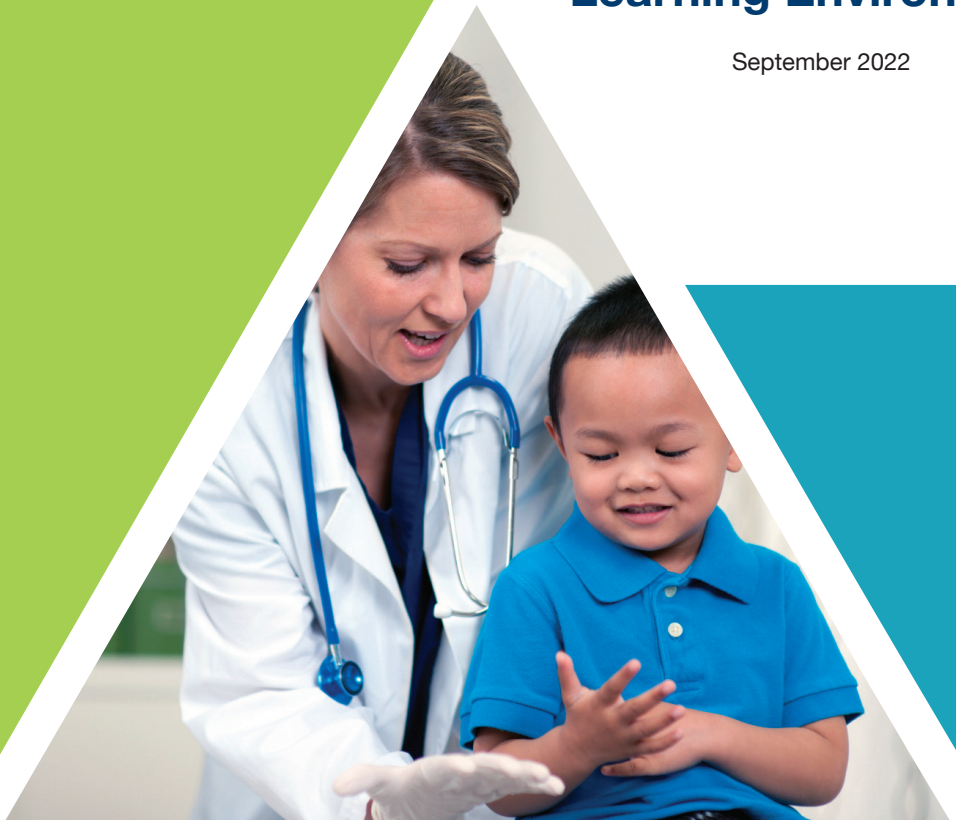
Supporting Children's Behavioral Health in the Learning Environment

September 2022



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Ohio Children's Hospital Association
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Introduction

Introduction

In an effort to better understand and improve state of Ohio services and investments in children's programming, Ohio Excels, the Children's Defense Fund – Ohio, and the Ohio Children's Hospital Association have created a state of Ohio children's program inventory with a specific focus on behavioral health and social-emotional learning (SEL). The inventory includes 78 discrete, service-oriented children's programs funded in whole or in substantial part by the state of Ohio through 75 appropriation line items across seven state agencies.

The acute need for more and better services to equip child-serving organizations to meet children's behavioral health and SEL needs has led these same organizations to produce this companion policy analysis. It identifies preliminary policy ideas and implications related to Ohio's current behavioral health delivery systems, including the growing use of wraparound health and education services designed to support at-risk children in school and other settings.

The policy context associated with creating an Ohio children's program inventory includes the related reality that more than ever, parents, teachers, and health and social service system experts recognize the value of acting early, acting with expertise, and acting across child-serving systems to secure better health, behavioral health, and educational outcomes for children. While parents and families have the most effective influence on children's mental and behavioral health, children also spend a significant part of their waking hours in school and participating in extracurricular activities – therefore, we must equip and support those who support children during these critical times of their day. Ohio's child-serving systems and schools are seeing children present with more complex behavioral health needs, often at younger ages than in the past. Stressful, if not traumatic, experiences associated with the coronavirus pandemic only exacerbate the problems.

It is also important to note that SEL and behavioral health are not the same thing. SEL can remove barriers to academic success and promote positive mental health through skills development that creates important "protective factors" that serve as a buffer against mental health risks, which include being able to have positive relationships with others. SEL promotes self-awareness, self-management, critical thinking, responsible decision-making, and the ability to work in teams. In this regard, SEL supports positive student mental health through its role as what is described as a Tier 1 support, or universal strategies that promote a student's strengths and prevent risks. The more intensive areas of behavioral health services and support (Tiers 2 and 3) involve more targeted early intervention to intensive treatment and support for students who require it.

In Ohio, the depth of these problems raises concerns about a mismatch between growing patient needs and system capacity, which includes questions about the adequacy, efficacy, and alignment of related state investments in children's behavioral health and SEL.

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This situation is reflective of national trendlines that show increasing levels of need for pediatric behavioral health services and problems accessing these services. For instance, an estimated 17% of youth 6-17 experience a mental health disorder, but only 51% of those youth actually receive treatment in a given year. And from 2007 to 2018, the national suicide rate for those age 10 to 24 increased 60% and is now the second leading cause of death for this group. Part of the access issue is linked to the fact that more than 60% of all counties in the United States—including 80% of all rural counties—do not have a single psychiatrist.[1] These shortages are evident in Ohio as well. The American Academy of Child and Adolescent Psychiatry estimates that for every 100,000 Ohio children, there are just 11 psychiatrists, which matches the national median. The association labels Ohio as one of 41 states with a "severe shortage."[2]

1 http://www.newamericaneconomy.org/wp-content/uploads/2017/10/NAE_PsychiatristShortage_V6-1.pdf

2 https://www.dispatch.com/news/20200301/psychiatrist-shortage--limits-nationwide-childrenrsquos-behavioral-health-program

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And while greater capacity is essential, there is also the important issue of better measuring outcomes at the medical condition level as part of a broader effort to improve population health. Fortunately, pediatric medicine in Ohio has made important strides forward in this area. The separate, but related, issue of enhancing SEL is also gaining growing attention as an avenue for action.

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With further regard to the question of need, a recent Centers for Disease Control and Prevention (CDC) policy brief notes that on average 15% of young children 2-8 years of age in the United States have a parent-reported mental, behavioral, or developmental disorder (MBDD) diagnosis. The percentage of children with diagnosed MBDD is similar for rural and urban areas at 18.6% and 15.2% respectively. Yet, according to the federal Health Resources and Services Administration (HRSA), 61% of geographic areas with a mental health professional shortage are rural or partially rural. This provider gap includes an estimate from the Substance Abuse and Mental Health Services Administration (SAMSHA) and the U.S. Bureau of Health Professions that the number of child and adolescent psychiatrists increased to 8,312 in 2020, but that this fell short of the estimated 12,624 needed nationally to meet demand.[3]

The Ohio Scene

Ohio fell from 11th to 25th nationally, a drop of 14 places, which is the biggest drop of any state but Texas.

The Ohio story mirrors these patterns. A recently released Mental Health in America annual mental health ranking report (2022: State of Mental Health in America) reveals that nearly 25% of Ohio adults are experiencing mental health issues. This means that Ohio fell from 11th to 25th nationally, a drop of 14 places, which is the biggest drop of any state but Texas. The same rankings report shows that Ohio ranks 18th nationally in terms of youth prevalence of mental illness.

