Connecting Students to Mental Health Services

Creative Collaborations, Funding, and Evidence-Based Practices



A toolkit from:

The California School-Based Health Alliance &
Fight Crime: Invest in Kids *California*

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CALIFORNIA SCHOOL-BASED HEALTH ALLIANCE
Putting Health Care Where Kids Are

FIGHT CRIME: Invest in Kids California

Acknowledgements

Fight Crime: Invest in Kids is a national, bipartisan, nonprofit, anti-crime organization. The organization has a membership of nearly 5,000 police chiefs, sheriffs, district attorneys, other law enforcement leaders, and violence survivors. The members take a hard-nosed look at what approaches work—and what don't—to prevent crime and violence. They then recommend effective strategies to state and national policymakers. It operates under the umbrella of the Council for a Strong America.

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Introduction: Connecting Students to Mental Health Services

Addressing Student Mental Health

Students with undiagnosed or untreated mental health issues rank among the most pressing concerns in schools across California, directly impacting student attendance, behavior, and readiness to learn.[1] Students with unmet mental health needs have worse educational outcomes than students who are receiving appropriate treatment and support. When students' needs are not addressed, they are more likely to experience difficulties in school, including higher rates of suspensions, expulsions, dropouts, and truancy, as well as lower grades and test scores. Learning opportunities for all students can be negatively impacted: In the classroom, teachers report "disruptive behavior [by students with mental health disorders] and [teachers'] lack of information and training in mental health issues as major barriers to instruction."[2]

For students with mental health needs, treatment is not always accessible or affordable. More than 20 percent of school-aged children have a mental health diagnosis but only one-third of diagnosed children and teens in the general population receive treatment.[3] More than 40 percent of school-aged children have related problems severe enough to warrant intervention, such as a history of trauma, grief and loss, or family mental health problems.[4] For teens with diagnosed mental health disorders living in poverty, 90 percent report not receiving counseling or other services.[5]

Children and youth involved in the juvenile justice and child welfare systems have a greater prevalence of mental health disorders, which often go untreated. For example, more than 90 percent of youth in the juvenile justice system have mental health problems, and as many as 70 percent of all foster care children in California will develop mental health problems.[6] Additionally, recent data from the California Board of State and Community Corrections shows that nearly half of the daily 8,200 juveniles in custody or on electronic monitoring statewide have "open mental health cases."[7]

The most common mental health concerns for children and youth are depression, anxiety, Attention Deficit Hyperactivity Disorder, and substance abuse.[8] Exposure to violence and other repeated childhood trauma disproportionately impacts students of color and can also contribute to mental health symptoms.[9] Children and teens living in violent homes or communities often exhibit symptoms of Post-Traumatic Stress Disorder,[10] including gaps in their learning[11], behavioral issues in the classroom, struggles with attention, and relationship difficulties.

Linking Care Through Schools

An effective approach linking youth to mental health services is to provide services where students are: at school. In partnership with county agencies and community-based organizations, schools have a leading role to play in the prevention and treatment of student mental health needs. Indeed, 70 percent of children nationwide receiving mental health services get them at school.[12] School sites are prime locations to conduct screenings and assessments, provide treatment, link to services in the community, coordinate case management for students, provide teacher training to create a positive learning environment for all, and provide early intervention and prevention services.

There are many barriers to connecting students to mental health services through schools. Top among the challenges is the lack of resources that compounds competing agendas between schools, county agencies, and community-based providers. These often "siloed" groups focus on the same students, but work separately rather than collaboratively on academics, behavior, mental health, and various other

competing needs. Another challenge in identifying and treating mental health disorders for students is the lack of cross-disciplinary skills: teachers are generally not experts on mental health and therapists are not educators working in the classroom. Another issue includes gaining or maintaining family involvement in services, which is critical to successful interventions.

Effective school-linked and school-based mental health collaborations overcome many obstacles by coordinating resources among schools, the community, and county agencies. They build partnerships between the education and mental health systems and can include special education programs to deliver resources to children with mental health disorders. School-linked partnerships provide treatment on campus, connect students to community-based providers, train teachers on identifying trauma and other mental health needs, and much more. Effective school-based mental health partnerships increase access for students and families, provide prevention and early intervention services, and involve multi-disciplinary providers creating linkages among schools, community, and families.

Toolkit Overview

Fight Crime: Invest in Kids *California* and the California School-Based Health Alliance identified seven counties involved in innovative collaborations to provide mental health resources to children in partnership with schools. The case studies highlight creative county partnerships, practices, and funding models that provide mental health services for students and are aimed at improving outcomes in academics, behavior, social and emotional health, and juvenile and criminal justice.

Case Study Overview	
County	**Focus of Collaboration**
Kings County	Truancy prevention
Lake County	Expansion through Medicaid match of local school funds
Orange County	MHSA-PEI expansion of school-based services
Riverside County	Diversion for delinquent and pre-delinquent youth
San Bernardino County	Prevention of future special education needs
San Diego County	Medi-Cal EPSDT expansion of school-based services
Santa Cruz County	Creation of district-specific nonprofit agency

The case studies highlight:

- **Collaborations** built around school attendance, special education, court diversion, expansion of Medi-Cal, and multi-pronged funding structures. The case studies describe the partnership and structures that counties have used to make these collaborations work.

- **Funding models,** including expanded access to Medi-Cal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) and use of the Mental Health Services Act (MHSA) funds. Other models use those resources as the foundation with which to build a strong collaboration and leverage additional federal, state, local, and private financing. Counties with limited funding have found success by combining resources and establishing partnerships among community organizations, schools, and county agencies.

- **Evidence-based practices**, especially those with evidence of crime-prevention and mental health outcomes. Implementation of evidence-based practices—therapies and other interventions shown to bring about mental health and other outcomes in youth—is an effective

way to maximize the benefits of limited funding and resources. Research shows that there are specific evidence-based programs that not only help restore young people to good health, including mental health, but also help prevent future harmful or criminal behavior. Therapies for youth with crime-prevention as well as mental health outcomes pay for their investment in reduced incarceration costs and other fiscal savings.

Following the case studies, more detailed information about funding streams and evidence-based practices (EBPs) identified in the case studies is provided. All the funding streams identified in the case studies are included in the appendices with more information about the funding stream, the populations targeted, and the funding allocation process. The appendix on EBPs describes many of the practices identified through interviews with counties highlighted by the case counties. This information is included to provide resources to other counties or local communities who are interested in applying some of the lessons from the case studies in their own jurisdictions.

Kings County

- ✓ ***Challenge***: Rising truancy rates in Kings County.
- ✓ ***Accomplishment***: Linking of 70 families with chronically truant students to mental health services through the Student Attendance Review Board and court processes.

Like other Student Attendance Review Boards around the state, those in Kings County are composed of school and community members who meet regularly to help truant or disorderly students and their parents resolve school attendance and behavior problems. Students experiencing these problems are referred to a SARB after the school has exhausted site-level resources. The Kings County Truancy Intervention and Prevention Program (TIPP) formed in 2012 to combat rising truancy rates in schools countywide by addressing the mental health needs of chronically truant students. The program was developed as the result of a conversation between the county District Attorney, the county Truant Officer, and the county's Behavioral Health Department. They saw the potential to collaborate to bring additional services into the existing Student Attendance Review Board (SARB) process to make it more effective. This concept became the foundation for TIPP.

What makes TIPP in Kings County innovative is the level of commitment by the District Attorney's office to combating truancy and the strong partnership with county behavioral health to provide immediate services and referrals. TIPP is not only a way to increase school attendance by providing access to mental health services—it also helps reduce crime based on the DA's strong belief that truancy reduction leads to crime reduction. Additionally, the county behavioral health department has invested significant resources in TIPP, including staffing the SARB with mental health professionals called Recovery Support Coordinators.

Strategies

Referrals for support through School Attendance Review Boards

A guiding principle of TIPP is that truancy is frequently the symptom of deeper issues. When a SARB comes together once or twice a month to review cases of truant students, the Recovery Support Coordinators provided by the county behavioral health department play a critical role. The Recovery Support Coordinators attend hearings, make referrals, review data, and participate in the development of long-range goals for improving school attendance and graduation rates. They link referred families to the mental health services they need, including evidence-based practices like Parent-Child Interaction Therapy. The use of Recovery Support Coordinators as an early intervention helps prevent the need for more intensive mental health interventions down the road.

Delivering services to students and families

As part of TIPP, the county department of behavioral health contracts with community-based mental health organizations to provide an unlicensed "roving" clinician that offers direct services to students referred by school staff, ensuring immediate access to care at school locations. The clinician typically provides four to six sessions with the students to stabilize or address an issue and, if there is a need for longer-term services, to assess and transfer the case to a long-term clinician who can address more intensive needs. While students can access services through the schools, it can be more difficult for parents to access services. TIPP recognizes the need to engage parents and families to address the underlying issues of truancy. The behavioral health department also directly hires another unlicensed

clinician who, among other clinical services, runs the program's LifeSTEPs class, a daylong, psycho-educational class required for parents whose children are referred to TIPP. The class addresses such issues as parental involvement in children's education, setting limits and boundaries, and identifying substance abuse and mental health issues.

Leadership from District Attorney's Office

A critical partner in the collaboration is the leadership and support of the District Attorney (DA), who made fighting truancy a priority in his office and dedicated two Deputy DAs with the responsibility for truancy enforcement. Although the goal of the SARB is to keep students in school and provide them with a meaningful educational experience, SARBs have the power to order parents to participate in services and comply with its recommendations. They also have the power to refer cases that are non-compliant to the DA for prosecution. The DA prosecutes all cases that are referred to them by the County SARB because that means the family has not rectified the issue, participated in services, or complied with SARB recommendations. Most cases where parents have not complied result in a fine, though some do go to court as misdemeanor cases. When families are brought to court, the DA pushes for a gradual increase in penalties from fines to 6 months in jail. For repeat offenders or in the most egregious cases, the DA does push directly for jail time. Later, a judge reviews the case and if the families have complied with mental health treatment and other recommendations of the SARB, the charges are dropped.

Funding Snapshot

Primary funding for direct behavioral health services and school-based interventions within TIPP come from the Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) and Community Services and Supports (CSS) components. MHSA-PEI serves youth who are members of high-risk groups who are at risk of or with onset of a mental health disorder or emotional disturbance. Students who appear at SARB hearings fall into two MHSA-PEI priority populations: those at risk of school failure and those at risk of criminal justice involvement.

- MHSA-PEI and MHSA-CSS fund the Recovery Support Coordinators hired by county behavioral health who participate in SARB hearings and provide linkages to mental health services.
- MHSA-CSS funds pay for an unlicensed "roving" clinician employed through a community-based mental health agency who provides brief mental health services on campus.
- MHSA-PEI funds pay for a second unlicensed clinician hired by the department of behavioral health to provide parent psycho-educational courses in addition to other clinical services.

For More Information

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Lake County

The Safe Schools Program is Lake County's unique investment in school-based mental health that was initially launched in 2001 through the Lake County Office of Education (LCOE). Today, it has been sustained and expanded through their innovative Medi-Cal Match Project that pools school district, county office of education, and county behavioral health resources to drawdown federal Medicaid match.

The Safe Schools Program is currently in five out of the seven school districts in Lake County. It provides a range of on-campus services staffed by three clinicians, two clinical psychologists, and two school counselors from LCOE. Services provided through the program include assessments to determine treatment needs, therapy with a clinician or clinical psychologist for higher need students, behavior rehabilitation for lower need students, after school group counseling and individual therapy, and additional support for significant adults in the students' lives. LCOE's program staff also collaborate with school staff by participating in team meetings and are available to triage issues that may come up and fall outside a clinician's set caseload.

- ✓ ***Challenge:*** After a federal grant created an effective program for school-based mental health services, many schools wanted to establish the program on their campuses, yet few resources existed to expand the program.
- ✓ ***Accomplishment:*** Development of a unique Medi-Cal Match Project that combines local school district funds with a federal Medicaid match expanded the school-based mental health program from one school district in 2010 to five school districts in 2014.

Strategies

Federal grant allows County Office of Education to directly hire school clinicians

The Lake County Safe Schools Program formed in 2001 through a federal Safe Schools Healthy Students grant. Like many rural counties, Lake County was challenged by a lack of private mental health providers in its communities. To address this challenge, the Lake County Office of Education (LCOE) used the federal grant to directly hire school mental health clinicians. This initial investment from the federal grant laid the foundation for the Safe Schools program as it exists currently—with mental health providers hired and deployed through LCOE.

