which could have been mitigated with access to comprehensive school mental health services.

Stakeholders from different backgrounds and professions all agreed on one aspect – the need for greater prevention and early intervention services, before children enter formal schooling and during their K-12 education. Stakeholders also were clear that services needed to physically meet children and families where they are, which is more often in schools and communities rather than offices. Community members wanted a greater focus on wellness, rather than diagnosis, through prevention and early intervention efforts.

A mental health professional at a December 2016 subcommittee said children are often diagnosed later than they should be, which delays treatment: "You don't want it to get to that point. You want to help them early."

3. Common Barriers Block Efforts to Support Healthy Development

Stakeholders identified common barriers to promoting student wellness and addressing the signs and symptoms of mental health needs when they first arise, including the following:

- The education system's priority focus on learning and academic achievement can overshadow other contributing factors to student success. Although the education system has evolved to address the "whole child" and support social and emotional learning, the focus on academic achievement continues to dominate school policy and resource allocation.
- Schools lack on-campus resources, including sufficient numbers of school-based mental health professionals to evaluate the needs of students and provide services and supports. Educators find it challenging to recognize and respond appropriately to children's mental health needs, particularly in the absence of school-based mental health professionals.
- The complexity of family needs challenge schools and counties to engage families as equal partners to support children's mental health.
- Mental health services and supports for children and their families are often poorly organized across systems – education, county behavioral health, child welfare, and juvenile justice.
- Stigma and shame about mental health needs are pervasive in families and communities.

4. Trust Needs to be Built with Families

Stakeholders emphasized the importance of building trust and working in close partnership with families, especially those from unserved and underserved communities. Focus groups and community forums revealed a disconnection and cultural divide between families and institutions, including education and county behavioral health. At an African American community forum, participants talked about a general fear and distrust of social institutions because of the removal of African American children from their homes by Child Protective Services. An African American community stakeholder, said:

"I believe it all boils down to trust. It's very difficult to establish trust. We grew up seeing it – kids getting split up. It's difficult to place the trust in people at school."

This mistrust extended to relationships with educators and school employees, especially if these individuals were not from the communities they served and held implicit biases about those communities.

This disconnection was heightened in communities where programs and services did not match the language, cultural beliefs and practices regarding mental health, especially regarding stigma and shame. For example, during the Asian and Pacific Islander Community forum held in Fresno, a Southeast Asian community provider shared that families in her community will rarely seek clinic-based services and open-up to a stranger. She spent a considerable amount of time getting to know families in their homes and building trust by washing dishes and helping around the house before offering services.

Across racial and ethnic groups, parents wanted greater communication and better, more trusting relationships with their children's schools and teachers. They wanted more information about mental health, parenting, and the availability of services for their children. They also wanted the opportunity to participate in mental health trainings and workshops with teachers so that they were "all on the same page" in rearing and educating their children.

5. Educators Need Support

Educators and school staff are on the frontlines of mental health for children and youth. Yet, they may not receive the training and support to work with children with mental health needs in their classrooms. Participants emphasized the importance of building mental health literacy across school campuses by training all school staff, including bus drivers and food services workers. Communities of color wanted schools to train staff to be trauma-informed and recognize that acting out behavior can stem from exposure to stressful and adverse events that require empathy and support rather than punishment. These communities also wanted to see more training and support for gender and cultural sensitivity, competence, and humility in schools.

Stakeholders also advocated for greater attention to educator wellbeing due to high levels of stress, burnout, and attrition.

As one stakeholder said, "If educators are not well, then students are not well."

"If educators are not well, then students are not well."

6. Siloed Services Need to be Connected

A parent at a Commission public hearing in January 2017 described the system this way:

"There is definitely a lot of finger pointing of whose job it is...you go to the medical community and (they say) those are supports that the school should be providing. And you go to the school and they say we don't provide those supports. So, you just end up with medication, but no one wants to handle the support that goes with that."

Parents and other stakeholders highlighted the disconnections between school and mental health programs, services, systems and professionals – and the negative impact those disconnections have on children and families. Parents and family members feel alone and frustrated when they try to navigate systems with diffused responsibility and little or no communication or coordination across schools and mental health providers. The Commission learned through focus groups with educators and families that a variety of barriers (e.g., parental consent, referrals, transportation, appointment wait times, privacy concerns, etc.) can deter successful linkages.

A school social worker described her efforts to refer an elementary student to community mental health services because of the severity of his condition, only to face an arduous six-month process of getting services for the child and family. She felt there was an implicit distrust between the schools and county behavioral health departments, which was augmented by a lack of structure and clear process for client referrals and data sharing that resulted in long delays in children receiving treatment.

Stakeholders advocated for greater connection and collaboration between school districts and community mental health providers to provide a comprehensive array of services in school.

The Commission's inquiry revealed the imperative of building a sustainable, cross-system infrastructure, which prompted the Commission to explore the complexity of leveraging different systems and funding mechanisms to support school readiness and success – and informed the Commission's principles for advancing comprehensive school mental health in California.

These communities...wanted to see more training and support for gender and cultural sensitivity, competence, and humility in schools.

II.

THE IMPERATIVE OF PREVENTION AND EARLY INTERVENTION

Mental health needs among children are stunningly common. The science is providing increasing clarity that the early years of life and the social conditions that children grow up in are foundational to their mental wellness. For many young Californians, however, childhood is filled with trauma and toxic stress. Proactive efforts to address and respond to mental health needs can improve outcomes. The MHSA requires investments in prevention and early intervention programs, and several counties to target early childhood.[17] But a systems approach to these systemic issues is lacking in most communities.

Mental Health Needs are Common

Mental health needs are the most common and disabling medical conditions impacting children. Up to one out of every five children have a diagnosable mental health disorder.[18] Among the 9.6 million children in California, roughly 1.8 million could be in need of mental health services and supports.

Certain groups of children experience mental health needs at higher rates than the general population, including those living in low-income families, those involved with the child welfare or juvenile justice systems, and those who experience family rejection, abuse and neglect.[19,20,21]

Common mental health needs in children are attention-deficit hyperactivity disorder (ADHD), anxiety disorders, and depression.[22] These disorders often co-occur, increasing symptom severity and disease burden.[23] Mental health needs negatively impact every aspect of a child's life; changing the way they learn, behave, and manage emotion. If left unaddressed, mental health needs disrupt a child's development and ability to reach their full potential in life.[24]

One out of every five children have a diagnosable mental health disorder.

Half of all lifetime mental health needs emerge before the age 14 and three-quarters before age 24.[25] The mental health needs that have the earliest onset are impulse control and anxiety disorders, which usually begin in childhood or early adolescence.[26] Mood disorders (including depression) generally begin later, with rates rising in early adolescence and increasing in linear fashion into middle adulthood.[27]

Mental health needs in youth have increased in recent years. Emotional distress, major depression, and suicide ideation are on the rise among youth.[28] Suicide is the second leading cause of death for youth.[29]

Many children suffer without help. Approximately half to three-quarters do not receive mental health treatment or services.[30,31] For children living in low-income households with limited English proficiency, unmet mental health needs are even greater.[32]

The gap between need and care is both a major public health crisis and has serious implications for the future of California. As baby boomers age, younger generations bear a larger economic and social burden.[33] Public health experts and economists are finding common cause in the importance of all children growing up to be healthy and productive.

The Early Years and Social Conditions Are Determinants

In 1963, President John Kennedy said, "Children are the world's most valuable resources and its best hope for the future."[34] Unmet mental health needs erode that future and result in human suffering, lost human capital, and staggering economic losses.

The mental health of children is impacted by many different factors – genes and biology, as well as conditions in the family, neighborhood, social, economic, and physical environments.

The early years of development provide the foundation for mental health and wellness.[35] From birth to five, the brain develops at a rapid pace. During this time, connections are being made between brain cells and networks that provide the architecture of the brain. Ninety percent of the brain is developed by the age of 5.

Early experiences with caregivers and the environment shape the developing brain. Exposure to adverse events and toxic stress changes brain architecture and put children at risk for problems with self-regulation and learning, and later mental and physical health challenges.[36] This is primarily due to the overactivation of prolonged exposure to stress hormones.

Results from a California statewide maternal health survey suggest that many women are giving birth under stressful conditions.[37] A majority of Hispanic/Latina and African American mothers were unmarried and living in high poverty neighborhoods. One in 10 mothers were victims of intimate partner violence.[38] In addition, one in three mothers had experienced multiple hardships as children. Maternal stress heightens the risk for depression before and after birth.[39] Maternal depression can impair the mother-infant bond and be predictive of later learning and mental health needs for the child.[40]

Just as community members expressed, the conditions in which children are born, live, learn and play – known as the social determinants of health – have a direct impact on health and mental health risks and outcomes.[41] Healthy environments produce healthy children. Unhealthy environmental conditions such as poverty, food insecurity, racism and discrimination, housing instability or low-quality housing, neighborhood crime and violence, and lack of access to health care are associated with poorer health. Children living in poverty are more likely to experience multiple adverse events (witness violence, experience homelessness, etc.), which can lead to higher arousal and chronic stress accumulating over time and contributing to the development of chronic disease including mental health needs.[42]

Trauma and Toxic Stress Impact Mental Health

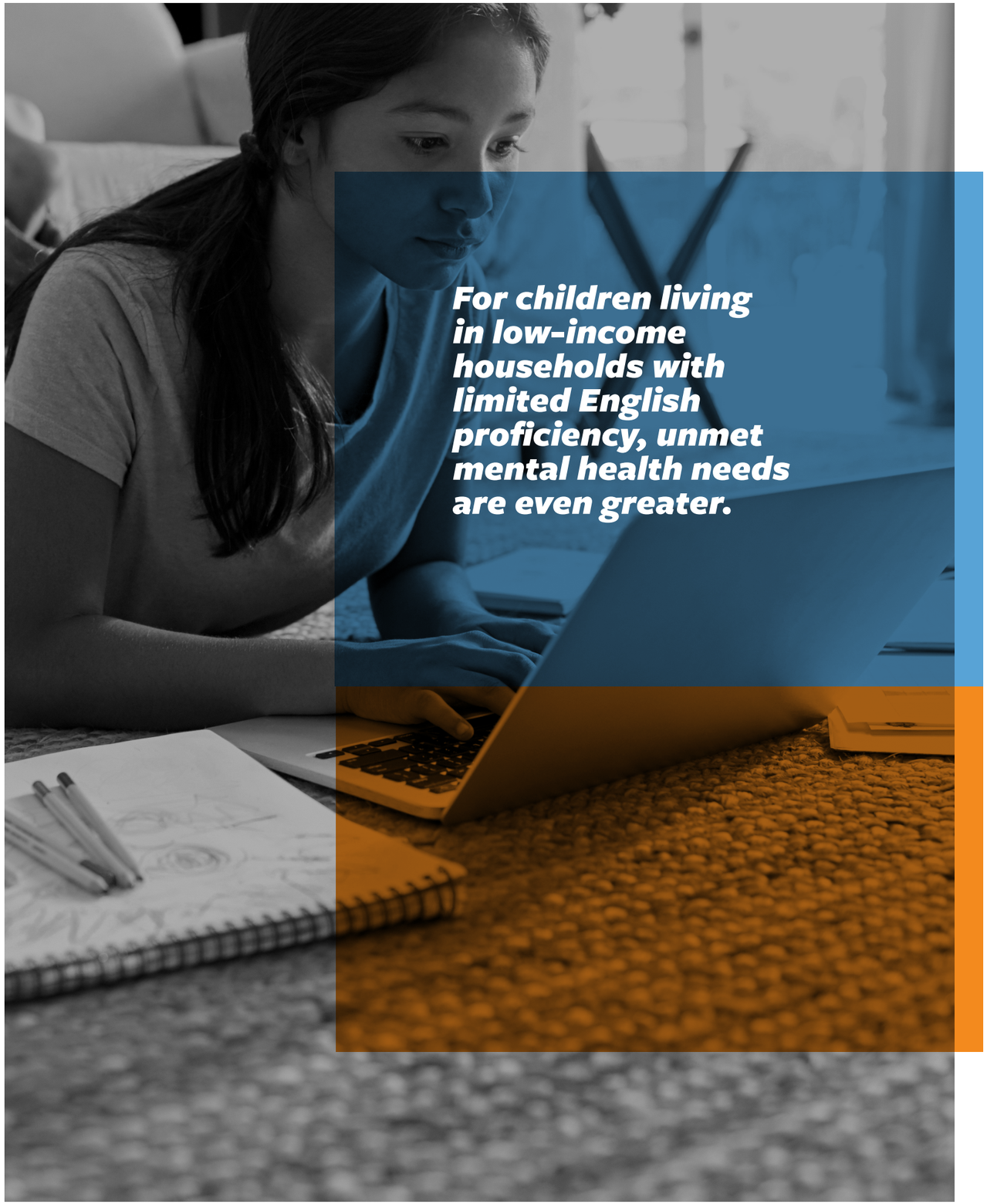
Jordan is a kindergartner who is struggling to learn and behave appropriately in the classroom. He has been inattentive, hyperactive, and acts aggressively toward others. His teacher is unable to manage or redirect his behavior and often resorts to sending him to the school office. He has recently been referred for a Special Education assessment. Since birth, Jordan has experienced multiple adverse events. His family lived in poverty and experienced housing instability. Jordan's mother suffered from postpartum depression soon after his birth, which impaired their attachment bond. By the age of 3, Jordan had been exposed to domestic violence, witnessed his father being arrested by police, and had been expelled from preschool.[43]

Some may ask, "What is wrong with Jordan? Is it ADHD, a conduct disorder, or some other developmental problem?" These questions can obscure the cause of Jordan's behavior. A different question to ask, "What has happened to Jordan?"[44]

Jordan's story illustrates the vulnerability of being exposed to adversity early in life. Science reveals that infants and young children are not built to handle chronic stress.[45] And yet, trauma –a perceived threat to self or others – is pervasive in the early years when children are most vulnerable to stress.[46] This is particularly true for those children living in low-income neighborhoods who are being exposed to high rates of family stress and community violence.[47]

Children experiencing trauma also experience a cascade of physiological responses. In the absence of safe and nurturing environments, they can get stuck in survival-based responses, including fight, flight, and freeze. Psychological responses and coping behaviors to trauma can be misunderstood by adults, parents, and teachers, and at times elicit punishment. These behaviors include ADHD-type behavior, hyper-arousal, anxiety, avoidance, dissociation, and numbing.

Sadly, trauma teaches children powerful lifelong lessons about themselves and the world – that the world is unsafe, other people cannot be trusted, and that they are



unlovable.[48] Lessons rooted in trauma disturb the internal world of children and their ability to regulate emotions, control their behavior, and feel safe in their own bodies.[49] Thus, Jordan was unable to learn or thrive in a classroom setting until his basic needs for safety and security could be addressed.

Without early screening and appropriate intervention, many children who have been exposed to trauma will not be prepared to meet the expectations of formal schooling and kindergarten.[50,51] They may begin school with few school readiness skills, which will decrease their likelihood of later school success.

Proactive Efforts Can Improve Outcomes

Mental health prevention and promotion can reduce risk and build protective factors to improve mental health and educational outcomes. Figure 1 identifies strategies and programs for supporting healthy development from birth to young adulthood.[52] Since the early years are foundational for mental health and school readiness, investments to increase access to prenatal care, home visitation programs, and early childhood interventions such as parenting and social-emotional learning programs can yield substantial economic and societal benefits.[53]

Community prevention efforts can build protective factors – attributes that are external (such as safety, family support, positive adult role models and healthy school climate) and internal to the child such as social-emotional competence, self-esteem, and achievement motivation. Strengthening families is foundational in building protective factors in children.[54] Increasing parental resilience, social connectedness, support, and knowledge of good parenting practices can reduce the likelihood of abuse and neglect and buffer the effects of adversity and trauma.[55]

Prevention and Early Intervention from Prenatal Development to Young Adulthood

Prenatal	Infancy	Early Childhood	Childhood	Early Adolescence	Adolescence	Young Adulthood
Foundation for mental health and school readiness						
Prenatal care						
Home visitation programs						
Early childhood intervention/SEL						
School climate & mental health literacy						
← Enhancing family strengths and parenting support →						
← Developmental/BH Screening →						
Local planning and coordination						
Training, technical assistance, data & policy						

Figure 1. A local whole child agenda should coordinate interventions at each developmental stage. Adapted from *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities* (2009) by the National Academy of Sciences, Washington, DC.

The Primary School: An Innovative Model for Beginning Early & Integrating Services[56]

The Primary School expands the boundaries of traditional education to include health care and family support in an integrated, service delivery model. Located in East Palo Alto, the school enrolls families at or before birth and commits to providing services and supports that engage high-need families and support healthy child development as the foundation for school achievement and success in life. Key features of the school include:

- Coordination across caring adults and systems. The school partners with health care providers to coordinate timely pediatric exams and developmental screenings to ensure that children are healthy and able to successfully participate in school.
- Children begin formal schooling at age 3 and are provided with a seamless educational experience from preschool to middle school.
- Families are engaged as partners and supported through group-based coaching to expand their social network and help them achieve personal goals.

The Primary School is creating a new and replicable system of care for serving California's children and families.

