



Failing Grade:

How California's School Districts
Have Abandoned Children
with Disabilities

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Introduction and Summary

Veronica’s story is just one of many reported by California families with children in need of mental health services at school, indicative of an alarming trend—that many school children who have a need for mental health services to benefit from their education are going without and, as a result, ending up in the juvenile justice system. These stories have been particularly prevalent since the obligation to provide mental health services to students in special education was transferred from county mental health agencies back to local education agencies (LEAs) five years ago. For the previous 25 years, special education students in California received educationally related mental health services through an interagency partnership between school districts and county mental health agencies. In a dramatic shift in 2011, the state enacted Assembly Bill (AB) 114 eliminating the state-mandated partnerships, charging the LEA with the sole responsibility of providing all educationally related mental health services needed by students in special education. Accompanying this transfer of responsibility was an annual state budget allocation of over \$400,000,000 earmarked for mental health services for students in special education.² This amount was significantly more than the mental health allocation under the prior system.³

Based on reports from families about their difficulty in obtaining needed mental health

“Veronica”¹ was 14 years old when she witnessed the murder of her twin brother. Following this traumatic event she became withdrawn and uncommunicative at school, but she was never referred for mental health services. One day she became so upset at school that she tried to leave the school grounds. The school resource officer tried to stop her and a scuffle ensued. Rather than try to understand what was happening with Veronica and whether she needed mental health services, the school had her arrested and she was made a ward of the court. Only after being placed on probation was Veronica referred for a mental health assessment, diagnosed with post-traumatic stress disorder, and provided mental health services.

services from LEAs, advocates for families grew increasingly concerned. This concern was shared by the legislature, leading Senator Beall, Chair of the Senate Select Committee on Mental Health, to request a state audit of how services for students in special education were affected by AB 114. The request focused particularly on outcomes and accountability for how state funds were spent.⁴ The final state audit report, issued in January 2016, confirmed the suspicions of concerned parents, advocates and public officials. The audit reports that there may be as many as 580,000 children who are not getting needed school-based mental health services, and that the California Department of Education (CDE), the state entity responsible for AB 114 funds, is tracking neither expenditures nor outcomes.⁵ Consequently there is simply too little data for auditors to determine whether the LEAs are meeting their responsibility to provide necessary mental health services to school children in special education.

Meanwhile, several advocacy organizations whose focus includes children's mental health and education issues, led by Western Center on Law and Poverty, Mental Health Advocacy Services, and Learning Rights Law Center,⁶ launched their own investigation into the status of mental health services in schools. Sadly, this group's findings paint a darker picture than the state audit, and reveal that many LEAs are not meeting their responsibilities to provide mental health services to children in school, and that California's children are suffering as a result.

Summary Conclusions and Recommendations

The major conclusions of this report are:

- Many LEAs are not complying with their legal obligations to identify children in need of school-based services, teach and provide necessary school-based mental health services and supports in integrated settings, and to provide intensive behavioral support services that meet each child's individualized, unique needs.
- Many children in need of school-based mental health services are not getting services or getting too few services, resulting in school discipline or juvenile arrests.
- Since the enactment of AB 114, there have been fewer students receiving mental health services in their Individual Education Program (IEP) and fewer types of mental health services available for students with emotional or behavioral problems.
- Too many children who have severe mental health conditions are learning and receiving services in segregated settings, instead of in classrooms with their peers.

This report recommends:

- That LEAs take immediate action to comply with the law by (1) identifying children in need of services, particularly before

taking disciplinary actions or engaging law enforcement, and (2) providing robust behavioral support services, like Wraparound and Intensive Home Based Services (IHBS), to meet children’s needs during general class time.

- Expanding state funding for parent-peer-advocacy programs to support parents and families seeking services through the IEP process.
- That each LEA develop and publish an annual “Mental Health Plan,” in consultation with stakeholders, which describes in detail the full array of mental health services available in school, including specific behavioral support and evidenced-based services, commitments and plans for coordinating community-based and school-based mental health services, and training parents and school personnel to engage in individualized treatment plans, and the process and procedures for obtaining such services.

The legislature should require the CDE to report annually on the outcomes for students receiving mental health services, develop a mechanism for tracking and reporting expenditures related to mental health services, and monitor the provision of services.

Background and Methodology

In order to capture what was happening around the state regarding the provision of educationally related mental health services, Western Center on Law and Poverty, Mental Health Advocacy Services and Learning Rights Law Center conducted written surveys and key informant interviews of parents, school administrators, mental health providers and special education advocates soliciting their experiences with obtaining mental health services as part of an IEP. We received responses from school administrators representing 15 school districts, special education advocates representing more than 900 children and youth each year, mental health providers serving children and youth in 20 counties, and over 70 parents. The data from the surveys were analyzed by Lois A. Weinberg, Ph.D., Professor, California State University Los Angeles and Jenny Chow, M.A., Gina Cobin, M.A., Paul Luelmo, M.A., and Bryan Thornton, M.A., doctoral students in the Joint Doctoral Program in Special Education between California State University Los Angeles and University of California Los Angeles. This information was compiled and is the basis of the preliminary findings below.⁷

Survey and Interview Results

Students in need of mental health services to succeed in school are receiving fewer services since AB 114 was enacted.