Additionally, in Ohio, these challenges are compounded by the state's relatively low rankings with regard to population health status, including pediatric health and diseases of despair, such as drug addiction. On the behavioral health front, a recent Health Policy Institute of Ohio policy brief reveals that nearly two-thirds of Ohioans have been exposed to adverse childhood experiences (ACEs). ACEs are potentially traumatic events that occur in childhood (0-17 years). These include aspects of a child's environment that can undermine their sense of safety, stability, and bonding such as growing up in a household with substance misuse, mental health problems or instability due to parental separation. ACEs are linked to chronic health problems, mental illness, and substance misuse in adulthood and can also negatively impact educational success and job opportunities.

Beyond Ohio Medicaid, which provides health care for 1.2 million children (0-18), the state of Ohio makes relatively modest investments in behavioral health programs for children and youth. This investment story is even truer with regard to the much smaller and newer state engagement and investment in SEL.

At the heart of these behavioral health and SEL issues is the two-pronged challenge of moving expeditiously to build urgently needed behavioral health service capacity while creating a more accessible, patient-centric system of care that better connects patients with health care professionals. With regard to the state's role, it is centrally about Medicaid and the need to improve behavioral health access and outcomes through system redesign, including OhioRISE (Resilience Through Integrated Systems and Excellence). The central value proposition for the state of Ohio with regard to behavioral

3 Mental Health Services for Children Policy Brief: Providing Access to Mental Health Services for Children in Rural Areas, CDC. https://www.cdc.gov/ruralhealth/child-health/policybrief.html

health for children and youth is to better leverage its market position to help create a comprehensive, integrated, and well-managed continuum of behavioral health care that is accessible to all Ohioans no matter who pays for the services.

Additionally, Ohio's other, often fragmented and under resourced, behavioral health programs housed in a range of state agencies need better coordination both within state government and, as necessary, with private and intergovernmental service partners, including primary care practitioners who are on the frontlines of behavioral health care. The central goal of this work, which is already being propelled forward by county child-serving system leaders with the leadership of Governor Mike DeWine and his Children's Cabinet, is to contribute to the funding and development of an accessible, affordable, and effective behavioral health system.

Children's Programming Policy Report and Its Federal Funding Context

In an attempt to address this problem set, this companion report to the children's program inventory outlines related, albeit preliminary, behavioral health and SEL policy ideas and implications. The report reflects initial communication with relevant Ohio stakeholders; the policy ideas are provided for purposes of discussion and further consideration.

The policy ideas and implications are categorized relative to their primary, but not necessarily exclusive, focus as follows:

- Contextually relevant policy and fiscal realities that need to be understood and taken into account as policy ideas are considered;
- Preliminary behavioral health ideas; and
- Preliminary social-emotional learning ideas.

Following these sections is a discussion of potential next steps and the prioritization of the preliminary policy ideas that appear to be the most actionable within a FY 2022-2023 timeframe. Importantly, this fiscal timeframe is one that includes relative fiscal continuity and stability, which is being provided in powerful ways through a historically large infusion of federal stimulus funds produced in response to the COVID-19 pandemic. To date, according to *Federal Funding Information For The States,* Ohio's share of these 2020 and 2021 federal appropriations totals an estimated $41.082 billion in federal agency grants and $86.476 billion in non-grants resources, such as enhanced unemployment insurance payments and the Paycheck Protection Program.[4] The federal legislative acts that are the source of these funds – all of which became law since the COVID-19 pandemic began in March 2020 – are listed below along with total Ohio appropriations. The source of this data (and the American Rescue Plan Act data listed below) is the Bureau of Fiscal Services of the U.S. Department of the Treasury (usaspending.gov).

- Paycheck Protection Program and Health Care Enhancement Act ($260.818 million)
- Families First Coronavirus Response Act ($680.72 million)
- Executive Action ($1.407 billion)
- Coronavirus Preparedness and Response Act ($30.213 million)
- Consolidated Appropriations Act ($5.479 billion)
- CARES Act, Families First Coronavirus Response Act ($820.477 million)
- CARES Act ($70.943 billion)
- American Rescue Plan Act – ARPA – ($35.017 billion)

4 Federal Funds Information for States, State funding for Coronavirus Pandemic, version 37, released November 2, 2021.

Importantly, ARPA passed with Ohio receiving $18.9 billion in non-grant funding via direct payments of $1,400 per person from the U.S. Treasury to eligible Ohio residents. Key ARPA appropriations for Ohio include the following allocations of which many concern children's education and health-related programming:

- State Fiscal Relief Fund: $5.63 billion
- Local Fiscal Relief Fund: $5.32 billion
- Elementary and Secondary School Emergency Relief Fund (ESSER): $4.47 billion
- Emergency Assistance to Nonpublic Schools (EANS): $153.9 million
- Child Care and Development Block Grant: $501.36 million
- Child Care Stabilization Grants: $801.88 million
- Head Start: $39.65 million
- Mental Health Block Grant: $43.89 million
- Substance Abuse Block Grant: $51.88 million

Included in Ohio's overall federal stimulus funding is $6.565 billion in primary and secondary education funding that flows from ten funding sources, including $5.715 billion in ESSER (Elementary and Secondary School Emergency Relief) I, II and III funds, to local Ohio education agencies. The allocation model for most of these fund tracts the poverty-related Title I program and its focus on helping schools meet the needs of low-income, at-risk students. Consistent with this federal policy approach, the largest portion, approximately two-thirds, of these education dollars has been allocated to three of Ohio's eight school district typologies, as well as to brick-and-mortar charter schools, according to data provided by the Ohio Department of Education:

- Urban 8 School Districts: 28.96%
- Urban – High Poverty: 16.85%
- Small Town – High Poverty: 9.69%
- Brick and Mortar Charters: 10.73%

The other one-third of the funds were allocated to rural and suburban districts, as well as small town districts with low student poverty.

In terms of how this resource allocation aligns with student population, the results are as follows as it relates to each categories' share of total statewide student population (ADM) according to data provided by the Ohio Department of Education:

- Urban 8 School Districts: 12.23%
- Urban – High Poverty: 12.81%
- Small Town – High Poverty: 11.55%
- Brick and Mortar Charters: 6.98%

In sum, approximately two-thirds of the funds were allocated to schools that educate 43.57% of public school students while approximately one-third of the funds were allocated to school districts that educate 56.43% of these students.

Enabled by the presence of these funds and encouraged by growing concerns about the demand for behavioral health services – including a 24% increase in emergency room visits for mental health reasons for children ages 5 through 11, and a more than 30% increase in visits for those between 12 and 17 years old in 2020 – several targeted investments have been made recently in pediatric behavioral health.[5] Leading examples include:

- The U.S. Department of Education has announced a new resource, *Supporting Child and Student Social, Emotional, Behavioral and Mental Health.* It outlines key challenges in providing and accessing mental health supports in schools and provides evidence-based recommendations for educators, staff, and providers to create a system of supports for students.[6]
- Substance Abuse and Mental Health Services Administration (SAMHSA) awarded $54 million in federal grants to Community Mental Health Centers across Ohio, including $3.54 million for Child Focus, Inc. in Cincinnati and $1.4 million for Child Guidance and Family Solutions in Akron.[7]
- In August 2021, the Biden administration announced nearly $85 million in funding for mental health awareness, training, and treatment. The funding includes $10.7 million in ARPA funds from the Health Resources and Services Administration for the Pediatric Mental Health Care Access Program, which trains primary care providers to treat and refer children for mental health issues. Another $74.2 million in grants is being distributed to districts from SAMHSA to raise awareness about youth mental health issues and train school personnel and programs that coordinate treatment for young people with emotional disorders.[8]

5 https://www.whitehouse.gov/briefing-room/statements-releases/2021/10/19/fact-sheet-improving-access-and-care-for-youth-mental-health-and-substance-use-conditions/#:~:text=In%202020%2C%20there%20was%20a,12%20and%2017%20years%20old.&text=Even%20for%20those%20with%20coverage,behavioral%20health%20care%20services%20remain.