MHSA Requires Prevention and Early Intervention Investments

The Mental Health Services Act provides dedicated funding for prevention and early intervention (PEI) programs in county mental health systems to promote mental health and reduce the risk of individuals developing serious mental health needs.[57] Approximately 20 percent of MHSA revenues received by counties must be spent on PEI strategies. Approximately $350 million to $400 million dollars are available for PEI each year; 51 percent of these funds to be used to serve individuals from birth to 25 year of age.

The intention of the PEI component is to move the mental health system toward a "help first" rather than a "fail first" system. PEI strategies can target a range of activities and services from reducing risk and building protective factors (prevention) to enhancing outcomes and recovery early in the course of mental illness (early intervention), or a combination of the two. These efforts are most often successful when partnerships are linked across systems including education, mental health, social services and criminal justice, which is encouraged by the requirement that county PEI programs engage with underserved communities and work to reduce stigma.

The act directs PEI strategies to address the negative outcomes associated with untreated mental health needs, including school failure. From a strengths-based perspective, PEI funds can be used to support and enhance school success. School success can be defined many ways and includes learning, student achievement, school engagement, and eventually graduation from high school and college, to name a few. However, the proverbial saying that "school success begins at home" provides context for understanding the student experience. A student's success is embedded in loving and supportive families, and safe, healthy schools and communities.

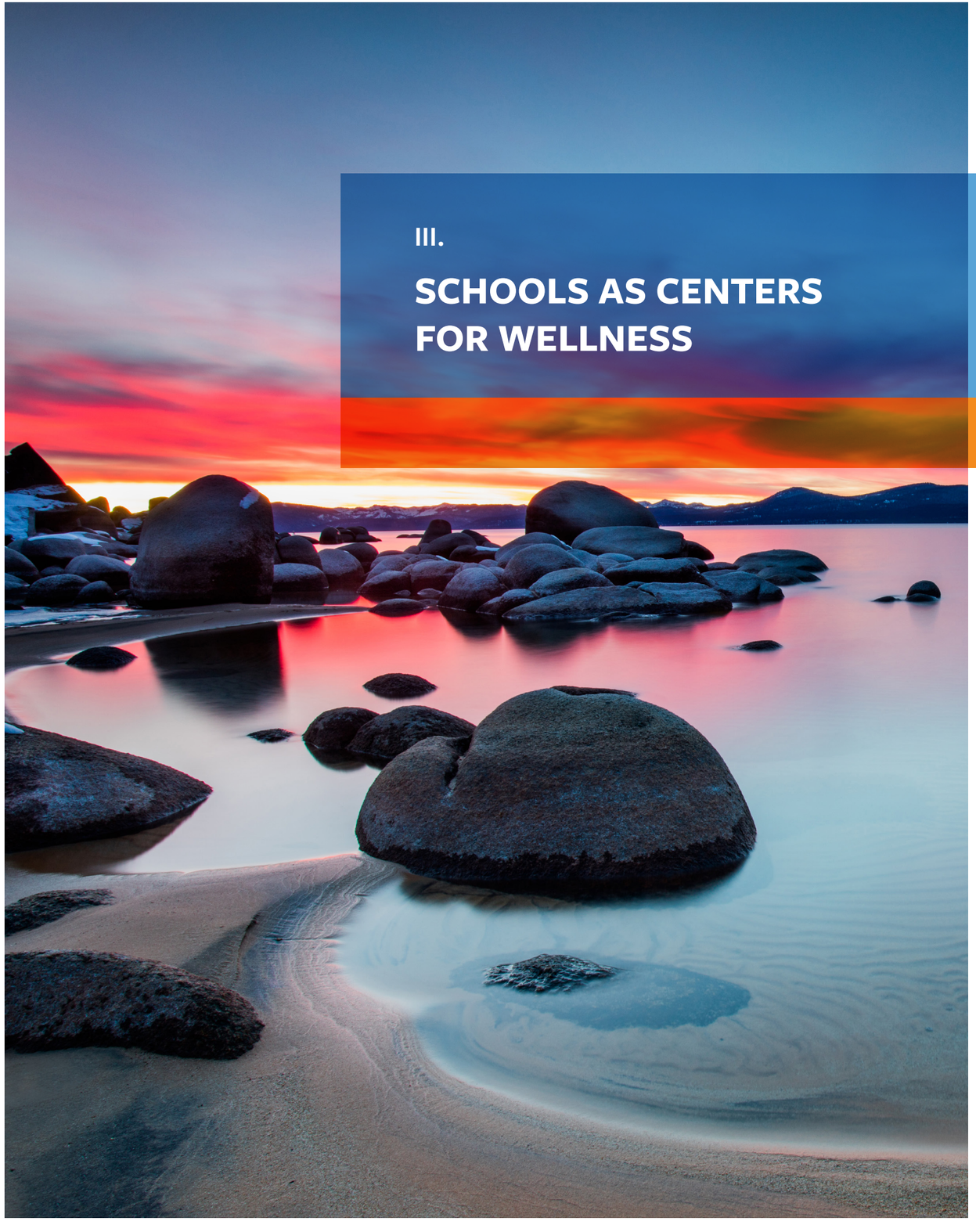
The research literature suggests that a child's readiness for kindergarten plays an important role in later school success.[58] Thus, efforts to bolster school success can begin as early as infancy and include parents, families, and educators in different community settings. Some county MHSA programs address the early building blocks of school success (See Appendix A). These programs strengthen early relationships, build social and emotional competence in young children, and include developmental screenings, including screening for trauma, social and emotional functioning.

But a Broad, Systems Approach is Lacking

While counties use MHSA to fund programs for young children and their families, most programs do not focus on children younger than 8-years-old or address early trauma as a precursor to mental illness. In addition, programs that are focused on specific ages or circumstances usually operate as independent "add-ons" and may only reach a small number of individuals.

Stakeholders said too often county PEI programs are tied to Medi-Cal, which requires a mental health diagnosis for the provision of services. These stakeholders felt that using PEI dollars as the Medi-Cal match was a "fail first" approach – not in the spirit of PEI, of addressing problems early so that a child does need a diagnosis or continuation of traditional mental health services.

Generally speaking, most counties do not have a strategic plan for enhancing school success and student mental wellness through prevention and early intervention beginning at birth. Many different agencies and organizations serve families with young children and students with little coordination of services and/or leveraging of resources across various service systems. Some county First 5 commissions and school districts report being unaware of or left out of the community planning process required in the development of MHSA programs. These entities would like to see more robust community engagement and a stronger commitment to assessing the needs of young children and families.



III.

SCHOOLS AS CENTERS FOR WELLNESS

Schools are essential partners in supporting the mental health and wellness of children and youth, and several partnerships are working across systems to meet the diverse needs of California's students to improve outcomes through comprehensive school mental health.

Children cannot grow, learn, and thrive if they are unable to pay attention and self-regulate due to a mental health condition. Thus, improving school performance must also focus on supporting student mental, emotional and behavioral health.

Schools also are central to family and community life and can increase access to mental health services and reduce stigma. Children spend almost one-third of their lives at school (approximately 180 days a year). And by extension, parents and younger siblings also are connected to the schools, allowing practitioners to provide additional education and referrals.

Schools are often termed the de facto mental health provider,[59] although many students with mental health needs do not receive services. Those who do receive mental health services typically receive them in schools rather than community clinics and offices. Schools can be the first line of defense in identifying and addressing mental health needs before they become severe and disabling.

To address the needs, and especially the disparities, California educators are cultivating a positive school climate and incorporating social emotional learning into curricula.[60,61,62] School-community partnerships are forming, and strong models are emerging. Experience is proving to be a good teacher in how to work better together – and one lesson is empowering youth to help them address their needs and increase resiliency.

California Students Have Disparate Experiences and Outcomes

California has 6.2 million students enrolled in K-12 schools. California's students are among the most diverse in the country.[63] Approximately 51 percent of students are Latino/Latinx, 27 percent are white, 11 percent are Asian American, and 5 percent are African American.[64]

Based on national and state prevalence rates, between 620,000 and 1,240,000 students are estimated to have a mental health condition. Surveys of California high school students paint a sobering picture of student disconnection, victimization and mental health symptomology:

- Only 48 percent of high school students feel connected to their school. Approximately 1 in 3 feel chronically sad and hopeless.
- One in five report being harassed or bullied.
- Approximately 1 in 3 feel chronically sad and hopeless.
- Almost 1 in 5 have seriously considered suicide in the past year.[65]

Certain groups of students are at higher risk. LGBTQ students experience alarmingly high rates of bullying, harassment, and victimization and as a result report feeling less safe at school than their non-LGBTQ peers.[66] Between 50 to 70 percent of LGBTQ students in California report experiencing verbal harassment and bullying.[67] LBGTQ students in California are also two times more likely to report depression symptomology (i.e., chronic sadness) and three times more likely to report suicidal ideation than non-LGBTQ peers.[68]

Other student groups such as Muslim students experience victimization at school that can have a negative impact on their wellbeing.[69] Muslim students can experience offensive remarks and discrimination at school due to their religion and are two times more likely to be bullied than their non-Muslim peers.[70]

The vast majority of students will not receive the services and supports they need.[71] Unmet trauma and mental health needs are strongly associated with barriers to learning such as disengagement, chronic absenteeism, suspension and expulsion (and by extension, the school-to- prison pipeline), and school dropout.[72,73,74]

More than 75 percent of school principals in California indicate that students' emotional and mental health were a moderate or severe problem at their school.[75] Furthermore, two-thirds of teachers report they are unequipped to address their students' mental health needs.[76]

California school climate data show disparities in student outcomes that may be associated with unmet mental health needs:

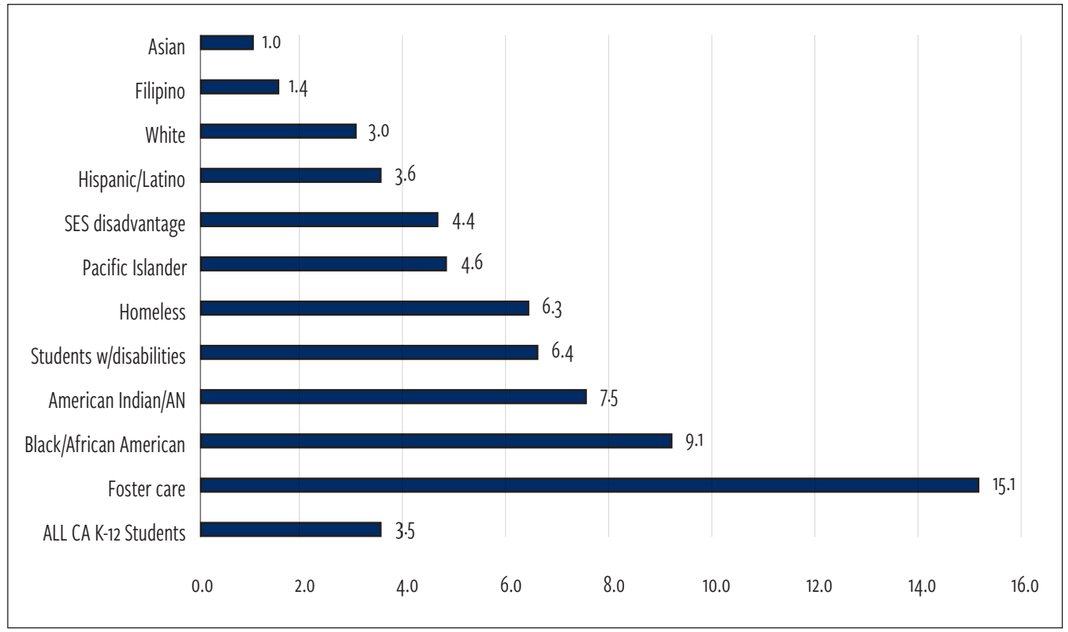
1. Disparities in Chronic Absenteeism

- African American, Native American, and Pacific Islander students are more than twice as likely to be chronically absent (missing greater than 10 percent of school days during the academic year) than their white peers.[77]
- Approximately 1 in 5 African American, Native American, and Pacific Islander students are chronically absent, compared to 1 in 10 white students.[78]
- Chronic absenteeism is highest among students in foster care (28 percent) and students who are homeless (25 percent).[79] Within these student groups, disparities exist. Among students who are homeless, 42 percent of African American students and 40 percent of Native American students miss more than 10 percent of academic instruction during the school year, compared to 29 percent of white students.[80]

2. Disparities in Suspension and Expulsion

- Students in foster care, African American students, and Native American students, are more likely to be suspended or expelled than other groups of students.[81]
- The highest disparities exist for African American boys K-3, who are 5.6 times more likely to be suspended or expelled than the statewide average.[82]
- African American males in the foster care system are more likely to be suspended than all other groups of students: 27 percent of African American male students in the foster care system were suspended.[83]
- The highest rates of suspension for African American students classified as foster youth occurred in middle school. Forty-one percent of African American males in grades 7 and 8 and in the foster care system were suspended.[84]

Figure 1. California 2018-19 Suspension Rates by Student Group



The figure above provides suspension rates for different groups of students.[85] Students in the foster care system are almost five times more likely to be suspended than the statewide average.[86] The most common reasons for suspension – violent incident (no injury) and willful defiance – suggest that these students may be targets of implicit bias and/or experience challenges with interpreting the intention of others, communication, resolving conflict, and self-regulation (all of which are common among children who have experienced trauma).[87,88,89,90]

In 2015-16, 2,525 California students were arrested and 24,897 were referrals to police.[91] African American students were four times more likely to be arrested at school than white students.[92] An analysis of school incident reports between 2011 and 2019 in the Los Angeles County Unified School District showed a precipitous rise in counseling-related incidents (e.g., suicidal behavior) for whom the best responders would be school mental health personnel rather than school police.[93]

School-based mental health services can enhance school response to crises and reduce disciplinary measures.[94]

School-based mental health services can improve school absences and reduce disciplinary measures.

Spotlight on Oakland, California and Racial-Ethnic Disparities

"This data represents real children in our communities – children impacted by poverty, racism, isolation, violence and lack of opportunity and access to quality preschool education and other critical health, mental health and human services" – Curtiss Sarikey, Chief of Staff, Oakland Unified School District.[95]

- 29 percent of African American and Latinx boys are kindergarten ready, compared to 82 percent of non-Latinx, white boys.
- 11 percent of African American boys and 13 percent of Latinx boys are reading proficiently by the end of 3rd grade, compared to 65 percent non-Latinx, white boys.
- African American students are 6.8 times more likely to be identified as emotionally disturbed than non-Latinx, white students.
- More than half of African American 5th grade students have had friends or family members die by violence.[96]

Solutions in the Oakland Unified School District included implementation of:

- **Full-Service Community Schools** to create a cradle-to-career approach to educating and developing the whole child to close achievement and opportunity gaps. These efforts aligned around partnerships around a common agenda and goals, strong family-school partnerships, and developing networks of support based on the local needs.
- **Social and Emotional Learning (SEL) standards** for Pre-K through adult. SEL provides the foundation for prevention – addressing issues of implicit bias and creating trauma/healing-informed environments.

Addressing Mental Health Can Enhance Learning and Wellness

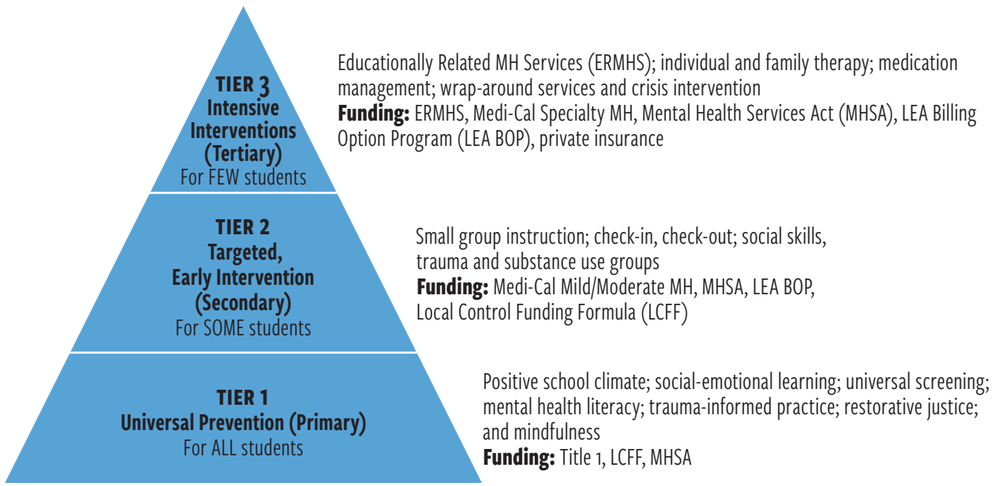
Many terms are used to describe the provision of mental health services in schools – school mental health, school-based mental health services, and the expanded school mental health framework. These terms refer to school and staff efforts to respond to nonacademic barriers to learning, including social, emotional, and behavioral challenges. Recently, the term comprehensive school mental health has been used to emphasize the importance of providing a full array of mental health services to students based on their strengths, needs, and developmental status.[97] School mental health systems based on a multi-tiered system of supports (MTSS) model provide a continuum of services and supports across tiers of intervention:

- **Tier 1:** Universal, prevention services for all students to promote wellness and a healthy school climate.
- **Tier 2:** Targeted (selective) services for some children at risk and/or showing signs and symptoms of developing mental health needs; and
- **Tier 3: I**ntensive (indicative) services for few students with greater mental health needs.[98]

Like MTSS, Positive Behavioral Interventions and Supports (PBIS) and the Integrated Systems Framework (ISF) are multi-tiered frameworks used to deliver a continuum of services and supports in schools that support student behavior and academic outcomes. PBIS is a proactive approach for supporting healthy and appropriate student behavior and establishing a positive school climate.[99] PBIS is structured to meet individual student needs, using evidence-based approaches at each of the three tiers of services and supports. PBIS operates in over 3,000 California schools and is an evidence-based approach to reducing the use of punitive school discipline.[100,101] ISF builds upon PBIS, integrating it into a multi-tiered system of support that includes school mental health, community mental health, and families.[102]

Research clearly links the provision of school mental health services to many positive school and student outcomes. School mental health is associated with improved academic performance, increased school engagement, reduction in disciplinary measures, decreased need for Special Education, and increased graduation rates.[103,104,105]

Within a multi-tiered system of support, between 15 and 20 percent of students are estimated to need support beyond Tier I, universal interventions. However, as stakeholders noted, the MTSS pyramid is often "inverted" in disadvantaged communities. This results in



Social-emotional learning "is the process through which children and adults understand and manage emotions, set and achieve positive goals, feel and show empathy for others, establish and maintain positive relationships, and make responsible decisions."

school staff feeling overwhelmed by "crisis management" and the large number of students who need more intensive interventions beyond Tier I. Some stakeholders expressed concern that Tier I interventions were not fully established. Thus, schools responded to student needs when problems became "acute and recognizable."