Local and federal matching funds help reinvigorate school program

After the four-year Safe Schools Healthy Families grant period ended, LCOE became an EPSDT subcontractor with Lake County Behavioral Health to serve Medi-Cal students. LCOE experienced various ups and downs in funding for their program due to inconsistent availability of Medi-Cal contracts from county behavioral health. Around 2006, the county eliminated Medi-Cal contracts to LCOE altogether due to lack of funding.

In 2010 county behavioral health restored its contract with LCOE's Safe Schools Program. This time the subcontract was to provide mental health services at Highlands Academy, an alternative school for grades 3-8 with a high need for school-based mental health services. To fund this contract, the county used Mental Health Services Act–Prevention and Early Intervention (MHSA-PEI) dollars, which were matched with federal Medicaid dollars. The contract covers the full cost for LCOE to provide services at Highlands Academy. The school bears no additional costs.

Innovative Medi-Cal Match Project allows program to expand countywide

Recently, county behavioral health developed a second contract with LCOE to expand the Safe Schools Program to other school sites. The Medi-Cal Match Project was developed once other school districts in the county witnessed the benefits of the Safe Schools Program at Highlands Academy and expressed interest in replicating the program on their campuses.

The Medi-Cal Match Project shares the costs of the services between county behavioral health, LCOE, and school districts as follows:

- Through guidance from LCOE and county behavioral health, interested school districts identify their own funds that they could contribute to the county to draw down the federal match. County behavioral health must ensure that the match dollars contributed by the school districts and LCOE come from non-federal funding sources.
- LCOE maintains a fund for half the costs of services provided in the schools. LCOE maintains this fund through a combination of dollars from school district and LCOE general budgets.
- To address concerns about whether county behavioral health could use funds from another county entity (in this case, the LCOE) to drawdown federal Medicaid match, county behavioral health and LCOE developed a system where LCOE provides the match funds to county behavioral health upfront in a separate account.
- County behavioral health then uses those funds from LCOE and school districts to draw down the federal Medicaid match, and returns the now doubled funds to LCOE to support the mental health services in the school.

While putting up the match amount from school budgets can be a barrier, Rob Young, Coordinator of the Safe Schools Program, notes that "most sites want these mental health services in their schools and it is cheaper to put up part of the match amount than to hire their own mental health clinician." Scott Abbott, the Compliance Manager for LCBH, describes the blending of funding to support the Safe Schools Program as a "win-win for us: kids are getting the services they need and schools are getting support to meet the needs of their students."

Funding Snapshot

The source of funds used to support the Safe Schools Program varies based on the location of the program:

- For services at Highlands Academy, county MHSA-PEI funds are used as the local match for federal Medicaid dollars.
- For services at all other schools, LCOE and school district general funds are combined to provide for the local match for federal Medicaid dollars.

For More Information

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Orange County

The Orange County Healthcare Agency and the Orange County Department of Education (OCDE) wanted to expand mental health prevention and early intervention services for the community. Through a strong and ongoing stakeholder process, the county engaged representatives of schools, community organizations, and healthcare partners. The coalition of partners established a range of school-based programs, from expert medical consultation, to teacher training and direct counseling services. With investment in higher-level policy and community engagement, Orange County has been thoughtful about designing services and programs that respond to community need.

- ✓ ***Challenge:*** Leverage new resources to expand prevention and early intervention services particularly in schools.
- ✓ ***Accomplishment:*** Comprehensive school-based services, from teacher training to direct counseling, developed through strong partnerships. Over 125 school and community-based staff conduct trainings in schools throughout the county.

Strategies

Medical Officer facilitates linkage among countywide partners

In 2009, the Orange County Department of Education established the Center for Healthy Kids and Schools, a public/private partnership between the Healthcare Agency, OCDE, the Children and Families Commission of Orange County (First Five), and local health care partners. A major accomplishment of the Center was to secure a Medical Officer for the schools in the county, a unique role for a physician in a county office of education. The role of Medical Officer includes:

- Providing trainings through OCDE
- Conducting workshops and webinars for school and community professionals on mental health
- Helping to build partnerships among community mental health providers and schools
- Advising the work of the county Crisis Response Team
- Assisting school districts with the development and implementation of mental health-related policies and procedures
- Facilitating a County/School Integrated Health Advisory Council which involves school and community members in reviewing and advocating for integrated school mental health and wellness programs.

Overall, the Center for Healthy Kids and Schools has increased collaboration and funding in the county to improve access to and quality of resources for students, families, and educators. Funding for the Center is provided by MHSA–Prevention and Early Intervention (PEI), Proposition 10 tobacco tax dollars (California Children and Families Act of 1998), and Hoag Hospital. The Center also pursues grant funding to further support its work.

OCDE expands prevention education with the Student Mental Health Trainers' Cadre

As part of the MHSA, the California County Superintendents Educational Services Association funded OCDE and 10 other Regional Lead County Offices of Education to conduct activities addressing prevention and early identification of mental health issues for K-12 students. OCDE created the Student Mental Health Trainers' Cadre, a team of trainers who conduct workshops in mental health education and early intervention services. This "train the trainer" model allowed OCDE to reach more school employees than they could with their existing staff. Trainers in the cadre conduct the Eliminating Barriers to Learning staff development program, as well as trainings around other school mental health

topics, in their local schools and organizations. Over 125 multi-disciplinary professionals, both school district and community-based staff members, have joined the cadre.

OCDE has also worked with schools to implement evidence-based approaches and interventions. They have implemented Positive Behavioral Interventions and Support (PBIS), a school-wide tiered framework that can transform school climate and discipline in 240 schools countywide. They have also implemented The Resilient Mindful Learner Project, an intensive training in stress reduction and mindfulness for teachers and their students. Teachers learn to incorporate mindfulness into their classroom with the goal of reducing behavioral issues, improving student attention and focus, and developing self-soothing techniques.

One stop referral service newly available to school staff

The Behavioral Health Department of Orange County created a single point of contact for residents' questions about behavioral health resources. OC Links, a one-stop phone and webchat referral service, is staffed by trained behavioral health professionals called "clinical navigators". The service receives requests daily from community members, families, school staff and participants seeking programs from the County's behavioral health system. OC Links is promoted county-wide, and has conducted specific outreach to teachers, administrators, and other school staff. Referrals and linkages provided include child and adult mental health, alcohol and drug inpatient and outpatient programs, crisis services, and prevention and early intervention programs.

Funding Snapshot

- MHSA-PEI funds support the prevention and education services provided by the Student Mental Health Trainer's Cadre.
- MHSA-PEI, Proposition 10 dollars, OCDE in-kind, and Hoag Hospital support the Medical Officer and the OC Center for Healthy Kids and Schools.
- The OC Center for Healthy Kids and Schools is able to bring in additional funding from foundations and local funders to sustain their work.
- MHSA funds the OC Links program .

For More Information

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Riverside County

Prior to 2001, the lack of community involvement and partnerships among juvenile justice system agencies in Riverside County often led to first time juvenile offenders receiving few meaningful or rehabilitative services. Furthermore, due to enormous caseloads and limited financial resources, minors that did end up in juvenile court (excluding serious or repeat offenders) spent very little time before a judge, received little to no supervision from probation officers, and probation terms were not strictly enforced. It became apparent to the county's juvenile justice system agencies that a coordinated, community-based approach was needed to deter future criminality and address the unmet needs of at-risk youth. After the passage of crime-prevention legislation in 2000, funding became available for the Probation Department to create a uniform system of pre-court programs for juveniles, which enabled the Department to implement the Youth Accountability Teams (YAT) Program across the county. This program ensured that juvenile offenders received community-based services and emphasized efforts around rehabilitation and the prevention of future crime.

- ✓ ***Challenge***: Lack of interagency partnerships and community involvement resulted in less effective services for juvenile offenders.
- ✓ ***Accomplishment***: The development of a countywide multi-agency community-based program establishing 18 Youth Accountability Teams serving students in 16 school districts. The program led to a 32 percent decrease in juvenile court filings (2011-2012) and kept 72 percent of participating youth out of the juvenile justice system.

Strategies

Implementation of a multi-agency community-based approach

The YAT Program is a multi-agency prevention project that intervenes early in the lives of young people in order to help them get back on track and stay out of trouble with the law. YAT participants fall into two categories: delinquent youth who have been arrested for a crime but not yet charged, and pre-delinquent youth who are at-risk but have not been arrested. The primary goal of YAT is to divert entry into the juvenile justice system through intensive supervision and linkages to school, community, county mental health, and other services. Participants are held accountable for negative behavior and receive mentoring and support services, which increase the likelihood of success at school, home, and in the community and decrease the likelihood of further involvement in criminal behavior. YAT impacts the entire family by offering parenting classes and requiring parents to attend educational programs with their child. Riverside County has 18 YATs serving students in 16 school districts. At any given time, there are over 500 minors participating in YAT countywide and each team manages a caseload of 30 to 40 youth.

Supporting youth through a collaborative approach to supervision led by Probation

Through YAT, both delinquent and at-risk youth are intensively supervised and supported at school district offices (either on a school campus or in a district office building) by teams consisting of representatives from various departments. These teams include:

- A deputy probation officer for supervision and case management;
- A deputy district attorney who addresses the legal ramifications of delinquency;
- A mental health professional for counseling, group intervention, and referrals to other agencies;

- School site officials to address the youth's educational needs and progress; and
- Representatives from local law enforcement agencies to assist with supervising and monitoring of the youth.

In general, the team members are assigned full time to one YAT team and work side by side in the same office. The exception involves the deputy district attorneys who are assigned to two to three separate YAT teams and join their assigned teams approximately one to two days per week.

The YAT program is an intensive supervision program. Minors in the YAT program get more supervision than any other program in the Riverside County juvenile justice system. The team attempts to meet with each minor on their caseload at least once a week. If a youth needs more support or is struggling with issues at home, school, or in the community, the team will try to have more contact with that youth. Additionally, the team will bring the minors on their caseload together for group programming, including special classes covering a wide range of topics such as anger management, academic and professional success, college preparation, victim awareness, anti-bullying, etc.

Although all YAT members work in a collaborative fashion, the Probation Department leads the team. The Department makes all intake decisions, is the fiscal agent for the program, defines the roles of partner agencies, and ultimately is responsible for supervision of the participants. Representatives from the other participating agencies actively contribute as team members, making referrals to the program, counseling minors and their parents, attending meetings, and planning educational activities.

Targeting delinquent youth through pre-court probation

YAT serves mainly as a pre-court probation program for middle and high school students who have been arrested but not yet charged with a crime. For this group of minors, YAT is a voluntary program where delinquent youth and their parents sign a written agreement to participate in the program as an alternative to formal criminal charges. Program participation is limited to a period of six months. Probation officers individually assess each youth and establish terms in a contract that are appropriate to the minor's underlying offense and life situation. The contract terms outline conduct and participation expectations such as attending school, obeying parents and team directives, participating in community service, submitting an apology letter to the victim, and attending counseling or educational services such as anger management, school and career preparation, and life skills training. As required by state regulations, the program must include a specific plan that addresses the underlying conditions that bring the youth within the jurisdiction of the court. Once signed, failure to follow conditions of the contract could result in court ordered fines, community service hours, a juvenile work program, juvenile hall time, and having a formal record in juvenile court.

Two thirds of referrals for YAT are for delinquent youth and come from police officers or sheriff's deputies. YAT tends to be more effective with this population because there is an incentive for the youth to succeed in order to avoid court and formal prosecution, resulting in jail time or fines. Though referring partners may offer recommendations, the ultimate YAT intake decision lies with the Probation Department. Factors restricting YAT eligibility include the youth already being a ward of the court or having previously participated in a pre-court probation program, committed a serious felony offense or sex crime, or caused damage exceeding $1,000. The Probation Department also completes a suitability assessment and contacts the minor's parents to discuss the possibility of their child participating in YAT and to assess the parents' ability to cooperate in the program.

