Policy Forum

School Mental Health/Positive Behavioral Support: Collaborative State Initiatives

Convened
May 17-19, 2004

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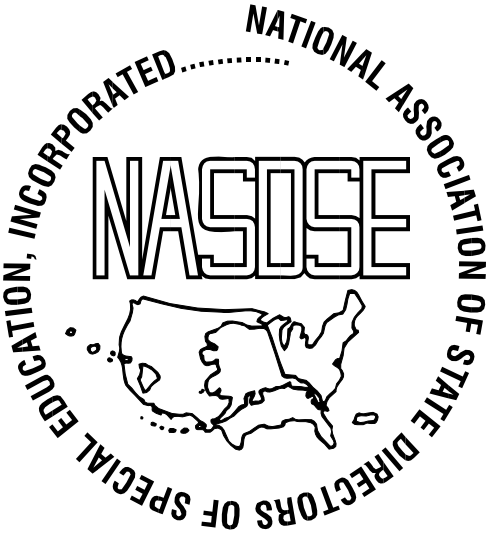

Project Forum at the National Association of State Directors of Special Education (NASDSE) is a cooperative agreement funded by the Office of Special Education Programs of the U.S. Department of Education. The project carries out a variety of activities that provide information needed for program improvement and promotes the utilization of research data and other information for improving outcomes for students with disabilities. The project also provides technical assistance and information on emerging issues and convenes small work groups to gather expert input, obtain feedback and develop conceptual frameworks related to critical topics in special education.

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Collaborative State Initiatives

Project Forum and IDEA Partnership at NASDSE
May 17-19, 2004

Background and Objectives

This document reports on the background, purpose and proceedings of a policy forum entitled, *School Mental Health/Positive Behavioral Support: Collaborative State Initiatives*, held in Alexandria, Virginia on May 17-19, 2004. Project Forum and the Individuals with Disabilities Education Act (IDEA) Partnership, both at the National Association of State Directors of Special Education (NASDSE), convened this policy forum as part of their respective cooperative agreements with the U.S. Department of Education's Office of Special Education Programs (OSEP). NASDSE, together with the National Association of State Mental Health Provider Directors (NASMHPD), developed a shared agenda for school-based mental health with mental health agencies, schools and families, and pursued state-based initiatives through the Policymaker Partnership Project (PMP).[1] These initiatives are continuing through the IDEA Partnership, which began in November 2003.

Objectives of the Policy Forum

- Clarify the intersection between school mental health and positive behavioral support initiatives and what their intersection means to the field
- Describe collaborative state and local initiatives in the area of school mental health and positive behavior support, including those that emphasize interdisciplinary approaches
- Examine factors that facilitate the development of these collaborations and support their success
- Examine challenges to the development of these collaborations and factors that impede their success
- Consider critical outreach to others doing related work (e.g., dropout prevention, juvenile justice)
- Identify ways in which federal and state policy can support these collaborations

Preparation for Policy Forum

Project Forum and the IDEA Partnership worked closely with OSEP to select participants whose knowledge and experience in the field of mental health and positive behavioral support (PBS) would contribute to accomplishing the policy forum's objectives. Invited participants included parent advocates, program coordinators, mental health professionals, researchers, state education agency (SEA) staff and state directors of special education. The participant list can be found in Appendix A.

[1] PMP was funded by OSEP from 1998 to 2003.

Project Forum and the IDEA Partnership developed the policy forum agenda, in collaboration with OSEP, to accomplish the objectives of the meeting. The agenda can be found in Appendix B.

Overview of the Policy Forum

The policy forum was held in Alexandria, Virginia, May 17-19, 2004. The opening session began with a dinner on Monday evening, May 17. Bill East, NASDSE Executive Director; Lou Danielson, Director, Research to Practice Division, OSEP; Joy Markowitz, Project Forum Director; and Joanne Cashman, IDEA Partnership Director, made opening remarks. After participants introduced themselves, Andy Hyman, Director of the National Association of State Mental Health Program Directors spoke about the President's Commission on Mental Health and its relationship to the President's New Freedom Initiative.

Continuing on Tuesday morning, May 18, Tim Lewis, University of Missouri, provided an overview of Positive Behavioral Support (PBS);[2] Terre Garner, Ohio Federation of Families for Children's Mental Health, presented on parents as consumers; and Mark Weist, Center for School Mental Health Assistance at the University of Maryland, provided a school-based mental health perspective. Following these presentations, Joanne Cashman facilitated a large group debriefing. Five states – Florida, Illinois, Missouri, New Hampshire and Ohio – shared examples of linkages between PBS and mental health systems of care. Participants spent the remainder of Tuesday and Wednesday morning engaged in small group activities and large group discussions. The final task for participants was generating recommendations for collaboration of PBS and mental health at the federal, state and local levels.

Summary of Presentations and Participant Discussions

Opening Remarks

Bill East, Executive Director, NASDSE

NASDSE has an interest in promoting both positive behavioral support and mental health initiatives. We are doing this by working with state contacts, proposing language for the IDEA reauthorization and supporting states that have State Improvement Grants (SIGs) for reading and PBS initiatives. NASDSE has also worked with our partners in school-based mental health to promote communities of practice, participated in national conferences and recently sponsored and convened a national satellite teleconference on May 5, 2004 featuring the work that is being done in Ohio. All of this work needs to be brought together to create positive learning environments in our schools and to create a future for communities that highlights, promotes and coordinates the work in mental health and education so that children and families can get the services they need.

[2] The terms positive behavioral support (PBS) and positive behavior intervention and support (PBIS) are both used throughout this document. In most cases, the authors have selected the term used by a particular speaker or state. For further discussion on terminology, please see page 22 of this document.

When school-wide behavioral support and mental health services work together, students and families benefit and learning can occur in a positive environment. Sometimes, when working with students and families, the roles and services of education and mental health professionals will overlap. The challenge is to provide a system of services that is not confusing for students and families. Over the next couple of days, we are asking policy forum participants to focus on commonalities for sharing resources and expertise with the goal of meeting that challenge.

Lou Danielson, Director, Research to Practice, OSEP

The National Longitudinal Transition Study (NLTS) of high school students was conducted in the 1980's and early 1990's. The data showed that students with serious emotional disturbance had an extraordinarily high dropout rate. About half were dropping out of school and of those that dropped out, about half were arrested within two years of exiting school. In the early 1990's, OSEP developed a national agenda for this population of students because it was a great challenge for schools to effectively serve this population without support. Also, there were data to suggest that some schools found ways to remove these students from their buildings. Among students with serious emotional disturbance, there were extraordinarily high rates of exclusion. As a result of what was happening to this population of students around the country, the Department of Education reaffirmed IDEA's position regarding suspensions, expulsions and cessation of services.

During the reauthorization of IDEA in 1997, discipline became one of the main issues debated. Unfortunately, there was more anecdotal information than representative data on suspensions and expulsions. It became clear that a more substantial investment needed to be made in the collection of data on creating safe schools.

Shortly after the reauthorization of IDEA, OSEP funded the technical assistance center for Positive Behavioral Interventions and Supports (PBIS) to support and deliver school-wide primary interventions (e.g., targeting all youth), secondary interventions (e.g., targeting youth at-risk for problem behavior who need more than the primary prevention level) and tertiary interventions (e.g., targeting youth with the most intense behavior support needs). OSEP began investing in grades K-3 due to the concern that we were not getting to the students early enough. The research demonstrated that in order for schools to be successful, efforts must be targeted at the youngest students. Another reason for investing in grades K-3 was the concern that students from preschool programs were being excluded as a result of their maladaptive behavior and that schools were not seeking more positive ways to deal with these issues within the school setting.