Strengthening and coordinating an array of Tier I universal evidence-based programs is critically important to the wellbeing of students and foundational to a comprehensive school mental health system. It is also in line with what stakeholders, including parents and caregivers, want more of in schools – prevention and early intervention activities. These activities require ongoing training and support for school staff who are on the front lines of student mental health and should be tailored to the age and developmental status of students.

Advancing Tier 1:
Universal Prevention for All Students

A Positive School Climate is Essential

In addition to academic curriculum, schools can support healthy development by providing safe, supportive spaces for children to grow, learn and thrive. A positive school climate is a major factor in student experiences and success.[106] School climate is multifaceted and includes the physical conditions of buildings and classrooms; the social conditions, such as the quality of relationships and equitable and fair treatment; and, academic conditions, such as too much pressure and homework.[107] These conditions represent the quality and character of school life and influence the feelings the schools invoke, such as whether students feel safe, supported, and connected.[108]

Four aspects of school climate are associated with mental health and wellbeing: 1) positive social connections and relationships; 2) school safety; 3) school connectedness; and, 4) academic environment.[109] Students who feel that their schools have these characteristics report better psychosocial wellbeing, more positive and pro-social behaviors, fewer mental health issues, and fewer delinquent or risk behaviors.[110,111]

A positive school climate benefits all students, especially those at risk.[112]

Trauma-informed or "trauma-sensitive" schools recognize that many children have had traumatic experiences – a universal theme expressed during the community outreach efforts for this project. Trauma-sensitive schools help children feel safe – in the classroom, hallways, cafeteria, playground and on the school bus – so that they can learn.[113]

Core features include a holistic approach to student learning, creating positive relationships with teachers and peers, connecting students to the school community (rather than pulling them out of class and away from others), and staff working together and assuming shared responsibility for all students.[114]

A positive school climate benefits all students, especially those at risk.

LGBTQ and Gender Inclusive Schools

"Trauma, shame, and rejection in children are the trajectory into mental health needs and suicide ideation in transgender and non-binary youth. It starts young" (LGBTQ leader, September 7, 2018 Education Forum). Transgender and gender diverse youth face more hostile school climates and are 3 to 10 times more likely to be diagnosed with a mental health need.[115] As part of comprehensive school mental health, school environments should be healthy, safe, and affirming and inclusive, and include:[116,117]

- Curriculum that explores human diversity.
- Education and training for parents and educators in LGBTQ cultural competency and how to support LGBTQ children and youth.
- Engaging LGBTQ students and their families in school mental health policy and planning.
- Policies that explicitly protect students from bullying, harassment, and discrimination on the basis of sexual orientation, gender identity or gender expression.
- Strengthening student-led clubs such as the Gay-Straight Alliance and provide adult support.
- School compliance with AB 1266 requiring students "be permitted to participate in sex-segregated school programs, activities, and use facilities consistent with their gender identity."[118]

Social and Emotional Skills are Among the New Basics

Schools can also promote healthy development and positive mental health among students, especially those impacted by trauma, by fostering social and emotional learning (SEL). According to the Collaborative for Academic, Social, and Emotional Learning (CASEL), social-emotional learning "is the process through which children and adults understand and manage emotions, set and achieve positive goals, feel and show empathy for others, establish and maintain positive relationships, and make responsible decisions."[119]

Five Core Competencies of Social and Emotional Learning and Acquired Skills[123]

Social and Emotional Competencies	Skills
Self-awareness	Recognizing feelings, self-confidence and self-efficacy
Self-regulation	Regulating emotions, thoughts, and behaviors; controlling impulses, working towards goals
Social awareness	Understanding different perspectives, empathy, respect for others
Relationship skills	Communicating effectively, establishing and maintaining relationships with others
Responsible decision-making	Problem-solving, understanding the consequences of actions

The positive benefits of SEL programs are well documented. Children who experience SEL programs have higher school achievement, better coping skills and resiliency, and fewer conduct problems. SEL programming also has reduced the school readiness gap and increased academic success for children from disadvantaged backgrounds.[120]

SEL programs have a positive return on investments. On average, every $1 spent on SEL programming produces an economic return of $11.[121] Providing children with early social and emotional skills is linked with positive adult outcomes, as well, including educational attainment, employment, civic engagement, positive mental health, and healthy relationships later in life.[122]

Educator Wellness is Integral to Student Wellness

In addressing student mental health and wellness, policies and programming should attend to the wellbeing of adults in a child's life. Parents, caregivers, educators, and other adults provide proximal contexts for children's development.[124] Adult who struggle with stress, past/present trauma, and mental health and substance abuse concerns are less able to provide safe, consistent, and loving environments for the children.[125]

Teachers and school staff are on the frontlines of student mental health. They are not immune to the stress and trauma in the lives of their students. Data on adverse childhood events (ACEs) suggest that educators are exposed to many children who have experienced trauma, and that puts them at risk.[126]

High levels of stress and burnout are common in the teaching profession,[127] which coupled with large numbers of students with trauma suggests the importance of better understanding the mental health needs of educators. For teachers and staff in low-income schools – who are less likely than their counterparts in high-income schools to be mentored and supported (known as the "support gap") – stress and burnout may be especially common and complicated by compassion fatigue and secondary trauma.[128]

Trauma-informed programs can address both teacher wellbeing and the classroom/school environment. A core feature of trauma-informed schools is to combat burnout, compassion fatigue, and secondary trauma by helping teachers create greater self-awareness around physical, emotional, and cognitive reactions in the classroom.[129]

More than 100 MHSA PEI programs provide student mental health and wellness services.

Wellness Challenges Confronting Educators

Burnout – Chronic stress that arises when workers feel exhausted, dissatisfied, powerless and/or overwhelmed at work. (Burnout has many causes and is not necessarily trauma related.)

Compassion Fatigue – Profound stress and exhaustion that arises from caregiving and repeatedly hearing/witnessing trauma and suffering, which leads to an inability to care or feel empathy for others ("having nothing left to give").

Secondary Traumatic Stress – The development of PTSD-like symptoms as a result of working with or being close to people experiencing trauma and suffering. STS is also known as vicarious trauma and represents the fundamental changes in a person's worldview and sense of self as a result of working with traumatized individuals.

The above concepts often overlap. For example, unaddressed secondary traumatic stress can lead to compassion fatigue.

An MHSA PEI program in Orange County provides teachers with stress management and mindfulness training.[130] The training is part of the Resilient Mindful Learner Project at the Orange County Department of Education. K-12 teachers learn how to manage classroom stress and develop resiliency. Through the training, teachers:

- Learn about the biology of trauma and toxic stress, and its impact on student behavior and learning.
- Develop self-awareness around their own sources and levels of stress, and learn how to manage stress in healthier ways.
- Learn to recognize the signs of stress in their students and implement self-regulation strategies, such as mindfulness into the day-to-day classroom environment.

To successfully implement and sustain these practices, teachers receive in-class coaching and support from an ongoing learning/training cohort. Preliminary evaluation of the program suggests that after the training, teachers have a greater sense of competence and use less disciplinary means in their classroom.[131]

MHSA Funds are Supporting Prevention and Early Intervention in Schools

More than 100 MHSA PEI programs provide student mental health and wellness services.[132] Many of these programs support school-based interventions, including:

- Social-emotional learning and resilience building
- Positive Behavior Intervention Strategies (PBIS)
- Bullying and violence prevention

Some counties – including El Dorado, Los Angeles, and Monterey – use PEI funds to provide professional and paraprofessional mental health staff on school campuses. A smaller number of counties have blended PEI and other funds to build continuums of care within schools. For example, the San Francisco Department of Public Health-Behavioral Health Services collaborated with community-based organizations and San Francisco Unified School District to establish Wellness Centers.

Schools serve as hubs for a range of services and supports to students who have difficulties in school due to trauma, immigration stress, poverty, and family dysfunction. Services are prevention and/or resiliency-focused and are provided during and after school hours. Mental health consultation is also provided for teachers, administrators, and staff, particularly those who are experiencing challenges with student behavior and emerging mental health needs.

An Opportunity: County behavioral health departments can address school failure, which is one of the negative outcomes in the MHSA, by aligning PEI plans with a school district's local control and accountability plan (LCAP) to improve student outcomes.

Tier 2: Targeted Early Intervention for At-Risk Students

Targeted early intervention (Tier 2) is critical in preventing mental health needs from becoming chronic and severe and requiring more intensive services. Tier 2 services and supports are designed for students who are at risk, or who may be exhibiting problem behaviors, mild distress or functional impairment and require more focused interventions than provided at Tier 1. Students are identified through screening, assessment, referral, or other teaming processes; and interventions are matched to individual student needs and generally geared toward skill development and/or building protective factors. Evidence-based interventions may include brief, individualized interventions (e.g., motivational interviewing) small group instruction, support groups, mentoring, or classroom-based supports such as daily check-ins with a teacher.

Tier 3: Intensive Intervention for Students with More Serious Needs

Students who have emotional and behavioral challenges or a mental health diagnosis may require more individualized, intensive services and supports (Tier 3). These interventions are tailored to the unique needs of student through an individualized plan of treatment that is implemented and monitored by a team of educators and mental health professionals in collaboration with parents and caregivers. Supports at Tier 3 may include individual, family, or group therapy, wrap-around service planning, and case management.

Mental Health Professionals Working Together is Essential

Mental health professionals from different disciplines need to collaborate in schools and with community agencies to meet the needs of students and families.

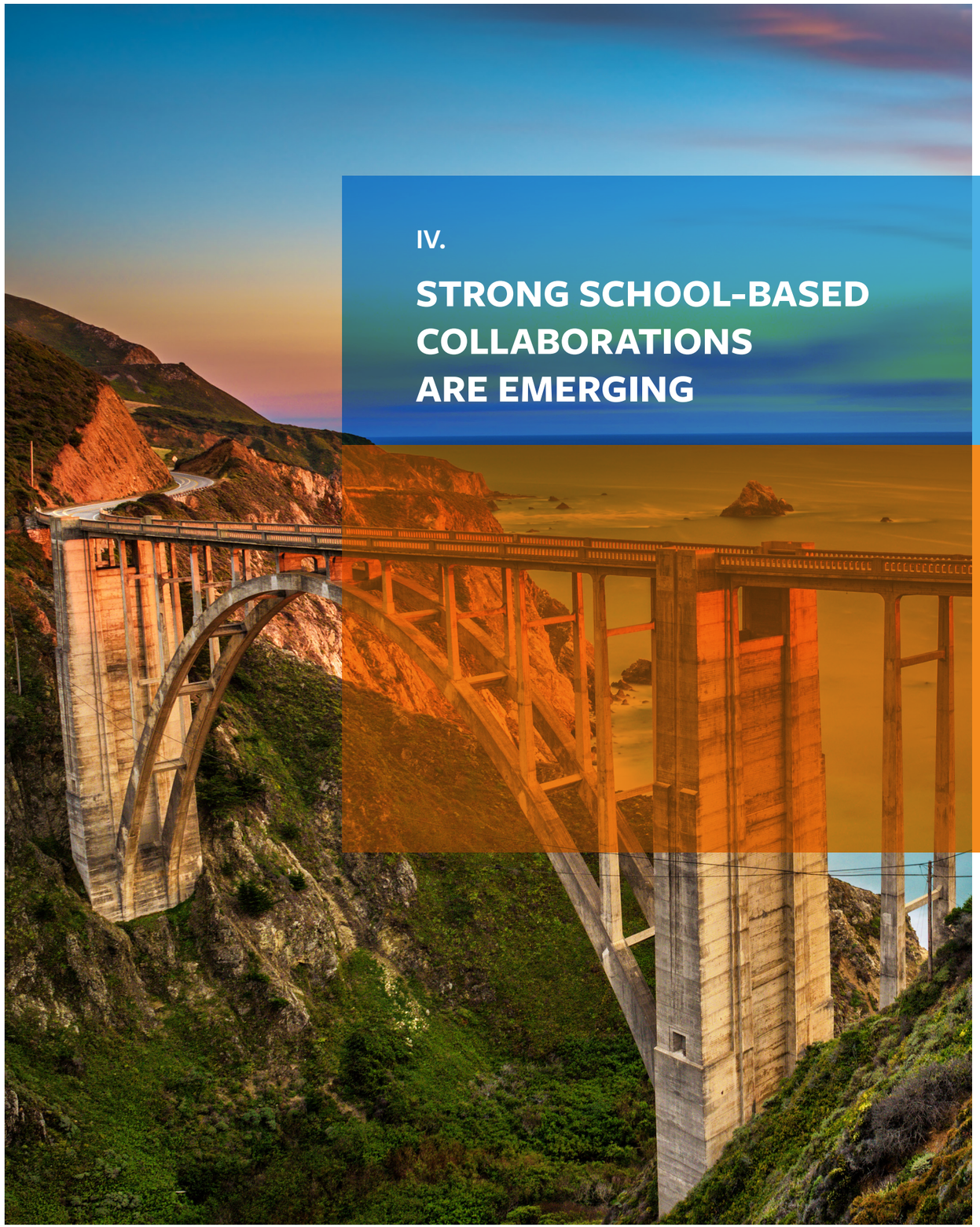
Schools-based mental health professionals (also known as specialized instructional support personnel) include school counselors, school psychologists, school social workers, and school nurses. These professionals bring specific skills to help students overcome barriers to learning.

In 2018-19, California employed 10,426 school counselors, 6,329 school psychologists, 885 school social workers, and 2,720 school nurses.

These numbers are well below what would be required to meet the recommended ratio of 1 school-based mental health professional for every 250-500 students. On average, California's K-12 schools have one counselor for every 626 students, one school psychologist for every 1,041 students, and one school social worker for every 7,308 students.

Given school budget constraints and professional shortages, integration of the school system with community-based mental health services and supports is vital. Community-based mental health professionals play an important role in delivering school mental health services in coordination with their school-based counterparts.

In addition to academic curriculum, schools can support healthy development by providing safe, supportive spaces for children to grow, learn and thrive.



IV.

STRONG SCHOOL-BASED COLLABORATIONS ARE EMERGING

Across California, schools and local agencies are responding to student mental health needs in creative and innovative ways through partnership and collaboration. Communities are breaking down traditionally siloed systems to build comprehensive and integrated responses. Leadership is emerging from county offices of education, behavioral health departments, and community-based organizations working in close collaboration with other community partners.

At the state level, the California Department of Education has led through Project Cal-Well and the guidance of the Student Mental Health Policy Workgroup.[133] A list of models and partnerships are provided in Appendix B.