Targeting pre-delinquent youth to prevent criminal behavior

YAT also includes supervision of at-risk pre-delinquent juveniles (such as truants, substance abusers, and curfew violators) before they get into more serious trouble. One third of YAT Program participants are at-risk students who are referred by teachers, counselors, school resource officers, School Attendance Review Boards, and parents. Teams assist these students by coordinating links to school, community, and county services to curb truancy, disobedient behavior, substance abuse, and to address educational needs. Legally, there are no formal consequences (such as fines or juvenile hall time) if a pre-delinquent youth violates the contract or fails the program; therefore, pre-delinquent youth that are accepted into the YAT program are generally limited to cases where both the youth and the parents are genuinely interested in the services and support provided by the YAT program.

Funding Snapshot

The source of YAT funding is the state's Juvenile Justice Crime Prevention Act (JJCPA), which was enacted in 2000 to support and improve juvenile justice prevention and intervention programs in California.

- JJCPA funds the 18 Youth Accountability Teams.
- As required by the JJCPA legislation and vital to ongoing funding, California State University San Bernardino gathers all YAT statistics, analyzes program results, and compiles them for an annual report submitted to the Board of State and Community Corrections. The ongoing analysis found that 72 percent of the delinquent minors placed on a YAT contract complete the program and are diverted from the juvenile justice system.

For More Information

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San Bernardino County

Similar to other SELPAs around the state, the Desert/Mountain Special Education Local Plan Area (DM SELPA) oversees counseling services to eligible students with special needs within San Bernardino County. The DM SELPA is composed of twenty-six school districts and is governed by the superintendents of each district with the San Bernardino County Superintendent of Schools serving as the administrative unit. In 2003, after more than ten years providing mental health services to special education students, the DM SELPA was awarded a local Medi-Cal EPSDT contract for mental health services and created an internal division, the Desert/Mountain Children's Center, to serve Medi-Cal eligible students. A SELPA-wide framework was put in place to coordinate special education and general education services under a single system.

- ✓ ***Challenge***: Connecting all students to mental health services.
- ✓ ***Accomplishment***: Build on the SELPA infrastructure to coordinate special education funding and Medi-Cal EPSDT through a single framework that offers three tiers of service to all students.

Strategies

Building on SELPA infrastructure to provide general education services.

The Desert/Mountain Children's Center (DMCC) is a counseling center created within the DM SELPA. DMCC not only provides services to students in special education, but also contracts with the County Department of Behavioral Health to serve general education students. Under this contract, the DMCC provides school-based mental health services billable through Medi-Cal EPSDT. Currently, a majority of therapies offered by DMCC are provided at the child's school site, however individual, group, and family therapy are also provided at three clinics throughout the county or in the home. Since the majority of services are provided in school-based settings and the DM SELPA region covers over 20,000 square miles, therapists sometimes travel up to two hours to provide services. Referrals for mental health services may be made through the child's school, parents, doctors, or external sources. Since its inception, the DMCC has continued to build its relationship with the County Department of Behavioral Health and has grown to become the largest children's mental health provider in San Bernardino County.

Interconnected Multi-Tiered Systems of Support (I-MTSS) at multiple schools

The DM SELPA implemented an overarching framework for providing school-based support services throughout the SELPA region, the Interconnected Multi-Tiered Systems of Support (I-MTSS). I-MTSS coordinates services for special education and general education students into a single system using separate funding streams. The key concepts of I-MTSS are to invest in prevention first, coordinate multiple tiers of support, and offer timely access to support for students who need it. As a division within the DM SELPA, DMCC coordinates and provides the mental health services within the framework.

I-MTSS incorporates a school-wide strategy for improving behavior and school climate known as Positive Behavior Interventions and Support (PBIS). PBIS is currently in 67 schools in the SELPA. PBIS is an evidence-based model with three response levels:

- Tier 1 covers universal prevention strategies that promote inclusive practices for special education students and also prevent the need for more intensive services for general education

students. Tier 1 includes common agreement on 3-5 rules that are positively stated and implemented schoolwide (e.g. Be Respectful, Be Responsible, Be Safe). The rules are operationalized as expected behaviors and then explicitly taught in every environment in the schools. Examples of tier 1 interventions are bullying prevention and education programs or trainings for teachers in trauma-informed classroom management.

- Tier 2 includes more targeted interventions for youth whose tier 1 supports were ineffective. Services could include a therapeutic or skill-building group for students with behavioral challenges and the implementation of a check-in, check-out system with a caring adult.
- Tier 3 supports are available for those few students needing individual, intensive interventions such as individual counseling and family services.

Using AB 114 ERMHS funds to leverage Medi-Cal EPSDT

In 2006, the county's budget was impacted by an economic downturn, which resulted in the possibility that the County Department of Behavioral Health would be forced to cut their EPSDT contract with DMCC. Faced with this possibility, which would shut down services for students partway through the school year, the DM SELPA offered their general education funds as the local match for the DMCC's Medi-Cal EPSDT contract. This allowed for the mental health services to continue under DMCC's EPSDT contract with the county.

In 2010, AB 114 transferred the responsibility to provide mental health services to special education students from the county to school districts. It also provided school districts with designated funding for these services. Since some special education students eligible for Medi-Cal were already receiving mental health services through the DMCC, the school districts agreed to further leverage their AB 114 funds with Medi-Cal EPSDT funds. As such, a portion of AB 114 funds are used as the local match to drawdown state and federal EPSDT funds. This allowed the DMCC to increase their budget for Medi-Cal EPSDT specialty mental health services without further impacting the school district budgets or the county general fund.

Coordination of special education and Medi-Cal EPSDT to provide services to all students

To provide services to general and special education students, the DM SELPA and its DMCC division work together to efficiently coordinate resources.

- The DM SELPA is funded primarily through AB 602 Special Education Apportionment.
- DMCC is a Medi-Cal EPSDT provider and contracts with the Department of Behavioral Health to provide behavioral supports for general and special education students who are eligible for Medi-Cal EPSDT and meet medical necessity. AB 114 funds support students who qualify for special education services and require mental health therapy to improve their educational progress. A small portion of children who are not eligible for Medi-Cal or special education receive mental health services through a variety of strategies (such as private insurance, sliding scale, or pro bono).

Funding Snapshot

To provide academic, behavioral and social/emotional supports for students, the DM SELPA and DMCC work together to fund the resources efficiently within the I-MTSS framework.

- AB 602 Special Education funds support special education programs and services operated by districts within the DM SELPA, to address the academic supports within I-MTSS.
- AB 114 Educationally-Related Mental Health Services funds support students who qualify for special education services and require mental health therapy to improve their educational progress.

- Medi-Cal EPSDT covers resources at the DMCC, which focuses on mental health and behavioral supports within I-MTSS for general and special education students who are eligible and have met medical necessity.
- The DM SELPA utilizes a portion of their AB 114 Educationally-Related Mental Health Services funds to contract with the DMCC for the provision of school-based mental health services for all students with disabilities. With permission from the Department of Behavioral Health, the DMCC uses a portion of these state dollars as the match for their Medi-Cal EPSDT contract. This has allowed DMCC to increase their EPSDT budget without further burdening the local government general funds, while also providing financial relief to partner school districts that were previously paying a "fee for service" out of their own budgets for mental health services.

For More Information

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San Diego County

In 1998, the County of San Diego was primarily providing mental health services to children and adolescents through regionally based clinics. The County recognized the need to develop new strategies to reach more children including children and youth served by the juvenile justice system, the child welfare system, and/or whose primary language was other than English. The County employed several strategies to reach these populations, one of which was an extensive expansion of Medi-Cal EPSDT in schools.

- ✓ ***Challenge***: Improving on a system of regionally based clinics to expand and enhance mental health services for system involved and underserved children and youth.
- ✓ ***Accomplishment:*** Expansion of mental health services from seven school-based programs in 1997 to 380 in 2014, which represents over 50 percent of all schools countywide, by utilizing Medi-Cal and additional resources.

Strategies

Medi-Cal EPSDT expanded through school districts partnering with preferred providers

The County of San Diego Children's Mental Health System reached out to school superintendents, special education directors, and pupil personnel directors to identify districts that wanted to implement or expand school-based services using Medi-Cal EPSDT funds. At the same time, the County released a proposal to community mental health clinics for school-based contracts. Schools interested in expanding school-based services were asked to select district staff with experience in mental health to participate in the County Source Selection Committee, a committee that reviews and selects contractors based on proposals from community agencies. The committee selected the winning proposals and created a pool of eligible community mental health providers. School districts were then given the authority to identify their agency of choice from the pool of eligible providers. Over the next several years, school-based mental health services were expanded from seven schools in 1997 to 380 schools in 2014.

One school district became a Medi-Cal provider for students in special education

In one district, the County's partnership went further. First, using start-up funding from a federal Safe Schools/Healthy Students grant, the San Diego Unified School District (SDUSD) hired clinicians and "rehabilitation specialists" to provide services for students in special education. These staff became part of the SDUSD Mental Health Resource Center. Next, the county contracted with the Mental Health Resource Center to become a Medi-Cal provider, so that district clinicians could bill for EPSDT reimbursable services. In addition to providing therapy to individual students, the mental health staff provided on-site consultation with teachers, administrators, and families of high-need students. This focus on classroom climate and adult capacity building resulted in a significant decrease in the number of special education students transferred out to alternative schools or inpatient programs. Currently In 2014, the SDUSD Mental Health Resource Center district employs 90 clinicians working in 120 schools.

MHSA resources addressed the service gap for children without Medi-Cal

The EPSDT expansion was a huge success in reaching students with Medi-Cal. However, an additional identified need was the provision of mental health services to students who were not covered by Medi-Cal. In 2004, additional revenue through Mental Health Services Act–Community Services and Supports (MHSA-CSS) allowed the County to significantly fill the non-Medi-Cal service gap in existing school-based programs. The County added funds to existing school-based contracts with community-based providers based on historical estimates of students served and adjusted as necessary. The County also used MHSA-CSS funding

to expand support offered in schools to include case management services.
County-funded school-based therapists are well integrated into schools. Students covered by Medi-Cal have direct access to mental health services in their schools. Low incomes students without Medi-Cal can be served at their schools or connected to local clinics and other social services.

MHSA funds broad school-based prevention

In addition to the school-based clinical and case management services, the County invested additional MHSA–Prevention and Early Intervention (PEI) and CSS funds into other types of school-based prevention programs. PEI funds support the Positive Parenting Program (Triple P), Incredible Years, Building Effective Schools Together, and an evidence-based suicide prevention program in middle and high schools. As a result, students and families have access to services that address mental health concerns earlier and prevent the need for more intensive care.

Funding Snapshot

- Medi-Cal EPSDT contracts with mental health provider agencies that locate clinical staff in schools.
- Unique funding strategy by San Diego Unified School District to allow Mental Health Resource Center staff to bill EPSDT by becoming a Medi-Cal provider.
- Supplementation of EPSDT contracts with MHSA-CSS funds to enable agencies to extend services to students without Medi-Cal as well as to enhance with case management services.
- Use of additional MHSA-PEI funds to support prevention programs in schools.

For More Information

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Santa Cruz County

In 1984, the Pajaro Valley Unified School District (PVUSD), which serves more than half the students in Santa Cruz County, established an Office for Drug and Alcohol Prevention and Student Assistance to help address the issue of drugs in schools. Its early policies required the district to issue five-day suspensions to students caught with drugs on campus; however, this punishment was not working to discourage drugs on campus. As a result, Pajaro Valley Prevention and Student Assistance (PVPSA) was developed as a school-based student assistance program focused on treatment rather than punishment that provided support and supervision to keep students on campus and in class. Evaluations documented that this reduced the number of incidents of drug possession on school campuses and resulted in fewer repeat offenders.

- ✓ ***Challenge***: School district policy of suspending students for five days when caught on campus with drugs did not work to discourage the problem.
- ✓ ***Accomplishment***: Developed a successful school-based student assistance program by establishing a nonprofit agency dedicated to serving the school district.

Strategies

Nonprofit agency dedicated to school district able to leverage diverse resources

As PVPSA grew, a more efficient way of managing the program was needed. It was recommended that the prevention programs be separated from the school district and, in 1990, PVPSA became a dedicated nonprofit agency to PVUSD. The agency was governed by the Superintendents from the County Office of Education and PVUSD, as well as the Watsonville Police Chief, Mayor, and other community leaders. Shortly thereafter, PVPSA became a model "dedicated nonprofit agency" and put together a guidebook about their innovative organizational structure through a grant from the U.S. Department of Education.