6 https://www.ed.gov/news/press-releases/us-department-education-releases-new-resource-supporting-child-and-student-social-emotional-behavioral-and-mental-health-during-covid-19-era#:~:text=Today%2C%20the%20U.S.%20Department%20of,being%20among%20children%20and%20students.

7 https://www.portman.senate.gov/newsroom/press-releases/portman-announces-54-million-federal-grants-benefit-community-mental-health

8 https://www.npr.org/sections/back-to-school-live-updates/2021/08/27/1031493941/childrens-mental-health-gets-millions-in-funding-from-the-biden-administration

Considerations for Policy Design & Implementation

CONSIDERATIONS FOR POLICY DESIGN & IMPLEMENTATION

This section of the report identifies contextually relevant issues that relate directly to successfully analyzing, developing, and advancing reforms in Ohio children's behavioral health and SEL policies and programs.

1. Ohio's Budget Format Creates Challenges with Policy Implementation and Evaluation

Ohio's state operating budget structures agency budgets at the line-item level using abbreviated authorizing language that often fails to provide clarity and specificity regarding populations served, intended results, and related funding allocations. This is particularly problematic for children's programming given the importance of age distinction in child development. This issue relates primarily to the allocation of funds within appropriation line items, which can make it challenging to baseline current policies and programs and track financial investments. And while endless detail or the curtailment of fiscal flexibility is not required, greater conceptual clarity – as well as an ongoing and biennially-updated children's program inventory – would help with policy implementation and evaluation.

2. Children's Policy and Program Framing Questions

In determining the need and rationale for enhanced state investments in children's behavioral health and SEL programming, it will be important to determine, from a system's perspective, what the state's role should be going forward and whether it should be expanded significantly to include assistance for children and youth (and their families) who are *not* Medicaid eligible. *With regard to the latter, outside of educational and institutional settings, Ohio spends very little on behavioral health services for children and youth who are not Medicaid eligible and thus have family incomes above 200% of the federal poverty level.*

3. Relevant Local Government and Service System Issues

Historically reflective of the state commitment to a philosophy of "local control," Ohio's bifurcated state-local system governance and operational complexity has sometimes led to limited progress in: determining necessary levels of state funding; setting statewide performance expectations; creating a continuum of care; pursuing program implementation fidelity and quality; holding systems accountable for results, including continuous improvement; and pursuing cross system partnerships. As a practical matter, this means that the degree to which a child's health needs are met depends to a great extent on where they live. At present, Medicaid is one of the few statewide constants in behavioral health services and even within it there are ongoing access and parity issues in a state/federal program that spends only 14% of its funds on children who, as a group, represent 40% of Ohio's 3.2 million Medicaid recipients.

Consistent with these concerns, many child advocates argue that the state should work with stakeholders to establish and help design and fund a standardized, statewide continuum of behavioral health care for children that Ohioans can access regardless of where they live, their family income or their insurance coverage. Beyond promotion and prevention programming, advocates recommend that the continuum should recognize that children and youth living with mental illness and substance use disorders have chronic diseases that require ongoing disease management, as well as short- and longer-term recovery supports. Likely using a staged approach, system improvement efforts could build on Evidence-Based Practices and Response-to-Intervention models. At the family level, the need is great. According to a 2020 study in *Social Science and Medicine,* the long-term cost of childhood psychological problems results in a lifetime loss in family income of approximately $300,000.[9]

9 https://www.sciencedirect.com/science/article/abs/pii/S0277953610002686?via%3Dihub

4. State Fiscal Conditions

Ohio's decades-long experience with a relatively slow growth economy has translated into modest state revenue increases that have been further reduced by tax cuts. This has meant that real increases in state spending have been modest at best beyond Medicaid, which has grown beyond inflationary increases largely because of policy-driven population eligibility expansions and related increases in the share of Medicaid paid for by the federal government. This increase has, at least indirectly, enhanced the ability of both state and local governments to expand behavioral health care services to Medicaid eligible children and adults.

The coronavirus-triggered 2020 recession temporarily drove down state revenue growth and increased certain state costs. Nevertheless, the state still met pre-pandemic, FY 2021 revenue estimates due primarily to a huge and historic infusion of federal stimulus funds. Calendar year 2021 has seen an economic recovery that enabled a stable, continuation FY 2022-2023 budget to be proposed and passed (Am. Sub. House Bill 110). This budget provides stable, continuation funding for most state programs, including children's programs, all of which were maintained and in some cases received enhanced funding. Overall, total All Funds appropriations increased 6.3% in FY 2022 and 0.4% in FY 2023. And as of the end of December 2021, year-to-date FY 2022 General Revenue Fund revenues were 2.4% above estimate while total General Revenue Fund disbursements were 1.9% below estimate.

Within this fiscal context, the Ohio General Assembly moved forward in the FY 2022-2023 biennial budget to advance stage one of a new school funding formula. The Fair School Funding Plan, a priority for House Speaker Bob Cupp, is an inputs-based school funding model that creates a base cost methodology based on student-teacher ratios, minimum staffing levels, and actual costs; the methodology uses both property and income for all districts. The formula also incorporates an instructional and student supports component that specifically includes SEL and school safety. This component equates to approximately 15% of the proposed new per pupil base cost. Additionally, the new formula also provides, for the first time, direct funding for community (charter) schools, scholarship programs, STEM schools, and open enrollment.

Final budget negotiations produced agreement on the first two years of a proposed six-year phase in of this new funding formula; however, the Ohio Senate did not concur to any further action in terms of future year funding. This stance relates to concerns that the formula will ultimately be much more expensive than the estimate of $2 billion (FY 2021 dollars) if the six-year plan is fully phased-in.

Beyond the enactment of the FY 2022-2023 state operating budget and the previously referenced $84 million allocation of federal stimulus funds for pediatric behavioral health facilities, calendar year 2021 legislative activity included multiple allocations of federal stimulus funds for other discrete children's programing related uses. In addition to per pupil, formula-based school aid, leading examples include the following FY 2022 appropriations of these one-time federal funds:

- Ohio University's Voinovich School of Leadership and Public Service will coordinate a new center focused on supporting the state's behavioral health system. The Center of Excellence for Behavioral Health Prevention and Promotion will be funded by $4.5 million in federal COVID relief funds. $3 million of this amount will be used to create a hub for prevention science and to award grants and mini-grants to help communities identify local prevention needs and solutions, advance the use of prevention science, and support the prevention workforce. The Center will, for the first time, provide Ohio with a centralized, consistent, and culturally relevant approach to advancing prevention services.
- Passed in December 2021, House Bill 169 was the legislative vehicle for allocating another round of federal stimulus funds. Leading examples of FY 2022 allocations of relevance to Ohio children's programming included the following appropriations/set-asides:
    - $9.057 million for the establishment or expansion of school-based health centers at public schools.
    - $15 million for the Ohio Department of Education to make grants or contracts to support student wellness and success initiatives, including, but not limited to, mental health, prevention education, suicide prevention, trauma informed practices, and other initiatives supporting non-academic barriers to student success.