Continuum of Collaboration[136]

Communication	Cooperation	Coordination	Coalition	Integration

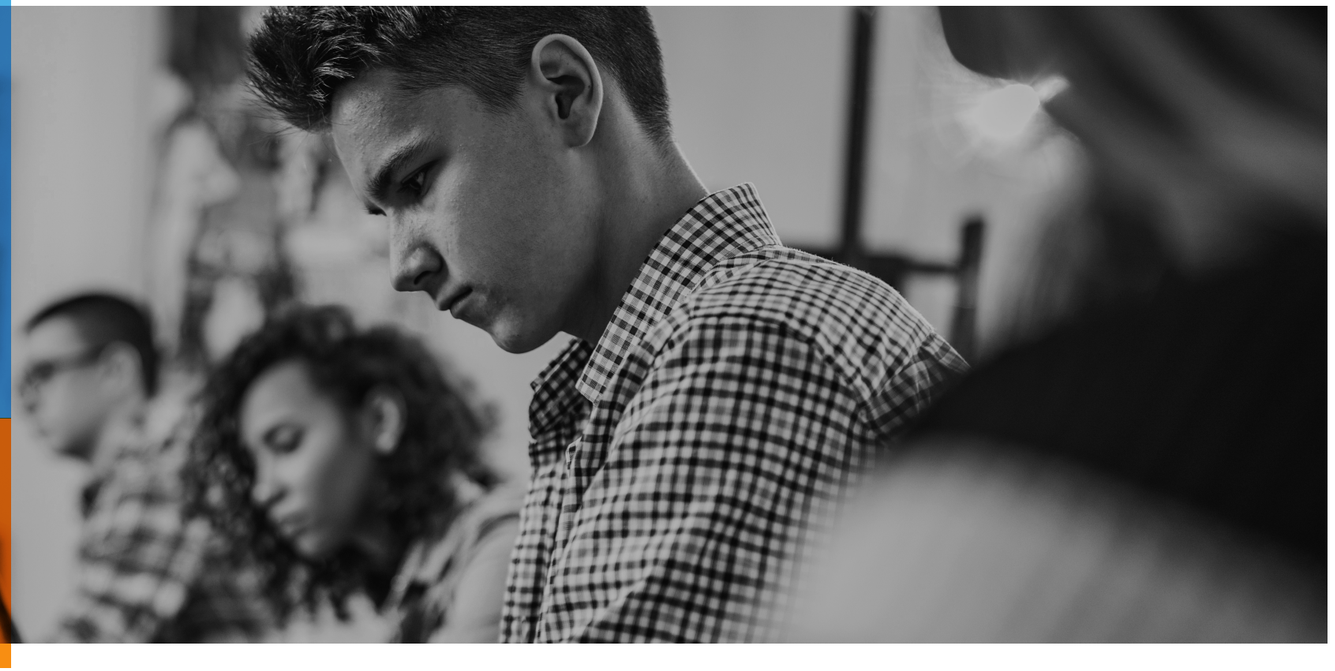
Low Level Collaboration	→	High Level Collaboration
Limited or no formal agreement		Formal agreements
Work toward different goals and outcomes		Work toward shared goals and outcomes
Agencies remain in control of resources and funding		Agencies share responsibility for resources and funding
Staff managed by agency		Staff managed by partnership
Decision making by agency		Joint decision-making
Affiliation to agency		Affiliation to partnership
Accountable to agency		Accountable to partnership
Agency-Focused	→	**Collaboration-Focused**

Key Elements of Mental Health Collaboratives

Collaboration between school and community partners is required to identify needs, align resources, and implement services and support. These partnerships range from modest relationships where schools and community agencies communicate and cooperate to more sophisticated collaborations with integration of services and supports through formal agreements, shared goals and joint decision-making.[134] According to the National Center for School Mental Health, best practices in comprehensive school mental health include:

- Strong and effective partnerships between schools, families, and community agencies based on shared vision and goals.
- Needs assessment and resource mapping to identify school and community needs and resource availability.
- Strong and effective implementation and alignment of universal interventions, including a healthy school climate and culture.
- Integrated, multi-disciplinary teams at all administrative levels to implement and monitor services and supports.
- Data-driven, quality improvement practices.
- Educator and staff wellness, support, and professional development.
- Sustainability of services through blending and braiding multiple funding streams.[135]

Collaborations involve considerable administrative time, planning, and creativity to make programs/services sustainable long after grants have ended.



Lessons Learned: Patience and Persistence are Essential

Collaborative partnership models are designed to respond to the unique needs of students and families in their community, as there is no "one size fits all" approach. Educators and mental health providers shared with the Commission the lessons learned in forging partnerships and building collaborative processes across systems. The following provides a brief summary of identified challenges and opportunities.

Partners noted that collaboratives can be especially challenging to build and sustain since each entity has different missions and goals, organizational structures, professional cultures, confidentiality and dating sharing regulations and funding mechanisms. State legislation has inadvertently made it difficult to break down silos by specifying which students are eligible for mental health services and how those services are delivered. For example, Assembly Bill (AB) 114 transferred responsibility for educationally related mental health services (ERMHS) from county behavioral health departments back to schools.[137] Under AB 114, school districts are responsible for providing mental health services only to those students with Individualized Education Programs (IEPs) who have mental health challenges that impair their learning and ability to access school curriculum.

...California lacks enough mental health professionals employed in school settings to provide a comprehensive range of services and supports.

In addition, California lacks enough mental health professionals employed in school settings to provide a comprehensive range of services and supports. California lags behind many other states in the ratio of mental health professionals to students.[138,139,140,141]

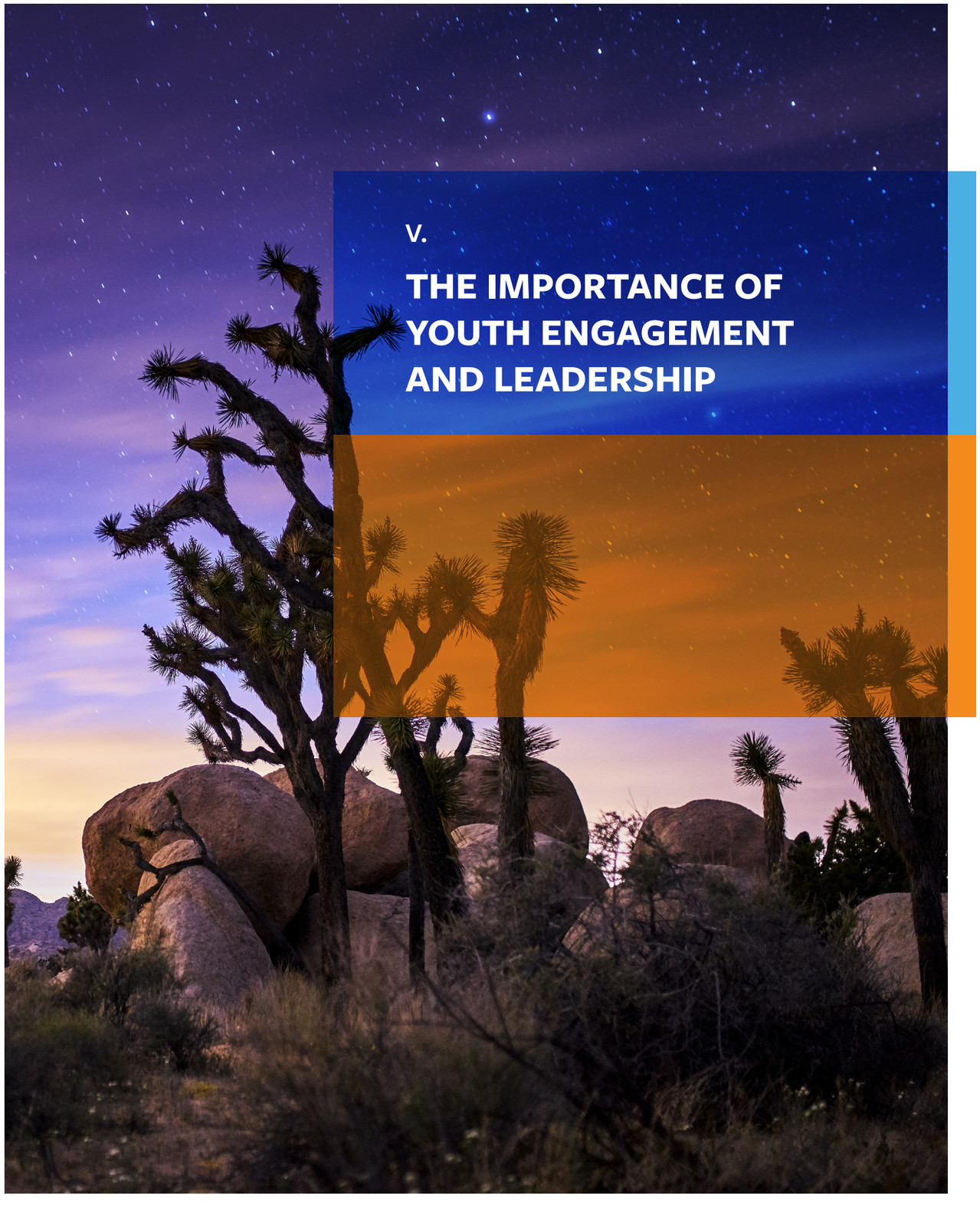
Community partners have learned many lessons. First and foremost, integration is hard work. As Kasey Rodenbush, behavioral health services manager at Monterey County, said: "Patience and persistence are essential. Mental health integration demands a shift in how system cultures work together, which takes time and commitment." All stakeholders, she said, must be at the table to identify the needs of students in the community, develop a plan, and carefully implement.

Second, bridging different professional cultures and languages requires interdisciplinary training so that all partners speak the same language and have a common set of goals.

Third, data must guide planning and decision-making at all levels of the governance structure –county, school districts and schools.

Fourth, schools must have a strong foundation of Tier I universal services and supports for all students to build upon. Universal services and supports are critical for establishing the positive school culture and social and emotional learning that forms the basis for comprehensive school mental health.

Lastly, schools and counties need technical assistance to align resources and maximize service delivery. Often, services and supports are in place, but are not efficiently coordinated.



V.
THE IMPORTANCE OF YOUTH ENGAGEMENT AND LEADERSHIP

Youth-driven movements to support youth mental health and wellness are rising across California and the nation. California's youth leaders are stepping up to educate their peers about mental health in schools, shape school-community mental health programs, and create accountability for youth-driven mental health systems. These movements are bringing young people together to be advocates for greater mental health awareness and to become leaders in designing services in their schools and communities. Youth involvement in mental health programming leads to better quality services that are responsive to the needs of youth.[142,143] Since stigma is a primary barrier to youth seeking mental health services or helping a friend in crisis, youth can play an important role in reducing stigma among their peers through outreach and engagement, education and support.[144]

...across California, youth leaders are countering stigma and creating safe space for youth to open up, share their stories, and get connected to services.

On school campuses across California, youth leaders are countering stigma and creating safe spaces for youth to open up, share their stories, and get connected to services. The National Alliance of Mental Illness (NAMI) Campus High School (NCHS) Clubs are one example of a mechanism to support youth leadership and advocacy within schools and communities.[145] Some 70 student-led NCHS clubs in partnership with local NAMI Affiliates in California are promoting mental health awareness, learning ways to support friends or family members with mental illness, educating the school community about mental wellness, and supporting and connecting students to services.[146]

The California Health Occupations Students of America (Cal-HOSA): Future Health Professionals is another student-led effort to address mental health on school campuses, often partnering with NAMI clubs. Cal-HOSA chapters are comprised of students interested in the health and mental health professions; more than 200 middle and high schools in California have chapters.[147] Cal-HOSA has implemented the Mental Health Prevention and Early Intervention Consortium in schools to increase awareness of the risk factors associated with mental health needs, early detection, and treatment.[148] At one of the consortium schools, a high school in Madera County, youth serve as mental health ambassadors and facilitate peer-to-peer sessions and support networks around mental health for students.[149] These youth conduct mental health outreach to parents in their community, many of whom are farmworkers.

Other grassroots efforts are springing up on high school campuses. For example, Dublin High School students came together after a fellow student died by suicide to create a youth-led movement to address mental health in their school.[150] The Elephant in the Room Project enables students to connect with other students and share their personal stories in a safe environment. The project uses the hashtag campaign #YouCanTalkToMe to advertise events, connect students, and provide support.

Youth also have played leadership roles at the county level. For example, the Humboldt County Transition Age Youth Collaboration is a unit within the Transition Age Youth Division of the Department of Health and Human Services.[151] The collaborative includes two partner organizations to build youth-responsive and youth-informed systems of care. The collaborative includes a Youth Advisory Board comprised of 16-to-26 year olds who have experience with foster care, mental health, juvenile justice or homelessness. The advisory board is predicated on the belief that youth are experts in the systems that serve them and are vitally important in transforming the system to respond to the needs of youth. Advisory board members are paid for their time and expertise, participate in local meetings about youth, drive youth-led local projects and initiatives, and provide training to other partners on engaging youth and developing youth informed approaches to service provision.

Eight out of 58 counties have children or youth advisory committees.[152] This represents an unrealized opportunity to engage youth in the MHSA community planning process, tap into their expertise, and support youth leadership.

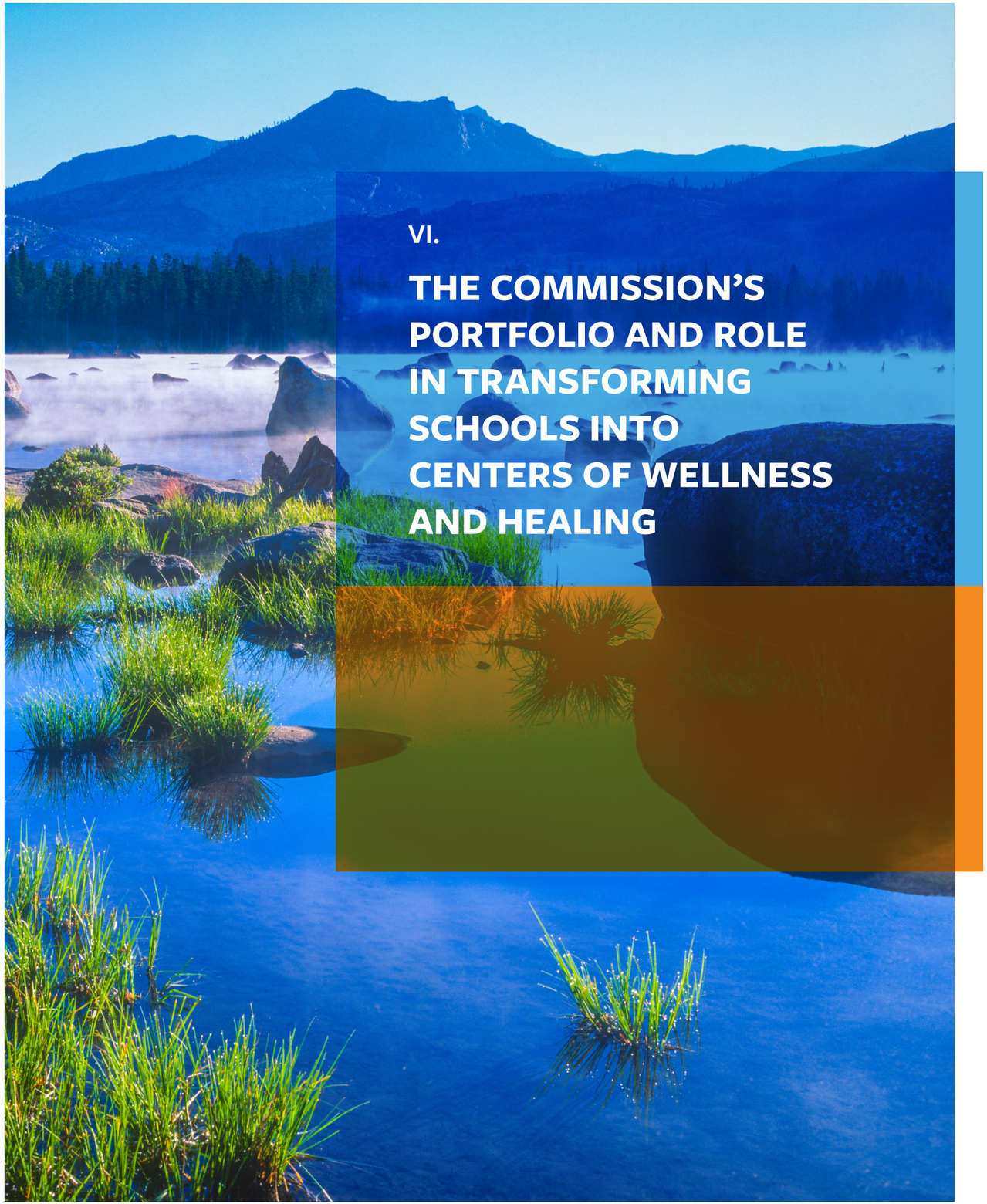
Momentum is building for involving youth leadership in designing youth-centered programs and systems.[153,154] This energy, excitement and momentum can be harnessed by schools and communities, provided youth engagement is based on active participation and decision-making rather than "decoration" and "tokenism."

Hart's Ladder of Youth Participation[156]

Degrees of Participation	Youth-Initiated, Shared Decisions With Adults
	Youth-Initiated and Directed
	Adult-Initiated, Shared Decisions With Young People
	Consulted and Informed
	Assigned But Informed
Non-participation	Tokenism
	Decoration
	Manipulation

Hart's framework of children and youth participation can help schools and communities understand the different degrees of participation and engagement in program development, and support young people in initiating programs and sharing decision-making with adults through youth-led activism and youth-adult partnerships.[155]

Providing youth with opportunities to make meaningful contributions to their schools and communities through participation and leadership in various settings contributes to positive youth development.[157] These activities can help youth strengthen connections to others, be caring and compassionate, develop character, and allow for a greater sense of self-confidence and competence (known as the 5 C's of Positive Youth Development).



VI.

THE COMMISSION'S PORTFOLIO AND ROLE IN TRANSFORMING SCHOOLS INTO CENTERS OF WELLNESS AND HEALING

Under its broad authority to advance the goals of the Mental Health Services Act, the Commission has prioritized children's mental health and has elevated the importance of schools as a point of access for services and a core partner in promoting mental wellbeing. The Commission has fostered public discussions in hearings and community forums. It has supported innovation projects involving school-based partnerships. It has partnered with other state agencies and advised the Governor and the Legislature on ways to incentivize and strengthen community collaborations. This section summarizes the Commission's efforts to catalyze school-based mental health partnerships.

