Healing-Centered Community Schools

A Key Investment for COVID-19 Recovery

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Educators and policymakers have increasingly turned their attention—and $2.8 billion in funding—to community school strategies as a way to mitigate the learning of the COVID-19 pandemic. A healing-centered community school implements a whole child approach to teaching and learning to address the fundamental physiological and safety needs of students as central to their cognitive development and growth. Strengthening and sustaining such strategies require intentional, complementary investments in policy, funding, and resources across general education, early learning, special education, health, and community development. This brief provides guidance for educators, policymakers, and advocates who wish to deploy state and federal recovery resources to address immediate student needs and build sustainable systems and practices that serve all students and advance equity.

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Introduction

The magnitude of the social, economic, and health trauma for students and families in the wake of the COVID-19 pandemic has made clear the interdependence between health and learning.[1] To that end, school and district leaders are recognizing the salience of a community school strategy as a promising approach to mitigating the learning impacts of social and economic distress that worsened during the pandemic. Most of these efforts are characterized by a focus on student and family—supports, such as health and social services, expanded learning, and community engagement—that have not traditionally been within the core work of education. These services are seen as even more crucial as districts respond to an extensive period of tumultuous uncertainty, crisis teaching, and significant challenges to equity brought about by the pandemic. Although such services are important, community schools that are narrowly focused on, for example, health and wellness programs and direct social services are not likely to be effective or sustainable in the long run. Effective implementation must move beyond a cursory definition of community schools as an integrated services intervention.

Educators recognize the enormous need for whole child teaching and learning, and policymakers have solidified their commitment to this approach by allocating $2.8 billion in the 2021–22 state budget.[2] However, questions remain around how to make such transformative shifts a reality, especially given the lack of alignment and integration across services for youth and families as well as the lack of sustainable funding.

This brief lays out a vision for how leaders at all levels of education, health, early learning, and other child-serving systems can build the capacity and integration needed to sustain such strategies into the future. We discuss the importance of a relationship-centered, student-centered, collaborative approach as central to community schools before outlining how new, substantial state and federal resources can be used to support a sustainable, healing-centered community school strategy. We make recommendations to district, county, and state decision makers as well as philanthropic partners for how this moment can advance policy and systems integration to sustain healing-centered community schools. The companion practice brief, *Practices of a Healing-Centered Community School*, provides a more extensive discussion about the core principles and implementation practices of effective healing-centered community schools.

What Are Healing-Centered Community Schools?

Healing-centered community schools create teaching and learning environments that extend beyond the service needs of the student to consider and value community, culture, agency, relationships, meaning making, and achievement—largely collective and community-based processes. With this foundation, healing-centered community schools deeply examine

the shared environmental context that causes harm to students (and teachers) within schools and the community to address and transform toxic systems, policies, and practices.

A healing-centered community school recognizes that integrated supports and opportunities are only effective when there is a fundamental transformation of the relationships and practices of teaching and learning. Trusting, student-centered relationships are a fundamental precursor to providing integrated services for students and families. Students and their families are more than data points, clients, patients, or cases. They are central, dynamic actors within a community and are empowered in their learning, health, and welfare. Caring adults (e.g., educators, content experts, policy influencers, and decision makers) ground their work by listening to young people and their caregivers, understanding their individual and collective histories, experiences, and contexts, and from that place creating the conditions for them to thrive.

A partnership-based approach to implementation and funding can include strategic integration of general education, early education, mental and physical health, special education, public safety, and public health dollars to support a comprehensive Multi-Tiered System of Supports (MTSS, see page 5) to ensure that instruction and intervention are matched to students' academic, behavioral, and social-emotional needs. This might include professional learning and strong collaborative structures and practices to:[3]