- $11 million to be used to support family and community liaisons at educational service centers and the Ohio Statewide Family Engagement Center.
- $5 million for the Ohio Department of Education to make grants or contracts to support evidence-based strategies to increase attendance and decrease chronic absenteeism in partnership with the Stay in the Game Network.
- $70 million to be used by the Ohio Department of Education through grants or contracts to support learning loss and academic recovery efforts.
- $639 million for a Child Care ARPA Supplement (Ohio Department of Job and Family Services)

5. Policy Implementation: The Need for Focused, Sustained Leadership

Given the importance and complexity of children's policy and program issues, Ohio policy makers should consider creating and institutionalizing a children's programming related policy implementation forum with adequate resources. Addressing often intractable children's related problems through state policy reforms is exceedingly complex, difficult work. But even if the right policies are developed, what is sometimes even more difficult is the work of policy implementation. And this issue will only become more difficult with growing organizational complexity and the reality that public-private partnerships, formal and informal, will increasingly take the place of a public-only approach. Already, though, policy implementation is often a graveyard for policy ideas. Sometimes this is good because it weeds out poorly designed programs; but, in many cases, better strategic collaboration and management that includes smart thinking about policy implementation can make the difference between success and failure. With this in mind, it makes sense for the state to consider devoting more analysis and funding to the work of policy implementation by creating a state level forum for interagency analysis, action and, importantly, evaluation. This approach will also help policy makers gain a better understanding of how to measure results and how to improve system productivity.

Behavioral Health Policy Opportunities

Behavioral Health Policy Opportunities

This section of the report focuses on children's behavioral health services and related preliminary policy opportunities and implications.

In Ohio, there are 16 behavioral health related programs across seven state agencies. These funds may be used for the provision of direct services, including, but not limited to, employing counselors, group therapy, clinical care, psychiatric hospitalization, and school readiness. Exclusive of Medicaid, funding within agency line items associated with these programs approximates $120.3 million in FY 2021. Because these line items fund other allowable uses beyond children's behavioral health, it is difficult to ascertain exactly how much was directed for these purposes without further reporting and analysis.

1. **Create a State of Ohio Children's Budget.** Create a separate Ohio Children's Budget in an effort to enhance strategic direction, program coherence, and organizational synergy. This whole child approach would help facilitate planning and action using a collaborative, interagency-focused effort to manage toward measurably better health and education outcomes – including behavioral health and SEL – for children and youth.

   Additionally, given the central financial and programmatic significance of Ohio Medicaid, an Ohio Children's Budget could facilitate greater analysis and understanding of how Medicaid funding could be used more effectively to implement a whole child approach to achieving better health outcomes through more effective prevention, intervention, and disease management, all of which include reducing escalating cost growth. In fact, according to a 2017 Kaiser Family Foundation Fact Sheet given their greater needs, total Medicaid 2011 spending per enrollee (including medical, behavioral health, and long-term care services) is nearly four times higher for children with a behavioral health, diagnosis compared to those without this diagnosis. Importantly, prevention, early intervention and smart disease management can change this cost picture substantially.[10]

2. **Address Essential Workforce Needs in Order to Build a More Robust Behavioral Health System for Children and Youth.** Create a statewide strategy to recruit, train, and retain a skilled workforce to provide high-quality, whole child focused learning environments adept at delivering trauma-informed behavioral health services and interventions. Relevant workforce participants include child-serving system professionals, early childhood and K-12 educators, behavioral health professionals and well-child/pediatric and family practitioners. According to a 2018 ten-year job outlook report from ODJFS, employment forecasters anticipate an increased need for behavioral disorder, mental health, and substance abuse counselors (17.6%); psychiatrists (12.8%); clinical, counseling and school psychologists (12.4%); and psychiatric technicians (11.7%).[11]

3. **Support and Expand Early Childhood Mental Health Consultants.** Support and consider expanding the Early Childhood Mental Health Consultation (ECMH) program. This proven program focuses on promoting mental health and social and emotional development for children ages birth to six years. ECMH consultants provide services to help young children succeed in early learning environments and in their homes by working with families, childcare providers, and other early childhood professionals on skills that address behavioral health care needs.

   The State of Ohio has been gradually expanding this program under the administration of the Ohio Department of Mental Health and Addiction Services (OhioMHAS). As the demand for these services continues to increase, the state should determine how to take the program to scale as part of a comprehensive school readiness strategy.

4. **Dedicate a Children's Behavioral Health Line Item at OhioMHAS.** Better targeting existing and new resources could help ensure a sustained focus on children's behavioral health; it could also help ensure that necessary services depend less on local levy resources, Medicaid eligibility, Medicaid service limitations, or short-term federal grants. It is hard to make children's behavioral health a more significant, long-term state priority without corresponding (and dedicated) state funding. A full continuum of behavioral health care requires access to ongoing statewide funding.

10 https://www.kff.org/medicaid/fact-sheet/ten-things-to-know-about-medicaids-role-for-children-with-behavioral-health-needs/

11 https://ohiolmi.com/Home/Projections

Through FY 2011 (129th General Assembly) the state of Ohio funded a dedicated line item for Children's Behavioral Health (GRF335-404) within the Ohio Department of Mental Health. This children's programming focused on serving children with mental health or substance-use disorder needs and on mitigating the increased costs that occur in other child-serving systems when care and supports are not available. The separate line item, which provided approximately $7.4 million in funding each year, was consolidated with other non-Medicaid services (Community and Hospital Mental Health Services) into one GRF line item, 335505, Local Mental Health Systems of Care. Line item 335505 was only modestly increased over previous year funding, however, which resulted in an overall decrease in funding. Additionally, it is unclear the degree to which funding under the new line item has been dedicated for mental health services specific to children.

5. **Identify and Advance Best Practices Relative to Addressing Trauma-Related Children's Needs.** Significant strides have been made relative to understanding how Adverse Childhood Experiences (ACEs) impact an individual's ongoing physical and behavioral health. In fact, a pre-pandemic Health Policy Institute of Ohio analysis revealed that approximately two-thirds of those surveyed experienced an adverse childhood experience.[12] With this in mind, it makes sense to expand the state's effort to ensure that all child-serving professionals have the training necessary to utilize trauma-informed practices within their systems and programs and ensure that these approaches are implemented with fidelity. The state may need to subsidize some professional development efforts to ensure that ongoing coaching and technical assistance is available to maintain fidelity to the training and to attain expected outcomes for children. This includes helping child-serving programs update procedures, protocols, and practices to support trauma-informed care.

6. **Allocate Resources to Better Serve Students with Disabilities.** From a child-centered perspective, what are better ways to use state resources, including ODE's Student Wellness and Success Fund, to serve students with disabilities who are overrepresented in traditional at-risk populations. This is an increasingly significant and relevant question because, as a group, students with disabilities have significant behavioral health related needs that are likely often not well addressed due to local and state program capacity problems and the lack of a comprehensive and coordinated system of care.