As an agency independent from but dedicated to the school district, PVPSA has greater flexibility to coordinate resources. It leverages public funds from the local, county, state, and federal government, and applies for private foundation grants on behalf of the school district. PVPSA brings together a broad range of stakeholders including PVUSD, law enforcement, the city, and other county agencies who work collaboratively to identify and pursue outside funding opportunities. Examples of leveraging funding include successfully applying for California Gang Reduction Intervention and Prevention Program grants and Mental Health Services Act—Prevention and Early Intervention (MHSA-PEI) funds to support a position at a drug and alcohol program on one of their school campuses. PVPSA also represents the interests of the school district as a local stakeholder and community-based provider in countywide planning initiatives or partnerships, such as the county MHSA Planning Commission, the Special Education Local Planning Area (SELPA), and the Student Attendance Review Board.

PVPSA provides an array of therapies to meet the various needs of students

As a service provider, PVPSA enhances the learning environment through conflict mediation, truancy interventions, gang prevention, and alcohol and other drug use prevention. A range of school-based counseling programs are accessible to thousands of PVUSD students in grades K-12, including evidence-based practices like Cognitive Behavioral Therapy. The Student Assistance Programs are available for students at most schools where PVPSA provides a counselor, depending of funding. Individual, group, and family services are provided, and referrals to community resources are made when appropriate. For older students, individual counseling and peer support groups are available for youth engaged in at-risk

behavior such as substance use, truancy, and gang involvement. Short-term family counseling and referrals to community resources are also provided.

In addition to the school-based programs, PVPSA also offers clinic-based counseling services. Counseling staff includes licensed therapists, interns in Marriage Family Therapy and Clinical Social Work tracks, and youth development specialists. For students involved in the juvenile justice system, the Criminal Justice Program provides counseling to intervene early and effectively. It works on youth violence prevention and juvenile justice programs in collaboration with the Santa Cruz County Probation Department and Watsonville Police Department. PVPSA also responds to critical incidents in the community in collaboration with the police by providing support and resources to victims and their families, and hopefully, preventing retaliation.

Master's-level interns provide effective services

One of the keys to the success of the program is the participation of Master's-level interns studying Marriage & Family Therapy and Clinical Social Work at local Bay Area colleges and universities. At no cost, these interns provide high quality, flexible mental health services that are typically not eligible for Medi-Cal EPSDT reimbursement. The interns also provide a cost effective way for PVPSA to staff its programs. More than 1,000 students receive counseling services through this program. Interns conduct an array of mental health activities on campus including conflict mediation, crisis intervention, grief and loss counseling, behavior modification, and staff consultation.

Funding Snapshot

As a Dedicated Nonprofit Agency, PVPSA is able to access funds from multiple sources to provide a range of services to students. Some funding streams are used to provide direct mental health services for students. Other funding streams are leveraged by PVPSA for specific projects, to increase capacity, or to build collaborations between county partners to prevent school dropout, fight gangs, deter substance abuse, and support general and special education.

- Medi-Cal EPSDT is the primary funding mechanism for most services for eligible students.
- Some private insurance and payments on a sliding scale are accepted for services.
- CalGRIP funding in partnership with the Watsonville Police Department supports school dropout and gang prevention work in Watsonville.
- MHSA-PEI funds support a position at a drug and alcohol program in PVUSD.
- County Probation Department funds services for youth on formal probation or first time offenders.
- AB 602 funding from PVUSD's Special Education Local Planning Area (SELPA) help PVPSA provide mental health support to students with special learning needs.

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Student Mental Health Funding Streams

Successful county partnerships linking students to mental health services can be financed through a variety of local, state, and federal funding streams. This section highlights several of the funding streams supporting county collaborations that link students to mental health services and evidence-based therapies as needed. The summaries for each funding stream include a brief description, eligible child or adolescent populations, services that can be covered, including evidence-based practices, the funding process, and a link to additional information.

Statewide Funding Streams

1. Medi-Cal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
2. Mental Health Services Act (MHSA)
    a. MHSA-Prevention and Early Intervention (PEI)
    b. MHSA-Community Services and Support (CSS)
3. AB 602 Special Education Local Planning Area (SELPA) Allocation
4. AB 114 Educationally-Related Mental Health Services (ERMHS)
5. California Gang Reduction, Intervention and Prevention (CalGRIP) Program
6. California Victim Compensation Program (CalVCP)
7. Child Abuse Treatment (CHAT) Grants
8. Juvenile Justice Crime Prevention Act (JJCPA)
9. Local Control Funding Formula (LCFF)
10. The Youthful Offender Block Grant (YOBG)

1. Medi-Cal Early Prevention, Screening, Diagnosis & Treatment (EPSDT)

Description	EPSDT is a federal entitlement that requires states and counties to provide comprehensive and preventative health care services to low-income children under 21 who are enrolled in Medicaid. In California, Medicaid is referred to as Medi-Cal. The EPSDT component of Medi-Cal aims to ensure that all children and adolescents have access to appropriate preventive, dental, mental health, and developmental, and specialty services. The federal government matches state dollars to fund these mandatory services.
Eligible Child or Adolescent Populations	Children under 21 who are enrolled in full-scope Medi-Cal are eligible for EPSDT. "Full-scope" is a benefit category that refers to applicants who meet the eligibility requirements and have access to the "full scope" of medical services under Medi-Cal. In contrast, there are other Medi-Cal benefit categories that have more limited medical services, for example, Emergency Medi-Cal.
Services Covered	Medi-Cal EPSDT providers offer two key benefits for all eligible children: • *Comprehensive Screening Services*: Comprehensive health screenings that include, at a minimum, medical, dental, vision, and hearing; developmental history; physical exams including assessment of nutritional status, immunizations, laboratory tests, health education, lead screenings. Screenings must follow a pre-set periodicity schedule, as well as when needed. • *Medically Necessary Services:* States are required to provide medical, diagnostic, and treatment services in order to "correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services" (42 USC § 1396d(r)(5)). These include dental services, prescription drugs, physical therapy, and medical equipment. These benefits include supplemental specialty mental health services for eligible children under 21 through county Medi-Cal mental health plans. These services are provided by mental health specialists, such as psychiatrists, psychologists, licensed clinical social workers, and licensed marriage and family therapists and involve conditions not responsive to treatment by a physical health care provider. Services include mental health, rehabilitative, psychiatric inpatient hospital, and psychiatric nursing facility services. EPSDT requires that Medi-Cal programs engage in outreach and notification services for eligible children and families, as well as offer scheduling, transportation, referral, and appointment follow-up assistance. Medi-Cal EPSDT funds a variety of practices that can include evidence-based practices such as: • Aggression Replacement Training (ART) • Cognitive Behavioral Therapy (CBT) • Functional Family Therapy (FFT) • Incredible Years (IY) • Multisystemic Therapy (MST) • Parent-Child Interaction Therapy (PCIT)

	• Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
Funding Process	In 2012, California transferred oversight of a number of health and mental health programs, including EPSDT mental health services, to the counties. Prior to this realignment, EPSDT services were billable through Medi-Cal reimbursement and a combination of county, state, and federal funds, with the counties paying a 5 percent share of cost, the state paying 45 percent, and the federal government matching at 50 percent. Under realignment, counties receive an annual allocation from the state based on historical spending and county demographics for EPSDT mental health services. County behavioral health departments are responsible for using this allocation to provide EPSDT mandated services. While there was concern that counties would be responsible for covering the costs of care above the allocation from the state, the state recently confirmed that, if counties spend above their allocation, the state would augment the realigned amount with additional funds. All medically necessary diagnostic and treatment services (within the federal definition of Medicaid medical assistance) must be covered by EPSDT, regardless if these services are covered for adults 21 years or older through Medicaid.
Additional Information	EPSDT Overview – Health Resources and Services Administration (HRSA): http://mchb.hrsa.gov/epsdt/overview.html EPSDT Program – Medi-Cal Services for Children, National Health Law Program: http://healthconsumer.org/Medi-CalOverview2008Ch12.pdf

2. Mental Health Services Act (MHSA)

Established in 2004 by the passage of Proposition 63, MHSA requires each county mental health department to submit an integrated three-year plan that is reviewed annually.
In their MHSA plans, counties are required to submit a listing of all programs for which MHSA funding is requested and identify expenditures for each type of funding (for example, in the Community Services and Supports component, Full Service Partnership, System Development, and Outreach and Engagement) and for each target age group (Children and Youth, Transition-Aged Youth, Adult, and Older Adult).

More than $8 billion has been generated since Proposition 63 went into effect in 2005 as the Mental Health Services Act. Proposition 63 is funded by levying a 1 percent tax on personal income above $1 million. Revenues are distributed directly to counties, with no more than 5 percent used for state-level administration. County allocations are based on total population, households with incomes below 200 percent of the federal poverty level, percentage uninsured, and prevalence of mental illness. Allocations are adjusted based on cost of living and existing resources. Counties with fewer than 200,000 residents receive a set amount.

Target populations include children and adolescents with Serious Emotional Disturbance and transition-aged youth who are unserved, underserved, or inappropriately served (e.g., homeless, frequent hospital users, individuals with criminal justice history). The MHSA includes a Prevention and Early Intervention (PEI) component, the purpose of which is to prevent mental illness from becoming severe and disabling.

Proposition 63 also established the Mental Health Services Oversight and Accountability Commission (MHSOAC) to oversee the implementation of MHSA. MHSOAC oversees the Adults and Older Adults Systems of Care Act, Human Resources, the Children's Mental Health Services Act, PEI and Innovation Programs. Prior to March 2011, the MSHOAC oversaw the review and approval process of the Innovative (INN) and Prevention & Early Intervention (PEI) components of MHS. However, Assembly Bill 100 shifted the role of the MHSOAC from review and approval towards evaluation, training, and technical assistance to counties for planning. As of June 2012, MHSOAC resumed approval of county INN plans.

Currently, the MHSOAC receives and reviews all county integrated three-year plans, annual updates, and annual Revenue and Expenditure Reports. The California Department of Health Care Services – Mental Health Services Division provides information about funding and reporting guidelines. Local County Boards of Supervisors approve MHSA funding for all other components, including PEI and Community Services and Supports (CSS).

A. Mental Health Services Act–Prevention and Early Intervention (MHSA-PEI)

Description	MHSA allocates 20 percent of the Mental Health Services Fund to counties for PEI as a key strategy to prevent mental illness from becoming severe and disabling and to improve timely access for underserved populations. PEI programs emphasize strategies to reduce negative outcomes that may result from untreated mental illness: suicide, incarcerations, school failure or dropout, unemployment, prolonged suffering, homelessness, and removal of children from their homes. PEI proposed regulations define "prevention" as efforts to bring about mental

	health and related outcomes for individuals at greater than average risk of developing a potentially serious mental health disorder, including addressing relapse prevention for individuals in recovery from a serious mental illness. Prevention, according to current PEI guidelines, works by "reducing risk factors or stressors, building protective factors, and increasing support. Prevention promotes positive cognitive, social, and emotional development and encourages a state of well-being that allows the individual to function well in the face of changing and sometimes challenging circumstances." MHSA calls for an approach to prevention that is integrated, accessible, culturally competent, strength-based, effective, and that targets investments with the aim of avoiding costs (in human suffering and resources) for treatment services."[13] "Early intervention" is defined as addressing people early in the onset of a mental disorder. PEI proposed regulations intend early intervention to measurably improve the mental health problem or disorder very early in its manifestation and avoid the need for more extensive mental health treatment or services.
Eligible Child or Adolescent Populations	PEI programs must serve all age groups and at least 51 percent of county PEI funding must target individuals between the ages of 0 and 25. Counties with a population less than 200,000 are exempted from these age requirements.

Services Covered	MHSA-PEI funding supports:
	• Outreach to families, primary care health care providers, and others to recognize the early signs of potentially severe and disabling mental illnesses.
	• Access and linkage to medically necessary care provided by county mental health programs for children with severe mental illness, as defined in Section 5600.3 of the Welfare and Institutions Code.
	• Reduction in stigma associated with either being diagnosed with a mental illness or seeking mental health services.
	• Reduction in discrimination against people with mental illness.
	• Strategies to reduce negative outcomes that may result from untreated mental illness, including:
	  ○ Suicide;
	  ○ Incarcerations;
	  ○ School failure or dropout;
	  ○ Prolonged suffering;
	  ○ Homelessness; and
	  ○ Removal of children from their homes.
	