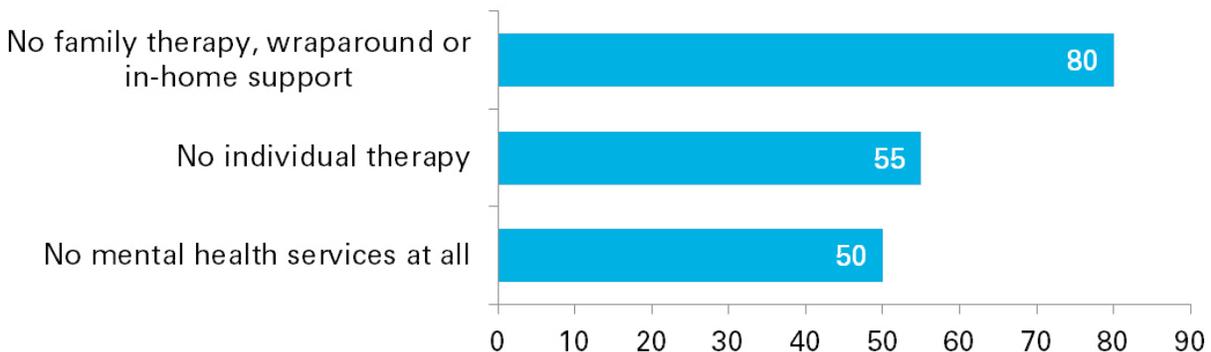
The overall picture painted by survey and interview respondents is that there are fewer students receiving mental health services as part of an IEP and fewer types of mental health services available for students with emotional or behavioral problems. Moreover, students who are receiving services at school receive them less often and are less likely to receive services in their general education classroom where they are needed the most and likely to have the greatest impact. Parents of children with severe emotional and behavior conditions were asked about what services, if any, their children were receiving at school. The following chart shows their responses.

Behind the Numbers

“Educationally Related Mental Health Services are incredibly inconsistent across school districts and LEAs. You can have a great [service array] in one area and lack quality services in another. This lack of consistency is problematic.”

—Special Education Advocate

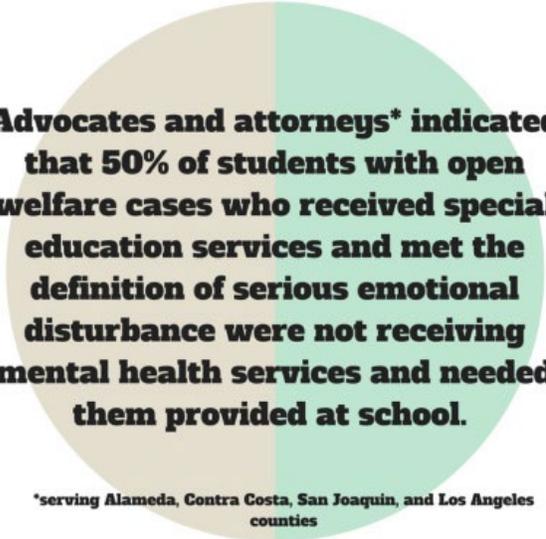
Percent of Surveyed Families Lacking Mental Health Services Through IEP



Mental health providers and special education advocates provided similar feedback. They also indicated that foster youth and children in the juvenile justice system are particularly impacted by the changes brought about by AB 114. They often face the same problems in obtaining mental health services at school as other students. In particular, foster youth are equally likely to face delays in obtaining school-based services and difficulty in obtaining services that are individualized and of sufficient intensity to meet their needs. Foster youth are also unlikely to see their community-based providers coordinate and align services and intervention goals with school-based providers. For these children, these failures often have particularly negative outcomes, including arrests and incarceration for school-based behavior that is directly linked to mental disabilities.⁸

Schools are not following the Child Find Requirement: Too few children are identified and referred for services and end up in the juvenile justice system.

According to the state audit, there are an estimated 700,000 California children with serious emotional disturbances but only 120,000 receiving mental health services as part of an individualized education plan.⁹ Fifty percent of parents responding to our survey reported that their children with emotional or behavioral disorders were not receiving mental health services as part of an IEP. Survey respondents and key informant interviews also revealed that many LEAs are



Advocates and attorneys* indicated that 50% of students with open welfare cases who received special education services and met the definition of serious emotional disturbance were not receiving mental health services and needed them provided at school.

*serving Alameda, Contra Costa, San Joaquin, and Los Angeles counties

Advocates and attorneys who served children in

Los Angeles County
indicated that



50%

of the students who
-were involved with Probation
-received special education services, and
-met the definition of serious emotional disturbance
 were **NOT** receiving mental health services and needed them in school.

particularly unresponsive to direct requests to provide special education services to children with emotional and behavior problems.

They also reported that school personnel may be aware that children are receiving community-based and home-based mental health services or are exhibiting symptoms indicative of a mental health condition in the classroom, but often do not refer the children for a special education evaluation because teachers and other school personnel do not see a connection to mental health needs, and mislabel the behavior as “bad behavior” or criminal conduct.