   This problem was substantiated in a 2017 Kaiser Family Foundation Fact Sheet (*Ten Things To Know About Medicaid's Role For Children With Behavioral Health Needs),* which revealed that 59% of children with special health care needs have or are at greater risk for chronic physical, developmental, behavioral, or emotional conditions. Additionally, the fact sheet notes that half of children eligible for Medicaid based on a disability have a behavioral health diagnosis, compared to 44% of those eligible based on foster care, and 11% of those eligible based on poverty as of 2011.[13] Students with special education needs, who compose over 15% of Ohio public school students, are overrepresented in these health categories. Importantly, the U.S. Office of Special Education Programs (OSEP) issued a letter of significant guidance related to the implementation of Positive Behavior Interventions and Supports (PBIS), reminding states and districts of their responsibility for ensuring a Free Appropriate Public Education (FAPE) to students with disabilities, including the student's Individualized Education Program (IEP) team addressing the implications of a child's behavioral needs. These realities should be taken into careful consideration as Ohio embarks on its recently approved and funded study of special education funding, which is to be completed by December 31, 2022. Another consideration should be an analysis of the effectiveness of the Ohio Medicaid School Program, which allows school resources devoted to special education related costs to be used to draw down federal (Medicaid) matching funds.

12 https://www.healthpolicyohio.org/wp-content/uploads/2021/01/ACEs_FactSheet1.pdf

13 https://www.kff.org/medicaid/fact-sheet/ten-things-to-know-about-medicaids-role-for-children-with-behavioral-health-needs/

7. **Maintain the Multi-System Youth and Innovation Fund and Associated Technical Assistance.** With an $8 million FY 2020 appropriation, this program is designed to prevent custody relinquishment of children and youth solely for the purpose of obtaining needed treatment. Many of these multi-system youth present with multiple needs or a dual diagnosis where behavioral health is a significant factor, and many have experienced trauma. Through December 2020, the fund made provider-direct payments for treatment and/or supports for 389 children from 76 counties. The program is administered by Ohio Family and Children First. Although a new program, it builds on lessons learned from previous multi-system efforts frequently referred to as "Cluster Funds." (Note: Established in 1993, and currently defined as the Governor's Children's Cabinet with the purpose of streamlining and coordinating government services for children and families, Ohio Family and Children First is a partnership of state and local governments, communities, and families that enhances the well-being of Ohio children and families by building community capacity, coordinating systems and services, and engaging families.)

8. **Support OhioRISE and Related Child-Centered, Disease Management Initiatives Within Ohio's Medicaid Program.** OhioRISE (Resilience through Integrated Systems and Excellence) sets up a specialized managed care organization (MCO) within Ohio Medicaid to provide health services to the most complex multi-system youth, including those who are in need of significant behavioral health services, who are often not served effectively, and are too often sent out of state for exceedingly high-cost placements due to Ohio's program capacity problems. Once implemented in 2022, OhioRISE is expected to serve 55,000 to 60,000 children and youth by the end of year one via a new 1915(c) federal waiver.

   OhioRISE recognizes that children and youth living with mental illness and/or substance abuse disorders are facing chronic diseases that require ongoing disease management. Within the OhioRISE construct, services will include: intensive care coordination, intensive home-based treatment, psychiatric residential treatment facility, mobile response, and stabilization services. OhioRISE is a promising Medicaid program reform designed to improve health services and outcomes and be more cost effective. This approach should be supported as part of a broader strategy to better address behavioral health and related issues.

9. **Stand up a Statewide System of Crisis Response and Stabilization for Children and Youth.** According to many behavioral health professionals, when a child experiences an acute behavioral health crisis, the immediate need to stabilize the situation too often becomes a scramble to match the child's needs with an experienced professional or a potential hospital or residential treatment bed.

   This means that crisis stabilization often defaults to emergency room visits that may or may not lead to helpful supports. Additional state leadership and funding is likely required to move beyond today's patchwork of services. There are ADAMHs Board partnerships that could serve as models for initial investment. An identified priority is the development of regional system infrastructure, including more in-person stabilization beds and step-down programs to help children return to their homes from residential treatment. Experts argue that a crisis response system must be open to all, which means that it must move beyond the Medicaid population and Medicaid funding.

   Developing a true crisis response system for children and youth would be a significant step toward creating a continuum of behavioral health care for children and youth. It would also help facilitate implementation of the 9-8-8 helpline. (In October 2020, the President signed the National Suicide Designation Act of 2020, which established, in law, 9-8-8 as a universal number for mental health crises and suicide prevention. The number became operational in July 2022. With regard to funding, the law enables states to enact fees similar to those in place for 9-1-1 that will support expanded services at the local level. To date, Ohio has not enacted such a fee.)

Social-Emotional Learning

Policy Opportunities

Social-Emotional Learning Policy Opportunities

Listed below are preliminary policy ideas and policy implications that have emerged from the development of an Ohio children's program inventory. ***The working definition of SEL is as follows: From a practitioner perspective, social-emotional learning is the process through which people acquire the knowledge, skills, and attitudes to develop healthy identities, manage emotions and achieve personal and collective goals, show empathy, and work successfully with others. SEL includes self-awareness, self-management, social awareness, responsible decision-making and relationship skills.***

While the core concepts involved with SEL have always been with us, SEL as a formal educational initiative is relatively new. This means that there are few distinct SEL programs in Ohio and in most other states. However, action on this front is evolving and includes the Ohio program initiatives and related ideas identified below. It also includes formal, albeit voluntary, K-12 SEL Standards developed by the Ohio Department of Education and approved by the State Board of Education. Additionally, there are initial studies regarding program efficacy that suggest that a dollar invested in effective SEL programming results in preventing problems that would otherwise materialize and require various educational and health interventions, including behavioral health interventions. For instance, a 2015 study by Columbia University's Center for Cost-Benefit Studies in Education found that SEL benefits outweighed costs by a very significant amount.[14] These are long-term benefits to students, schools, and communities. As noted in the report summary:

The most important empirical finding [of the study] is that each of the six interventions for improving SEL shows measurable benefits that exceed its costs, often by considerable amounts. There is a positive return on investments for all of these educational reforms on social and emotional learning. And the aggregate result also shows considerable benefits relative to costs, with an average benefit-cost ratio of 11 to 1 among the six interventions. This means that, on average, for every dollar invested equally across the six SEL interventions, there is a return of eleven dollars, a substantial economic return.

Overall, the study concludes that while SEL interventions are likely to pass a benefit-cost test, there is considerable additional research to be performed to establish the "full extent and magnitude of the benefits of SEL. The full economic benefit of SEL is not yet established."

As for the Ohio SEL scene, there are six SEL-only state programs all of which are funded by the Ohio Department of Education. There are two additional "shared" programs that relate substantively to both SEL and behavioral health within ODE. The SEL programs focus primarily on supporting educators in the school system with professional development, instructional strategies for teachers and administrators, as well as implementation coaching. SEL-specific earmarks approximate $12.4 million in FY 2021, exclusive of foundation aid, Student Wellness and Success Funds, Head Start and early education funds, which can be used for these purposes at a school district's discretion.

1. **Enhance Student Wellness and Success Funds (SWSF).** New in the FY 2020-2021 state biennial budget was a SWSF fund totaling $275 million in FY 2020 and $400 million in FY 2021. The central purpose of the fund is to enhance the wellness and educational success of students at-risk of educational failure. Unsurprisingly, in FY 2020, the initial start-up year, only 53% of the funds were expended. The service category with the most projects and spending was mental health. With regard to total FY 2020 spending, about one-third was used to supplant eligible programming; about one-third was used to enhance existing programs and about one-third was spent on new (eligible) programming.