SB 82/SB 833 Triage Grant Program

The Commission administers the investment in Mental Health Wellness Act (SB 82 of 2013),[158] which funds community-based mental health crisis services. Most programs funded under the first round of grants targeted adults. Based on concerns raised by children's advocates, the act was amended (SB 833 in 2016) to authorize Triage grants for a continuum of crisis intervention services and supports for children and youth 21-years-old and under.[159] In response, the Commission allocated 50 percent of Triage grants in a second round of funding to children's programs.

In addition, the Commission designated part of the funds as incentives for school-county collaborations. In 2018, funds were awarded to four entities: the California Association of Health and Education Linked Professions JPA (CAHELP in San Bernardino County) Humboldt County, Placer County, and the Tulare County Office of Education.

These collaborations are: 1) building and strengthening partnerships between education and community mental health, 2) supporting school-based and community-based strategies to improve access to care, and 3) enhancing crisis services that are responsive to the needs of children and youth.

In addition, the Commission awarded Triage contracts to four local agencies that are operating school-based Triage programs: the counties of Humboldt, Riverside, Sacramento, and San Luis Obispo.

A statewide evaluation of these programs will be conducted to understand the link between implementation and outcomes, as well as the lessons learned in developing a roadmap for other communities to follow. Opportunities for training and technical assistance can be leveraged with Triage grants to build learning communities statewide.

...the Commission has prioritized children's mental health and has elevated the importance of schools...

Mental Health Student Services Act (MHSSA)

Due to widespread interest in school-county partnerships, the 2019-20 state budget included the Mental Health Student Services Act (MHSSA), which provides $40 million one-time and $10 million ongoing funding for additional mental health partnerships between county behavioral health departments and school districts, charter schools, and county offices of education.[160]

The act specifies that partnering agencies should emphasize the prevention of health needs from becoming severe and disabling, timely access to services, the reduction of stigma, and outreach to families and service professionals to recognize early signs.

In the fall of 2019, the Commission conducted statewide listening sessions to allow stakeholders to shape how funds should be allocated. The Commission in November 2019 adopted criteria for the allocation of funds. In 2020, two rounds of grants were awarded to 18 counties: 10 to established school-county partnerships and eight to new and emerging school-county partnerships. The enthusiasm and interest in these grants, as indicated by the 38 out of 58 counties and their school partners submitting grant proposals, must be built upon and sustained if the State is to ensure that each child is intellectually and emotional nourished.

Partnership with the California Department of Education

The Commission has partnered with the Department of Education on several projects. First, the Commission consults with the State Superintendent of Public Instruction to ensure the MHSSA grants are aligned with the goals of the educational community. Second, the Commission contracted with the Department of Education to build and enhance school-county partnerships through the development of a toolkit and statewide learning collaborative. Stakeholders have indicated a need for more resources, including training and technical assistance to begin and sustain this work.

The Commission also is working with CDE to link educational and mental health data. Data matching has the potential to yield important information on the impact of mental wellness on educational outcomes, the needs for services and the effectiveness of interventions. A data forum will be held to engage stakeholders on key data-related issues and to strengthen partnerships that can link data for improving the quality of services and outcomes.

Triage School-Collaboration Grantees

CAHELP, San Bernardino County

- Leveraged 20 years of collaborative relationships, including partnerships with 15 school districts, 141 schools, 10 state preschools, and county agencies and community-based organizations.
- Hired mental health professionals who provide multi-tiered system of prevention, intervention, and triage supports including preventative supports, early identification, crisis interventions, crisis stabilization, mobile crisis support, intensive case management and linkages to service.

Humboldt County

- Leveraged 27 years of collaborative relationships, including partnerships with 31 school districts, as well as the 0-8 Mental Health Collaborative, and the Humboldt Del Norte SELPA.
- Hired mental health professionals who work alongside other school personnel to identify students in need of support, determine and provide treatment.

Placer County

- Leveraged 30 years of collaborative relationships between nine local entities and a robust governance group called the System Management Advocacy Resource Team (SMART).
- Hired school social workers and family/youth/community liaisons who form a team, along with existing school-based mental health professionals to create five school-based Wellness Centers.

Tulare County Office of Education

- Leveraged 24 years of collaborative relationships with 41 partners and an established Governance Group.
- Created the Mental Wellness Services program within the Tulare County Office of Education, in active collaboration with the Tulare County Health and Human Services, Mental Health Department and respective partners to hire school mental health professionals.

Youth Innovation Project

The Commission in 2018 launched the Youth Innovation Project and established a Youth Innovation Project Planning Committee, comprised of 14 youth from 12 counties to guide the project.[161] Led by Commission Chair Khatera Tamplen, the Committee is working to identify and develop concepts for youth-centered county innovation projects with the potential for significantly improving treatment and outcomes for youth. The Commission contracted with three youth serving organizations to provide support, training and capacity building for the committee.

The committee reviewed the mental health literature, results from a statewide survey on youth mental wellness, and findings from four focus groups of youth held in different parts of the state. The committee identified mental health promotion and prevention in schools and colleges as a key opportunity for exploring innovative solutions. The committee also recommended that research-informed tools and strategies such as positive youth development and youth-led action research be incorporated into projects.

The Commission is working with county leaders to partner with the committee and local youth to host regional idea labs that explore innovations to increase preventive mental health services in schools.

The Commission has also funded youth-led organizations such as the California Youth and Empowerment Network (CAYEN) and the California Youth Connection (CYC) to facilitate transition-age youth (TAY) engagement with California's mental health system. CAYEN has a statewide TAY board comprised of those who have been "touched by" the mental health, juvenile justice, or foster care systems.[162] CAYEN empowers TAY leaders to "create positive change" in the mental health system through involvement in decision-making and bridging multiple systems to improve outcomes for youth. CYC is led by current and former youth in the foster care system who have been instrumental in transforming the foster care system through youth-led outreach, training, organizing, and advocacy.[163] CYC operates a youth-led project – No Stigma, No Barriers – which is designed to improve mental health outcomes for youth. A key finding from this outreach is that youth want services and supports that are strengths-based, peer-led, and wellness-oriented.

The Commission also has supported innovation projects that center on youth voice and leadership. In 2018, the Commission approved $15 million to open one-stop, youth mental health clinics in Santa Clara County.[164] These clinics were inspired by a model in Australia called headspace. The Santa Clara County allcove innovation is a partnership between Santa Clara County Behavioral Services and Stanford University Center for Youth Mental Health and Wellbeing. A Youth Advisory Committee was established to ensure that youth voice and experiences inform the development of allcove centers and their services. The allcove centers provide youth with access to holistic services, including onsite mental health and substance abuse counseling, physical health care services, and linkages to education, housing, employment, as well as intensive treatment options.

Suicide Prevention

The Commission in November 2019 adopted Striving for Zero, the State's suicide prevention plan for 2020-2025.[165] Young people disproportionately attempt suicide and young people of color are particularly at risk. Striving for Zero provides four specific actions the State and communities can take to advance a public health approach to suicide prevention: 1) Develop a networked infrastructure of organizations, resources and information; 2) reduce risk by promoting safe environments, resiliency and connectedness; 3) increase early identification and connection to services; and, 4) improve suicide-related services and supports.[166]

The plan was prepared at the direction of AB 114 (Chapter 38, Statutes of 2017).[167] The Commission conducted extensive public outreach and deep consultation with subject matter experts. The plan includes detailed recommendations and an action plan to reduce suicide, minimize harm to families and communities, and improve outcomes for survivors – including actions to address the risks to students and youth in general. The Commission was provided direction and resources in the 2020-21 budget act to begin implementing the plan.

The Commission is working with county leaders to partner with the Youth Innovation committee and local youth to host regional idea labs...

The Prevention and Early Intervention Project

Senate Bill 1004 (Chapter 843, Statutes of 2018) directed the Commission to establish priorities and a statewide strategy for prevention and early intervention services.[168] This project is exploring opportunities to promote mental health and reduce factors that may prevent people with mental health needs from thriving. The goals of this exploration are to equip people, families, and communities and systems with information to expand effective prevention and early intervention strategies. Children and youth are prioritized in the legislation, with a focus on childhood trauma, youth outreach and engagement, early psychosis and mood disorder detection, and suicide prevention. This project is scheduled to be completed in early 2021.

Supporting Transformational Change

The Mental Health Services Act was crafted to support transformational change in mental health care and the Mental Health Services Oversight and Accountability Commission was given the authorities and the responsibilities to drive that change.

The principles outlined below indicate the need for transformational change in school mental health and the imperative – morally, socially and economically – to meet the needs of every child. New spending and programs alone will not produce the required improvements.

As a whole, the principles call for a reordering of priorities, the development of new and stronger partnerships, as well as the integration of resources, including facilities and funding, but most importantly professional staffs. Concerted effort is required to develop more strategic knowledge, rapidly transfer that knowledge into practice, iterate on services and interventions, and evaluate for continuous improvement.

An essential element of this transformation is the deep collaboration among community-scale governments and equal collaboration among state agencies that support and guide their efforts. All partner agencies need to develop new capacities to innovate, execute, evaluate and improve strategies, programs and services.

Toward these ends, the Commission can use its authorities and capacities in the following ways:

1. **Oversight and accountability.** The "Transparency Suite" on the Commission's website will continually be improved so that policymakers, administrators, practitioners and parents can get information on how MHSA funds are being spent to prevent, intervene and treat mental health needs in children, and through schools in particular. Over time, more details on the programs and outcomes will be added.
2. **Program review and data collection.** The Commission will proactively review county Three-year MHSA, Innovation, and Prevention and Early Intervention plans for information and insights on the attributes, extent and impact of programs, and explore with counties and other partners how to accelerate the pace and scale of progress.
3. **Strategic projects.** The Commission's development of the Prevention and Early Intervention strategies and priorities directed by SB 1004 will incorporate the information and insights in this report. The Commission also will assess how to better align its program review and accountabilities functions to the goals of improving school mental health and children's mental health more broadly.
4. **Grant programs.** The Commission will work with recipients of the Mental Health Wellness Act (Triage) grants and the Mental Health Student Services Act grants to determine how future investments can improve outcomes by building stronger partnerships, integrating services, braiding funds and evaluating programs for continuous improvements.

The Commission in November 2019 adopted Striving for Zero, the State's suicide prevention plan for 2020-2025.

The Commission also will continue to deploy its overall charge to advance mental wellbeing – and specifically the wellbeing of children and families – with the following activities:

- The Commission will convene mental health and education policymakers, experts and practitioners to understand and resolve issues that prevent progress. The Commission also will engage private and civic sector leaders, including researchers, health care providers, employers and community leaders to develop understanding and encourage innovation.
- The Commission will identify and resolve conflicts among policies, regulations, funding streams and cultures that slow or thwart efforts to develop human-centered services that cost-effectively meet the needs of individuals, families and communities.
- The Commission will support and evaluate service-level collaboratives striving to improve outcomes and learning collaboratives among enterprising counties and their partners.

VII.

PRINCIPLES FOR ADVANCING STUDENT MENTAL HEALTH

To guide the system-level changes that are underway – and need to be accelerated – the Commission developed principles that distill the knowledge, wisdom and experience that are known and needed to fortify school mental health. These guiding principles are intended to inspire and inform the myriad of decisions being made by leaders in communities and at the state. Several next steps and opportunities also are defined, and the Commission forecasts the authorities and capacities that can be deployed to support a well-functioning system approach.

Guiding Principle 1. Each Child Should be Emotionally and Intellectually Nourished

A commitment to equity and reducing disparities is central to a school mental health strategy. Disparities in student disciplinary action, chronic absenteeism, and other negative outcomes must be eliminated. To address disparities, schools must confront and counter racism and implicit bias, and engage with students and families in discussions about race, racial justice, and LGBTQ issues.

- Establish a continuum of culturally, linguistically, and LGBTQ-responsive mental health services and supports across tiers of intervention.
- Adopt trauma- and healing-informed practices to mitigate trauma and toxic stress in students.
- Implement positive discipline strategies such as restorative justice to reduce suspensions and expulsions.
- Establish educator preparation and training programs to support student wellness, and to raise awareness about bias and stereotypes.

..all students should feel safe, valued, respected, and supported at school.

Guiding Principle 2. Schools Should Be Centers of Wellness and Healing

Schools, youth, families, and health systems must work together to promote student wellness. Through these efforts, all students should feel safe, valued, respected, and supported at school. In addition, the wellbeing of educators and school staff needs to be prioritized and supported along with training and preparation. To establish schools as centers of wellness and healing:

- Ensure each student has at least one adult at school they can trust and turn to for support.
- Prioritize social and emotional skill development and establish social and emotional learning standards.[169]
- Review policies and practices that may hinder the mental wellness of students, particularly those that have a disproportionate negative impact on students of color, LGBTQ students, students in foster care, and other student groups.
- Provide students with daily opportunities to strengthen wellness and resiliency skills.
- Provide students with access to “safe spaces” during times of stress and need.
- Develop workplace policies and encourage private-public partnerships to support school employee wellness.

Guiding Principle 3. Health and Education Must Join Together

School-health system collaborations are essential to support student and family wellness. School and county health services should be integrated into a comprehensive and seamless continuum of support that is easily accessible to students and families. In this system, workforce capacity must be addressed for collaborations to be successful. Mental health personnel should be located on school campuses to enhance prevention and early intervention efforts, coordinate school-community collaboration, support teachers and staff, and connect students and families to additional community services when needed. To strengthen and deepen collaboration:

- Incentivize community collaboration.
- Leverage existing centers and networks to provide training and technical assistance to local communities to disseminate best practices and build sustainability.
- Address workforce shortages of mental health practitioners, particularly those from underserved communities.
- Improve ratios of school-based mental health professionals-to-students.

Guiding Principle 4. Prevention and Early Intervention Must Be Prioritized

Healthy mental, emotional, and behavioral development in early childhood is foundational for school readiness and success. Poverty, trauma, and other social determinants of health undermine healthy child and family development. Strengthening mental health promotion, prevention, and early intervention can build family resilience, promote healing, and reduce the prevalence and severity of mental health needs in society. Early and regular screenings are essential to a prevention and early intervention strategy. To enhance children's healthy development and reduce the risk of developing a mental health need:

- Increase access to prenatal and postpartum care, screen for maternal mood disorders, and provide linkage to services and supports.
- Provide home-visitation to families at risk.
- Increase early childhood screening and mental health consultation.
- Expand access to affordable housing, bolster food security, and increase transportation support.
- Increase family knowledge of parenting and healthy development.
- Give concrete support to families in times of need, expand social networks and deepen community connections.
- Expand school entry health exam requirements to include mental health, trauma, and social determinants of health.
- Screen K-12 students regularly and at times of transition.

Guiding Principle 5. Youth and Families Must Be Engaged and Have Ownership

Student wellbeing is inseparable from family wellbeing. Programming and interventions with students should include their families. Schools should engage with families, build and strengthen trust, and provide access to resources to strengthen family wellbeing. Youth and families should have leadership roles at all levels of decision-making and service delivery. Responsive and respectful services should be designed to promote equity and reduce disparities, support best practice models and community-defined strategies, and are rooted in cultural, linguistic, and LGBTQ competence. To put youth and families at the center of school wellness:

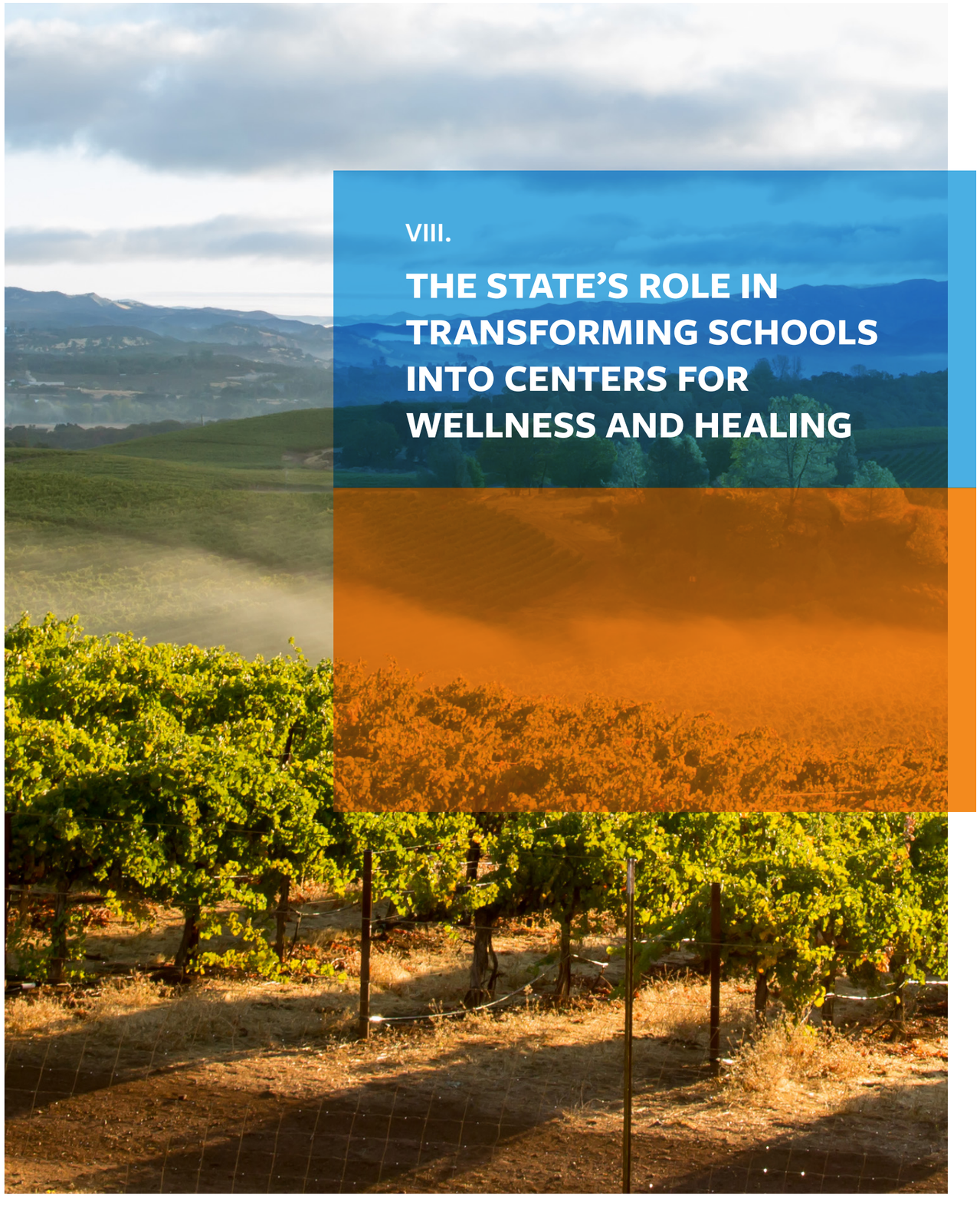
- Establish youth and family wellness councils to guide school planning and policy.
- Engage youth and parents in training and teaming for school mental health and wellness.
- Engage with communities to develop positive discipline policies.
- Establish whole-family supports and services.
- Promote cultural understanding and humility, and provide culturally relevant community-wellness practices.