The Individuals with Disabilities Education Act (IDEA) includes the Child Find mandate which requires all school districts to identify, locate and evaluate all children with disabilities, regardless of the severity of their disabilities. This obligation to identify all children who may need special education services exists even if the school is not providing special education services to the child.¹⁰

This failure to identify mental health needs often results in harsh school discipline such as suspensions, expulsions or arrests.¹¹ Ironically, it is often not until a child is arrested, and convicted, for school-based behavior, that they are assessed and referred to mental health services.¹² There may be several causes for this type of inaction. AB 114 realigned the fiscal incentives for identifying students in need of educationally related mental health services. Since the enactment of AB 114, all mental health services are paid out of the

Behind the Numbers

Michael is a 9-year-old, male student with social phobia and anxiety disorders, which included symptoms that made leaving his room a serious obstacle. Michael’s mother informed the school numerous times about his condition, and made multiple requests for a special education assessment. The district replied that they could not assess the student because he could not attend school, essentially using the child’s mental health condition against him as an excuse for their inaction to address it.

school districts' general fund. This has led mental health providers to report that school personnel have discouraged them from recommending that families apply for special education services.

The survey responses clearly indicate that the schools are not following the Child Find obligation. As a consequence, LEAs and the CDE should take action to require districts to perform an independent evaluation of each student's eligibility for special education, and secure an assessment of mental health service needs whenever certain "triggering" events occur, such as a student's involvement in a certain number of disciplinary incidents, reaching a certain number of suspensions, or when the school is contemplating contacting police due to behavior.

There is reported intersectionality between limited English proficiency and difficulties in obtaining school-based mental health services.

A common complaint made by survey and interview respondents was that schools were disrespectful to both the parent advocates and the parents of students with mental health service needs, especially for parents with limited English proficiency. At least one legal advocate reported that school dysfunction coupled with lack of language access posed a significant barrier to obtaining educationally related mental health services. One parent advocate stated that she could take the poor treatment, but for parents, being mistreated when simply trying to obtain the services that

their child needed to thrive at school made navigating the system extremely difficult.

LEAs and school districts must be held to their obligation to provide appropriate language access assistance to parents with limited English proficiency so as to facilitate, rather than erect additional barriers to such parents' participation in IEPs and related actions affecting their child's school-based mental health service needs.¹³

Schools define "related services" too narrowly and thereby deprive students in special education of the opportunity to learn and thrive.

Many survey respondents reported that students need services and supports to address behaviors stemming from mental health conditions that impact the student's ability to engage in positive social peer interactions, but that school districts do not see such needs as part of a student's educational needs.

The school districts' view is inconsistent with several aspects of special education law. Child Find is not limited to the realm of academic performance when it comes to identifying students who may need special education. Federal regulations specifically include social and emotional status, among others, as an area of suspected disability, and educational performance includes consideration of a student's academic, social, health, emotional, communicative, physical, and vocational

needs, per the Ninth Circuit court decision in *Seattle School Dist. No. 1 v. B.S.* (1996).

The school districts' view is also inconsistent with the legal requirement regarding related services. Section 504 of the Rehabilitation Act requires a school district to provide a "free appropriate public education" (FAPE) to each qualified person with a disability who is in the school district's jurisdiction.¹⁴ The legal definition of FAPE, as defined by IDEA, includes both special education and related services.¹⁵ The term "related services" is intentionally broad; IDEA lists a number of examples, including psychological services, social work services, and counseling services, "as may be required to assist a child with a disability to benefit from special education."¹⁶ The broad definition of related services naturally correlates with the broad definition of education performance, which includes "consideration of a student's academic, social, health, emotional, communicative, physical, and vocational needs."¹⁷ Despite an intentionally broad definition of related services to support an intentionally broad definition of educational performance, many school districts have taken a remarkably narrow view. The survey and interview responses indicate that many school districts are telling students that their mental health and emotional well-being are not aspects of their educational performance, or, when it is, that the only service available to meet the student's unique needs is on-site counseling. The decision to artificially extract the mental health component from a child's education,

or resort to a uniform service to address varied, complex needs, reflects a myopic and inadequate understanding of both related services and special education. The results are bleak. Students are left without the resources that federal law clearly intended them to have and are forced to navigate an overwhelming landscape without support or direction. It is no surprise to see students underserved when we see school districts cut holes in IDEA's deliberately expansive canvass.

LEAs must immediately take steps to develop written policies and procedures to define "related service" broadly, and to develop a holistic review of a student's needs. The definition of "related service" must be clarified so that LEAs and school districts can meet their obligation to educate students in special education with mental health needs on par with their peers.

When students are provided services, they are often inadequate or the wrong services.

Survey respondents reported that students with challenging mental health conditions—conditions severe enough such that counseling or therapy is not sufficient to produce needed behavioral changes—are receiving too few, ineffectual, and the wrong services in school. The services are often limited to individual counseling services, once or twice a week. Most reported that even when the student received behavior support services, they were too infrequent and were not targeted enough to be effective.

Research shows that students with challenging mental health conditions can thrive in classrooms with their peers when they receive behavioral support services, skills training, including social skills training, behavior coaching, mentoring services, or other services that are designed to produce behavior changes.¹⁸ Studies show that when these students receive these types of services, their school attendance and performance improves and disciplinary actions, law enforcement contacts, and out-of-home placements decrease.¹⁹

Behind the Numbers

“The kids don’t get enough, don’t get them on time, and get them at a time during the day that isn’t convenient, such as during class or on a place on campus where it’s obvious and the kids are embarrassed.”