   In the FY 2022-2023 state operating budget, SWSF was increased substantially, rising from $400 million in FY 2021 to $500 million in FY 2022 and to $600 million in FY 2023. However, the allocation of these funds has been changed and integrated into the new school funding formula. Going forward, school districts will be funded for SWSF staff as one of the student support base funding components. The funding for these staff positions is based on a salary and benefits

14 https://static1.squarespace.com/static/583b86882e69cfc61c6c26dc/t/59089094cd0f6810013b15ff/1493733525917/SEL-Re

formula that includes the assumption that there will be a minimum of five student wellness and success staff funded per school district.

Given this increased funding and the significance of the challenges being addressed – with many if not most of them related to poverty – it seems reasonable to call for a gradual stop to supplanting; it also seems reasonable to require clearer policy parameters, evidence-based practices, and robust evaluations so that the state and the schools get the very best return on investment in the form of enhanced student achievement and well-being.

2. **Measure SEL Implementation and Pilot Efficacy Studies.** Consider creating SEL demonstration projects that involve an integrated, whole child approach to learning and include first-rate program evaluation designed to measure the efficacy of these programs. Gain greater clarity regarding the potential for integrating SEL more effectively into early education. SEL appears to have promise and resonates with both research findings and common-sense experience that children with significant social and emotional challenges will likely have difficulties with many daily activities, including learning in school and in the world of work. It also makes sense to be proactive by intervening early and effectively as part of school readiness and early education. This approach aligns with the notion that life skills (otherwise known as "soft skills") and the ability to demonstrate associated competencies are in high demand by Ohio employers. In fact, the state's OhioMeansJobs-Readiness Seal includes these skills. The seal is a formal designation that a student can earn by demonstrating the professional skills that are required for success in the workplace. There are 15 skills in total; examples of life skills related to SEL include: reliability, work ethic, punctuality, discipline, and teamwork/collaboration.

   Importantly, there is a need for ongoing research to determine the efficacy of SEL. This is particularly true because some critics of SEL question its teaching of life skills that have traditionally been the domain of families. Meanwhile, other, perhaps more politically progressive, critics have voiced concerns that SEL's potential is being limited because it is too narrowly focused on behavioral change encouraged by educators focused too much on classroom management related matters.

3. **Expand Services to Help Students Transition from Remote Learning Back Into the Classroom.** Create/advance assistance for at-risk children who, because of the COVID-19 pandemic, were often learning remotely and need ongoing help catching up as they transition to classroom-based instruction. A December 2020 national study by McKinsey and Company estimates that the shift to remote school in Spring 2020 set white students back by one-to-three months in math, while students of color lost three-to-five months. As the coronavirus pandemic persists through this academic year, McKinsey estimates losses will escalate.[15]

   A follow-up July 27, 2021, McKinsey article *(COVID-19 and education: The lingering effects of unfinished learning)* states that, on average, the pandemic's impact on K-12 students left them five months behind in mathematics and four months behind in reading by the end of the 2020-2021 school year. The article goes on to say that the pandemic's impact was actually broader because of its negative effect on students' health and well-being. In fact, more than 35% of parents surveyed said that they were very or extremely concerned about their children's mental health.

   Ohio-based evidence concerning the negative educational impact of the pandemic is found in a January 2021 study commissioned by the Ohio Department of Education. The study, *The COVID-19 Pandemic and Student Achievement on Ohio's Third-Grade English Language Assessment,* found that:

   - Average achievement on the Ohio Third-Grade English Language Arts (ELA) assessment declined by approximately 0.23 standard deviations between fall 2019 and fall 2020. This is roughly equivalent to one-third of a year's worth of learning. The proportion of students

15 https://www.mckinsey.com/industries/public-and-social-sector/our-insights/covid-19-and-learning-loss-disparities-grow-and-students-need-help#

scoring at the "proficient" level fell by approximately 9 percentage points and the proportion of students scoring sufficiently high to satisfy previous requirements for promotion to fourth grade decreased by approximately 8 percentage points. (The state adjusted promotion requirements during the pandemic.)

- During the same period, Black students experienced test score declines that were nearly 50% larger than white students—for a total decline of approximately one-half of a year's worth of learning. The scores of economically disadvantaged students also fell more than scores of students not identified as such.
- Although most Ohio school districts experienced declines in third-grade test scores, there was considerable variation in test score changes across the state. For example, over 10% of districts (over 60 districts) experienced no test score declines during the pandemic. A substantial portion of student achievement impacts are tied to how significantly COVID-19 affected unemployment, with larger test score declines in areas that experienced the sharpest job losses. It appears that COVID-related unemployment explains approximately one-third of the decrease in average test scores statewide.[16]

Despite the movement of students back into full-time classroom settings, remote learning will likely be a greater part of the student experience for many. While most students and teachers are making this work, early evidence suggests that at-risk students who were already behind their regular education peers in student achievement fell further behind during the pandemic and have yet to catch up. Others, unfortunately, have effectively disenrolled. ODE estimated that by the close of the 2020-2021 school year, over 50,000 Ohio public school students were either chronically absent or not coming to school at all. The department is working to employ federal funds to advance attendance recovery initiatives to address this significant challenge.

This situation also appears to be increasing behavioral health related problems in Ohio and nationally. With this in mind, consideration should be given to using federal funds not just for attendance recovery, but to expand educational support/wraparound services to help these students succeed. Without action and programming that does not currently exist, these problems will only grow larger.

Governor DeWine is aware of these issues and asked school districts to devise responsive learning plans by April 1, 2021. To assess the impact on students caused by pandemic-related disruptions, each Ohio school district was required to submit an Extended Learning Plan to the Ohio Department of Education. In calling for school districts to create their plans, Governor DeWine challenged communities and educational stakeholders to work together to ensure students are receiving the help and support they need.

An internal department review of submitted school district extended learning plans revealed a focus on a handful of priority areas impacting a majority of school districts, including SEL, credit recovery, literacy and math, chronic absenteeism, and family engagement.

To address these issues, 70% of school district plans called for summer school and other extended year programs; 36% identified before and after school programming as a key strategy; and 45% identified educational service centers (ESCs) or other community organizations as critical implementation partners.

These extended learning and continuity of learning plans will guide districts on how to effectively utilize federal stimulus funds to address pandemic-induced learning loss and associated challenges including non-academic barriers to learning.

16 http://glenn.osu.edu/educational-governance/reports/reports-attributes/ODE_ThirdGradeELA_KL_1-27-2021.pdf.

This Ohio story is part of a broader national data picture that reveals behavioral health difficulties arising from the COVID-19 pandemic. A September 2020 Child Mind Institute/IPSOS poll of American parents who have recently used or sought out mental health treatment for their child found that more than two-thirds said they had witnessed a decline in their child's emotional well-being (72%), behavior (68%), and physical health due to decreased activities/exercise (68%).

4. **Support Parents, Families and Guardians Regarding Whole-Child Development and Their Role in Their Child's Learning and Growth.** There are few state resources dedicated directly to helping families enhance their children's social and emotional development. Examples of what research suggests would help families in this regard include: online parent toolkits, SEL aligned with school readiness and early education, and targeted support for kinship families. Relevant SEL program development and expansion efforts (state and local) could be facilitated by ODE using a combination of Student Wellness and Success Funds and COVID-19 related federal stimulus funds earmarked for primary and secondary education. A leading example of this is the Family and Community Partnership Liaisons employed by Ohio's ESCs under a federal grant through the Ohio Department of Education. Funded with CARES Act funds, the liaisons are to connect schools, families, and youth to community resources and local systems of care. If proven effective, the state will need to examine how to sustain the work behind the one-time grant funds.