Early and regular screenings are essential to a prevention and early intervention strategy.

Guiding Principle 6. Sustainable Funding, Continuity and Collaborative Leadership are Critical to Making Schools Centers of Wellness and Healing

State leadership is needed to align policies, funding, training and technical assistance to local communities and schools in developing sustainably funded, comprehensive school mental health services that prioritize prevention and early intervention. Community leadership should identify local needs, coordinate community strategic planning processes, and align resources, funding, and quality improvement efforts. Data collection, evaluation and clear system-wide metrics are required for effective planning, decision-making, service delivery, communication, and quality improvement efforts. To institutionalize and sustain schools as centers of wellness and healing:

- Establish a leadership body of state agencies to develop a statewide action agenda in collaboration with local communities for advancing comprehensive school mental health and wellness systems.
- Support local and regional training, technical assistance, innovation, and sustainability.
- Establish local cross-system partnerships to support school readiness, student wellness, and academic success.
- Align MHSA Community Program Planning with Local Control and Accountability Plans (LCAPs) to improve student outcomes.
- Develop an integrated data system, linking education and mental health data to identify, develop, and monitor indicators of student mental health and wellness.
- Facilitate research and evaluation to inform decision-making at the state and local level.



VIII.

THE STATE'S ROLE IN TRANSFORMING SCHOOLS INTO CENTERS FOR WELLNESS AND HEALING

The evidence is overwhelming that collaborative state and local leadership coupled with a significant investment in school mental health will advantage the next generation of Californians as they navigate a socially and economically dynamic world. The State's investment must provide additional services and build the adaptive and sustainable systems required to provide effective services.

California's initial investment in school mental health has revealed the need and the ambition of community stewards to address this need. Educators, health professionals and children's advocates are acting out of a sense of urgency to respond to the physical, emotional and developmental needs of children, which cannot be met with academic curriculum or teaching techniques alone. They are cobbling together the financial and professional resources, and applying and adapting emerging programs to stabilize children and families and to make learning possible. The response to the Commission's Triage and Mental Health Student Services Act grants have been several times the available resources.

The State's investments also have revealed the need to take a systemic approach. Schools, county behavioral health departments and other partners are developing programs based on their existing relationships, available knowledge and funding, and political will. Each is discovering and developing programs and services. Their efforts – and the return on the State's investment – would be significantly enhanced by peer-based learning and the development of comprehensive research-based models that are sustainable, impactful and adaptive from design.

The response to the Commission's Triage and Mental Health Services Act grants have been several times the available resources.

Successful school and health system partnerships have common key elements:

1. Shared governance structures and accountability at all levels of decision-making.
2. Needs assessment and resource mapping to identify school and community needs and resource availability.
3. Strategic financing models to braid diverse funding streams and draw down federal entitlement dollars.
4. Integrated data systems that enable better service delivery, evaluation and continuing improvement while complying with privacy rules.
5. Strong and effective implementation and alignment of universal interventions, such as school climate, PBIS, social and emotional learning, universal screening, trauma-sensitive practices and restorative justice.
6. Integrated, multi-disciplinary teams at all administrative levels to implement and monitor services and supports.
7. A professional workforce equipped with the knowledge, preparation, training, and wellness to respond to student mental health needs.

The System of Support for K-12 education provides the infrastructure for developing models and professional skills.[170] California educators have created a structure to help all schools close the achievement gap, with tiered and specialized support for schools with additional needs. The structure includes the State Board of Education, State Superintendent of Public Instruction, Department of Education, County Offices of Education, and the California Collaborative for Educational Excellence. Select county offices of education serve as regional leads to supports other COEs and districts. And other county offices and districts serve as subject-matter leads, including community engagement, equity, special education, English learners and math.

Design Criteria

The system should be engineered to meet the following criteria:

Sustainability. The mental health needs of schoolchildren cannot effectively be met with time-limited grants provided only when state revenue exceeds the previous year's budget. The evidence is overwhelming that mental health is integral to education itself. One-time funds can be used as start-up funds, to develop service systems, engineer ways to better tap into and align existing funds, including federal Medicaid funds, and develop proposals for ongoing funds.

Outcome oriented. Communities should be provided with expert assistance in designing well-functioning partnerships that deliver the intended results. The assistance should help local agencies develop effective school mental health systems and coordinate state actions to align funding and provide regulatory clarity.

Continuous improvement. Partnerships should be developed to adapt, replicate and scale proven practices, as well as to evaluate and incorporate new scientific knowledge and experiential insights. State actions should be aligned to support these abilities.

Recommendations

1. State Leadership

The Governor and the Legislature should establish a leadership structure dedicated to the development of schools as centers for wellness and healing. The Governor's office should lead this effort, in partnership with the State Board of Education and Superintendent of Public Instruction, with operational leadership from the Department of Health Care Services, the California Department of Education and other agencies that can make a contribution. The leadership structure should work closely with the K-12 Statewide System of Support. The operational leadership should have dedicated staff charged with developing and implementing a state-level strategy to support community-level partnerships.

2. State Investment

The State should make a significant investment to establish schools as centers for wellness and healing. This foundational investment will require a multi-year commitment to developing the model programs, the data and management systems and the workforce. It will require allocating more funding for services, and developing a sustainable funding strategy that links and leverages related funding and existing services, as described below.

3. State-supported Capacity Building

Funding alone – particularly "one-time funding" that initiates projects with no plan for sustainability – will not be enough to address the social-emotional needs of children. The state-level leadership structure must help counties and school districts develop the system-level capacities required to integrated resources, adapt evidence-based practices and manage for continuous improvement. The capacity building efforts should include these elements:

a. Model / program development. Successful models have common attributes based on research, experience and evaluation. The governance, management and programs are adapted to the needs, characteristics and cultures of communities. The significant diversity in communities and capacities requires a comprehensive effort to help all communities apply what is already known and develop the capacities required for effective services. The K-12 System of Support should be expanded and funded to provide this technical expertise to schools, and find ways to enhance preventive support to early learning programs that serve children ages birth to five.

b. Data and management. Effective data and management systems are needed at both the community and the state level to provide quality services and to align policies and funding to enable communities to be efficient and effective. The K-12 System of Support should facilitate the local capacity for data and cross-system management with education and mental health systems, and facilitate ongoing policy evaluation at the state level.

c. Workforce. The Budget Act of 2019-20 allocated to the Office of Statewide Health Planning more than $100 million in General Fund and funding from the MHSA Workforce Education and Training Program. OSHPD should be directed to work with county behavioral health and the K-12 System of Support to identify specific school-based workforce needs and allocate future fiscal year funding to students and educational providers.

d. Funding. The State needs to expeditiously spend available funds to initiate this effort and develop a sustainable funding system that will allow services to be provided in good and bad economic periods. The Governor and the Legislature should make a multi-year funding commitment for services, while also investing in system capacity and system sustainability. Among the considerations:

- Structure one-time funds to ramp up spending and then be reduced as ongoing funds are incorporated or created. Communities often are required to ramp up spending before they have developed programs, hired staff and developed management systems. Grant funds often run out when the programs are beginning to show impact. Spending should be coordinated and paced with capacity building activities.
- The State and K-12 System of Support should work together to develop and test options for braiding existing funds – including MHSA, Medi-Cal, LEA BOP, SMAA, ERMHS, LCFF, private insurance, and other funds including First 5 funds for younger siblings of children being served through schools. The State and communities must share the objective of achieving financial sustainability and pursue opportunities to create more flexibility from existing funds or to develop new funding sources.

Concluding Thoughts

Although this project began with a focus on student mental health, it expanded to include early childhood mental health and trauma. What happens to children prior to entering formal schooling matters. Children's social and emotional health and ability to self-regulate are critical to school readiness and later school success.

Children come to school bearing the burden of societal ills such as poverty, exposure to interpersonal and community violence, racism and discrimination, and intergenerational trauma. Strengthening local coordination of prevention and early identification can reduce the risk of trauma exposure, identify emerging mental health issues, and ensure timely intervention when needed.

Establishing schools as centers for wellness and healing through partnerships with health systems and robust family engagement can effectively support the needs of all children and prepare them "to live, work and thrive." With proper leadership, planning, collaboration, training and technical assistance, California has the opportunity to become a national leader in school mental health with an innovative whole-child agenda, ensuring our state's next generation is prepared for success.

Endnotes

1. National Council of State Education Agencies (NCSEA) (2019). *Addressing the epidemic of trauma in schools.* http://www.nea.org/assets/docs/NEA%20Student%20Trauma%20Report%207-31.pdf

2. Austin, G., Polik, J., Hanson, T., & Zheng, C. (2018). *School climate, substance use, and student well-being in California, 2015-17. Results of the sixteenth biennial statewide student survey, grades 7, 9, and 11.* San Francisco: WestEd. https://data.calschls.org/resources/Biennial_State_1517.pdf

3. Twenge, J. M., Cooper, A. B., Joiner, T. E., Duffy, M. E., & Binau, S. G. (2019). Age, period, and cohort trends in mood disorde indicators and suicide-related outcomes in a nationally representative dataset, 2005–2017. *Journal of Abnormal Psychology, 128*(3), 185–199. https://doi.org/10.1037/abn0000410

4. Center on the Developing Child (2010). *The foundations of lifelong health* (InBrief). www.developingchild.harvard.edu

5. Slopen, N., Shonkoff, J. P., Albert, M., Yoshikawa, H., Jacobs, A., Stoltz, R., & Williams, D. R. (2016). Racial disparities in child adversity in the U.S. *American Journal of Preventive Medicine 50*(1), 47-56. https://doi.org/10.1016/j.amepre.2015.06.013

6. The Children's Partnership and Early Edge California (2000). *Federal immigration policies have spread fear of deportation among immigrant families.* https://www.childrenspartnership.org/wp-content/uploads/2019/11/TCP-Immigration-Final-Brief.pdf

7. The Education Trust-West. (2017) *Undocumented students in California: What you should know.* https://edsource.org/2017/1-in-8-children-in-california-schools-have-an-undocumented-parent/580621

8. California Department of Education. *Dataquest. Suspension and Expulsion Rates.* https://data1.cde.ca.gov/dataquest/

9. Mental Health Student Services Act (2019 Budget bill). California Welfare and Institutions Code, Division 5, Part 4. Chapter 3.[5886- 5886]. https://leginfo.legislature.ca.gov/faces/codes_displayTexxhtml?lawCode=WIC&division=5.&title=&part=4.&chapter=3.&article=

10. The California Department of Education under Project Cal-Well trains youth mental health responders across the State.

11. State conferences devoted to student wellness and school climate include, but are not limited to, the California Student Mental Wellness Conference https://www.wellnesstogether.org/conference California PBIS Conference http://www.pbisca.org/departments/educationalservices/prevention/cpc/pbis/Pages/cf-conference.aspx and Breaking Barriers (http://www.breakingbarriersca.org/2019-symposium).

12. Mental Health Services Oversight and Accountability Commission (MHSOAC) *Youth innovation project*. https://mhsoac.ca.gov/what-we-do/projects/youth-innovation-project

13. *Santa Clara County allcove.* https://www.allcove.org/

14. The K-12 State System of Support is comprised of the State Board of Education, State Superintendent of Public Instruction, Department of Education, County Offices of Education, and the California Collaborative for Educational Excellence.

15. Mental Health Services Oversight and Accountability Commission (MHSOAC) *Triage program overview.* https://mhsoac.ca.gov/what-we-do/triage/triage-program-overview

16. Mental Health Student Services Act (2019 Budget bill). California Welfare and Institutions Code, Division 5, Part 4. Chapter 3.[5886- 5886].

17. Mental Health Services Act (as of January 27, 2020). https://mhsoac.ca.gov/sites/default/files/MHSA%20Jan2020_0.pdf

18. Avenevoli, S., Baio, J., Bitsko, R. H., Blumberg, S. J., Brody, D. J., Crosby, A., ... & Huang, L. N. (2013). *Mental health surveillance among children--United States, 2005-2011.* https://stacks.cdc.gov/view/cdc/13598

19. Cree, R. A., Bitsko, R.H., Robinson, L. R., Holbrook, J. R., Danielson, M. L., Smith, D.S., Kaminski, J.W., Kenney, M. K., Peacock, G. (2018). Health care, family, and community factors associated with mental, behavioral, and developmental disorders and poverty among children aged 2–8 years — United States. *MMWR Morb Mortal Wkly Rep 67*(5), 1377-1383. http://dx.doi.org/10.15585/mmwr.mm6750a1

20. Bronsard, G, Alessandrini, M., Fond, G., Loundou, A., Auquier, P., Tordjman, S., & Boyer, L. (2016). The prevalence of mental disorders among children and adolescents in the child welfare system: A systematic review and meta-analysis. *Medicine (Baltimore), 95*(7), e2622. https://doi.org/10.1097/MD.0000000000002622

21. Vermeiren, R., Jespers, I., & Moffitt, T. (2006). Mental health problems in juvenile justice populations. *Child Adolescent Psychiatry Clin N Am., 15*(2), 333-335. https://doi.org/10.1016/j.chc.2005.11.008

22. Merikangas, K. R., Nakamura, E. F., & Kessler, R. C. (2009). Epidemiology of mental disorders in children and adolescents. *Dialogues Clinical Neuroscience, 11*(1), 7–20. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2807642/

23. Merikangas, et al., 2009.

24. Center on the Developing Child (2013). *Early childhood mental health* (InBrief). www.developingchild.harvard.edu

25. Kessler, R. C., Angermeyer, M., Anthony, J. C., DE Graaf, R., Demyttenaere, K., Gasquet, I., & DE Girolamo, G., et al. (2007). Lifetime prevalence and age-of-onset distributions of mental disorders in the World Health Organization's World Mental Health Survey Initiative. *World Psychiatry 6*, 168–76. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2174588/

26. Kessler, 2007.

27. Kessler, 2007.

28. Twenge, J. M., Cooper, A. B., Joiner, T. E., Duffy, M. E., & Binau, S. G. (2019). Age, period, and cohort trends in mood disorder indicators and suicide-related outcomes in a nationally representative dataset, 2005–2017. *Journal of Abnormal Psychology, 128*(3), 185–199. https://doi.org/10.1037/abn0000410

29. Centers for Disease Control and Prevention (CDC) (2019). Deaths: Final data for 2017. *National Vital Statistics Report, 68* (6). https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68_09-508.pdf

30. Whitney, D. G., & Peterson, M. D. (2019). US national and state-level prevalence of mental health disorders and disparities of mental health care use in children. *JAMA Pediatrics, 173*(4), 389-391. https://doi.org/10.1001/jamapediatrics.2018.5399

31. Padillo-Frausto, I., Grant, D., Aydin, M., & Aguilar-Gaxiola, S. (2014). Three out of four children with mental health needs in California do not receive treatment despite having health care coverage. *UCLA Center for Health Policy Research.* http://healthpolicy.ucla.edu/Pages/home.aspx

32. Padillo-Frausto, et al., 2014.

33. Myers, D. (2017). *The new importance of children in America.* Palo Alto, CA and Washington, DC: The Lucile Packard Foundation for Children's Health and Children's Hospital Association (CHA). https://www.lpfch.org/sites/default/files/field/publications/newimportanceofchildren_myers_1.pdf

34. John F. Kennedy, Re: United States Committee for UNICEF July 25, 1963.

35. Center on the Developing Child (2010). *The foundations of lifelong health* (InBrief). www.developingchild.harvard.edu.