—Special education advocate on how many schools deal with the need for mental health services

Anna, a 16-year-old female student, had a history of severe behavior and diagnoses of Major Depressive Disorder and Bipolar Disorder. She had been placed in an out-of-state residential treatment center. When Anna came home, the school district offered virtually no step-down services. She went from 24-hour care at the residential treatment center to just 60 minutes a week of in-school counseling upon returning home. Legal intervention was required to halt the regression experienced by the student as a result of the steep drop-off in services and clear systematic breakdown. Anna is now attending school with one-on-one services.

Effective school-based interventions are:

- individualized, flexible, and strengths-based;
- designed to improve behavior, social, and communication skills;
- provided in sufficient quantity, intensity, and duration to prevent placement outside a general education setting; and
- designed to be implemented in the settings where the student naturally spends time, including the general education classroom, the hallway, the playground, the cafeteria, during extracurricular activities, and for older students, activities that support the transition to postsecondary education or work.²⁰

Specific Common School-based Interventions that are effective:²¹

- *Individualized positive behavior supports.* School staff use what they have learned about the student's strengths and interests to develop a set of individualized rewards for the student for exhibiting appropriate behavior. Such rewards may include consistently delivered public praise, the ability to earn points toward a specific reward, or "dollars" to spend in the school's store on items the student chooses or a special lunch or outing with a favorite classmate or teacher.
- *Behavior coaching.* A mental health professional, or a paraprofessional under that professional's supervision, helps the

student develop replacement behaviors for behaviors that interfere with the student's success in achieving educational objectives. Usually, this should include observing the student in, and practicing replacement behaviors in, natural settings at the school, and giving feedback to the student.

- *Skills training, including social skills training.* A teacher, a mental health professional, or a paraprofessional under the professional's supervision works with students on skills, including identifying and addressing skills deficits and teaching new skills or enhancing existing skills. Many students need such assistance with learning social skills (behaviors the student uses to advance social objectives), anger management skills, self-management skills, conflict resolution skills, study skills, and/or decision-making skills. After learning and rehearsing skills, perhaps as part of a small learning group, the student should practice skills in natural settings at the school. The trainer should observe the student in these settings and provide feedback.
- *Mentoring activities.* A paraprofessional mentor provides training, coaching and support to further the student's social and communication skills at school. Mentoring may focus on helping the student enhance interpersonal communication, problem solving, and conflict resolution, and relating appropriately to other students or school staff. The mentor engages in structured

activities to advance the goals in the student's school-based intervention plan.

- *Periodic check-ins.* The student checks in, at the beginning of school, during the day, and/or at the end of school, with an adult at the school with whom the student has developed, or can develop, a positive working relationship. The staff member can “take the student’s temperature,” and help the student stay focused on the student’s academic and behavior goals for the day while taking care that the student does not ask to check in to avoid instruction. Also, teachers may check in with students periodically during classes to ensure the student is focused on goals for the day, including during unstructured class time.
- *Evidence-based therapy.* A licensed Master’s-level therapist provides therapy to the student to help ameliorate the student’s mental health symptoms. The therapist should use Cognitive Behavioral Therapy or other evidence-based practices that meet the student’s needs. The therapist should investigate and address the impact of any trauma the student may have experienced.
- *Peer support.* Another student who has received or is receiving behavior services helps develop and meet goals; serves as an advocate, mentor, or mediator; and links the student with peers or with school-based activities. The peer can mentor and facilitate in ways that are both accessible and acceptable to the student. Peer support

can be especially helpful for students transitioning to a new school.

- *Transition services, including work opportunities.* Work opportunities incentivize students by engaging them in vocational areas of interest, or areas in which they have specific skills. Achieving competitive employment helps students improve their confidence and provides them with an opportunity to practice social skills outside of school. School staff, including mentors and peers, can assist students in identifying job opportunities and provide feedback about successes and challenges on the job. Other services promoting a smooth transition to adult life, such as preparation for postsecondary education and teaching independent living skills, may be helpful behavior interventions as well.

Children with challenging mental health conditions are often segregated rather than placed in an integrated classroom setting.

Children with serious mental health conditions are often sent to community day schools, nonpublic schools, or segregated in classrooms or resource rooms away from their peers in general education schools. In these schools, families and special education advocates surveyed indicate that students are not afforded the same opportunity to achieve academic success as their peers or to participate in the extracurricular activities with their peers. Students with disabilities

and students without disabilities must be placed in the same setting, to the maximum extent appropriate to the education needs of the students with disabilities. LEAs must place a student with a disability in the regular education environment, unless it is demonstrated by the recipient that the student's needs cannot be met satisfactorily with the use of supplementary aids and services. Students with disabilities must participate with nondisabled students in both academic and nonacademic services, including meals, recess, and physical education, to the maximum extent appropriate to their individual needs.