	MHSA-PEI funds a variety of practices for individuals at risk of or with early onset of a potentially serious mental illness that can include evidence-based practices such as:
	• Aggression Replacement Training (ART)
	• Cognitive Behavioral Therapy (CBT)
	• Functional Family Therapy (FFT)

	• Incredible Years (IY) • Multisystemic Therapy (MST) • Parent-Child Interaction Therapy (PCIT) • Positive Behavior Intervention and Supports (PBIS) • Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
Funding Process	Funding is approved of and administered by each county's behavioral health or mental health department after review and comment by the local Mental Health Board. Counties submit an integrated plan comprised of the relevant MHSA components to MHSOAC. As of January 2012, the Mental Health Services Oversight and Accountability Commission (MHSOAC) had approved over $1 billion of PEI funds for all 58 counties. An additional $129 million was approved for statewide PEI efforts to prevent suicide, reduce stigma and discrimination, and improve student mental health.[14]
Additional Information	California Mental Health Services Act, Prevention and Early Intervention Clearinghouse: http://www.preventionearlyintervention.org/go/WhyMentalHealthPrevention.aspx Mental Health Services Oversight and Accountability Commission: http://www.mhsoac.ca.gov/Counties/PEI/Prevention-and-Early-Intervention.aspx

B. Mental Health Services Act–Community Support Services (MHSA-CSS)

Description	MHSA allocates 55 percent of funds to Community Services and Supports (CSS) to provide funding for services identified in children's and adults' system of care treatment plans that are not funded through any other source (public or private insurance). These systems of care are the programs, services, and strategies identified by each county through its stakeholder process to serve unserved and underserved populations with a serious mental illness, and include an emphasis on eliminating racial and other disparities.
Eligible Child or Adolescent Populations	All ages must be served by a county's CSS components. Disparities in access to services for underserved populations and regions of the county must be addressed.
Services Covered	CSS provides funding for services identified in a children's and adults system of care treatment plans that are not funded through any other source (public or private insurance). MHSA-CSS funds a variety of practices that can include evidence-based practices for individuals with a serious mental illness such as: • Aggression Replacement Training (ART)

	• Cognitive Behavioral Therapy (CBT) • Functional Family Therapy (FFT) • Incredible Years (IY) • Multisystemic Therapy (MST) • Parent-Child Interaction Therapy (PCIT) • Positive Behavior Intervention and Supports (PBIS) • Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
Funding Process	Funding is approved of and administered by each county's behavioral health or mental health department. Counties submit an integrated plan comprised of the relevant MHSA components to MHSOAC.
Additional Information	Mental Health Services Act – Components: http://www.mhsoac.ca.gov/About_MHSOAC/About_Prop63_Components.aspx More information about county CSS investments can be found on each county's behavioral health or mental health department website.

3. Assembly Bill 602 (Enacted 1997) – Special Education Local Planning Area (SELPA) Apportionment

Description	SELPAs are consortiums of school districts and county offices of education within a geographical region of sufficient size and scope. A region might be composed of a group of many small districts or a single large district, but each region must be of sufficient size and scope to provide the full continuum of services for youth residing within the SELPA boundaries. The current SELPA funding model is based on California legislation passed in 1997 (AB 602) that implemented a "census-based" special education funding structure. The formula allocates funding based on a SELPA's total average daily attendance (ADA), with the remainder distributed based on specific circumstances, rather than on the number of students identified to receive special education services.
Eligible Child or Adolescent Populations	All K-12 SELPAs are eligible for funding. SELPAs must provide for all special education service needs of children residing within the region boundaries. A student qualifies for special education once the school determines that it cannot meet the student's needs through the general education programs. Once this is determined, the student is assessed for a disability and whether that disability interferes with the student's education.
Services Covered	While SELPAs receive AB 602 funds based on overall ADA counts, they generally use these funds to support the excess costs of educating students with disabilities and provide all the services identified in a student's Individualized Education Plan. AB 602 funds also complement additional special education funding (see #4, AB 114) that helps provide educationally necessary mental health services to students with disabilities. AB 602 funds a variety of practices that can include evidence-based practices such as: • Cognitive Behavioral Therapy (CBT) • Parent-Child Interaction Therapy (PCIT) • Positive Behavior Intervention and Support (PBIS)
Funding Process	The AB 602 base allocation—which in 2012-13 included about $2.9 billion in state funds and $1 billion in federal Individuals with Disabilities Education Act (IDEA) monies—is the largest source of funding that SELPAs receive for special education. Each SELPA has a unique per-pupil special education funding rate consisting of both state and federal funds. These AB 602 rates vary across SELPAs from about $500 to $1,100 per student, based primarily on what the SELPA received before the AB 602 legislation was adopted. The exact mix of federal and state funds making up each rate varies based on a number of factors. Federal IDEA funds average about $180 per student, with state funds making up the difference.
Additional Information	Assembly Bill 602 SELPA Apportionment: http://www.cde.ca.gov/fg/aa/se/ab602apptdat.asp

4. Assembly Bill 114 (Enacted 2011) – Educationally-Related Mental Health Services (ERMHS)

Description	Assembly Bill (AB) 114 changed the process by which students in Special Education receive mental health services. Previously, under AB 3632, county mental health departments provided services. However, realignment under AB 114 requires all California school districts to be solely responsible for ensuring that students with disabilities, as designated by their Individualized Educational Plan (IEP), receive the mental health services necessary to benefit from a special education program.
Eligible Child or Adolescent Populations	Students with IEPs who demonstrate behavioral health issues that impact their ability to learn and access the school curriculum are eligible for AB 114. ERMHS funds are not restricted to students who have "emotional disturbance" as their identified disability.
Services Covered	Services must be included in the IEP and can include: individual counseling, parent counseling, social work services, psychological services, and residential treatment. Any service agreed upon by the student's IEP team as necessary for the student to receive a free and appropriate public education may be considered a related service and covered by AB 114 funds. There are three primary ways districts are meeting the AB 114 requirement: 1. School districts hire mental health professionals (i.e., credentialed and/or licensed social workers, psychologists) and provide services through these staff. 2. School districts contract with community mental health agencies or other qualified professionals to provide services. 3. School districts contract with county mental health departments to provide services. AB 114 funds a variety of practices that can include evidence-based practices such as Positive Behavior Intervention and Supports (PBIS).
Funding Process	Funding is distributed from the California Department of Education directly to Special Education Local Plan Areas (SELPAs) based on the average daily attendance of all pupils in the SELPA (regardless of how many pupils have an IEP or disability). SELPAs then determine how to allocate dollars to the individual districts and schools.
Additional Information	Assembly Bill 114 Special Education Transition: http://www.cde.ca.gov/sp/se/ac/ab114twg.asp

5. California Gang Reduction, Intervention and Prevention (CalGRIP) Program

Description	CalGRIP is a competitive grant program funded through the State Restitution Fund of the California Victim Compensation Program. CalGRIP provides grants to local governments since 2007 for local anti-gang programs. The initiative provides resources to jurisdictions using a local collaborative effort for gang prevention, intervention, reentry, education, job training and skills development, mental health, family and community services, and/or suppression activities.
Eligible Child or Adolescent Populations	Children and youth who exhibit high-risk behaviors related to gang involvement, are at risk of joining a gang, are already a gang member, or are on probation are eligible for CalGRIP funded programs.
Services Covered	The Board of State and Community Corrections, which oversees the CalGRIP program, requires the use of evidence-based practices (EBPs), and requests grantees to identify the EBPs applied in the most recent Request for Proposals. Additionally, several cities use CalGRIP to run data-driven Operation Ceasefire-like models, a targeted "carrot and stick" intervention that provides high-risk youth with meaningful opportunities to choose alternatives to violence and engages local communities to support youth who are making these choices to turn their lives around. CalGRIP funds a variety of practices that can include evidence-based practices such as: • Aggression Replacement Training (ART) • Functional Family Therapy (FFT) • Multisystemic Therapy (MST) • Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
Funding Process	Annually, $9.2 million in total funding is competitively awarded to jurisdictions that are using local collaborative approaches for gang prevention, intervention, and suppression activities. Each region may request up to $250,000 and is required to provide a 100 percent local match of the funds awarded.
Additional Information	Board of State and Community Corrections – Corrections Planning and Programs: http://www.bscc.ca.gov/s_cppgrantfundedprograms.php

6. California Victim Compensation Program (CalVCP)

Description	The California Victim Compensation Program (CalVCP) is a reimbursement program providing financial assistance to crime victims since 1965. The fund was modified through legislation in 2008 (AB 2809-Leno) to provide mental health services for child witnesses of crimes.
Eligible Child or Adolescent Populations	Children who have directly experienced physical or sexual abuse, witnessed domestic violence, or any violent crime for which a police or Child Protective Services report was filed in the state of California may qualify for services under the state's Victim Compensation Program. For certain crimes, emotional injury alone is enough to qualify. Direct victims and family members of victims can receive between 15-40 sessions of treatment. The fund was modified in 2008 to allow minor witnesses to also be eligible for assistance even if he or she is unrelated to the crime victim. To qualify, the minor witness must have been in close proximity to the crime. The program cannot pay any expense for a person who is on felony probation, on parole, in jail, or in prison.
Services Covered	CalVCP may help pay for expenses related to a crime such as: • Medical and dental treatment; • Mental health services; • Income loss; • Funeral and burial expenses; • Loss of support for dependents when a victim is killed or disabled because of a crime; • Home or vehicle modifications; • Home security; • Relocation; and • Crime scene cleanup. CalVCP funds a variety of practices that can include evidence-based practices such as: • Aggression Replacement Training (ART) • Cognitive Behavioral Therapy (CBT) • Functional Family Therapy (FFT) • Parent-Child Interaction Therapy (PCIT) • Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
Funding Process	CalVCP is considered the payer of last resort and can only pay for treatment expenses after other available sources of payment are applied. Those alternative sources include, but are not limited to, health insurance, workers compensation insurance, automobile insurance, Medi-Cal, and Medicare. CalVCP can only reimburse crime-related expenses, with limits on how much can be paid for each incidence. Crime victims should contact the local Victim Witness Assistance Center in their

	county. A victim advocate at the Center can help victims complete and submit required paperwork. The victim advocate can also help victims learn more about the criminal justice system. Funding for CalVCP varies annually and comes from restitution fines and orders, penalty assessments levied on persons convicted of crimes and traffic offenses, and federal matching funds. In 2012-13, CalVCP paid $62 million in victim compensation requests, of which, more than $21 million was used for mental health services. Of more than 54,000 applications for VCP funding, over 19,000 were for minors. The maximum reimbursement per claim, including dental, medical, and mental health treatment expenses, is currently $63,000. Additionally, minors who suffer emotional injuries from witnessing a violent crime may be eligible for up to $5,000 in mental health counseling through CalVCP.
Additional Information	The California Victim Compensation Program (CalVCP): http://vcgcb.ca.gov/victims/ Victim Witness Assistance Center: http://vcgcb.ca.gov/victims/localhelp.aspx