OSEP went further by making investments in the National Center on Education, Disability and Juvenile Justice (EDJJ)[3] and Project REACH – The National Center for Students with Intensive Social, Emotional and Behavioral Needs.[4] The central focus of Project REACH is intervention-based assessment, ecologically and culturally-responsive practices, and collaboration across systems of care. Unfortunately, preliminary data from the National Longitudinal Transition Study II show that the *outcomes* may not be getting better for students with emotional disturbance (e.g., dropout rate, arrest rate). However, *services* are better (e.g., more students with

[3] For more information, go to www.edjj.org.
[4] For more information, go to www.lehigh.edu/projectreach.

behavior plans in their IEPs, increases in the number of students receiving mental health services).

Andrew Hyman, Director of Government Relations, The National Association of State Mental Health Program Directors (NASMHPD) – *The President's New Freedom Commission on Mental Health: Opportunity for Transformation*

The report of the President's New Freedom Commission on Mental Health was issued in July 2003. This was the first time in 25 years that there was a presidential mental health commission. The last such commission was during Jimmy Carter's term as president. The Carter Commission report focused on inpatient services and de-institutionalization, with little emphasis on community-based care. In 1999, the Surgeon General issued a report on mental health and identified the effectiveness of mental health services and where such services fell on the spectrum of health care. This was an important step because it allowed policy makers to talk about mental health, but it did not mention the policy changes that were needed at the federal, state and local levels.

Today, the emphasis is no longer on de-institutionalization as it was during the 1970's when there were more than 350,000 residents in state hospitals at one time – that number is now under 50,000. The emphasis has shifted to addressing the needs of people in settings outside of mental health facilities (e.g., children in schools, children and adults in the juvenile and criminal justice systems, adults living on the streets or in shelters for the homeless and people on welfare). The shift from a focus on the mental health system to the mental health needs of the broader community is a significant difference and this shift is reflected in the work of the President's New Freedom Commission on Mental Health.

Since it was enacted into law in 1965, Medicaid has become the primary source of financing for public mental health systems. Unfortunately, Medicaid providers often have limited experience with mental health needs and may not provide or understand the value of mental health services as do people working in the mental health agencies. The challenge is now educating and involving those outside of the mental health system in serving persons with mental illness. Other challenges include the following:

- Many people seeking health care also have mental health problems and vice versa.
- Almost 50 percent of the people involved with the welfare system have a mental health disorder.
- A high percentage of youth in the juvenile justice system also have a mental health disorder (e.g., 66-80% of youth in one particular system had at least one psychiatric disorder).
- At least 16 percent of the people in the prison system have a serious mental illness.
- Almost 50 percent of homeless people have experienced some type of mental illness.
- Some schools that have special education programs with students with serious emotional disturbances have the highest incidence of school failure.

To illustrate the difference between 1978 and 2003 in regard to mental health policy, Michael Hogan, Ph.D., President of NASMHPD, recalls a comment made by Rosalynn Carter with

respect to President Carter's Commission on Mental Health. The former First Lady was asked what she thought had changed since the work of the Carter Commission. She responded, "We now know that recovery is possible for any individual with a mental illness." President Bush's New Freedom Commission on Mental Health decided that this would be an important theme to pursue in its work.

The New Freedom Commission on Mental Health came about because of a campaign promise made by then Texas Governor George W. Bush in response to the mental health community's insistence that the administration focus on certain mental health issues. As a result, on April 29, 2002, President Bush announced that he would establish a mental health commission. During his speech, President Bush also declared that Americans with mental illness deserve a health system that treats mental illness with the same urgency as physical illness.

President Bush identified three areas for the mental health commission to address: (1) the stigma of mental illness; (2) fragmentation of the mental health system; and (3) treatment inequalities in mental health care. President Bush stated in his Executive Order, "The Commission's goal shall be to recommend improvements that enable adults with serious mental illness and children with severe emotional disturbances to live, work, learn and participate fully in their communities." The Commission was charged with conducting a comprehensive study of the U.S. mental health service delivery system and recommending improvements to the President. An interim report, issued October 29, 2004, stated that publicly funded mental health systems are not oriented to recovery because diagnoses are not made early enough, the system is not consumer-centered and evidence-based practices are lacking. Moreover, the care is not accessible where it is needed (e.g., through child welfare programs and in schools, early education programs, workplaces, primary care facilities and juvenile and criminal justice facilities).

In July 2003, the Commission issued its final report, *Achieving the Promise: Transforming Mental Health Care in America,*[5] which addresses six goals that assert that in a transformed mental health system:

1) Americans understand that mental health is essential to overall health.
2) Mental health is consumer and family driven.
3) Disparities in mental health services are eliminated.
4) Early mental health screening, assessment and referral to services are common practice.
5) Excellent mental health care is delivered and research is accelerated.
6) Technology is used to access mental health care and information.

In order to successfully achieve these goals, it is important for leaders from a variety of agencies/systems (e.g., special education, criminal justice, welfare system and Medicaid) to get involved and work together on these issues. It is also important to establish a national focus on the mental health needs of younger children and families to address screening, assessment, early intervention, treatment, training and financing. The President's proposed 2005 budget includes funding to promote this effort through state incentive grants (SIG) for mental health transformation. Funds would be awarded through a competitive process to about 14 states.

[5] The final report can be found at www.mentalhealthcommission.gov

Shortly after the release of the Commission's report, the U.S. Department of Health and Human Services' (HHS) Secretary Tommy Thompson reported that HHS would conduct a thorough review and assessment of the Commission's final report with the goal of implementing appropriate steps to strengthen our mental health system. The Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services is responsible for implementing the set of recommendations from the final report and coming up with an action plan.

To ensure that the goals and recommendations identified in the Commission report are carried forward, NASMHPD joined with the Bazelon Center for Mental Health Law, the National Alliance for the Mentally Ill (NAMI), the National Mental Health Association (NMHA) and twelve other organizations to establish the Campaign for Mental Health Reform. The Campaign is premised on the fact that these and other advocacy organizations share nearly identical values and can "speak with one voice" with respect to the following principles and goals: (1) equal access to mental health care; (2) promotion of recovery and full community participation in all systems of care; (3) need for a strong safety net (protecting Medicaid, protecting IDEA); and (4) enhanced quality and accountability.

The Campaign is focusing on the following policy initiatives:

- Mentally Ill Offender Treatment and Crime Reduction Act;
- custody relinquishment (e.g., Family Opportunity Act, Keeping Families Together Act);
- reauthorization of the Substance Abuse and Mental Health Services Administration;
- Youth Suicide Early Intervention and Prevention Expansion Act; and
- budget/appropriations for mental health programs administered at the federal level.

One of the biggest challenges for the Campaign is effectively bringing together the mental health community. Other challenges include identifying a robust and achievable policy agenda, learning from states that have successful mental health programs, understanding the federal barriers that states confront and working to get the message out to the non-mental health community (e.g., businesses, lawmakers).

Tim Lewis, University of Missouri - *Overview of Positive Behavior Support*

Dr. Lewis is a professor and Chair of Special Education at the University of Missouri. He has been working with PBS for over 15 years. He attended the University of Oregon and served on its faculty. He is also part of the Positive Behavioral Interventions and Support Technical Assistance Center funded by OSEP and has worked with schools, districts and states throughout the U.S. to implement PBS. He gave the following overview of PBS:

First, it's important to think about "audience." At the PBIS Center, we have really moved from speaking only to each other, to talking to administrators, school superintendents and school boards. We are also beginning to have conversations with mental health and juvenile justice. It's also important to think about language. I'm a special educator and teacher, not a mental health worker. I don't mean to minimize children with mental health problems, but I tend to talk about

discipline and problem behavior, which resonates with educators. It's really important that everyone around the room learns to talk to educators. Finally, we need to recognize that schools provide regular, predictable, positive learning and teaching environments; positive adult peer models; and opportunities for academic achievement – all of which have been shown to be linked to mental health and wellness.