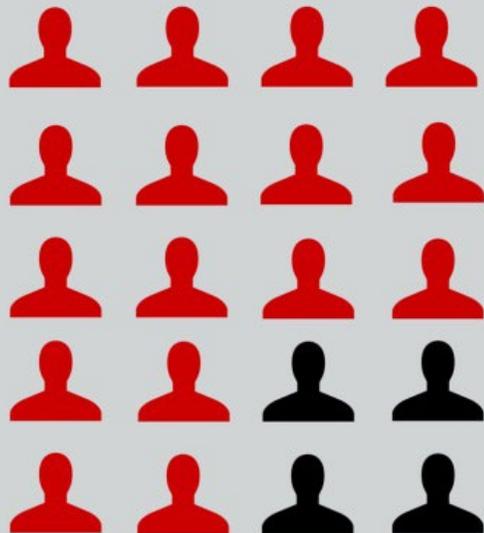
Studies show that students with disabilities, including behavioral disabilities, who are meaningfully included in general education classes and other nonsegregated learning environments with appropriate supports, especially continuously from an early age, have better academic outcomes such as better attendance and higher math and reading scores.²²

Parents, teachers, and school personnel are often not trained on specific behavioral interventions for students with mental illnesses.²³

Because students are not provided individualized strength-needs-based behavior intervention plans, school staff is unaware of school conditions or actions that might trigger negative behavior, or how to promote positive behavior. Parents, advocates and providers report that school staff are rarely trained

80%

of all parents of children with emotional or behavioral disorders reported a lack of parent training in their IEP.

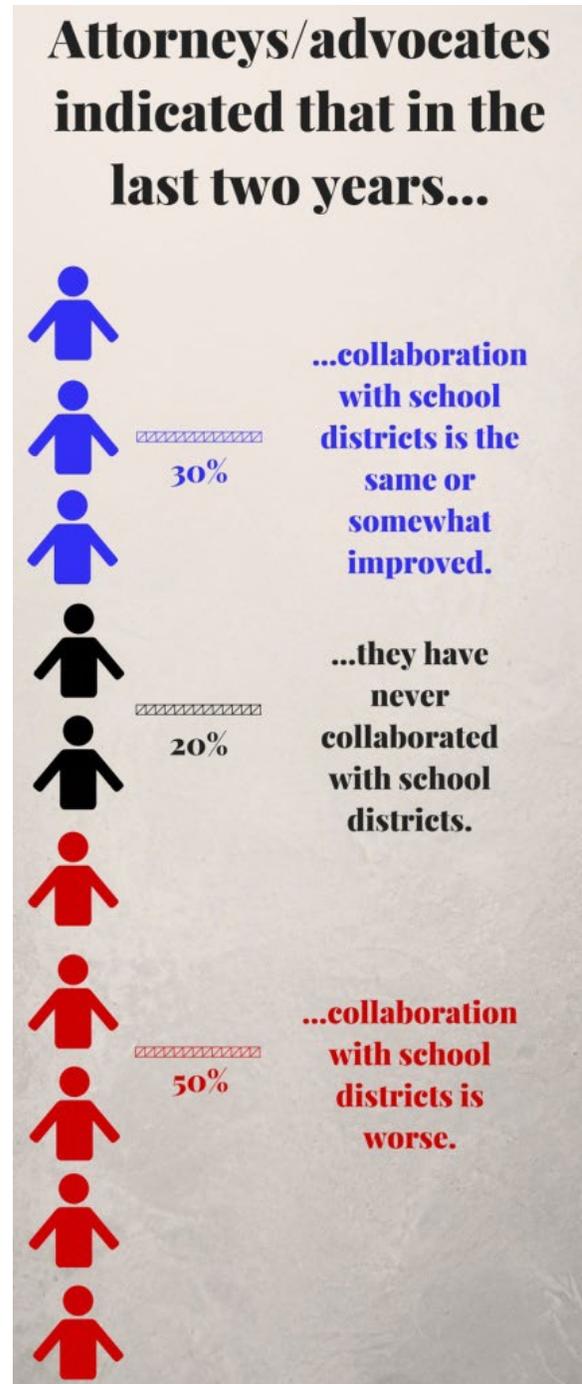


to participate in a student’s individualized behavior intervention plan, which often means that a student’s negative behavior is attributed to delinquency or behavioral problems rather than their mental illness. They also report that parents are almost never trained in how to support school-based interventions at home or in the community.²⁴

Training is especially effective when done by a trusted colleague who models the intervention, such as the instruction of the replacement behavior or the delivery of positive reinforcement in the classroom. Supervisors and trainers can observe the teacher and provide feedback about plan implementation. The student may need training on working with staff on implementing the plan, including if the student has a role in collecting behavior data. Parents should be trained on how to implement interventions at home that support the school’s plan and the child’s education goals.²⁵

Services are not provided as part of a coordinated individualized behavior intervention plan that is designed to be implemented at school and in the community.

Although often flawed, the interagency collaboration mandate under AB 3632, the predecessor to AB 114, linked schools with outside agencies. The repeal of AB 3632 dismantled that system overnight with no replacement system. Parents, special education advocates and providers report that in many school districts, there is now a lack



of communication and coordination between community-based mental health providers and school providers, which can result in school counselors and community providers working at cross-purposes, or a misalignment between school- and community-based interventions. They all reported that school-based services are developed based on, as part of, and in concert with, community-based intervention plans that are designed to produce positive behavioral changes infrequently and inconsistently across the state.