7. Child Abuse Treatment (CHAT) Grants

Description	The Child Abuse Treatment (CHAT) Program funds both government and nonprofit community-based organizations that have a minimum of two years experience providing child abuse treatment services in California. CHAT grants facilitate therapeutic treatment services to child victims of abuse and provide support services to non-offending family members. Under this program, child abuse victims must be provided comprehensive psychotherapy services, with an emphasis on underserved children including children who are dependents of the court and children in the welfare system.
Eligible Child or Adolescent Populations	Child Abuse Treatment services are available on a limited basis to students who have a history of some type of trauma but have no report from Child Protective Services or the police. This includes school and community violence such as being bullied; parental neglect; domestic violence; sexual, physical, and emotional abuse; hate crimes; child abduction; children whose lives are victimized by parental substance abuse; high tech crimes against children; and runaway youth. CHAT grants are available through the California Governor's Office of Emergency Services.
Services Covered	CHAT funding may help pay for: • Outreach and intake; • Crisis intervention; • Individual psychotherapy and group mental health counseling; • Meeting with the child's non-offending family member and/or caregiver in order to help him/her assist with therapeutic services for the child; • Case management; • Information and referral services; • Assistance in providing information on crime victim compensation services and assistance in understanding and helping the child prepare to attend criminal justice procedures by referring the child client to the local victim/witness assistance center; and • Transportation services for the child victim and non-offending family member and/or caregiver. CHAT funds a variety of practices that can include evidence-based practices such as: • Functional Family Therapy (FFT) • Parent-Child Interaction Therapy (PCIT) • Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
Funding Process	Projects implementing this program are either government agencies, nonprofit community-based organizations, or American Indian tribes/organizations that were originally selected through a competitive Request for Proposal process in the Spring of 2004 and who have continued to maintain high quality services for youth. Nearly $8.3 million in federal Victims of Crime Act (VOCA) funds are available for

	the CHAT Program for FY 2013-14. Ongoing funding for the CHAT Program is contingent upon California Office of Emergency Services' receipt of federal grant awards and passage of the annual State Budget Act.
Additional Information	CalEMA: 2013-14 Child Abuse Treatment (CHAT) Program: http://www.calema.ca.gov/GrantsProcessing/_layouts/DispItem.aspx?List=a0ffeea6-5a86-4de1-b7d8-268add1d7015&ID=116&RootFolder=%2FGrantsProcessing%2FLists%2FGrants&Web=345b2b9e-94a0-43c4-aebb-c89984ba6450

8. Juvenile Justice Crime Prevention Act (JJCPA)

Description	Enacted in 2000, the Juvenile Justice Crime Prevention Act (JJCPA) provides a statewide dedicated funding stream for local juvenile justice programs designed to curb juvenile crime, including intensive family interventions, after-school programs for at-risk teens, gang and truancy prevention, job training, and diversion programs. JJCPA supports 149 programs in 56 participating counties and serves nearly 90,000 at-risk and delinquent youths annually. The Department of Finance credits JJCPA with "curbing juvenile crime" and deterring "countless thousands" of juveniles from ending up in custody.
Eligible Child or Adolescent Populations	JJCPA's diverse programs serve youth at different stages of contact with the juvenile justice system. Generally, programs fall into three main categories: Prevention, Intervention, and Aftercare, but many programs are in more than one of these categories: 1. Prevention programs target youth who have not yet entered, but are at risk of entering, the juvenile justice system. These include anti-truancy and after-school programs. 2. Intervention programs serve youth who have already been arrested and are in custody or on probation. Within the area of intervention, many programs focus on different levels of juvenile offenders, ranging from first-time, low-level offenders to serious, chronic offenders. Some intervention programs also provide alternative adjudication, such as Drug Court, Neighborhood Accountability Boards, and Victim/Restorative Justice. 3. Aftercare programs provide services for youth who are transitioning out of custody back into society, such as Day Reporting Centers.
Services Covered	JJCPA funds a variety of programs throughout the state that provide a range of comprehensive services including: • Mental health services, including assessments and individual, group, and family counseling; • Substance abuse treatment; • Gang prevention and intervention; • Job skills, employment, and vocational training; • Gender-specific programs for girls; • Community service; • Life skills training; • Anger management classes; and • Academic assistance. JJCPA funds a variety of practices that can include evidence-based practices such as: • Aggression Replacement Training (ART) • Cognitive Behavioral Therapy (CBT) • Functional Family Therapy (FFT) • Multisystemic Therapy (MST)

Funding Process	JJCPA is funded through public safety dollars constitutionally guaranteed by Proposition 30 (2012). JJCPA currently receives approximately $107 million in annual funding, which is distributed to counties based on a formula. County Juvenile Justice Coordinating Councils have discretion to determine how to utilize this funding. JJCPA programs are required to monitor their outcomes and report that information to the state each year. Evaluations of these outcomes suggest that JJCPA programs have a strong track record of success.
Additional Information	Board of State and Community Corrections – Corrections Planning and Programs: http://www.bscc.ca.gov/s_cppgrantfundedprograms.php

9. Local Control Funding Formula (LCFF)

Description	The Local Control Funding Formula, enacted through the 2013-14 state budget, is the new system for calculating funding for most public schools in California. Each district receives a "base grant" per student, plus additional "supplemental and concentration" grants for targeted students who are low income, foster youth, or English-Language Learners.
Eligible Child or Adolescent Populations	All K-12 students in public schools are eligible for LCFF funds, with more funding for targeted students who are low income, in foster care, or English-Language Learners.
Services Covered	LCFF funds almost every service provided by public schools, including teacher salaries, classroom materials, and facilities. LCFF can be used for school-based mental health programs and staff, including social workers, counselors, nurses, and psychologists. Given that LCFF is in its early stages of implementation, it is not yet clear what evidence-based practices LCFF will support.
Funding Process	School districts are currently receiving LCFF funds, which will increase through 2020. Districts must submit a three-year Local Control and Accountability Plan (LCAP) and annual LCAP updates to their County Office of Education. The LCAP must demonstrate how funds will be used to support targeted students in eight distinct state priorities. It is estimated that, after years of cuts, at full implementation, LCFF will bring school funding back to at least 2007 levels. The state priorities most linked to student mental health include "pupil engagement" as measured in part by attendance and "school climate" as measured in part by suspension and expulsion rates.
Additional Information	California Department of Education – Local Control Funding Formula: http://www.cde.ca.gov/fg/aa/lc/

10. Youthful Offender Block Grant (YOBG)

Description	The Youthful Offender Block Grant (YOBG) program provides state funding for counties to deliver custody and care (i.e., appropriate rehabilitative and supervisory services) to youthful offenders. With the 2007 juvenile justice realignment, county jurisdictions are now responsible for the care and supervision of these youthful offenders formerly under state control.
Eligible Child or Adolescent Populations	YOBG funding covers juvenile offenders who are no longer housed in state facilities and instead are the responsibility of county jurisdictions. Consistent with the intent to give counties broad flexibility to manage the realigned juvenile population, YOBG regulations allow counties to supplant funds and spend their allocations as needed. Consequently, some counties have chosen to use YOBG funds to offset cuts elsewhere in their budgets. Some use it for infrastructure or to fill staffing needs, while others apply it to capacity building, direct services, and placement of juveniles. Because counties can decide how to best spend YOBG funding, not all provide services.
Services Covered	Given county flexibility in using these funds, YOBG expenditures reported by counties range significantly including funding six different types of placements, 31 types of direct services, and seven types of capacity-building activities. Some of the key expenditures that counties could employ for school-linked mental health services include: • Adequate risk and needs assessments; • The ability to utilize a multitude of graduated sanctions from treatment to intensive supervision and detention; • Re-entry and aftercare programs; • Agency capacity building; and • The formation or expansion of regional networks. Although these grants do not require funding evidence-based practices, many counties have opted to utilize YOBG funds to implement or maintain EBPs. Evidence-Based Practices supported by YOBG include: • Aggression Replacement Training (ART) • Cognitive Behavioral Therapy (CBT) • Functional Family Therapy (FFT) • Multisystemic Therapy (MST)
Funding Process	Individual county allocation amounts are based on a statutory formula that gives equal weight to county juvenile population and juvenile felony dispositions. By May 1 of each year, every county is required to submit a Juvenile Justice Development Plan/Funding Application that identifies how it plans to spend YOBG funds in the upcoming fiscal year. Similarly, by October 1 of each year, every county is required to submit a report on the actual expenditure of YOBG funds in the prior fiscal year. YOBG allocated approximately $103 million in 2013-14, up from $93.4 million the previous year.

	To receive YOBG funding, counties submit annual funding applications and annual reports of expenditures and performance outcomes to the Board of State and Community Corrections (BSCC).
Additional Information	Board of State and Community Corrections – Corrections Planning and Programs: http://www.bscc.ca.gov/s_cppgrantfundedprograms.php

Evidence-Based Practices

Providing students access to mental health resources can be complicated and expensive. With limited funds, complex systems of care, and numerous therapies to choose from, the best way to ensure that students will receive effective interventions is to rely on evidence-based practices (EBPs). Similar to rigorous medical studies, there is now solid evidence gathered from a growing number of randomized control trials that shows what really works for youth mental health services. Especially when funding is scarce, decision makers and program implementers are best served by utilizing and expanding programs that are based in rigorous research, with a record of successful replication, and with evidence of effectiveness. Choosing or expanding the right EBP and faithfully implementing it with well-qualified and well-trained staff, can easily pay for itself by reducing future crime, as an example.

The student mental health programs highlighted in this toolkit implement evidence-based programs, promising and emerging practices, and interventions that may not have been fully investigated for effectiveness yet. The case studies highlight the evidence-based programs implemented where appropriate. This section provides an overview of the EBPs mentioned in the case studies and primarily highlights therapies for youth with demonstrated crime prevention outcomes, which has been the focus of most analyses of evidence-based programs for youth. There may be additional evidence-based programs not included below with strong mental health, but not crime prevention, outcomes.

Rating Scales

Each therapy is listed with at least one ranking from top federal and private agencies that rated the effectiveness of prevention programs. Evaluations are focused on programs designed to reduce or eliminate problem behaviors in youth such as delinquency, aggression, violence, substance use, school behavioral problems, mental health problems, and risk factors identified as predictive of these problems. The three rating scales used are:[15]

1. The University of Colorado Boulder – Blueprints for Healthy Youth Development
   - Name: Blueprints
   - Rating Levels: Model Programs, Promising Programs
   - Overview: The Blueprints mission is to identify truly outstanding violence and drug prevention (and most recently mental and physical health, education, and self-regulation) programs for children and adolescents that meet a high scientific standard of effectiveness.

2. U.S. Department of Justice – Office of Juvenile Justice and Delinquency Prevention
   - Name: OJJDP
   - Rating Levels: Effective, Promising, No Effects
   - Overview: OJJDP's Model Programs Guide is designed to assist practitioners and communities in implementing evidence-based prevention and intervention programs that can make a difference in the lives of children and communities. Study reviewers analyze the most rigorous evaluation research available to assess the quality, strength, and achievement of the program goals.

3. U.S. Department of Health & Human Services – Substance Abuse & Mental Health Services Administration
   - Name: SAMHSA
   - Rating Levels: 0–4 for Individual Outcomes (4 is highest ranking)

Overview: SAMHSA's National Registry of Evidence-Based Programs and Practices is a searchable online database of independently evaluated and rated therapies to assist the public in identifying approaches that have been scientifically evaluated to prevent and treat mental health and substance use disorders and are also ready to be disseminated in the field.

Cost-Benefit Analysis

The Washington State Institute for Public Policy (WSIPP) calculates the costs associated with EBPs. The WSIPP cost-benefit analysis examines the monetary value of programs to determine the cost per youth and whether the benefits exceed the costs. WSIPP's research approach to identifying evidence-based programs includes determining "what works" to improve outcomes using meta-analyses of data, calculations to see if the benefits of a program exceed its costs, plus additional statistical analysis to estimate how likely it is that the results reported can be replicated in the real world.[16] It should be noted that this analysis considers the cost of implementation for Washington State. The costs of the practice are not the same everywhere and vary by location and system.

Evidence & Funding Streams

Therapies are described briefly with statistical, and occasionally more anecdotal, evidence of effectiveness. The descriptions include a website link for the reader to visit for more information about the therapy.

Also included are examples of funding sources that can be leveraged to provide access to each of the listed EBPs for students. Funding sources have been pulled directly from the case studies in addition to background research where EBPs are funded outside of the defined county collaborations in the toolkit, but could be accessed by students in partnership with county or community providers if needed.