36. Center on the Developing Child (2013). *Early childhood mental health* (InBrief). www.developingchild.harvard.edu.

37. Statewide Data Snapshots: Data from the Maternal and Infant Health Assessment (MIHA) Survey. Sacramento: California Department of Public Health, Maternal, Child and Adolescent Health Division. www.cdph.ca.gov/Programs/CFH/DMCAH/MIHA/Pages/Data-and-Reports.aspx?Name=SnapshotBy.

38. Statewide Data Snapshots: Data from the Maternal and Infant Health Assessment (MIHA).

39. Maternal stress heightens the risk for depression before and after birth.

40. Maternal depression can impair the mother-infant bond and be predictive of later learning and mental health needs for the child

41. Healthy People 2020. *Social determinants of health.* www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

42. Evans, G. W., & Kim, P. (2013). Childhood poverty, chronic stress, self-regulation, and coping. *Child Development Perspectives, 7*(1), 43-48.

43. Expert panelist testimony of Chandra Ghosh-Ippen, Associate Director of the Child Trauma Research Program at University of California, San Francisco, and Director of Dissemination and Implementation for Child-Parent Psychotherapy to the Mental Health Services Oversight and Accountability Commission on March 22, 2018.

44. Expert panelist testimony of Chandra Ghosh-Ippen.

45. The National Child Traumatic Stress Network. *Early childhood trauma.* https://www.nctsn.org/what-is-child-trauma/trauma-types/early-childhood-trauma

46. The National Child Traumatic Stress Network.

47. Crusto C. A., Whitson M. L., Walling S. M., Feinn R., Friedman S. R., Reynolds J., Amer M., Kaufman J. S., (2010). Posttraumatic stress among young children exposed to family violence and other potentially traumatic events. *Journal of Traumatic Stress, 23*(6), 716-24.

48. Expert panelist testimony of Chandra Ghosh-Ippen, Associate Director of the Child Trauma Research Program at University of California, San Francisco, and Director of Dissemination and Implementation for Child-Parent Psychotherapy to the Mental Health Services Oversight and Accountability Commission on March 22, 2018.

49. Expert panelist testimony of Chandra Ghosh-Ippen.

50. 50 Obradović, J., Bush, N. R., Stamperdahl, J., Adler, N. E., & Boyce, W. T. (2010) Biological sensitivity to context: the interactive effects of stress reactivity and family adversity on socioemotional behavior and school readiness. *Child Development, 81*(1), 270–289. doi:10.1111/j.1467-8624.2009.01394.x

51. Blair, C., & Raver, C. C. (2015). School readiness and self-regulation: a developmental psychobiological approach. *Annual Review Psychology, 66*, 711–731. doi:10.1146/annurev-psych-010814-015221

52. National Research Council (US) and Institute of Medicine (US) Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults: Research Advances and Promising Interventions; O'Connell ME, Boat T, Warner KE, editors. (2009) *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities.* Washington (DC): National Academies Press. doi:10.17226/12480

53. National Research Council (US) and Institute of Medicine (US) Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults.

54. Harper Browne, C. (2014). *The Strengthening Families Approach and Protective Factors Framework: Branching out and reaching deeper.* Washington, DC: Center for the Study of Social Policy.

55. Harper Browne, 2014.

56. The Primary School 2017-2018 annual report. https://www.theprimaryschool.org/.

57. Mental Health Services Act (MHSA) Prevention and Early Intervention Regulations (As of July 1, 2018). Title 9 California Code of Regulations, Division 1, Chapter 14 MHSA Article 2. Definitions. https://mhsoac.ca.gov/sites/default/files/documents/2018-10/02PEI%20Regulations_Effective%20July2018.pdf

58. Duncan, G. J., Chantelle J.,Claessens, A., Magnuson, K., Huston, A. C., Klebanov, P., Pagani, L. S., Feinstein, L., Engel, M., Brooks-Gunn, J., Sexton, H., Duckworth, K., & Japel, C. (2007). School readiness and later achievement. *Developmental Psychology, 43*(6), 1428-1446. doi: 10.1037/0012-1649.43.6.1428.

59. Burns, B. J., Costello, E. J., Angold, A., Tweed, D. et al. (1995). Children's mental health service use across service sectors. *Health Affairs 14*(3): 149-159. https://doi.org/10.1377/hlthaff.14.3.147

60. California Department of Education. *LCFF resources: Priority 6 school climate.* https://www.cde.ca.gov/eo/in/lcff1sys-pri6res.asp

61. California Department of Education. (2018). *California's social and emotional learning guiding principles.* https://www.cde.ca.gov/eo/in/socialemotionallearning.asp

62. California PBIS Coalition. *PBIS implementation in California.* http://www.pbisca.org/departments/educationalservices/prevention/cpc/pbis/Pages/pbisgrowth.aspx

63. California Department of Education. *Dataquest, Student Enrollment Data 2018-19*. https://data1.cde.ca.gov/dataquest/

64. California Department of Education, *Dataquest.*

65. Austin, G., Polik, J., Hanson, T., & Zheng, C. (2018). School climate, substance use, and student well-being in California, 2015-17. *Results of the Sixteenth Biennial Statewide Student Survey, Grades 7, 9, and 11.* San Francisco: WestEd.

66. Hanson, T., Zhang, G., Cerna, R., Stern, A., & Austin, G. (2019). *Understanding the experiences of LGBTQ students in California.* San Francisco, CA: WestEd. https://www.wested.org/wp-content/uploads/2019/10/Understanding-Experience-of-LGBTQ-Students-in-California.pdf

67. Hanson, T., et al. (2019).

68. Hanson, T., et al. (2019).

69. Council on American-Islamic Relations, CAIR-California. (2019). Singled out: *Islamophobia in the classroom and the impact of discrimination on Muslim students.* https://ca.cair.com/sfba/wp-content/uploads/sites/10/2019/09/Anti-Bully-Report_2019.pdf

70. Council on American-Islamic Relations, CAIR-California. (2019).

71. Padilla Frausto, I., Grant, D., Aydin, M., & Aguilar-Gaxiola, S. (2014). Three out of four children with mental health needs in California do not receive treatment despite having health care coverage. *UCLA Center for Health Policy Research.* http://healthpolicy.ucla.edu/Pages/home.aspx

72. Wood, J. J., Lynne, S. D., Langer, D. A., Wood, P. A., Clark, S. L., Eddy, J. M., & Ialongo, N. (2012). School attendance problems and youth psychopathology: Structural cross-lagged regression models in three longitudinal datasets. *Child Development, 83*(1), 351–366.

73. DeSocio, J., & Hootman, J. (2004). Children's mental health and school success. *The Journal of School Nursing, 20*(4), 189-96. https://doi.org/10.1177%2F10598405040200040201

74. Tobin, T. J., & Sugai, G. M. (1999). Discipline problems, placements, and outcomes for students with serious emotional disturbance. *Behavioral Disorders, 24*(2), 109-121. https://doi.org/10.1177/019874299902400209

75. Kaufman, J. H., Seelam, R., Woodbridge, M. W., Sontag-Padilla, L., Osilla, K. C., & Stein, B. D. (2016). Student mental health in California's K-12 Schools: School principal reports of common problems and activities to address them. *Rand Health Quarterly, 5*(3), 9. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5158211/

76. *California School Staff Survey Statewide Results, 2015-2017: Main Report*. San Francisco: WestEd Health and Justice Program for the California Department of Education.

77. California Department of Education, *Dataquest.* Chronic Absenteeism. https://data1.cde.ca.gov/dataquest/

78. California Department of Education, *Dataquest*. Chronic Absenteeism.

79. California Department of Education, *Dataquest*. Chronic Absenteeism.

80. California Department of Education, *Dataquest*. Chronic Absenteeism.

81. California Department of Education, *Dataquest*. Suspension and Expulsion Rates. https://data1.cde.ca.gov/dataquest/

82. Wood, J. L., Harris III, F., & Howard, T. C. (2018). Get out! Black male suspensions in California public schools. San Diego, CA: Community College Equity Assessment Lab and the UCLA Black Male Institute. http://blackmaleinstitute.org/wp-content/uploads/2018/02/GET-OUT-Black-Male-Suspensions-in-California-Public-Schools_lo.pdf

83. Wood, J. L., Harris III, F., & Howard, T. C. (2018).

84. Wood, J. L., Harris III, F., & Howard, T. C. (2018).

85. California Department of Education, *Dataquest*. Suspension and Expulsion Rates. https://data1.cde.ca.gov/dataquest/

86. California Department of Education, *Dataquest.*

87. California Department of Education, *Dataquest.*

88. Chin, M. J., Quinn, D. M., Dhaliwal, T. K., & Lovison, V. S. (2020). Bias in the air: A nationwide exploration of teachers' implicit racial attitudes, aggregate bias, and student outcomes. *Educational Researcher.* https://doi.org/10.3102/0013189X20937240

89. Dvir, Y., Ford, J. D., Hill, M., & Frazier, J. A. (2014). Childhood maltreatment, emotional dysregulation, and psychiatric comorbidities. *Harvard Review of Psychiatry, 22*(3), 149–161. https://doi.org/10.1097/HRP.0000000000000014

90. van der Kolk, B. A. (2003). The neurobiology of childhood trauma and abuse. *Child and Adolescent Psychiatric Clinics of North America, 12*, 293 – 317. doi:10.1016/S1056-4993(03)00003-8

91. US Department of Education's Office of Civil Rights Data Collection. https://ocrdata.ed.gov/

92. US Department of Education's Office of Civil Rights Data Collection.

93. Edwards, E. C., Edwards, E. J., and Howard, T. (2020). *Keeping students safe in Los Angeles: An analysis of LAUSD school incident reports & funding.* Los Angeles, CA. UCLA Black Male Institute. http://blackmaleinstitute.org/wp-content/uploads/2020/06/Keeping-Students-Safe-in-Los-Angeles-Final-Version-Updated-6-24.pdf

94. Kang-Yi, C. D., Wolk, C. B., Locke, J., Beidas, R. S., Lareef, I., Pisciella, A. E., Lim, S., Evans, A. C., & Mandell, D. S. (2018). Impact of school-based and out-of-school mental health services on reducing school absence and school suspension among children with psychiatric disorders. Evaluation and program planning, 67, 105–112. https://doi.org/10.1016/j.evalprogplan.2017.12.006

95. Expert panelist testimony of Curtiss Sarikey, Chief of Staff, Oakland Public Schools to the Mental Health Services Oversight and Accountability Commission on March 22, 2018.

96. Expert panelist testimony of Curtiss Sarikey.

97. National Center for School Mental Health (NCSMH) (2019). *Advancing comprehensive school mental health systems: Guidance from the field.* http://www.schoolmentalhealth.org/Resources/Foundations-of-School-Mental-Health/Advancing-Comprehensive-School-Mental-Health-Systems--Guidance-from-the-Field/

98. National Center for School Mental Health (NCSMH), 2019.

99. Horner, R.H., & Sugai, G. (2015). School-wide PBIS: An example of applied behavior analysis implemented at a scale of social importance. *Behavioral Analysis in Practice 8*, 80–85 (2015). https://doi.org/10.1007/s40617-015-0045-4

100. California PBIS Coalition. PBIS implementation in California. http://www.pbisca.org/departments/educationalservices/prevention/cpc/pbis/Pages/pbisgrowth.aspx

101. Anderson, C. M., & Kincaid, D. (2005). Applying behavior analysis to school violence and discipline problems: Schoolwide positive behavior support. *The Behavior analyst / MABA 28*(1), 49-63. DOI: 10.1007/BF03392103

102. Barrett, S., Eber, L., & Weist, M. (2013). *Advancing education effectiveness: Interconnecting school mental health and school-wide positive behavioral support.* https://www.pbis.org/resource/advancing-education-effectiveness-interconnecting-school-mental-health-and-school-wide-positive-behavior-support

103. Bavarian, N., Lewis, K. M., Dubois, D. L., Acock, A., Vuchinich, S., Silverthorn, N., Ê Flay, B. R. (2013) Using social-emotional and character development to improve academic outcomes: A matched-pair, cluster-randomized controlled trial in low-income, urban schools. *Journal of School Health, 83*(11), 771–779. https://doi.org/10.1111/josh.12093

104. Wyman, P. A., Cross, W., Brown, C.H., Yu, Q., Tu, X., & Eberly, S. (2010). Intervention to strengthen emotional self-regulation in children with emerging mental health problems: Proximal impact on social behavior. *Journal of Abnormal Child Psychology, 38*(5), 707–720. https://doi.org/10.1007/s10802-010-9398-x

105. Kang-Yi, C. D., Wolk, C. B., Locke, J., Beidas, R. S., Lareef, I., Pisciella, A. E., Lim, S., Evans, A. C., & Mandell, D. S. (2018). Impact of school-based and out-of-school mental health services on reducing school absence and school suspension among children with psychiatric disorders. Evaluation and program planning, 67, 105–112. https://doi.org/10.1016/j.evalprogplan.2017.12.006

106. National Center for Safe and Supportive Learning Environments. *School climate.* https://safesupportivelearning.ed.gov/safe-and-healthy-students/school-climate

107. National Center for Safe and Supportive Learning Environments.

108. National Center for Safe and Supportive Learning Environments.

109. Aldridge, J. M. & McChesney, K (2018). The relationships between school climate and adolescent mental health and wellbeing: A systematic literature review. *International Journal of Educational Research 88*, 121-145. https://doi.org/10.1016/j.ijer.2018.01.012

110. Aldridge & McChesney, 2018.

111. Lester, L. & Cross, D. (2015). The relationship between school climate and mental and emotional wellbeing over the transition from primary to secondary school. *Psychological Well Being 5*(1), 9. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4615665/

112. Berkowitz, R., Moore, H., Astor, R. A., & Benbenishty R. (2016) A research synthesis of the associations between socioeconomic background, inequality, school climate, and academic achievement. *Review of Educational Research, 87*(2), 425-469. https://doi.org/10.3102%2F0034654316669821

113. Cole, S. F., Greenwald O'Brien, J., Geron M. G., Ristuccia, J., Wallace, D. L., and Gregory, M. (2005). Helping traumatized children learn: Supportive school environments for children traumatized by family violence. *Massachusetts Advocates for Children, Trauma Learning and Policy Initiative.* https://traumasensitiveschools.org/tlpi-publications/download-a-free-copy-of-helping-traumatized-children-learn/.

114. Cole, et al., 2005.

115. Kosciw, J. G., Greytak, E. A., Zongrone, A. D., Clark, C. M., & Truong, N. L. (2018). The 2017 national school climate survey: The experiences of lesbian, gay, bisexual, transgender, and queer youth in our nation's schools. New York: GLSEN. https://www.glsen.org/research/school-climate-survey

116. Kosciw, et al., 2018.

117. O'Brien, R. P., Walker, P. M, Poteet, S. L., McAllister-Wallner, A., & Taylor, M. (2018). *Mapping the road to equity: The annual state of LGBTQ communities, 2018.* Sacramento, CA: #Out4MentalHealth Project.