The challenges schools/educators face today include: (1) an increase in problem behaviors; (2) scarce resources; (3) multiple pressures to meet the No Child Left Behind Act (NCLB) standards; (4) traditional discipline systems that do not change the behaviors of the most challenging students; (5) students with the most challenging behavior who require comprehensive systems of support; (6) general lack of discipline; and (7) a link between the general level of disruptive behavior and more extreme acts of violence.

Typical school responses to student behavior problems include: (1) increasing surveillance to avert problem behavior; (2) reviewing rules and sanctions; (3) extending the continuum of aversive consequences; (4) improving the consistency of use of punishments; (5) instituting zero tolerance policies; (6) introducing guards, students uniforms, metal detectors and video cameras; and (7) using suspension, expulsion and exclusionary options (e.g., alternative programs).

The danger is that punishment without proactive approaches will increase the very behaviors most schools list as their greatest challenges – aggression, vandalism, truancy and dropping out. The outcomes of the present discipline system include: (1) failed attempts to provide individualized and appropriate educational opportunities for all children, particularly those with disabilities or from diverse backgrounds; (2) disenfranchisement of families and communities; and (3) fragmented, redundant and inefficient multidisciplinary efforts.

The good news is that research indicates that the most effective responses to school violence are social skills training, academic restructuring and behavioral interventions. In other words, research points to the fact that some of the most effective strategies for dealing with problem behaviors are, in fact, *instructionally based* strategies. The challenge is ensuring that educators are fluent in using these strategies.

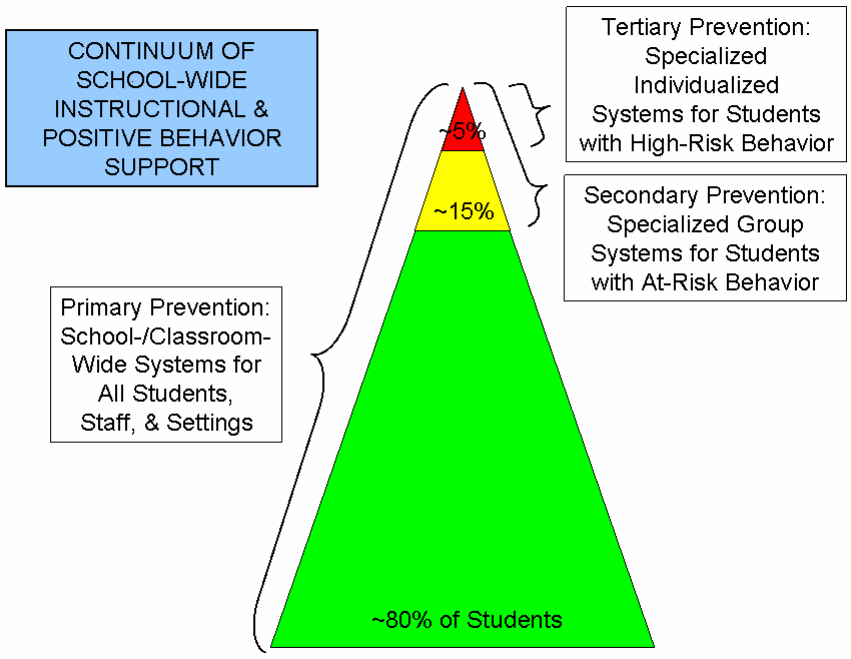
What is the answer? The answer is not the invention of new solutions, but the enhancement of the schools' capacity to do what they do well – accurately adopt and efficiently sustain their use of research-based practices, provide a full continuum of behavior support for all students and be part of a district-wide system of behavior support.

The PBIS Center defines PBS as a range of systemic and individualized strategies for achieving important social and learning outcomes while preventing problem behavior. PBS does not focus on behavioral prohibitions, but focuses instead on what children *should* be doing. PBS is not a specific practice or curriculum – it's a general approach to preventing problem behavior. PBS is not limited to any particular group of students – it's intended for all students. PBS is not new – it's based on a long history of behavioral practices and effective instructional design and strategies.

Critical activities of school-wide PBS include the following:

- training a school team, including at least one administrator;
- using data to guide intervention decisions;
- providing a continuum of behavioral supports;
- establishing school environments that support long-term success of effective practices (3-5 years);
- implementing consistent effective behavioral support;
- clearly defining expectations and teach them;
- celebrating when students master social/behavioral skills;
- monitoring student behavior and provide regular feedback;
- implementing behavioral support strategies at multiple levels (e.g., school-wide, setting-specific, classroom, and individual); and
- designing behavioral support strategies to meet the needs of all students.

(Figure 1)



The model in Figure 1 comes from a public health model for primary, secondary and tertiary support. It is used to illustrate the continuum of behavioral supports that makeup PBS. PBS requires that a single unified system be developed and implemented, rather than multiple systems. The system is then intensified to match the intensity of the challenges children bring into the schools. If we put a universal system in place, about 80 percent of students will master it. Another 15 percent will be at risk and will require additional support. The top five percent will require the most intensive supports. Mental health services are likely to be needed for this top five percent. Mental health workers need to be aware of the school-wide system and whatever

they develop needs to link to that system. Mental health should not be treated as a separate set of services – it is part of the PBS continuum.

The following are essential features of *school-wide PBS*: (1) clear definition of expected behaviors (as opposed to focusing solely on prohibitions); (2) procedures for teaching and practicing expected behaviors; (3) procedures for encouraging expected behaviors and discouraging problem behaviors; and (4) procedures for data collection and decision-making.

In the *classroom*, the focus is on behavior management, instructional management and environmental management. Support is also provided for teachers with students who display high rates of problem behavior. Within *non-classroom settings* (e.g., cafeterias, buses, common areas, bathrooms) the same logic is extended—PBS within non-classroom settings includes supervision and the development of routines to ensure success.

What do schools that implement PBS look like?

- Eighty percent of students can tell you what is expected of them.
- Positive adult-to-student interactions are more frequent than negative interactions.
- Evidence based practices are being used.
- Function-based behavior support is the foundation for addressing problem behavior.
- Data- and team-based decision-making are used.
- Administrators are active participants.
- The full continuum of behavior supports is available to all students.

PBS doesn't mean that children won't still display some problem behaviors, but capacity is built so they can be more successful in school. Data indicate that as office referrals go down in many schools, achievement test scores go up. Furthermore, as referrals go down, administrators get more time to focus on issues other than discipline and students receive more instructional time.

How does school-wide PBS relate to mental health? PBS alters risk-factors by building in protective factors (i.e., educational and social achievement), creating contexts in which schools can promote good mental health and establishing connect points for introducing mental health services.

For more information on the PBIS Center, see www.pbis.org.

Terre Garner, Ohio Federation of Families for Children's Mental Health – *Parents as Consumers*

Terre Garner is the parent of two children with mental health needs. She also has experience as an educator and mental health counselor. Ms. Garner talked about how parents frequently serve as key advocates for children with mental health problems and stressed that parents should be included as equal partners in developing and implementing school-based mental health initiatives. She shared the following anecdotes in order to illustrate the fact that parents often know more than professionals do about what their children need.

- An 18-year-old boy was about to be expelled from school in the last few months of his senior year, which would likely have resulted in not ever completing his high school education, because he used an inappropriate word when talking to a school administrator. His mother asked to see his file – which was four inches thick – and found that in spite of extensive documentation of problem behaviors over the years, the school had never provided any behavioral supports. His mother was able to advocate for him and through discussions with the school, she was able to keep him from being expelled.