Survey respondents working in or interfacing with several Southern California school districts report that their ability to advocate effectively for mental health services for students in special education has been significantly hampered since the end of AB 3632. According to parent advocates, before the end of AB 3632, they felt they had played an important role in identifying children who needed mental health services. Now they report that the schools are disinterested in working with them to obtain appropriate mental health services for the children who need them and are generally reluctant to provide services at all. Before the end of AB 3632, these parent advocates could turn to their local department of mental health to troubleshoot if they ran into problems at a school, but now this support is no longer available. Survey respondents also reported that outside providers have been denied access to the campus or a classroom for students they treat.

Further, mental health evaluations done by community-based providers are often excluded from the special education assessment. While schools have the responsibility to conduct the assessment, they should be required to consider any outside evaluation and to give a detailed rationale if they disagree.

The IEP is supposed to serve as “the cornerstone of a quality education for each child with a disability,” and creating an effective IEP, according to the U.S. Department of Education, requires parents, teachers, other school personnel and often the student to “come together to look closely at the student’s unique needs.”²⁶ When school districts fail to work with or even consider the assessments of mental health providers, or to work with parents and parent advocates, the very purpose of an IEP is turned on its head.

Policy Recommendations

Improve and support parent participation

Parent Peer Advocacy Programs should be expanded.

With few exceptions, parents reported difficulties getting appropriate mental health services for their child. “Disrespect” was often the word used by parents to describe their interaction with schools when seeking mental health services for their children, even though by law they are equal members of the IEP

team. While respect cannot be legislated (or litigated), there are changes in the process that can be made to ease the problems that parents often encounter. Expanding parent peer advocacy programs is an important way to address this problem. These programs would include experienced peer advocates who can support and mentor the parent through what often seems like a very intimidating and complicated process.

Improve Access to Services

Each LEA should develop and publish an annual “Mental Health Plan.”

The Mental Health Plan should be developed in consultation with stakeholders, including, but not limited to, parents, special education and mental health advocates, community mental health providers, child welfare advocates, and county mental health professionals, and should:

- Describe in detail the full scope of mental health services that are available to children with low, moderate and severe mental health conditions.
- Identify individuals within the district who work with parents in obtaining educationally related mental health services as part of an IEP, and coordinating community-based and school-based interventions, whether through an IEP or not.
- Include aggregate data, by race, ethnicity, national origin, color, gender, gender

identity, sexual orientation, age, and grade level, showing the number of students receiving mental health services as well as the number of students receiving each type of mental health service provided. The plan should also include an estimate of the unmet need for mental health services and an analysis of the barriers to meeting the need and document the aggregate use, cost, including funding source, and education outcomes of mental health services administered within the district from the prior academic year.

- Service use should be reported by type of services students had been provided the year prior and should include the frequency and location of those services.
- Discuss protocols for coordinating interventions with community-based providers.
- Include a training plan for parents and school personnel to support the school-based and community-based mental health interventions for each student with services.
- Have service outcomes that include, on an aggregate basis, academic achievement, behavior, discipline, juvenile justice contact, relevant testing results, and graduation rate of students who receive mental health services before or during the academic year.²⁷
- Be made publicly available.

As a function of the Child Find mandate, LEAs should develop protocols to assess for special education services any student brought to the LEA's attention by a parent or mental health provider as needing educationally related mental health services.

LEAs should be required to formalize a written procedure to assess all such children brought to the LEA's attention by a parent or provider. LEAs should immediately develop a plan to require districts to perform an evaluation of each student's eligibility for special education (or authorize an independent evaluation) and/or facilitate/secure an evaluation of whether mental health services are needed. In addition, LEAs should develop protocols to evaluate students' mental health needs whenever certain "triggering" events occur; for example, the student is involved in a certain number of disciplinary incidents, has a certain number of suspensions, has been referred to school-based police, or has been arrested.

The CDE should require LEAs to provide a wider variety of mental health services as mandated by federal law.

One of the recurring complaints in our findings is the lack of an array of effective mental health services offered by the schools. Instead, counseling is often the only service available; even then, it may be delivered as academic counseling rather than mental health therapy. IDEA requires that public schools provide a free and appropriate education which includes "related services" to its students in special education. These services must be

designed to meet a student's unique needs and prepare him or her for further education, employment, and independent living. IDEA's implementing regulations state that federally mandated related services include, but are not limited to: behavioral services, outpatient mental health counseling services, parent training and counseling, family therapy, social work services in schools, planning and case management, psychological services, psychiatric services for diagnostic and evaluation purposes, therapeutic recreation, and/or some combination of these services. This list of related services is not exhaustive and may include other services if required to assist a child with a disability to benefit from an education.²⁸ The mental health needs of California's students are complex and unique; surely they cannot all be addressed with the same uniform treatment that the authors are presently seeing. IDEA lists a variety of services for a reason, and LEAs should consider this array when developing an individualized program for their students. The LEA mental health plan described above will assist in ensuring that LEAs no longer resort to a singular service when attempting to address multiple, complex needs.

All LEAs should make available an array of school-based mental health services, including crisis services.