Next Steps:

Policy Action Items and Opportunities In FY 2022-2023

Achieving results in a children's policy and program environment that is not fully known or predictable requires strategic thinking and a focus on what is both doable and worth doing in creating a whole child centered behavioral health system and related SEL programming.

With this in mind, and after reviewing the preliminary ideas and policy implications that emerge from this report, outlined below are policy priorities for consideration and further discussion and action, including advocacy within the context of the current FY 2022-2023 state operating budget bill.

1. **Enhance Student Wellness and Success Fund.** Support enhancing Student Wellness and Success Fund (SWSF) with policy parameters and program accountability that use a whole child, student-centric approach to providing wraparound support services to at-risk children. For this to work effectively, there will need to be ongoing evaluations. Additionally, to help narrow service gaps, there should be an elimination of the current policy of allowing SWSF funds to supplant current funding for eligible student wellness related wraparound services. A portion of SWSF funds could be used for targeted behavioral health programs and SEL demonstration projects. It is also worth noting that SWSF funds could provide new opportunities for the state to match services so that programs with capacity or the ability to expand can help meet the needs of another, related behavioral health program. For example, state SWSF funding could be used in targeted behavioral health programming that is done in partnership with a county child-serving agency.

2. **Advance OhioRISE Medicaid Reform.** Support and prioritize the OhioRISE Medicaid reform to better serve multi-system youth who are currently having major difficulties receiving appropriate and effective health care services to address their complex, exceedingly high-cost needs. This has forced many of these youth to be served out-of-state at high cost and away from their families. In order for a new Medicaid managed care model to work well, appropriate project management, evaluation, and policy implementation knowledge and know-how will need to be put in place on both the state and the managed care side of this patient-centric model.

3. **Prioritize and Support a Crisis Intervention and Stabilization Model Systemwide.** Support and advance pediatric behavioral health by employing a crisis response and stabilization model. The federal government's *National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit,* is a care model that should be employed with fidelity in Ohio. The model defines good crisis care as:
    - An effective strategy for suicide prevention;
    - An approach that better aligns care to the unique needs of the individual;
    - A preferred strategy for the person in distress that offers services focused on resolving mental health and substance use crises;
    - A key element to reduce psychiatric hospital bed overuse;
    - An essential resource to eliminate psychiatric boarding in emergency departments;
    - A viable solution to the drains on law enforcement resources in the community; and
    - Crucial to reducing the fragmentation of mental health care.

    The national guidelines identify three essential elements within a "no wrong door" integrated crisis system: 24/7 regional crisis call centers; crisis mobile team response; and 24/7 crisis receiving and stabilization facilities.

4. **Bring Greater Strategic Focus to Children's Behavioral Health Management.** Re-establish a dedicated children's behavioral health program and appropriation line item in the Ohio Department of Mental Health and Addiction Services in an effort to fund, prioritize – and create greater accountability and transparency for – children's behavioral health outcomes. Prior to FY 2011, the state appropriated approximately $7.4 million each year dedicated specifically for children's behavioral health. Because there is no longer a dedicated children's behavioral health line item, funding for children's initiatives all fall within the same programmatic line item making it difficult to track and monitor at a state level the amount of funding and the types of services that are being committed to individual children's program initiatives at the local level. Increased outcome-based reporting on what funds are spent on what services and the impact of those services on behavioral health outcomes can also help facilitate the identification and sharing of best practices.

5. **Create Children's Behavioral Health Policy and Implementation Workgroup.** Create an organizational forum and related interagency/stakeholder workgroup that uses a whole child approach to develop a policy, program, and fiscal strategy to systemically address major issues in Ohio's children's behavioral health system. It will be essential to include policy implementation issues and not just policy development. This work should result, over time and using a staged approach, in a pediatric behavioral health continuum of care that is trauma informed, patient-centered, and value-added. Advanced effectively, this investment in systems change will likely pay big dividends. Importantly, the proposed workgroup should be advanced so it coordinates effectively with the Governor's Children's Cabinet and the Children's Behavioral Health Prevention Network Stakeholder Group.

6. **Support Implementation of a Behavioral Health Needs Assessment for Students with Chronic Absenteeism Issues.** The state of Ohio should identify a behavioral health needs assessment to evaluate the mental, emotional, and behavioral health of students, specifically including those who have been chronically absent. This information can assist in developing and advancing appropriate state level policy and funding decisions, including those related to attendance recovery and dropout prevention and recovery.

7. **Ensure Multi-Agency Initiatives to Advance SEL and Behavioral Health Supports are Aligned with Ohio's Whole Child Framework.** Ohio's strategic plan for education, *Each Child, Our Future,* calls for a whole child approach to education that goes beyond academics to ensure students are healthy, safe, engaged, supported, and challenged. ODE's Whole Child Framework is a blueprint to meet students' social-emotional, physical and safety needs, which are foundational to a child's intellectual and social development and necessary for students to fully engage in learning and school. ODE should work with other youth involved agencies to encourage proper alignment to the Whole Child Framework.[17]

   According to the *Prevention Services Survey Data Report* (December 2021), interagency progress is already being made. For instance, in FY 2020, $20 million in state funding was dedicated to support prevention services in schools through collaborative action by two state agencies: Education and Mental Health and Addiction Services. These support services were designed to reduce risk factors, build resilience, help students gain skills for success in life, and provide related professional development. Additionally, through Positive Behavioral Interventions and Supports (PBIS) Ohio schools are required to implement a framework offering three tiers of support for students.

8. **Utilize a Data-Based Decision-Making Model to Drive Behavioral Health System Improvement.** Moving effectively from policy to successful behavioral health system change will require sophisticated data collection and analysis. The state of Ohio should develop a more robust, integrated, and interagency data collection and monitoring process to gain a better understanding of how federal, state, and local policies influence mental, emotional, and behavioral health system outcomes. The first step forward should be a needs assessment.

17 http://education.ohio.gov/Topics/Student-Supports/Ohio-Supports-the-Whole-Child

Conclusion

Conclusion

A central question explored in this report is what the state's role is and should be in improving behavioral, social-emotional, and mental health services and related outcomes for children. The answer, at least in part, is to create the conditions for success. These conditions include: creating opportunities for students and best practice models for providers; setting standards; ensuring transparency; promoting cost effectiveness and efficiency in service delivery; encouraging needed interagency and intergovernmental coordination and collaboration; and monitoring program efficacy and related outcomes to ensure all children have access to high quality services.

Better leveraging relevant Ohio Medicaid resources may represent the greatest opportunity to design a system that benefits everyone. One idea is to increase coordination and cooperation between the Ohio Department of Medicaid and the Ohio Department of Education in order to establish more school-based health (and behavioral health) care centers and services, which is already being facilitated by Ohio's 2021 decision to allocate $84 million of federal stimulus funds to support pediatric behavioral health infrastructure improvements to enhance access to quality services.

Governor DeWine has indicated that this is a key administration priority as Ohio works to transform children's behavioral health and increase access and quality of care across all regions of Ohio. As noted in this report, the demand for pediatric behavioral health services exceeded capacity prior to the pandemic and reached emergency levels in many places in Ohio and nationally since the pandemic began in March 2020. And the gap between needs and program capacity has continued into the present.