- A middle school student with schizophrenia had spent all of his academic life in a locked institution. He had been outside of a locked facility once in seven years. The mother wanted her son to return home, but was surprised and anxious about the facility's decision to send him home on a Greyhound bus. The mother questioned the fact that a child who apparently needed such an intensive level of care for seven years could now ride unaccompanied on a bus. Once he was home, the boy was placed in a classroom for students with emotional disturbance. This environment was over-stimulating and the boy began to stand on his desk and flap his arms like a bird. School administrators tried to send the boy home for "at-home instruction." The mother once again advocated for her son, suggesting that the learning environment might be contributing to the boy's difficulties and demanding that the boy continue to receive instruction at school in a more appropriate class.

- A first grader was sent home three to four days per week because the teacher couldn't deal with his continual tapping on the table. The mother challenged this decision and asked the special education director for support. The special education director gave the boy a soft ball he could use to pound on the table without making any noise and the boy was able to stay in his class.

- An eighth grader was about to be suspended from school with the intention to expel him for calling the janitor a bad name. He had Asperger Syndrome, bipolar disorder and had had a number of brain surgeries. The janitor touched the student's head in a place where the student was extremely sensitive. The school insisted the boy be expelled because he broke the rules, but his mother insisted on a manifestation hearing because it was obvious to her that her son's reaction could be attributed to one or more of his disabilities. As a result of her intervention, the boy remained in school.

Parents bring valuable information to the table that helps professionals put together the pieces of the puzzle. Most of us are so invested in helping our children that we want to help teachers and mental health professionals by providing information. Parents are willing to advocate for school funds, talk to school boards, talk to legislators and say, "We need help." Parents want to roll up their sleeves and make schools successful. Parents are experts on their children, are partners in the arena of school-based mental health and really should be the senior or managing partners.

Policy forum participants commented that not all parents are good at advocating for their children and that schools and mental health professionals need to determine how best to work with these students and their families. Another participant suggested that someone in the community should serve as a family-school liaison; connecting families with schools and helping

families navigate the mental health system. A third participant talked about the importance of really "living" a family-centered approach to school-based mental (e.g., canceling IEP meetings if a parent cannot attend).

Mark Weist, Center for School Mental Health Assistance, U of MD – *Linking Positive Behavior Support and Expanded School Mental Health*

Dr. Weist works at the University of Maryland's Center for School Mental Health Assistance (CSMHA). CMSHA was established in 1995 with a grant from the Maternal and Child Health Bureau of the Health Resources and Services Administration (HRSA) and continued in 2000 with co-funding from SAMHSA.

The three primary goals of CSMHA are to: (1) increase public support for mental health in schools; (2) improve the quality of mental health promotion and intervention in schools; and (3) facilitate the integration of youth serving systems in the advancement of expanded school mental health. CSMHA's objectives are to provide technical assistance and consultation, provide national training and education, disseminate and develop knowledge and promote communication and networking.

There is a crisis in mental health for youth and children in the U.S. Although PBS is now used in more than 2,000 schools throughout the nation, most schools provide only very limited mental health evaluation and consultation for youth receiving special education services or in the referral process. Most community mental health services are also extremely limited and primarily serve youth with severe behavior problems. Mental health services provided by child welfare and juvenile justice are even more limited. In general, schools are still not employing evidence-based practices because research is not reaching practitioners.

According to estimates, three to five percent of youth have severe mental health impairments, 12 to 22 percent have diagnosable disorders and many more are at risk or could otherwise benefit from an effective mental health promotional approach. It is also estimated that less than a third of children who need mental health services receive them and of those who receive mental health care, fewer than 10 percent receive *effective* care.

Expanded school mental health programs link families, schools, mental health and other community systems. The purpose of expanded school mental health is to develop a full array of effective programs and services that improve the school environment, reduce barriers to learning, and provide prevention, early intervention and treatment for all children and youth – not just children and youth receiving special education services.

Child and adolescent mental health is tremendously under-resourced in the U.S. There is a need for infrastructure support, technical assistance and training. If you look at communities that don't have a special initiative or research program, almost none are doing effective prevention in the schools.

How do we move toward a school-wide continuum that's truly integrated and that contributes to a system of care in the community – a system of care that's not just there for the 3-5 percent of

students with emotional disturbance, but for all children and youth? We need to promote integrated approaches, support mental health programs such as PBS and build national to local linkages. We should strive to build a model of national level initiatives that interact with organized state level initiatives and in turn interact with localities. A truly shared agenda between schools and mental health reduces the burden on the educational system, acknowledges that other systems (e.g., mental health) will function better through their connection to the schools and moves a community toward a system of care perspective for all children, not just those diagnosed with emotional disturbance.

According to the pyramid model shared by Tim Lewis (see Figure 1), most of our mental health resources should be used to enhance the school environment and promote mental health more broadly. However, in reality, most of our resources are used for the relatively few students who require the most intensive supports. We need to build up the foundation and this is where PBS comes in.

There is a complementarity between PBS and expanded school mental health. Each emphasizes a different part of the triangle, but combined can mutually reinforce one another. PBS schools are doing wonders, but often do not attend adequately to students with mental health issues. Expanded school mental health programs, on the other hand, often struggle to implement broader, environmentally-focused interventions. PBS can help mental health folks be more environmentally focused. PBS can create readiness for a more intensive focus on mental health in the schools. PBS can assist in shifting the focus from more traditional therapists to more proactive, preventative approaches. Expanded school mental health can help understanding of youth with multiple needs and less observable problems (e.g., depression and anxiety).

The factors necessary for the development of an effective continuum of approaches include: outstanding staff and programs; ongoing training, technical assistance and support; and school and community buy-in and investment. Together, PBS and expanded school mental health constituencies can work to develop advocacy, policy improvement and resource enhancement to underpin all of their work.

Maryland's blueprint for children's mental health includes three pillars: quality and system improvement; service delivery support and treatment; and mental health promotion (early childhood and expanded school mental health). The Department of Education is leading the PBS initiative and the Mental Health Administration is leading the expanded school mental health initiative. The two systems are also working with other child serving systems to develop a unified and synergistic plan for advancing school mental health in the state.

More information on CSMHA can be found at http://csmha.umaryland.edu. Dr. Weist can be reached directly at csmha@psych.umaryland.edu.

Several policy forum participants noted that schools are already overburdened and that any reluctance to collaborate with mental health is not necessarily due to a lack of interest. Mental health providers must focus on concerns that are shared by schools and reduce the burden on schools. It is also important to show schools that expanded mental health services reduce costs (e.g., results in a drop in costly alternative placements). One participant asked about how mental

health service providers collect and use data. Dr. Weist described a continuum of approaches – from stories by families and administrators, to satisfaction data, to single case designs that look at changes in individual students. Dr. Weist added that very little research has looked at the integration of PBS and mental health systems of care. Finally, several participants talked about the importance of combining initiatives (e.g., school based health centers and safe schools). Efforts are being made to pull initiatives together, overlap data and begin to measure common outcomes.

Identification of Strategies

Joanne Cashman led the participants in a discussion about "boundary spanning" strategies that facilitate collaboration between educators and mental health providers. The strategies below, identified by the participants, reflect themes expressed by the presenters, as well as the experiences of the participants in building collaborations.

- Conduct functional assessment of the school building to determine how many school-based personnel and contractors are involved in PBS and mental health initiatives and their specific roles.
- Examine school and mental health needs and re-allocate existing resources accordingly before creating new positions and/or requesting new funding.
- Collect school-level data on academic and social achievement.
- Clarify language and terminology to ensure that partners have a common understanding.
- Use funding sources as a leverage point (e.g., joint budget requests are a tangible expression of collaboration; co-funding equals co-ownership).
- Value "in-kind" contributions from partners.
- Learn about sustainability from other collaborations.
- Provide opportunities for addressing unique local needs.
- Build collaborations on successful school initiatives.
- Emphasize effectiveness, efficiency and economy when building collaborations.
- Understand that building collaborations is a developmental process – coordination before collaboration.
- Provide cross-training and co-leadership opportunities for all partners.
- Acknowledge commonalities and differences among partners (e.g., values, approaches to training, etc.), then build on the shared beliefs and goals.
- Make assumptions explicit and clarify values.
- Involve leadership in collaborations (e.g., legislators, governor, etc.).
- Identify whose role it will be to communicate the message throughout the community.
- Require funds to follow children (e.g., Medicaid).
- Include more behavioral health (e.g., PBS) and mental health issues in personnel preparation.