School-based mental health services, including behavioral services, are necessary to afford students with emotional and behavioral problems equal opportunities to

advance academically and graduate. They also provide students with the opportunity to be educated in neighborhood schools along with their peers without disabilities. For example, Positive Behavioral Intervention and Supports (PBIS) is a framework or approach for assisting school personnel in adopting and organizing evidence-based behavioral interventions into an integrated continuum that enhances academic and social behavior outcomes for all students. Only 53 percent of the school administrators surveyed reported that they had a clear policy for handling a student in a mental health crisis. To serve their students, schools need to identify effective programs for treating mental health concerns, provide school environments that are positive and conducive to mental wellness, and ultimately ensure that systems are in place to prevent and respond appropriately to any mental health crisis.

Transparency and Enforcement

The CDE should take action to hold LEAs accountable for providing mental health services that produce positive education outcomes.

Since the repeal of AB 3632, the CDE has offered some clarification, but essentially no direction. With little guidance from the state, LEAs adapted to the best of their ability, but with varying results. A major criticism raised is the inconsistency and inadequacy of services across districts. Variability is not a problem as such, so long as individual needs are being met within each district; however, the

survey and interview responses used for this report indicate this is not being done. Explicit requirements for behavioral services and supports and evidence-based mental health programs in schools are needed, and only CDE can provide the leadership to ensure that this happens.

The CDE should hold LEAs accountable in measuring expenditures and outcomes of mental health services.

The state audit revealed that currently, no mechanism is in place to track mental health expenditures and practical outcomes for students who receive these services. Data and information is crucial in judging a program's effectiveness, both with regard to cost and outcomes. This report's recommendations above for LEAs to implement annual mental health plans must be supplemented by better oversight from the CDE. Monitoring is essential to ensure that these services are being provided in a manner according to state and federal law, and that inconsistency—in so much as meeting a child's needs—is minimized between districts. The nonfeasance of the state has created a situation where a child in "LEA A" might be getting significantly different services than a child with a similar need in "LEA B," with neither being able to testify with any certainty as to the strength or success of the education these children receive. The CDE must hold LEAs accountable to the annual mental health plan established above, continually monitor the spending and outcomes of these LEAs to ensure their

effectiveness, and work with LEAs that are shown to be substandard to ensure that every child in California receives the services he or she deserves to benefit from his or her education.

Conclusion

The parents, mental health providers, special education advocates, and school administrators who responded to surveys about the state of educationally related mental health services provide much-needed insight into actions that must be taken to ensure that all children have an opportunity to do well academically, to graduate and to build the academic, social and life skills necessary for success.

Endnotes

¹ The real names of the children described in this report have been changed to protect their privacy.

² California Department of Education, Available Funding and Spending Parameters (September 2013), <http://www.cde.ca.gov/sp/se/ac/avlblfndsrcspndngpar.asp>.

³ See AB 3632–AB 114 Transition of Educationally Related Mental Health Services Q & A (California Alliance of Child and Family Services) at http://www.dhcs.ca.gov/services/MH/Documents/CSI_2013_06_03c_AB_3632_AB_114b.pdf.

⁴ The California Department of Education (CDE) and four special education local plan areas (SELPAs) were selected as subjects for the audit.

⁵ California State Auditor, Report Number 2015-112, “*Student Mental Health Services: Some Students’ Services Were Affected by a New State Law, and the State Needs to Analyze Student Outcomes and Track Service Costs*,” January 19, 2016, <http://www.bsa.ca.gov/reports/2015-112/index.html>.

⁶ Western Center on Law and Poverty is a statewide legal organization that advocates in the courts, counties and capital to secure health care and other basic needs for low-income Californians. Western Center’s work on behalf of children with mental health needs includes obtaining a groundbreaking settlement obtained in 2011 that requires that California children in foster care or at risk of removal from their families receive intensive home- and community-based mental health services. Mental Health Advocacy Services, Inc. (MHAS) is a private nonprofit law firm established to provide free legal services to people with mental disabilities. MHAS assists both children and adults, with an emphasis on obtaining government benefits and services, protecting rights, and fighting discrimination. MHAS has advocated for children and their families to obtain educationally related mental health services for over 30 years. Founded in 2005, Learning Rights Law Center seeks to achieve education equity for low-income and disadvantaged students through direct services, direct advocacy litigation, and parent training. Learning Rights seeks to ensure that all students are provided with equitable access to the public education system, especially those students with mental health needs. Mental health services are an essential aspect of many students’ lives, and Learning Rights fights daily to ensure that these services are delivered with the appropriate care and continuity.

⁷ In addition to conducting surveys and interviews, the authors of this report made Public Records Act (PRA) requests to the California Department of Education and six local education agencies seeking information on the expenditure of AB 114 funds for mental health services and descriptions of the services provided. A review of the responses to this PRA revealed that there is no uniform way that the local education agencies

and school districts track AB 114 money, making it difficult to discern how the money is being spent and on what services, if any. Further, there appear to be great discrepancies between school districts in terms of transparency, expenditures and services. This supports the findings of the state audit that the lack of transparency in the expenditure of AB 114 funds makes it impossible to monitor, assess and ultimately improve services.