Evidence-Based Practices

1. Aggression Replacement Training (ART)
2. Cognitive Behavioral Therapy (CBT)
3. Functional Family Therapy (FFT)
4. Incredible Years (IY)
5. Multisystemic Therapy (MST)
6. Parent-Child Interaction Therapy (PCIT)
7. Positive Behavior Intervention and Supports (PBIS)
8. Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
9. Triple P – Positive Parenting Program (PPP)

Therapy ✓ ***EBP Level***[17]	**Program Description**[18]	**Funding Sources Include**
Aggression Replacement Training (ART) for Youth on Probation ✓ *OJJDP Effective Program*	ART is a low-cost, short-term, cognitive behavioral therapy for youth who display aggressive and other disruptive behaviors. The program is targeted at a wide range of youth, including students acting out in school and juveniles involved in or at risk of involvement in the criminal justice system. Counties implementing ART successfully maintain the program's fidelity by providing all three components of the training, which are designed to help participants with their interpersonal skills, anger management, and social problem-solving skills. This intervention is based on the proven Cognitive Behavioral Therapy approach shown in multiple randomized trials to be effective in treating children and adults for anxiety, depression, and other mental health problems. Juveniles returning to their communities following custody who did not receive ART were almost three times more likely to be re-arrested for a crime than those who went through the training. Another trial with gang members showed that those without ART were four times more likely to have been arrested following treatment. Cost: $1,540 per youth Benefit: $23.01 for every $1 invested For more information: http://aggressionreplacementtraining.com/	• Medi-Cal EPSDT • MHSA-PEI • MHSA-CSS • CalGRIP • JJCPA • YOBG • AB 602 Special Education funds • County Department of Behavioral or Mental Health funds • Child Abuse Treatment (CHAT) grants • CA Victim Compensation Program • Local school district funds
Cognitive Behavioral Therapy (CBT) for Depressed Adolescents ✓ *SAMSHA Program Ranked 3.4–3.7 out of 4.0*	CBT is a form of treatment that focuses on examining the relationships between thoughts, feelings, and behaviors. The therapy was developed from original research on what works to help many people, not just youthful offenders, change their problematic behaviors. Researchers found that many young offenders developed thinking, beliefs, and behaviors that repeatedly land them in trouble, often misinterpreting others' benign actions as threats. Many troubled juveniles approach challenging situations as victims, feeling they are hated and unfairly blamed. CBT interventions use tested, concrete methods for teaching teens to "stop and think before acting, to consider the consequences of their behavior, to conceptualize alternative ways of responding to interpersonal problems, and to consider the impact of their behavior on other people, particularly the victims." By learning what triggers their negative behaviors and by identifying and practicing more pro-social and effective ways to respond, CBT consistently reduces repeat crimes among both juveniles and adults. A review of 58 CBT randomized controlled trials and other careful trials found that, on average, the re-arrest rate among the adults or juveniles in CBT was 25 percent less than for those not in a CBT intervention. CBT can be successfully used with juveniles as an alternative to custody while they are on probation, while they are in custody, or with juveniles returning home from custody. The review also found that CBT is one of the most rigorously tested and reliably successful interventions to be found anywhere in the social sciences. Cost: $494 per youth Benefit: $11.01 for every $1 invested For more information: http://www.abct.org/ or http://www.nacbt.org	• Medi-Cal EPSDT • MHSA-PEI • MHSA-CSS • CalGRIP • JJCPA • YOBG • AB 602 Special Education funds • County Department of Behavioral or Mental Health funds • Child Abuse Treatment (CHAT) grants • CA Victim Compensation Program • Local school district funds

Therapy ✓ ***EBP Level***[17]	**Program Description**[18]	**Funding Sources Include**
Functional Family Therapy (FFT) for Youth on Probation ✓ *Blueprints Model Program* ✓ *OJJDP Effective Program*	FFT is a short-term, well-documented, and highly successful family intervention for at-risk and delinquent youth who are 11-18 years of age. FFT is often used for youth on probation, in lieu of custody, or as support when youth return to their family after custody. While FFT targets youth who have come in contact with the juvenile justice, mental health, or child welfare systems, younger siblings of referred youth often become part of the intervention process as well. FFT is a therapy with three specific phases that organize the intervention in a coherent manner, allowing clinicians to maintain focus in the context of considerable family and individual disruption. In one study FFT cut re-arrests in half and in another study juveniles in the intervention were one-fourth as likely to be placed outside their home in juvenile justice custody, in a psychiatric placement, or in foster care. Cost: $3,356 per youth Benefit: $11.50 for every $1 invested For more information: http://www.fftllc.com/	• Medi-Cal EPSDT • JJCPA • Child Abuse Treatment (CHAT) grants • CA Victim Compensation Program • Local school district funds
Incredible Years (IY) Parent and Child Training ✓ *Blueprints Promising Program* ✓ *OJJDP Effective Program* ✓ *SAMSHA Program Ranked 3.2–3.8 out of 4.0*	IY is a community-based intervention aimed at increasing social and emotional competence of children and reducing juvenile anti-social behavior. IY is targeted at children aged 2-12 years displaying behavioral and emotional problems, including high rates of aggression, defiance, and oppositional and impulsive behaviors. Young children with high rates of aggressive behavioral problems have been shown to be at great risk for developing substance abuse problems, becoming involved with deviant peer groups, dropping out of school, and engaging in delinquency and violence. The program consists of teacher, parent, and child training programs that emphasize different aspects to improve the child's behavior. Studies indicate that when both parent training and child training are offered, 95 percent of the children show a significant reduction in behavioral problems. When only child training is offered, there is a 74 percent reduction in behavioral problems, and when only parent training is offered, there is a 60 percent reduction in behavioral problems. Cost: $1,705 per youth Benefit: $0.79 for every $1 invested For more information: http://incredibleyears.com/	• Medi-Cal EPSDT • MHSA-PEI • First 5 • County Department of Behavioral or Mental Health funds • Local school district funds

Therapy ✓ ***EBP Level***[17]	**Program Description**[18]	**Funding Sources Include**
Multisystemic Therapy (MST) ✓ *Blueprints Model Program* ✓ *OJJDP Effective Program* ✓ *SAMHSA Program Ranked 2.9–3.3 out of 4.0*	MST is an intensive family- and community-based treatment program that targets the people, places, and activities of each youth's social network that contribute to their anti-social behavior, including their homes and families, schools and teachers, neighborhoods and friends. The program is intended for adolescents between the ages of 12-17, who have long histories of acting out or contact with the juvenile justice (JJ) system. MST is often used for youth on probation, in lieu of custody, or as support when youth return to their family after custody. The intervention is typically delivered in a youth's natural environment, which means that therapists are on call around the clock and go to the home, school, and community to work with the people who are part of the youth's world. When properly implemented, MST shows strong results of keeping chronic offenders and violent youths at home, in school, and out of trouble. A 22-year follow-up of one randomized trial of MST showed that those who did not receive MST were three and a half times more likely to be arrested for a violent felony than those who received the treatment. Another randomized trial of youth with serious emotional disturbances (SED) showed MST reduced the days youth were held in juvenile justice facilities, psychiatric hospitals or other out-of- home placements from an average of 12 days per month to four days per month. <u>MST-JJ</u> Cost: $7,522 per youth Benefit: $4.53 for every $1 invested <u>MST-SED</u> Cost: $7,235 per youth Benefit: $1.09 for every $1 invested For more information: http://mstservices.com/	• Medi-Cal EPSDT • MHSA-CSS • JJCPA • CalGRIP • County Department of Behavioral or Mental Health funds

Therapy ✓ ***EBP Level***[17]	**Program Description**[18]	**Funding Sources Include**
Parent-Child Interaction Therapy (PCIT) for Children with Disruptive Behavior ✓ *Blueprints Promising Program* ✓ *OJJDP Effective Program* ✓ *SAMSHA Program Ranked 3.1–3.9 out of 4.0*	PCIT is a program for children aged 2-8 years who display behavioral or emotional problems, such as aggression, non-compliance, defiance, and temper tantrums. PCIT has been adapted as an intervention for many different types of families, including those receiving child welfare services or exposed to violence, adoptive families, foster families, and those from other countries or who speak other languages. The program consists of two components where parents are taught to decrease negative aspects of their relationship with their children while strengthening their constructive skills. Parents are taught specific skills and practice them during the therapy sessions while therapists observe interactions between the child and parent and coach the parent accordingly. PCIT is delivered in a clinic-based setting and has been adapted for community mental health agencies, in-home delivery, and school-based services. PCIT outcome research has demonstrated significant improvements in the behavior of preschool- and early elementary-aged children. Studies indicate that children in the PCIT program showed significant improvement in behavior compared to those on waiting lists. The program has also been shown to be effective in reducing child abuse since the therapy targets both the child and the parent. One study out of the University of Oklahoma found that the re-referral rate for physical abuse was 30 percent lower for parents that participated in PCIT than for those that did not. <u>PCIT- Children with Disruptive Behavior</u> Cost: $1,362 per youth Benefit: $3.28 for every $1 invested <u>PCIT- Families in Child Welfare System</u> Cost: $1,582 per youth Benefit: $7.36 for every $1 invested For more information: http://www.pcit.org/	• Medi-Cal EPSDT • MHSA-PEI • MHSA-CSS • First 5 • AB 602 Special Education funds • County Department of Behavioral or Mental Health funds • Child Abuse Treatment (CHAT) grants • CA Victim Compensation Program • Local school district funds

Therapy ✓ ***EBP Level***[17]	**Program Description**[18]	**Funding Sources Include**
Positive Behavioral Interventions & Supports (PBIS) ✓ *SAMSHA Program Ranked 2.0–3.6 out of 4.0 (Safe & Civil Schools Model)*	PBIS, also known as School-Wide Positive Behavioral Support (SWPBIS), is a universal, school-wide prevention strategy for improving behavior and school climate. PBIS uses a three-tiered public health model to create school-wide, targeted, and individual systems of support. Disciplinary data is used to guide decision-making about program implementation and student response. At the universal level, schools create three to five clear behavioral expectations and rules that all students and teachers know. Responses to inappropriate behavior are clearly defined. Teachers and school leaders implement a rewards system to encourage students to exhibit positive behavior and be leaders for their peers. Students who do not improve their behavior under this universal level of support can receive more targeted interventions. For example, at the secondary level, students may participate in group therapy sessions or role-playing exercises. At the individual level, students can have an individualized behavioral analysis and/or receive individualized therapy. As of 2010, over 13,300 schools across the country were implementing SWPBIS. Non-randomized studies have shown strong reductions in office discipline referrals of up to 50 percent per year. Schools also report reductions in problem behavior and suspensions, a more positive school climate, greater safety, and improvements in academic achievement and attendance. California-specific data is very encouraging. At Pioneer High School in Woodland Joint Unified School District, implementation of SWPBIS has resulted in a 62 percent reduction in suspensions and significant increases in school attendance and achievement. In 2011-12 Pioneer HS saw an increase in ADA funding of $97,200 after starting their program with a federal Safe Schools Healthy Communities grant. Similarly at Garfield High School in Los Angeles, SWPBIS helped result in a reduction from 510 suspensions during the 2007-08 school year to 1 suspension during the 2010-11 school year. Additionally, the school experienced significant improvement in API, jumping from 597 points in 2007-08 to 707 in 2010-11 and in one year, implementation resulted in increased ADA funding of $363,216. Two randomized studies of PBIS found much more modest differences between the experimental and control groups, such as a slight reduction in the percentage of students referred to the office for discipline. This raises the question of whether PBIS, on its own, is responsible for the stronger results presented above or whether PBIS was part of other reforms taking place at the same time in those schools that together contributed to the dramatic results achieved. Another possibility is that the implementation of the PBIS programs in the randomized studies may have been less successful than elsewhere. From the available research, it is impossible to clarify exactly why the results are different. Cost: Cost varies. PBIS Technical Assistance Center estimates a pilot program in the first 15 sites in a district of 45 schools to be $5,000-10,000 per school for two years, and expanding into the next 15 sites at $3,800 per school for two years.[19] Benefit: No Cost-Benefit Analysis by WSIPP. For more information: http://www.pbis.org/ or http://www.fixschooldiscipline.org	• Individuals with Disabilities Education (IDEA) • Title I, Part A • School Improvement Grants (SIG) • Economic Impact Aid (EIA) • Safe Schools Healthy Communities • MHSA • Local Control Funding Formula (LCFF) • School Safety and Violence Prevention Act block grant