State Examples of Linkages Between PBS and MH Systems of Care

Representatives from five states were asked to talk about the following: (1) impetus for collaboration; (2) connections/linkages; (3) features (e.g., policy/regulations, strategic planning,

data collection, program initiatives or pilots, professional development, and service delivery system); and (4) future plans.

Florida - *Lee Clark, Bureau of Instructional Support and Community Services, Florida Department of Education, and Don Kincaid, Director of PBS Project, University of South Florida*

Florida's PBS project began in 1997, funded by the state's Department of Education, Bureau of Instructional Support and Community Service. Initially the project targeted only the top part of the triangle – the most severely impaired students. The project provided an intensive 10-day training for schools. However, many schools had difficulty finding the necessary time and energy to focus on the PBS project. One reason was the pressure of high stakes testing requirements. Also, even though the project had trained thousands of people, the focus was the team, not the system. After intensive training, nothing had changed because systems change had not been addressed effectively. A few years ago, the project began to focus on systems change at the district level to guarantee district buy-in and collaboration. The project grew from a few schools in the first year to 25 schools, then 50 schools, and this summer there will be an additional 100 schools involved.

Florida also has a multi-agency network for students with severe emotional disturbance, referred to as SEDNET. SEDNET started in 1983 in response to a common concern from mental health and education—the high number of students placed in out-of-state residential facilities. The impetus for working together was the fact that both agencies wanted to bring these students back into the state.

Together, mental health and education agencies developed strategies to bring students back and identify what it would take to provide wrap-around services that addressed family and educational needs. These efforts were very successful. The two agencies then set the goal of keeping students out of residential facilities *within* the state and bringing them back into the community. The network started to emerge. For example, legislation was passed authorizing a multi-agency service network for mentally disturbed students that included a definition of the network's function and responsibilities. A point person was identified for the project, as well as a regional project manager for each of Florida's 17 regions. The regional managers developed regional advisory boards comprised of stakeholders. Each regional project was funded so it would have enough money for staffing and start-up funds for direct services. That went well for a while, but family support planning teams started bringing students without disabilities into the program. Because the program was funded strictly out of IDEA money, it was necessary to go back to the legislature for general revenue funds that would support services for all students, not just those eligible under IDEA.

As the years passed, PBS emerged as an effective, research-based practice. It became clear that many students at the bottom of the pyramid benefited from PBS and Florida began to plan collaboration between its PBS and SEDNET projects. As students move up the pyramid to the top level, they work with Florida's family services planning team and have access to mental health services. SEDNET is also used to co-fund mental health service providers in the schools. SEDNET does not fund a mental health service provider by itself. Services are always co-funded

and that way there is co-ownership. The project manager uses the mental health money as leverage money to secure additional funds. For instance, last year there were 17 projects receiving $3 million. SEDNET was able to leverage that into $21 million in support services for approximately 44,000 children and youth.

In 2000, an evaluation of SEDNET was conducted that resulted in the following recommendations: (1) examine effective instruction strategies; (2) improve parent involvement; (3) emphasize pro-social discipline and promote social skills; and (4) collaborate with the PBS Project. In response to this, PBS began to collaborate with SEDNET. As a result, the same individual, someone familiar with the history of both projects, oversees both projects. Now, as part of Florida's school-wide PBS efforts, work is being done with at least half of the SEDNET coordinators around the state. PBS and SEDNET personnel are training together and some of Florida's SEDNET coordinators are assisting with the coordination of the entire PBS process.

Florida's PBS project requires that a planning process take place at the school, district and state levels – including representatives from SEDNET. This way, everyone is involved and understands what needs to happen. Planning meetings take place at least once per year and sometimes districts meet every quarter. Data is also being generated regarding academic success, discipline referrals and suspensions. In response to the merger of PBS and SEDNET, stakeholders are providing a lot of positive feedback. For instance, school psychologists are reporting that they are actually getting time to meet with students, and teachers are reporting that the atmosphere of the school has changed because they now know how to reward positive behaviors and create a positive school environment.

In terms of future plans, longitudinal data from schools are being collected in order to provide evidence of positive outcomes. These data will be crucial for expanding Florida's PBS budget. PBS plans to collaborate more closely with SEDNET in terms of providing wrap-around services. A legislative budget request is also being pursued in hopes of institutionalizing a budget for the PBS project similar to what is currently in place for SEDNET.

Additional information on Florida's Positive Behavior Support Project can be found at http://flpbs.fmhi.usf.edu/

Illinois – *Barbara Shaw, Children's Mental Health, State of Illinois, and Barbara Sims, EBD/PBIS, Illinois State Board of Education*

Illinois initiated the Emotional Behavioral Disabilities (EBD) network in 1990, a program that focuses on children with the most intensive support needs. The EBD network is funded through Illinois's IDEA Part B discretionary funds. Through the EBD network, the Department of Education worked closely with the Department of Children and Family Services (DCFS) to set up local networks in the state. The focus of the EBD network is to create wrap-around services for children and their families. There are now nearly 60 such networks in the state. To improve management, the state was divided into four regions. The structure of the local networks varies slightly from region to region. The minimal requirements are that each local network includes an educator, a community mental health provider and a representative from the Federation of Families.

The Department of Education started the process using Part B funds. As part of a contractual agreement between the Department of Education and DCFS, DCFS provides the Department of Education with matching funds. The pooled funds are then made available to pay for whatever services a child may need as determined by his or her wrap-around team. For example, funds have been used for respite care, tutors, transportation to therapy sessions, tuition for parents to attend school and even purchasing a new mattress. The wrap-around process may extend from several months to several years, depending on the needs of the family. A new step in the wrap-around process has to do with data collection.[6] The Department of Education recently started collecting data on the number of families who are successful in less restrictive settings with appropriate supports. The Department of Education calculates how much money is saved by not moving a particular child to a residential placement. These data are presented to the legislature when requesting more pooled funding for services to deflect out-of-home placements.

In 1998, the positive behavioral interventions and supports (PBIS) component was added. The program is now the statewide EBD/PBIS network.[7] There is one statewide coordinator for both components, as well as the same regional coordinators for each component. As in other states, Illinois's focus was first at the school level and then moved to the district level. Districts may start with an individual school, but commitment at the district level is required, including an administrator assigned to the project. Districts are required to adopt policies in support of PBIS as a means of involving the school board. In a number of regions, PBIS is being integrated into the schools that participate in Systems of Care. Also, those schools that do not make adequate yearly progress (AYP), as defined by the No Child Left Behind Act (NCLB),[8] become part of the Systems of Support (SOS) schools and are required to participate in PBIS.

Illinois also recently passed the Children's Mental Health Act, a legislative initiative of the Children's Mental Health Taskforce. The Taskforce was convened in 2002 and was a very broad effort that included representatives from violence prevention, public health, the Attorney General's office, children's advocacy groups of all kinds, educational groups, mental health groups, business and law enforcement. All of these groups worked together to produce a report titled *Children's Mental Health – An Urgent Priority for Illinois*.[9] Following release of the report, the task force advocated for passage of this ground-breaking legislation. The Children's Mental Health Act mandated a comprehensive children's mental health system in the state. Both the report and the Act acknowledge that Illinois must provide early intervention and prevention as part of a coordinated comprehensive approach across all the institutions that reach children. Through the Act, Illinois created a public/private partnership that reports to the governor. All the

[6] Presenters distributed a document titled, "Wraparound Progress Documentation 2003-2004 – Risk Factors Summary." The document includes data on risk factors and placement considerations and costs out the money saved by keeping children in less restrictive placements. The document can be obtained by contacting the presenters or Project Forum.