⁸ See Disability Rights Education & Defense Fund (DREDF), School-to-prison pipeline, <http://dredf.org/legal-advocacy/school-to-prison-pipeline/>.

⁹ California State Auditor Report 2015-112, p. 58, <http://www.bsa.ca.gov/pdfs/reports/2015-112.pdf>.

¹⁰ 20 U.S.C. § 1412(a)(3). The Office of Civil Rights (OCR) of the Education Department has accepted child find plans that include door-to-door surveys, brochure mailings, public education programs and other public meetings, physician referrals, contacts with day care providers, and surveys of private school personnel. See Luling, TX Indep. School Dist., 1975–1985 EHLR 257:417.

¹¹ Bazelon Center For Mental Health, The Role of Specialty Mental Health Courts in Meeting the Needs of Juvenile Offenders, discusses the connection between school discipline, failures to identify children with mental health needs and the juvenile justice system. See pp. 8–9. Available at <http://www.bazelon.org/LinkClick.aspx?fileticket=DkVxLF-KoUI%3D&tabid=142>.

¹² *Id.*; see also Department of Health Care Services, Expanding Juvenile Mental Health Courts in the Children’s System of Care (discussing California’s juvenile mental health courts), available at <http://www.dhcs.ca.gov/dataandstats/reports/Mental%20Health/JMHCPaper.pdf>.

¹³ See U.S. Department of Education’s Internal OCR Staff Guidance: Title VI Standards for Communication with Limited English Proficient Parents (November 5, 2010) at <https://www.gadoe.org/Curriculum-Instruction-and-Assessment/Curriculum-and-Instruction/Documents/ESOL/OCR%20Guidance%20on%20EL%20Parent%20Communication.pdf>.

¹⁴ 20 U.S.C. § 1401(9).

¹⁵ 20 U.S.C. § 1401(9).

¹⁶ 20 U.S.C. § 1401(26)(a).

¹⁷ *Seattle School District v. B.S.*, 82 F.3d 1493 (9th Cir. 1996).

¹⁸ See U.S. Dep’t of Education, New Accountability Framework Raises the Bar for State Special Education Programs (Jun. 24, 2014) (quoting U.S. Secretary of Education Arne Duncan: “Every child, regardless of income, race, background, or disability can succeed if provided the opportunity to learn. We know that when students with disabilities are held to high expectations and have access to the general curriculum in the regular classroom, they excel. We must be honest about student performance, so that we can give all students the supports and services they need to succeed.”).

¹⁹ Way to Go: School Success for Children with Mental Health Needs (Bazelon Center for Mental Health Law) at

<http://www.bazelon.org/LinkClick.aspx?fileticket=oVwByHXIK20%3d&tabid=104>.

²⁰ Ira Burnim, *School-Based Behavior Services*, p. 3 (Memorandum on file at the Bazelon Center for Mental Health Law, October 2015).

²¹ Bullet points are quoted from *id.*, pp. 3–6.

²² U.S. Department of Health and Human Services and U.S. Department of Education, Policy Statement of Inclusion of Children with Disabilities in Early Childhood Programs (September 14, 2015).

²³ Mental health advocates representing well over 20 counties reported that mental health services for children with severe emotional or behavior conditions are often provided by interns, rather than licensed and experienced child psychiatrists, clinicians, or trained and experienced paraprofessionals who are guided by such licensed professionals. Survey respondents reported that the school-based personnel providing counseling services often do not have the credentials, education, or training to provide evidence-based mental health services or behavior support services that have been shown to produce positive behavior changes.

²⁴ A report describing the benefits of parent training and optimism in the intervention plan on student outcomes. Combining Parent Education in Positive Behavior Support and Optimism Training to Improve Child and Family Outcomes, NADD Bulletin Volume XI Number 6 Article 1, available at: <http://thenadd.org/modal/bulletins/v11n6a1~.htm>.

²⁵ The Official Comments from 1999 to the Federal Regulations under IDEA, published in the March 12, 1999 Federal Register (Volume 64, No. 48, at p. 12,406 et seq.) state: “The definition of ‘parent counseling and training’ should be changed to recognize the more active role acknowledged for parents under the IDEA Amendments of 1997 as participants in the education of their children. Parents of children with disabilities are very important participants in the education process for their children. Helping them gain the skills that will enable them to help their children meet the goals and objectives of the IEP or IFSP will be a positive change for parents, will assist in furthering the education of their children, and will aid the schools as it will create opportunities to build reinforcing relationships between each child’s educational program and out-of-school learning” (emphasis added) (at p. 12,549).

²⁶ U.S. Department of Education, A Guide to the Individualized Education Program at <http://www2.ed.gov/parents/needs/speced/iepguide/index.html>.

²⁷ Some school districts are conducting reviews of their disciplinary practices and special education services with particular attention to identifying implicit biases, stereotype threats, racial anxiety and other unconscious phenomena that could produce disparities. More school districts should take steps to examine the intersection between race, disability, and school discipline as part of the Mental Health Plan development. <http://dredf.org/2015/03/26/antioch-school-officials-agree-to-groundbreaking-collaboration/>.

²⁸ 34 C.F.R. Section 104.33(c)(3); 34 C.F.R. Part 300 Appendix A (2001).