118. Assembly Bill No. 1266. Chapter 85. An act to amend Section 221.5 of the Education Code, relating to pupil rights. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201320140AB1266

119. Collaborative for Academic, Social, and Emotional Learning (CASEL). SEL definition https://casel.org/what-is-sel/.

120. Taylor, R. D. Oberle, E., Durlak, J.A., & Weissberg, R.P. (2017) Promoting positive youth development through school-based social and emotional learning interventions: A meta-analysis of follow-up effects. *Child Development, 88*(4),1156-1171. https://doi.org/10.1111/cdev.12864

121. Belfield, C., Bowden, Brooks, Klapp, A., Levin, H., Shand, R. & Zander, S. (2015). The economic value of social and emotional learning. *Center for Benefit-Cost Studies in Education Teachers College, Columbia University.* https://doi.org/10.1017/bca.2015.55

122. Belfield, et al., (2015).

123. Collaborative for Academic, Social, and Emotional Learning (CASEL).

124. Bronfenbrenner, U. (1979).*The ecology of human development.* Cambridge, MA: Harvard University Press.

125. Smith, M. Parental mental health: Disruptions to parenting and outcomes for children. *Child and Family Social Work, 9*(1), 3-11. https://doi.org/10.1111/j.1365-2206.2004.00312.x

126. Centers for Disease Control and Prevention, Kaiser Permanente (2016). The ACES study survey data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. https://www.cdc.gov/violenceprevention/acestudy/about.html

127. American Federation of Teachers, AFL-CIO (2017). *2017 educator quality of work life survey.* https://www.aft.org/sites/default/files/2017_eqwl_survey_web.pdf

128. Johnson, S. M., et al., (2004). The Support Gap: New Teachers' Early Experiences in High-Income and Low-Income Schools https://files.eric.ed.gov/fulltext/EJ853526.pdf

129. Cole, S. F., Greenwald O'Brien, J., Geron M. G., Ristuccia, J., Wallace, D. L., and Gregory, M. (2005). Helping traumatized children learn: Supportive school environments for children traumatized by family violence. *Massachusetts Advocates for Children, Trauma Learning and Policy Initiative.* https://traumasensitiveschools.org/tlpi-publications/download-a-free-copy-of-helping-traumatized-children-learn/

130. Orange County Department of Education. *Resilient mindful learner project: Stress management for teachers and students.* https://ocde.us/EducationalServices/LearningSupports/HealthyMinds/Pages/Resilient-Mindful-Learner-Pilot-Project.aspx

131. Orange County Department of Education, *Resilient mindful learner project.*

132. Mental Health Services Oversight and Accountability *Transparency suite.* https://www.mhsoac.ca.gov/resources/mhsoac-transparency-suite

133. California Department of Education. *Student Mental Health Policy Workgroup.* https://www.cde.ca.gov/ls/cg/mh/smhpworkgroup.asp

134. Horwath, J. & Morrison, T. (2007) Collaboration integration and change in children's services: critical issues and key ingredients. *Child Abuse and Neglect, 31*(1), 55-69. https://doi.org/10.1016/j.chiabu.2006.01.007

135. National Center for School Mental Health (NCSMH) (2019). *Advancing comprehensive school mental health systems: Guidance from the field.* http://www.schoolmentalhealth.org/Resources/Foundations-of-School-Mental-Health/Advancing-Comprehensive-School-Mental-Health-Systems--Guidance-from-the-Field/

136. Horwath & Morrison, 2007.

137. Assembly Bill 114 (AB 114) Chapter 43, Statutes of 2011 http://leginfo.ca.gov/pub/11-12/bill/asm/ab_0101-0150/ab_114_bill_20110630_chaptered.pdf

138. Reback, R. (2018). *Investments in student health and mental health in California's public schools. technical report. Getting down to facts II.* https://gettingdowntofacts.com/sites/default/files/2018-09/GDTFII_Report_Reback_1.pdf

139. National Association of School Couneslors. *Press Release, Student-to-School-Counselor Ratios.* https://www.schoolcounselor.org/press#:~:text=Student%2Dto%2DSchool%2DCounselor,Education%20Statistics%20is%20available%20here

140. National Association of School Psychologists. *NASP Practice Model Overview.* https://www.nasponline.org/standards-and-certification/nasp-practice-model/nasp-practice-model-implementation-guide/section-i-nasp-practice-model-overview/nasp-practice-model-overview

141. National Association for School Social Workers. *NASW Highlights the Growing Need for School Social Workers to Prevent School Violence, Mar 27, 2018.* https://www.socialworkers.org/News/News-Releases/ID/1633/NASW-Highlights-the-Growing-Need-for-School-Social-Workers-to-Prevent-School-Violence

142. Becker, K., Buckingham, S. L., & Brandt, N. E. (2014). Engaging youth and families in school mental health services. *Child and Adolescent Psychiatric Clinics, 24*(2), 385 – 398. https://doi.org/10.1016/j.chc.2014.11.002

143. Dunne, T., Avery, S. & Darcy, S. (2017). A review of effective youth engagement strategies for mental health and substance use interventions. *Journal of Adolescent Health, 60*(5), 487-512. https://doi.org/10.1016/j.jadohealth.2016.11.019

144. Committee on the Science of Changing Behavioral Health Social Norms; Board on Behavioral, Cognitive, and Sensory Sciences; Division of Behavioral and Social Sciences and Education; National Academies of Sciences, Engineering, and Medicine. (2016). *Ending discrimination against people with mental and substance use disorders: The evidence for stigma change.* Washington (DC): National Academies Press. https://www.ncbi.nlm.nih.gov/books/NBK384914/

145. National Alliance on Mental Illness, NAMI on campus. https://namica.org/upcoming-events/nami-on-campus/

146. MHSOAC staff personal correspondence with NAMI representation (2019).

147. California HOSA. https://www.cal-hosa.org/

148. Beck, C., Cherry, C., Loera, G., Behler, C., Bidwell, T., Coppola, J., Peña, T., Hernandez, I., Muñoz-Franco, E., Dale, K., Hunt, J., Tate, T., Valadez, J., & Mahan (2018). *Cal-HOSA: Addressing the hidden mental health epidemic and creating a new path toward wellness in schools.* California HOSA. https://www.cal-hosa.org/wp-content/uploads/pdf/cal-hosa-prevention-early-intervention.pdf

149. Beck, et al., 2018.

150. The Independent (September 19, 2019). *Dublin high wellness center opens to bolster students' emotional health.* https://www.independentnews.com/news/dublin-high-wellness-center-opens-to-bolster-students-emotional-health/article_e171a2f2-da51-11e9-8159-2ba579d81bc1.html

151. Humboldt County Transition Age Youth Collaboration. https://humboldtgov.org/542/Transition-Age-Youth-Programs

152. Institute for Local Government. *CA youth commissions and councils.* https://www.ca-ilg.org/post/ca-youth-commissions-councils-and-advisory-boards

153. Mental Health Services Oversight and Accountability Commission (MHSOAC) *Youth innovation project.* https://mhsoac.ca.gov/what-we-do/projects/youth-innovation-project

154. Santa Clara County allcove. https://www.allcove.org/

155. Hart, R. (1997) *Children's participation: The theory and practice of involving young citizens in community development and environmental care.* London: Earthscan.

156. Hart, 1997.

157. Lerner, R. M. (2004). Liberty: Thriving and civic engagement among America's youth. Thousand Oaks, CA: Sage.

158. Mental Health Wellness Act (SB 82 of 2013). http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201320140SB82

159. Senate Bill 833 (2016). https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160SB833

160. *Mental Health Student Services Act* (2019 Budget bill). California Welfare and Institutions Code, Division 5, Part 4. Chapter 3.[5886- 5886].

161. Mental Health Services Oversight and Accountability Commission (MHSOAC) *Youth innovation project*. https://mhsoac.ca.gov/what-we-do/projects/youth-innovation-project

162. *California Youth and Empowerment Network* (CAYEN). https://ca-yen.org/

163. *California Youth Connection* (CYC). https://calyouthconn.org/

164. *Santa Clara County allcove*. https://www.allcove.org/

165. *Striving for Zero: California's Strategic Plan for Suicide Prevention 2020-2025*. https://mhsoac.ca.gov/what-we-do/projects/suicide-prevention/final-report

166. *Striving for Zero: California's Strategic Plan for Suicide Prevention 2020-2025*.

167. Assembly Bill 114 (Chapter 38, Statutes of 2017). https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201720180AB114

168. Senate Bill 1004 (Chapter 843, Statutes of 2018). https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201720180SB1004

169. California's Social and Emotional Learning Guiding Principles. https://www.cde.ca.gov/eo/in/documents/selguidingprincipleswb.pdf

170. California Collaborative for Education Excellence. *California's system of support*. https://ccee-ca.org/system-of-support.asp

Appendix A: Examples of Early Childhood MHSA Programs

Shasta County Adverse Childhood Experiences (ACES)

Shasta County has leveraged PEI funds to support Shasta Strengthening Families, a local effort involving 30 agencies to strategically and collaboratively address adverse experiences. Shasta County residents have higher rates of adverse childhood experiences than the state's average. Forty percent of Shasta County adults report four or more experiences compared to 17 percent of adults statewide. The collaborative fosters greater partnerships and seamless service delivery across family-service agencies and medical providers. To raise awareness about trauma in different communities, the collaborative has hosted annual ACEs town halls.

Yolo County's Early Access and Screening Program

Yolo County's Early Access and Screening Program provides universal, developmental and behavioral health screening to parents and their children, birth to 5. Less than a third of California's children receive timely developmental, behavioral, and other health screenings from a health care provider; ranking California 30th in the nation. Screening rates are even lower for children of color. According to First 5 California, the screenings that are completed typically do not include a formal, structured assessment of a child's trauma history, mental health, or social and emotional functioning.

The Yolo program represents the first time that services for children, birth to 5 were included in the county's MHSA three-year plan. The program is a partnership with First 5 Yolo, which matches every PEI dollar to implement Help Me Grow (HMG). HMG aligns community resources to identify young children at risk, links families to services, and empowers families to support their child's development. HMG educates and encourages health care providers to conduct systematic screening of young children, and provides a centralized access point for providers, families and others to obtain information, support, and referrals.

Marin County's Early Childhood Programs

In Marin County, MHSA PEI funds are used to support Early Childhood Mental Health Consultation (ECMHC) in subsidized preschools and childcare sites in the region. ECMH is a prevention-based service to build the capacity of families and early care providers to support the social and emotional health of infants and young children and reduce challenging behaviors early before intervention is needed. A mental health consultant provides training, coaching, and consultation in different settings where children grow and learn – childcare, preschool, or in their home. Marin County also uses PEI dollars to support the implementation of an evidence-based positive parenting and family support system (Triple P) through training and technical assistance across settings and providers (mental health, primary care, schools, and family advocates). Triple P is designed to prevent and treat emotional and behavioral needs in children fostering healthy and positive family environments that help children realize their potential.

Imperial County's Innovation Program

Imperial County's Behavioral Health System Innovation Plan provides services in school settings to children ages 4 to 6 who are at risk for social and emotional needs. This partnership is based on implementation of First Steps to Success, an evidence-based intervention designed to help children improve their social and emotional skills at school and home. First Steps to Success has traditionally been implemented by school staff. Imperial's Innovation Plan embeds mental health staff in kindergarten and transitional kindergarten classrooms to coach students and provide ongoing consultation and support to teachers. This arrangement builds relationships across separate systems, and also provides children and family with links to community resources when needed.

Appendix B: School Mental Health and Wellness Models

Project Cal-Well: Federal Funds Support State Leadership and Awareness

California was one of 20 states awarded a five-year federal grant in 2014 to support expansion of school mental health. The grant – Advancing Wellness and Resilience in State Educational Agency (AWARE) – is funded under SAMHSA's Now is the Time Project. Project Cal-Well is led by the Department of Education in partnership with ABC Unified School District in Los Angeles County, Garden Grove School District in Orange County, and San Diego County Office of Education.

Project Cal-Well is working to increase mental health awareness in schools and communities, promote a positive school climate, and increase access to mental health services and supports in schools and communities through partnerships and system collaboration. Schools in Project Cal-Well have implemented schoolwide activities for all students that include positive behavioral interventions and support (PBIS), restorative justice, and social-emotional learning. They also have provided professional development training to educators and community members so they can recognize and support students who show signs and symptoms of mental health needs.

Since implementation of Project Cal-Well, schools have been able to hire additional specialized instructional support personnel and have markedly increased student utilization of mental health services and supports on school campuses. Schools also have increased school connectedness among students (feeling safe, close to people, and happy at school) and decreased suicide ideation, drug and alcohol use, and suspensions and expulsions.

Unconditional Education Model: Implementing a Multi-tiered System

Another approach is Seneca's Unconditional Education model. Seneca provides statewide educational, behavioral and mental health services to children and families. The Unconditional Education model arose out Seneca's long history working with children in foster care and group homes settings and the belief that children do not fail, but systems fail children.

Unconditional Education represents a paradigm shift from a traditional model of service delivery in which students must be referred to special education or mental health services, and those services are delivered by specialists in different settings. In the Unconditional Education model, integrated and coordinated services are available to all students. Love, compassion and respect are at the heart of the model. The belief that each student has the potential to succeed if adults and professionals take the time to understand both their past and current needs, and tailor, individualized services in response.

The Commission visited an elementary school in Contra Costa County where the Unconditional Education model had been implemented. Grant Elementary serves over 500 students in Kindergarten through 6th grade; the majority of whom are English Language Learners and live in families with incomes below the federal poverty level. Principal Farnaz Heydari said prior to implementation of the model, parents were not involved with school activities and some had even been banned from the school campus. She said that teachers were given limited support and often took on the trauma of their students. School suspensions and expulsions were commonplace.

Seneca assigned a full-time site coach to the school to implement a tiered intervention strategy using a PBIS framework. The site coach worked with the school to establish and facilitate teams including a community partnership team to improve the coordination of services between school staff and community providers. Principal Heydari emphasized that community partnerships are a core component for transformational change at her school. The teams established a common understanding of student mental health needs and goals for the both the school and the students, monitored student progress and outcomes, and linked students to appropriate services. Data cards were created for school staff with information about each student; color-coding note those students in need of more intensive support or services. This and other information were used by a multi-disciplinary team of

Appendix B: School Mental Health and Wellness Models

professionals to make decisions about which students might benefit from targeted or intensive services. After the first year of implementation, school suspensions were down, and teachers reported improvement in student behavior.

Hathaway-Sycamores School Based Mental Health Model

Hathaway-Sycamores Child and Family Services is a mental health and welfare agency providing services in Southern California. Hathaway-Sycamores has partnered with school districts since 1997 to provide school based mental health services throughout Los Angeles County including the Los Angeles Unified School District. In the Hathaway-Sycamores School Based Mental Health model, full-time therapists and community wellness specialists are embedded on school campuses. These professionals are fully integrated into the school community and work closely with educators to facilitate a safe and supportive learning environment that facilitates learning and supports healthy student social and emotional development. Under this model, a full provision of mental health services is provided including individual therapy, family, and group therapy; medication support; rehabilitation services; and co-occurring services for students with substance use disorders. Targeted services are also provided to students who are at risk and need additional support to be successful in school (e.g., life skills, social skills, coping skills and anger management). Students and their families have access to services year-round, even when school is not in session. School principals have reported declines in school disciplinary referrals since the inception of the model.

Other Recognized Leaders in School-County Partnerships

Several communities in California are making great strides in working together to support the mental health and wellbeing of children and families. These efforts began simply through relationships – conversations, dialogue building trust, and making commitment to work together. Positive working relationship are at the heart of successful partnerships. The following provide a brief summary of such efforts:

- **Fresno County** is among a growing number of counties leveraging the strength of local partnerships to collectively respond to student challenges. All 4 Youth is a $110 million campaign involving the Fresno County Behavioral Health Department, the Fresno County Office of Education, and local school districts and schools. The goal is to increase access to mental health services for all children regardless of Medi-Cal eligibility and insurance coverage, and to provide flexible, family-driven mental health services in the school, community, or home. Mental health clinicians are being phased into every school in the county over five years.

- **In Monterey County**, the County Office of Education and the Behavioral Health Department established a team of leaders from school districts, community providers, public health, child welfare, probation and a local university as a way to connect the systems that touch children and families and provide a county-wide continuum of mental health services. County mental health clinicians are embedded in schools and can provide mental health training, coaching, consultation and direct services. The school-based clinicians are connected through the collaborative to every part of the system of care in the community to provide seamless, coordinated services and supports.

- **Placer County** has a long history of bringing agencies together as part of a multidisciplinary team of professionals to form a children's system of care. Recently, Placer County Health and Human Services and Placer County Office of Education have recently established school-based Wellness Centers similar to models in San Francisco and Napa Valley unified school districts. The Wellness Centers are intended to deepen the existing county-wide education, mental health, child welfare, probation, and community partnerships to provide a full continuum of mental health services to students and families. Each Wellness Center is staffed by a school social worker, family/youth/community liaison, and other school staff including school counselors, school psychologists, and nurses to meet mental health

Appendix B: Continued

needs of students and families inside and outside of school. The Wellness Centers also serve as a resource hub for the community and are open before and after-school hours to serve working families.

- **In San Bernardino County**, the children's mental health system is shaped by the characteristics of the region – a large rural area with high rates of poverty. The Desert/Mountain Special Education Local Plan Area (SELPA) is a consortium of school districts and charters schools formed to provide mental health services to children at school because of the difficulty in transporting children to county mental health and child welfare offices. Desert Mountain SELPA was able to expand services in schools by entering into a contract with the San Bernardino County Department of Mental Health to provide school-based Early Periodic, Screening, Diagnosis, and Treatment (EPSDT) mental health services for children eligible for Medi-Cal. Hence, the Desert/Mountain Children's Center was established under the administrative umbrella of the Office of San Bernardino County Superintendent of Schools. Other programs followed including the first screening, assessment, referral, and treatment (SART) clinic in the county that was funded primarily through EPSDT funds from the county with a local match from First 5.

Appendix C: School Mental Health and Wellness Evidence-Based Practices

Tier 1 Universal Supports and Interventions	Positive Behavioral Interventions and Supports (PBIS) Collaborative for Academic, Social, and Emotional Learning Safe & Sound Guide (CASEL) Mental Health First Aid Restorative practices Caring School Community Program Second Step Program Project ACHIEVE: Stop & Think Social Skills Project for School REACH (Relationships, Effort, Aspirations, Cognition, and Heart) Search Institute's Develpmental Assets® Mindfullnes practices
Tier 2 Targeted Supports and Interventions	Check In Check Out (CICO) Behavior contracts Mentor-based support Self-monitoring First Steps to Success (Kindergarten and 1st grade) Small group social-emotional learning Small group social skills training
Tier 3 Targeted Supports and Interventions	Cognitive-Behavior Therapy (CBT) Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) The Cognitive Behavioral Intervention for Trauma in Schools (CBITS) Dialectical Behavior Therapy (DBT) for Youth Wraparound Service Coordination Functional Family Therapy (FFT) Multidimensional Family Therapy (MDFT) Multisystemic Therapy (MST) for Youth

Note: Interventions should be age and developmentally appropriate.

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