[7] Presenters distributed a document titled "Illinois PBIS: A Summary of Fiscal Year 2003 for the PBIS Component of the ISBE EBD/PBIS Network." Copies of the document may be obtained by contacting the presenters or Project Forum.

[8] NCLB is the 2001 reauthorization of the Elementary and Secondary Education Act.

[9] Presenters distributed a handout titled "Illinois Children's Mental Health Act Public Act 93-0495 (SB 1951)", as well a fact sheet advocating passage of the Act generated by the Children's Mental Health Taskforce. A copy of the Act and/or the accompanying document can be obtained by contacting the presenters or Project Forum.

state agencies that were part of the Task Force are included in the partnership. There are 25 appointed members ranging from family members to school nurses', psychologists' and pediatricians' associations. Major provisions of the law require the partnership to develop a cross-agency plan, link funding streams across agencies, establish local and statewide protocols and incorporate social and emotional development into the Illinois education systems.

The educational provisions of the Act are particularly noteworthy. The Act mandates that the Illinois State Board of Education develop and implement a plan for incorporating social and emotional learning standards as part of the Illinois learning standards.[10] The message communicated by this requirement is that social and emotional development are critical to academic success and life success and must be taught. In addition to standards, methodologies for measuring outcomes will also be developed. Districts are being asked to create policies incorporating students' social and emotional development into their educational programs and protocols for responding to students with social and emotional and mental health needs. Finally, built into the legislation is a public awareness campaign to both de-stigmatize mental health problems and heighten people's awareness of the importance of the social and emotional development of children.

The Act also includes a couple of funding mechanisms. Illinois will increase its Medicaid draw through having the Individual Care Grants matched and reimbursed. In addition, cost savings will occur through broadening of the pre-hospitalization screening process, which is conducted to ensure that less costly community-based services are provided, when possible, in lieu of psychiatric hospitalization. The legislation originally included a children's mental health fund into which the additional federal match and the costs savings would have been deposited (estimated to be $15-20 million annually). The fund was not part of the final legislation, but the Act does include a statement that the Medicaid agency is responsible for reporting annually on the dollar amount earned/saved – information that can be used to advocate for additional funding for children's mental health.

Missouri – *John Bamberg, Department of Elementary and Secondary Education, Division of Special Education; Tim Lewis, Department of Early Childhood and Elementary Education, University of Missouri; and Ed Morris, Children and Youth Services, Missouri Department of Mental Health*

In August of 1996, Missouri received a state improvement grant (SIG) that focused on PBS. At that time, Tim Lewis, from the University of Missouri, encouraged the state Department of Special Education to implement statewide PBS.[11] In response, the Department tasked the University of Missouri with building capacity via nine regional professional development centers around the state with a budget of about $250,000 per year. Lewis convened a leadership team made up of stakeholders and the team began to look at capacity building at the district and school level. What they learned was that it is not possible to have enough capacity/expertise in every

[10] Presenters distributed a handout titled "Core Components of a Comprehensive School District Policy on Social and Emotional Development." A copy of the document may be obtained by contacting the presenters or Project Forum.

[11] Presenters recommended that states consult a document titled "The Blueprint," located on the official PBIS website (www.pbis.org) for a set of guidelines regarding how to get state-wide PBIS initiatives started.

regional professional development center to meet the needs of all the schools because there are not enough people to do this. As a consequence, the leadership team began to focus on building capacity at the *district* level. Hopefully, the next cycle of SIGs will fund a district-designated PBS coordinator who will be sent to regional trainings and will in turn be responsible for training school-level teams.

Missouri applied for a second round of SIG funding, but has not yet heard if the grant was funded. The focus of this second SIG will be schools receiving Reading First[12] grants, as well as low performing schools. One thing the Division of Special Education did approximately two years ago was establish a system through which a special education consultant is housed at each of the nine regional professional development centers for the purpose of identifying and addressing barriers to achievement within each district. Low performing schools and Reading First schools automatically receive various professional development training modules that the Department has to offer – one of those being PBS. This year, trainings will be offered to district coaches. Those individuals will participate in two online courses taught by the University of Missouri and receive intensive training on functional behavior assessment (FBA), analysis of data and provision of PBS training to school-level teams. The coaches will be responsible for setting up the foundation and support system in their school districts, as well as in school buildings within their district. Assuming Missouri receives the second SIG, all the training done by the University of Missouri will focus on district-wide coaches. In addition to training district personnel to become coaches, the University of Missouri also plans to include mental health personnel. This will help ensure that schools and mental health are working together to provide seamless access to services.

Under the auspices of a grant funded by NASDSE and NASMHPD, the state conducted a series of focus group discussions that resulted in the development of a state-wide Shared Agenda based on approaches articulated in *Mental Health, Schools and Families Working Together for All Children and Youth: A Shared Agenda* (2001).[13] The focus group process looked at different initiatives going on in Missouri and selected exemplary communities with three common programs, primarily Systems of Care sites (some are federally funded sites and others are only funded by the state), Positive Behavioral Supports Schools and the School-Based Prevention, Intervention and Resources Initiative. In Missouri, Systems of Care tends to be associated with mental health efforts, PBS tends to be associated with education efforts and school prevention tends to be associated with substance abuse efforts. The idea was to bring these efforts together. The focus group process generated six primary recommendations for what districts, families and mental health professionals could do differently and how the state could support district efforts: (1) increase collaboration and support between mental health workers and school personnel; (2) make mental health training a priority; (3) make the prevention of mental illness a priority; (4) empower and support families at all levels; (5) create a statewide system of care network for the implementation of a Shared Agenda process; and (6) develop a statewide campaign to promote mental health awareness and reduce the stigma of mental illness. Examples of specific

[12] Reading First was authorized under Title I, Part B, Subpart 1 of the *No Child Left Behind Act of 2001* as a nationwide effort to improve reading skills of students in kindergarten through grade three.

[13] Presenters distributed an Executive Summary titled, "Mental Health, School, and Families Working Together: Toward a Shared Agenda in Missouri – A Report of Findings from the 2003 Missouri Focus Group Discussions." Copies of the document may be obtained by contacting presenters or Project Forum.

recommendations included training of new school board members and legislators and examining credentialing systems that prohibit professionals from working together.

New Hampshire – *Mary Ford, Bureau of Special Education, New Hampshire Department of Education; Debra Grabill SIG/Care – New Hampshire; and Joe Perry, Division of Behavioral Health, Children's Mental Health Services, Department of Health*

New Hampshire is in year five of a six-year effort, funded by SAMHSA (Substance Abuse Mental Health Services Administration) to create comprehensive community based Systems of Care for students with serious emotional disturbance (SED) and their families. The focus is specifically on students who are at risk of placement or have already been placed outside of their communities. This initiative, called Care New Hampshire, was a joint venture between the New Hampshire Department of Education (DOE) and Department of Health and Human Services (DHHS). The following are some of the requirements of Systems of Care grants. The first two requirements are that the grants be culturally competent and family driven. New Hampshire is developing measures to ensure that its infrastructure is embracing both of these values. Care New Hampshire has created state and regional level collaboratives that are working to build community capacity and develop the workforce for both the management of Systems of Care and the delivery of services and supports. Other components include targeted technical assistance and training initiatives and a public information and social marketing campaign. All of these components of System of Care development are part of a comprehensive strategic planning process. Both DOE and DHHS are sharing data as part of their outcome and evaluation process. New Hampshire has used extensive technical assistance (TA) contractors.