Therapy ✓ ***EBP Level***[17]	**Program Description**[18]	**Funding Sources Include**
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) ✓ *SAMSHA Program Ranked 3.6–3.8 out of 4.0* ✓ *OJJDP Effective Program*	TF-CBT is a short-term community-based cognitive behavioral intervention for children and youth who are experiencing significant emotional and behavioral difficulties related to traumatic life events. The program is targeted at children aged 3-18 years, particularly children who are not currently receiving mental health services and who may be experiencing PTSD symptoms or functional impairments due to earlier trauma. The program is intended to reduce symptoms of depression and psychological trauma by combining trauma sensitive interventions with cognitive behavioral therapy. Children and parents are provided knowledge and skills related to processing the trauma, managing distressing thoughts, feelings, and behaviors, as well as training on enhancing safety, parenting skills, and family communication. Ever since the 2009 shift towards prioritizing evidence-based practices in the County PEI Plan, Los Angeles has gone on to embed TF-CBT into many of its MHSA-PEI projects including Trauma Recovery Services, Juvenile Justice Services, Improving Access for Underserved Populations Project, and the American Indian Project. During 2012-13, Los Angeles County's MHSA-PEI funds provided more than 11,400 children and youth with TF-CBT services at a cost of $3,868 per child, ranking it one of the "Top 10 EBPs Delivered in the County" by number of clients served, according to the county's 2014-15 MHSA Expenditure Plan. Cost: $3,868 per Youth[20] Benefit: No Cost-Benefit Analysis by WSIPP. For more information: http://tfcbt.musc.edu/	• Medi-Cal EPSDT • MHSA-PEI • JJCPA • CalGRIP • County Department of Behavioral or Mental Health funds • Child Abuse Treatment (CHAT) grants • CA Victim Compensation Program • Local school district funds

Therapy ✓ ***EBP Level***[17]	**Program Description**[18]	**Funding Sources Include**
Triple P System – Positive Parenting Program ✓ Blueprints Promising Program ✓ OJJDP Effective Program ✓ SAMSHA Program Ranked 2.9–3.0 out of 4.0	Triple P—the Positive Parenting Program—is a universal or targeted system for delivering age-appropriate tools and techniques for parents to help their children behave responsibly. It reduces coercive parenting and increases positive reinforcements for desired behavior. Triple P lets parents pick what help they want, ranging from reading a newsletter article, to brief consultations, to ten weeks of parent coaching for parents with especially challenging children. It aims to prevent problems in the family, school and community before they arise and to create family environments that encourage children to realize their potential. The system has been provided for children by trained paraprofessionals in doctors' offices, child-care centers, or school settings. Triple P isn't a single program, but rather a suite of interventions of increasing intensity for parents of children from birth to 16 years old. It is delivered to parents of children from 0-12 years old, and with Teen Triple P for parents of 12-16 year olds. The Triple P system was developed through many randomized controlled group studies and, most recently, was tested in a universal intervention by Dr. Ron Prinz in counties throughout South Carolina with funding from the Centers for Disease Control and Prevention. For the thousands of children served in the counties randomly assigned to receive the efforts compared to the counties left out, Triple P counties averaged 25 percent reductions in abuse and neglect, 33 percent reductions in foster care placements, and 35 percent reductions in emergency room visits or hospitalizations for abuse.[21] <u>Triple P Level 4, Group</u> Cost: $383 per youth Benefit: $5.46 for every $1 invested <u>Triple P Level 4, Individual</u> Cost: $1,866 per youth Benefit: $1.56 for every $1 invested For more information: http://www.triplep-america.com/glo-en/home/	• County General Funds • Medi-Cal EPSDT • First 5 • Fee for Service • Health Insurance • MHSA-PEI • SAMHSA • Title IV-E Match

Resources

California County Superintendents Educational Services Association (CCSESA)

- Regional K-12 Student Mental Health Initiative
  http://www.regionalk12smhi.org
  This clearinghouse of resources and regional best practices is provided to assist California county offices of education, districts, and schools to develop and implement effective programs and services that promote the mental health and wellness of students in grades K-8, with linkages to preschool and grades 9-12.

The California Department of Education (CDE)

- Mental Health – Counseling/Student Support
  http://www.cde.ca.gov/ls/cg/mh/
  CDE provides strategies, resources, and training in psychological and mental health issues, including coping with tragedy, crisis intervention and prevention, school psychology, and suicide prevention.

- The Student Mental Health Policy Workgroup (SMHPW)
  http://www.cde.ca.gov/ls/cg/mh/smhpworkgroup.asp
  The State Superintendent of Public Instruction (SSPI) Tom Torlakson has convened a Student Mental Health Policy Workgroup (SMHPW) with funding from the California Mental Health Services Authority (CalMHSA). The all-volunteer, unpaid workgroup is comprised of teachers, school counselors, school social workers, school psychologists, school nurses, and school administrators, as well as state and county mental health professionals. The combined expertise of this diverse group assesses the current mental health needs of California students and gathers evidence to support its policy recommendations to the SSPI and to the California Legislature. The SMHPW meets on a quarterly basis and all meetings are open to the public.

- *A Guide to Student Mental Health and Wellness in California*
  www.macmh.org/macmh-publications
  A guide to help school staff identify and support students who are experiencing emotional distress. It includes sections on what educators may see if a student has a mental health disorder, how mental health disorders and medications affect student performance, and how to best form partnerships with parents. The *California Guide* also includes fact sheets on 15 common childhood mental health disorders. The fact sheets describe the disorders, list the common symptoms and behaviors, and give appropriate classroom strategies and accommodations. The *California Guide* is produced in collaboration with the California Department of Education, Placer County Office of Education, and the Minnesota Association for Children's Mental Health. Available to order from the Minnesota Association for Children's Mental Health (MACMH) for $26.95.

California Mental Health Services Authority (CalMHSA)

- CalMHSA is an organization of county governments working to improve mental health outcomes for individuals, families, and communities. It administers Prevention and Early Intervention programs funded by the Mental Health Services Act (MHSA/Proposition 63) on a statewide, regional, and local basis. It supports two resource websites supporting suicide prevention and stigma reduction:
  - Each Mind Matters: www.eachmindmatters.org
  - Know the Signs – Suicide is Preventable: http://www.suicideispreventable.org/

Washington State Institute for Public Policy (WSIPP)

- Evidence-Based Practice Benefit-Cost Results
  http://www.wsipp.wa.gov/BenefitCost
  The Washington legislature created the Washington State Institute for Public Policy in 1983. WSIPP is governed by a Board of Directors that represents the legislature, governor, and public universities. WSIPP's mission is to carry out practical, non-partisan research at the direction of the legislature or board of directors. WSIPP works closely with legislators, legislative and state agency staff, and experts in the field to ensure that studies answer relevant policy questions. Since the 1990s, the Washington State legislature has directed WSIPP to identify "evidence-based" policies. The goal is to provide Washington policymakers and budget writers with a list of well-researched public policies that can, with a high degree of certainty, lead to better statewide outcomes coupled with a more efficient use of taxpayer dollars. The included tables present the current findings for a variety of public policy topics. Items on these tables are updated periodically as new information becomes available.

The Center for the Study and Prevention of Violence (CSPV) at the University of Colorado at Boulder

- Blueprints for Healthy Youth Development
  http://www.colorado.edu/cspv/blueprints/ratings.html
  In 1996, the Center for the Study and Prevention of Violence (CSPV), at the University of Colorado at Boulder, with initial funding from the Colorado Division of Criminal Justice, Centers for Disease Control and Prevention, and the Pennsylvania Commission on Crime and Delinquency, and with major long-term funding from the Office of Juvenile Justice and Delinquency Prevention (OJJDP), designed and launched a national violence prevention initiative to identify and replicate violence prevention programs that are effective. The project, called Blueprints for Violence Prevention (today renamed Blueprints for Healthy Youth Development), identifies youth prevention and intervention programs that meet a strict scientific standard of program effectiveness. Program effectiveness is based upon an initial review by CSPV and a final review and recommendation from a distinguished Advisory Board, comprised of six to eight experts in the field of youth development. The model and promising programs, called Blueprints, have been effective in reducing problem behaviors and promoting healthy youth development. To date, more than 1,250 programs have been reviewed, and the Center continues to look for programs that meet the selection criteria. As a result of the funding from OJJDP, the Blueprints Initiative became a comprehensive effort to provide communities with a set of demonstrated effective programs and the technical assistance and monitoring necessary to plan for and develop an effective violence intervention.

Center for School Mental Health

- http://csmh.umaryland.edu/Resources/index.html
  The mission of the Center for School Mental Health (CSMH) is to strengthen policies and programs in school mental health to improve learning and promote success for America's youth. The Center compiles and creates a number of resources available online ranging in topics from clinician tools to funding to data collection to policy.

Endnotes

[1] Barrett, S., Eber, L., & Weist, M. (2013). Advancing Education Effectiveness: Interconnecting School Mental Health and School-wide Positive Behavior Support. *Center for School Mental Health*.

[2] Kataoka, S.H., Rowan, B., & Hoagwood, K.E. (2009). Bridging the Divide: In Search of Common Ground in Mental Health and Education Research and Policy. Psychiatric Services. 60(11): 1510-1515.

[3] Barrett, et. al

[4] Ibid.

[5] California Health Interview Survey. CHIS 2005 Public Use File. Los Angeles, CA: UCLA Center for Health Policy Research.

[6] Fight Crime: Invest in Kids *California*. *Proposition 63 Toolkit – From Promise to Practice: Mental Health Models that Work for Children and Youth*. 2004. Available at: http://www.fightcrime.org/state/2004/reports/prop-63-toolkit-promise-practice-mental-health-models-work-children-and-youth-200.

[7] Budget Act of 2014, AB 1468 (2013-2014), Chapter 26 (Cal. Stat. 2014). Available at: http://www.leginfo.ca.gov/pub/13-14/bill/asm/ab_1451-1500/ab_1468_bill_20140615_enrolled.htm.

[8] Knopf, D., Park, M.J., & Mulye, T.P. (2008). The Mental Health of Adolescents: A National Profile, 2008. National Adolescent Health Information Center. Available at: http://nahic.ucsf.edu/downloads/MentalHealthBrief.pdf.

[9] Katoka et.al.

[10] The California Endowment. (2010). *Healthy Communities Matter: The Importance of Place to the Health of Boys of Color*.

[11] Hurt, H., Malmud, E., Brodsky, N.L., & Giannetta, J. (2001). Exposure to violence: Psychological and academic correlates in child witnesses. *Archives of Pediatrics and Adolescent Medicine, 155*(12), 1351-1356.

[12] Hurwitz, Laura and Weston, Karen, *Using Coordinated School Health to Promote Mental Health for All Students*, National Assembly on School-Based Care, July 2010.

[13] Mental Health Services Oversight & Accountability Commission – MHSA Prevention, Early Intervention, and Innovation, Report of Findings, September 2012 Revised. Page 5 (citing PEI Guidelines, 2008, p. 7.).

[14] Mental Health Services Oversight & Accountability Commission. (December 2012). *Prevention and Early Intervention (PEI) Fact Sheet*. Available at: http://www.mhsoac.ca.gov/MHSOAC_Publications/docs/FactSheet_PEI_121912.pdf

[15] University of Colorado at Boulder – Center for the Study and Prevention of Violence. (2014). *Matrix of Prevention Programs January 2014*. Available at: http://www.colorado.edu/cspv/blueprints/ratings.html.

[16] Washington State Institute for Public Policy. (2014). *Benefit-Cost Results June 2014 update*. Available at: http://www.wsipp.wa.gov/BenefitCost/WsippBenefitCost_AllPrograms.

[17] Unless otherwise noted, the program rankings listed are from UC Boulder Center for the Study and Prevention of Violence – Institute of Behavioral Science, January 2014, *Matrix of Prevention Programs*. Available at: http://www.colorado.edu/cspv/blueprints/ratings.html.

[18] Unless otherwise noted, the costs and benefits listed are from Washington State Institute for Public Policy Benefit-Cost Results, 2014. Available at: http://www.wsipp.wa.gov/BenefitCost/WsippBenefitCost_AllPrograms.

[19] Horner, R., Sugai, G., Kincaid, D., George, H., Lewis, T., Eber, L., Barrett, S., & Algozzine, B. (2012). *What Does it Cost to Implement School-wide PBIS?* Available at: http://www.pbis.org/blueprint/evaluation-briefs/cost-of-implementation.

[20] Los Angeles County Department of Mental Health. (2014). *Mental Health Services Act – Three Year Program & Expenditure Plan Fiscal Years 2014-15 through 2016-17*, page 41. Available at: http://file.lacounty.gov/dmh/cms1_211892.pdf.

[21] Prinz, R.J., Sanders, M.R., Shapiro, C.J., Whitaker, D.J., & Lutzker, J.R. (2009). Population-based prevention of child maltreatment: The U.S. Triple P System Population Trial. *Prevention Science, 10*, 1-12; Ron Prinz, Professor, University of South Carolina. Personal communication on October 2, 2009.