COMMITMENT

The Children's Defense Fund-Ohio, Ohio Children's Hospital Association and Ohio Excels are committed to working with the state, other non-profit and private sector partners to move this work forward. It will take all of us working together to fulfill our obligation to Ohio's children and ensure their growing behavioral health and social emotional needs are met.

Glossary of Key Terms

Glossary

ACEs
Adverse childhood experiences, or ACEs, are potentially traumatic events that occur in childhood (0-17 years). ACEs are linked to chronic health problems, mental illness, and substance misuse in adulthood. ACEs can also negatively impact education and job opportunities. There are 10 types of childhood trauma. Five are personal — physical abuse, verbal abuse, sexual abuse, physical neglect, and emotional neglect. Five are related to other family members: a parent who's an alcoholic, a parent who's a victim of domestic violence, a family member in jail, a family member diagnosed with a mental illness, and the disappearance of a parent through divorce, death, or abandonment.

ADAMH Boards
Ohio currently has 50 Alcohol, Drug Addiction, and Mental Health (ADAMH) Boards. These county-level boards are statutorily empowered to plan, develop, fund, manage, and evaluate community-based mental health and addiction services. Federal, state, and local funds are utilized by local ADAMH boards as they work to ensure that mental health and addiction prevention, treatment, and recovery support services are available to individuals and families in communities throughout Ohio.

Behavioral Health
Behavioral health entails not just an individual's state of mind but their physical condition as well. Behavioral health in this context means the promotion of mental health, resilience, and wellbeing; the treatment of mental and substance use disorders; and the support of those who experience and/or are in recovery from these conditions, along with their families and communities. SEL and behavioral health are overlapping and intersecting policy and program areas. Research shows SEL is associated with a positive impact on important behavioral health variables that increase children's attachment to school and motivation to learn and reduce risky behaviors. Positive social skills are protective factors for behavioral health.

Family and Children First Councils (FCFCs)
Ohio Family and Children First is a partnership of state and local government, communities, and families that enhances the well-being of Ohio's children and families by building community capacity, coordinating systems and services, and engaging families. Ohio's FCFC vision is for every child and family to thrive and succeed within healthy communities; its mission is to increase the access, capacity, and effectiveness of services for the most vulnerable of our county's youth and their families whose needs extend beyond any one youth-serving program.

Mental Health
Mental health pertains entirely to a person's psychological state. As such, mental health includes one's emotional, psychological, and social well-being. Mental health is primarily concerned with the individual's state of being, while behavioral health refers to how behaviors impact an individual's well-being.

Multi-System Youth
Children who require services from more than one child-serving system, including children services, developmental disabilities, mental health and addiction, and juvenile justice.

Positive Behavioral Intervention Services (PBIS)
PBIS is a framework that guides school teams in the selection, integration, and implementation of evidence-based practices for improving academic, social, and behavioral outcomes for all students. The PBIS process emphasizes four integrated elements: **data** for decision making; evidence-based **interventions and practices** that support varying student needs (multi-tiered); **systems** that efficiently and effectively support implementation of these practices; and continual progress monitoring to ensure **outcomes** are met. PBIS is a systems change process that requires on-going commitment in order to create effective systems for teaching and addressing behavior and social-emotional skills.

Prevention

Interventions that occur before the onset of a problem, as well as interventions that prevent relapse, disability, and the consequences of severe mental illness or substance use disorders (OACBHA). Based on the audience, efforts range from universal prevention to interventions to treatment and may increase in intensity and become more individualized to mitigate or avoid a symptom or outcome.

- **Primary Prevention:** Interventions designed to prevent the onset or future incidence of a specific problem.
- **Secondary Prevention:** An early intervention that decreases the prevalence of a specific problem.
- **Tertiary Prevention:** Treatment designed to improve quality of life and reduce the symptoms after a disease or disorder has developed.

Response to Intervention Model (RTI)

Multi-tiered approach to the early identification and support of children/students with developmental, learning, or behavioral needs. Includes triaged screening and services.

School Counselors

School counselors develop curriculum, offer individual student planning, and deliver responsive services in order to assist students in developing and applying knowledge, skills, and mindsets for academic, career and social/emotional development. In Ohio, school counselors are licensed by the Ohio Department of Education. School counselors operate under a Professional Pupil Services license specializing in school counseling. The initial license is a 5-year professional license and covers grades K-12. They are subject to a state board of education adopted, standards-based framework for evaluation purposes. Licensure requirements for school counselors are in the Ohio Administrative Code section 3301-24-05.

School Nurse

Section 3319.221 of the Ohio Revised Code defines a school nurse. The state board of education is required to adopt rules establishing the standards and requirements for obtaining a school nurse license and a school nurse wellness coordinator license. At a minimum, the rules shall require that an applicant for a school nurse license be licensed as a registered nurse under Chapter 4723 of the Revised Code. A registered nurse employed by a school district or a school is required to apply for and receive a registration from the Ohio Department of Education that is valid for working in schools for five years.

School Psychologist

School psychologists help children and youth succeed academically, socially, and emotionally. They have specialized training in both education and mental health and know how to identify and lower barriers to learning. “The practice of school psychology” defined in law (Section 4732.01 of the Ohio Revised Code) is limited to the following services: (1) evaluation, diagnosis, or test interpretation limited to assessment of intellectual ability, learning patterns, achievement, motivation, behavior, or personality factors directly related to learning problems; (2) intervention services, including counseling, for children or adults for amelioration or prevention of educationally-related learning problems, including emotional and behavioral aspects of such problems; and (3) psychological, educational, or vocational consultation or direct educational services.

Social Worker

School social workers are specialized instructional support professionals who hold a master's degree in social work and who have specialized training and experience to work effectively in schools and with children. This training includes special education law, school law, and systems theory. School social workers often serve as the link between the home, school, and community in providing direct, as well as indirect, services to students, families, and school personnel to promote and support students' academic, social, emotional, and behavioral success. A social worker in the state of Ohio is required to hold a valid license issued under Chapter 4757 of the Ohio Revised Code. A social worker employed by a school district or school is required to apply for and receive a registration from the Ohio Department of Education that is valid for working in schools for five years.

Social & Emotional Learning (SEL)

Social-emotional learning is the process through which people acquire the knowledge, skills, and attitudes to develop healthy identities, manage emotions, achieve personal and collective goals, show empathy, and work successfully with others. SEL includes self-awareness, self-management, social awareness, responsible decision-making and relationship skills.

Serious Emotional Disorder (SED)

A diagnosable mental health disorder in children and youth where an extreme functional impairment limits or interferes with one's ability to function in the family, school, and/or community.

Social & Emotional Development

Behaviors that reflect children's emotional growth and their growing ability to successfully navigate their social worlds through interactions with adults and peers, including children's developing abilities to regulate attention, emotions, and behavior; and to establish positive relationships with familiar adults and peers. (Ohio Early Learning & Development Standards/National Research Council, 2008)

Wraparound Services

Provides a comprehensive, holistic, youth- and family-driven way of responding when children or youth experience serious physical health, mental health, or behavioral health challenges. Wraparound services put the child or youth and family at the center. With support from a team of professionals and natural supports, the family's ideas and perspectives about what they need and what will be helpful drive all the work in wraparound. Generally, care and services are individualized based on the strengths and culture of the children and their families. (National Wraparound Initiative)

children's defense fund ohio

Ohio Children's Hospital Association
Saving, protecting and enhancing children's lives

Ohio Excels