With respect to development of New Hampshire's infrastructure, from the very beginning, the state was aligning its Systems of Care grant with its State Improvement Grant (SIG). The goal was ultimately to create a memorandum of agreement (MOA) between the principle parties.[14] Until recently, it was a memorandum of understanding (MOU) for Systems of Care, but the language was changed to MOA for Systems of Care and Education. The idea behind the MOA is to use public affirmations and commitments to create new mindsets.

A PBIS team was initiated under Care New Hampshire with the intent of establishing PBIS within the schools. Subsequently, New Hampshire's PBIS initiative was expanded statewide by the DOE in response to its self-assessment, conducted in preparation for the Continuous Improvement Monitoring Process (CIMP), during which discipline was identified as a priority. Recognizing that students with disabilities would achieve better outcomes in schools with improved school climates, New Hampshire focused on PBIS as a vehicle to build local capacity to serve all students. What took New Hampshire to the next level was its IDEA Partnership grant, which allowed it to host a state summit on PBIS – a replication of the national summit.

In New Hampshire, resources were limited even before the budget cuts started and it was necessary to figure out how to accomplish more with less money. All of the partners came together and identified two main goals: shared training and collaborative planning. In terms of

[14] Presenters distributed a document titled: "Memorandum of Agreement Care NH: Systems of Care and Education for Children and Their Families (Draft 5-10-04)." Copies of this document may be obtained by contacting presenters or Project Forum.

shared training, the DOE determined that it could not implement the PBIS initiative alone because a significant number of students in New Hampshire were sent not only out of district, but out of *state*. In terms of the students with the most intensive support needs, it became clear the DOE must collaborate with mental health. The DOE designed and provided the universal training – for the bottom of the PBIS pyramid – in collaboration with the DHHS. The intensive training – for the top of the PBIS pyramid – was designed and led by the Care New Hampshire technical assistance team at DHHS.

Systems of Care is noteworthy in terms of the way it utilizes the family to drive the agenda and help develop the infrastructure for obtaining necessary services. As a consequence, the Bureau of Special Education funded an executive director to work with all the parent groups, in addition to funding an executive director to work with each local special education director. Using parent groups in collaboration with the National Alliance for the Mentally Ill (NAMI) and the Federation for Families, New Hampshire Systems of Care has created an almost seamless parent structure that is helping drive the agenda. Research has linked parent involvement to better student outcomes and the New Hampshire Department of Education hopes to expand parent involvement to other initiatives as well.[15]

New Hampshire's use of the term "Systems of Care and Education" really came into focus in January 2004. New Hampshire is developing a broad memorandum of agreement between DHHS and DOE to create a broad approach to the alignment of multiple initiatives that support families, schools and communities and serving New Hampshire's target populations. In addition to drafting a MOA between education and mental health, New Hampshire is developing a companion piece which more fully explains the vision of community based Systems of Care and Education.[16] The document describes the purpose of the collaboration; what Systems of Care in education would look like in terms of outcomes, strategies and product; and the role of schools in Systems of Care. The document also provides a history of Systems of Care in New Hampshire and the SIG/Care New Hampshire partnership. Next steps will include finalization of the MOA. A concurrent initiative has been an interagency improvement plan effort for Parts B and C. This is funded by an OSEP general supervision enhancement grant (GSEG). One of the recommendations that came out of that project was to improve the state's data collection system – a recommendation that will be reflected in the final version of New Hampshire's MOA.

Ohio – Stephanie Falor, Ohio Department of Education; Terre Garner, Ohio Federation of Families for Children's Mental Health; and Therese Johnston, Positive Education Program

Ohio educators, families and mental health professionals – including representatives from schools, juvenile justice, the Department of Mental Health and nurses – came together and

[15] Family involvement played a crucial role in securing special education funding for New Hampshire. In response to threatened budget cuts, parent groups successfully advocated to have language included in the budget preserving all $14 million of IDEA money.

[16] Presenters distributed a document titled, "Developing New Hampshire's Systems of Care and Education (Draft 5-16-04)." Copies of this document can be obtained by contacting presenters or Project Forum.

developed a single page summary of recommendations regarding the creation of a shared agenda for schools, families and mental health.[17] Major recommendations included:

- A statewide effort should be undertaken in Ohio to disseminate knowledge about links between mental health and school success and the importance of school-based mental health (SBMH) services.
- The educational and mental health systems in Ohio must challenge existing ideas and practices of "traditional" education and mental health services.
- Educators, mental health professionals and families in Ohio should work together to shape and implement policies and practices that comprehensively address children's wellbeing.

The recommendations were presented to a group of legislators on October 9, 2003 by educators, mental health advocates, students and families.[18] Following the presentation, a smaller steering committee of approximately 40 people worked together to refine the language that was used on that single page summary. The result was a set of defining principles and a list of goals and objectives, all of which are shared in the draft version of Ohio's Shared Agenda Initiative.[19] The two guiding principles are: (1) mental health is crucial to school success and (2) there are shared opportunities (mental health, schools, families) for improvements. Goals and objectives are to: (1) develop a common understanding among education, mental health, families and other stakeholders of key shared agenda concepts related to the critical links between mental health and schools success; (2) identify/expand/implement evidence-based practices that support the critical links between mental health and school success and identify "star" schools demonstrating the essential elements of the critical link; (3) positively influence allocations at the state and local levels; (4) positively influence the FY 05-06 state budget; and (5) expand capacity that will support mental health in schools through pre-service and in-service education, training and professional development. Most members of the steering committee agree that whatever the agreement is called, it is most important that mental health, education and families are working together.

Ohio also has an agency representative for each of its six regions and each representative is charged with organizing a regional group of stakeholders. In this way, Ohio is working to build capacity, not only at the state level, but at local levels as well. In terms of PBS, Ohio is working with the principals' associations and successfully promoting PBS at the leadership level. Future plans for Ohio's PBS project include collecting data and working more closely with model PBS schools within each region.

[17] Presenters distributed a document titled, "Legislative Forum on Mental Health and School Success – Creating a Shared Agenda: Recommendations (October 9, 2003)." Copies of this document can be obtained by contacting presenters or Project Forum.
[18] Testimony from the legislative session can be heard on http://www.units.muohio.edu/csbmhp/sharedagendalegforum.htm/.
[19] Presenters distributed a draft document titled "Mental Health – Education – Families: Shared Agenda Initiative – Steering Committee Consensus Summary of Guiding Principles, Goals and Objectives (2-4-04)." Copies of this document can be obtained by contacting the presenters or Project Forum.

Whole Group Discussion

The original intent of the whole group discussion was to talk about how to move forward with collaborative efforts between school mental health systems of care and positive behavioral support services. However, a few of the policy forum participants voiced confusion about use of the terms Positive Behavioral Interventions and Supports (PBIS) and Positive Behavioral Support (PBS).

One participant explained that the term PBS refers to the use of research-validated practices in schools. There are many schools and programs that that use PBS but call it something else. During further discussion it was noted that PBS has the following essential features:

- statement of purpose and clearly defined behavioral expectations (rules);
- procedures for teaching and practicing desired behaviors;
- procedures for encouraging desired behaviors;
- procedures for discouraging problem behaviors; and
- procedures for record keeping and decision making.

The essential features of PBS can be linked to the systems of care framework for mental health services. In the system of care approach, agencies work strategically in partnership with families and other formal and informal support systems. Participants in systems of care must:

- agree on common goals, values, and principles that will guide their efforts;
- develop a shared infrastructure to coordinate efforts toward the common goals of safety, permanency, and well-being; and
- work within that infrastructure to ensure the availability of a high quality array of community-based services to support families and preserve children safely in their homes and communities.

One participant added that the group should think about PBS as a blueprint for providing services to children and their families that involves mental health, wrap-around services and the schools.

The OSEP-funded center referred to above by Lou Danielson and described above by Tim Lewis, known as the OSEP Center for Positive Behavioral Interventions and Support was first called Positive Behavior Intervention Supports and Strategies. But this name was too long and it was shortened to PBS. However, because this was already a widely used acronym, (e.g., Public Broadcasting System) the name was changed again to PBIS.

As the discussion began to wrap-up, it was noted by several participants that it is not important whether one uses the term PBS or PBIS, as long as it refers to research-validated practices with the essential features described. The discussion was brought to a close when the participants explained that over the past few years, the goal of school mental health systems of care and positive behavioral support services has been to promote and clarify the shared agenda between researchers, administrators and technical assistance providers and mental health, schools and families. The intent of NASDSE and NASMHPD during the five years of PMP was to provide

opportunities for people to get together to find commonalities and promote what they are doing, and to assist those people who are ready to take the next steps. It is important to provide a forum to help people see the commonalities and to make an effort to bridge the different interests.

Recommendations for Education and Mental Health Collaborations

Policy forum participants were asked to make recommendations for improving collaboration between education and mental health at the federal, state and local levels. The participants generated the following recommendations.

Federal Level

- Include family agencies in federal initiatives (e.g., federal presentations, meetings) and enable families to take on leadership roles that will influence changes in the system.
- Model cross-agency initiatives by issuing shared funding announcements and providing joint technical assistance in order to promote change at the state level.
- Braid federal funding streams to encourage state–level collaboration.
- Identify a leader within Medicaid as a federal partner.
- Require federally funded projects to include essential features as described by the PBIS Center (e.g., clear expectations, statement of purpose, procedures for teaching and practicing expected behaviors).
- Identify similar work being done in education and mental health and link key individuals doing this work.
- Connect behavioral support initiatives that are provided through general education with such initiatives that are part of special education.
- Examine the value of intentional marketing of shared general and special education agendas at the local level.
- Increase funding for dissemination of information about PBS and mental health.
- Fund the replication of successful model demonstration programs that represent education and mental health collaboratives.
- Ensure that the organizations that make up the IDEA Partnership are up-to-date and knowledgeable about efforts for integrating PBS with mental health.
- Provide federal guidance to the various mental health programs to make certain that there is consistency and clarity in the usage of concepts, definitions and vocabulary and to facilitate connections among agencies doing similar work.
- Identify collaborative action steps that support those students with the most intensive mental health and behavioral needs (e.g., the top 5% of pyramid).
- Identify the workforce needs in the areas of PBS and mental health (e.g., interrelated roles, paraprofessional/professional capacity and personnel shortages).

State Level

- Ensure that state certifying and licensing bodies incorporate mental health/PBS collaboration and take these messages to institutions of higher education.

- Include mental health, education and families at seminars, professional/paraprofessional development activities, etc. to model collaboration.
- Involve a significant number of students in state-level activities (e.g., state summit) to develop leadership.
- Provide a flexible and sustainable flow of funds between agencies in order for the infrastructure to support collaborative initiatives.
- Provide leadership development opportunities for family members to ensure that families play a significant role in changing the system.
- Document outcomes of education and mental health collaboration.
- Fund model demonstrations of education and mental health collaboratives.
- Use State Improvement Grant (SIG) funds to support education and mental health collaborations.
- Identify similar work being done in education and mental health and link key individuals doing this work.
- Ensure that general education and special education are involved with dialogue about mental health issues.
- Examine the value of intentional marketing of shared general and special education agendas at the local level.
- Link PBS and non-school programs to create continuity (e.g., after school programs and Head Start).
- Appropriate money for marketing PBS and mental health collaborations.
- Coordinate replication/demonstration programs that address mental health and behavioral needs.
- Alert community about use of free media for dissemination of information about effective collaborations.
- Document the link between improved mental health and higher student achievement.

<u>Local Level</u>

- Include mental health, education and families at seminars, professional/paraprofessional development activities, etc. to model collaboration.
- Provide a flexible and sustainable flow of funds between agencies in order for the infrastructure to support collaborative initiatives.
- Provide leadership development opportunities for family members to ensure that families play a significant role in changing the system.
- Identify similar work being done in education and mental health and link key individuals doing this work.
- Link PBS initiatives in the school building with broader community initiatives (e.g., after school programs and Head Start).
- Examine the value of intentional marketing of shared general and special education agendas at the local level.
- Appropriate money for marketing PBS and mental health collaborations.
- Alert the community about use of free media for clarification about what mental health is in schools.

- Clarify the roles and responsibilities of parent liaisons related to mental health and PBS initiatives in schools and agencies.
- Involve local school boards in education and mental health collaborations.

Simple Messages and Key Points for the Public

Policy forum participants were asked to generate simple messages and key points for the public that will promote education and mental health collaborations. The discussion has been synthesized into the following bullets.

- Document the link between student achievement, success in the workplace and social-emotional health.
- Remove academic and non-academic barriers to student achievement.
- Understand brain functioning and learning as it relates to mental health and behavior.
- Collaborate with a range of partners.
- Involve the community in mental health and PBS initiatives.
- Examine the consequences of zero tolerance policies on families, schools and the community.
- Value family involvement in mental health and PBS initiatives.
- Enhance the success of all students.
- Ensure that all partners are communicating the same message, including during personnel preparation (e.g., Mental Health Workforce Coalition).

Next Steps

To promote continued collaboration between PBS and school mental health, there will be a community-building meeting at the National School-Based Mental Health Conference in October 2004. The IDEA Partnership has a featured strand at this conference that includes OSEP investments in dropout prevention and longitudinal studies on students with emotional disturbance, as well as a keynote address by George Sugai, Co-Director of the Center on Positive Behavioral Interventions and Supports. Connections to family systems will be promoted by the involvement of the National Information Center for Children and Youth with Disabilities (NICHCY) and the ALLIANCE for Parent Centers. There will also be two presentations by state-based models (Texas and Ohio), which are examples of policy and practice linkages. This meeting will provide an opportunity for stakeholders to share their commonalities. The intent is not to establish a new infrastructure, but to create a voluntary affiliation that will further the shared work among federal agencies, federally funded projects and national organizations.

Appendix A:
Participant List

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Participant List

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Appendix B:
Agenda

School Mental Health/Positive Behavioral Support: Collaborative State Initiatives

Project Forum and IDEA Partnership at NASDSE
May 17-19, 2004
Agenda

Monday, May 17, 2004

6:00 Buffet dinner served in hotel

6:30 Welcome from NASDSE
Bill East, Executive Director
Greetings from OSEP
Lou Danielson, Director, Research to Practice Division

6:45 Staff introductions
Participant introductions

7:15 President's Commission on Mental Health as part of New Freedom Initiative
Andy Hyman – The National Association of State Mental Health Program Directors

Comments and questions

8:00 Review of agenda and packet

8:10 Adjourn for day

Tuesday, May 18, 2004

8:30 Beverages

9:00 Opening and introductions of those not present Monday

9:15 Three 30 minute presentations with time for questions

Overview of Positive Behavioral Support (PBS)
Tim Lewis – University of Missouri

Parents as Consumers
Terre Garner – Ohio Federation of Families for Children's Mental Health

Expanded School-based Mental Health Perspective
Mark Weist - Center for School Mental Health Assistance, U of MD

11:45 Facilitated debriefing

12:00 Lunch provided – informal networking

1:15 State examples of linkages between PBS and MH systems of care –
Florida, Illinois, Missouri, New Hampshire, Ohio

2:45 Break

3:15 Small group discussions
Processing of earlier large group discussion - identification and reflection on major themes identified

4:15 Plans for next day

4:30 Adjourn for day

Wednesday, May 19, 2004

8:30 Beverages

9:00 Discussion and revision of Tuesday's small group work

10:00 Whole group discussion
Collaboration of PBS and MH at the federal, state and local levels and recommendations

11:00 Break

11:15 Next steps

11:45 Closing remarks