- **strengthen teaching** to emphasize personalized learning, student-owned learning, competency-based learning, and anytime, anywhere learning that is rooted in child development;[4]
- **create opportunities for families** to learn and work alongside teachers and school staff;[5]
- **establish behavioral management and discipline norms** that prioritize and promote mediation and restorative justice practices;[6]
- **ensure regular opportunities for student-led feedback** of instruction, student-led conferencing, and student-led training for educators and other school staff;[7]
- **establish interdisciplinary Coordination of Services Teams (COSTs)**, or comprehensive implementation of MTSS, including families and community partners;[8] and
- **leverage school, district, and partner resources** to build an interdisciplinary, shared data infrastructure to collect, manage, and facilitate the use of data as part of continuous improvement processes (e.g., interpretation/translation, data analysts, and improvement coaches).[9]

Most importantly, a core staffing role—sometimes called a community school coordinator or resource manager—is a dedicated site-based administrator whose focus is to provide a consistent organizational "backbone" to cross-sector partnerships and programs. Serving as "chief of staff" as part of a school's administrative leadership team, this manager is primarily responsible

for coordination and alignment across school leaders, staff, and partners to ensure that students, teachers, and families are supported. Return-on-investment studies of community school coordinator positions highlight the importance of the organizing infrastructure in being able to leverage local community assets, programs, and staffing resources.[10]

Healing-Centered Community School Investments

Despite the consensus on the interdependence of learning, community, and health, general education, special education, early education and childcare, mental and physical health, and community development approaches have historically been siloed. In meeting the need for an "integrated" approach rooted in the science of learning and development,[11] schools and districts have had to cobble together strategies individually across systems. The resulting scramble to maneuver philanthropic support, time-limited grant dollars, complicated billing of health systems, and competitive funds often reinforces the belief that only well-resourced districts can pay for all of the "extras" needed to implement a service-rich community school strategy.

Recently, however, state policymakers have articulated strong support for community school initiatives. The 2021–22 state budget[12] allocates more than $11 billion in funds to support community schools, afterschool programs, student behavioral and mental health programs, and efforts to improve school climate and conditions for learning. Specifically, the budget provides a one-time Proposition 98 General Fund investment of $2.8 billion to make additional grants through the California Community Schools Partnership Program, previously funded at $45 million in 2020. This expansion is intended to create new community schools and strengthen existing models as well as to provide technical assistance to support effective implementation. Additionally, the budget includes $1 billion ongoing Proposition 98 and $753 million one-time funds for expanded learning time; $52 million for professional development on social-emotional learning and trauma-informed practice; $10 million to support local education agencies (LEAs) in effectively using Medi-Cal; $4.4 billion to create a new behavioral health system for youth ages 0 to 25; $7 million in ongoing federal funding to expand family empowerment centers; $12 million to support school climate surveys; $50 million in one-time funds for MTSS;[13] and breakfast and lunch for all students through the Universal School Meals Program by increasing state meal reimbursements by $54 million in the 2021–22 fiscal year and $650 million ongoing Proposition 98 funding beginning in 2022–23.[14]

This state funding, paired with funding from the federal American Rescue Plan,[15] presents a monumental opportunity to invest in student-support staffing and programs like healing-centered community school strategies, which have been understaffed and underresourced for decades.[16]

A healing-centered community school strategy cannot be sustained without adequate and reliable long-term funding. Community schools must deploy recovery resources to respond to

the urgency of short-term needs and invest resources strategically to support longer term goals for transforming schools. Many essential student support services and opportunities are available and are often more sustainably funded through community-based organizations, childcare/child-serving systems, health services organizations, and other public sector, noneducation partners. However, the school infrastructure and capacity of existing school staff necessary to leverage, organize, and coordinate these services cannot withstand the sudden drops in funding that come with reliance on one-time dollars.

Health and Education Strategies for Sustainability

Funding and implementation of community school strategies should be shared by other systems of care that serve students and their families. In particular, Medi-Cal, California's Medicaid health care program, is a sustainable option to fund the programs and services that would otherwise be jeopardized if funded only through time-limited grants. Supported by federal and state taxes, Medi-Cal is intended to pay for a variety of medical services—including mental health—for children and adults with limited income and resources. A blended or leveraged Medi-Cal resource and capacity strategy can amplify and sustain district efforts to:

- **integrate mental health services**, including providing Tier 1, 2, and 3 academic, behavioral, and social-emotional supports;
- **use universal screening tools and data** and develop coordinated, interdisciplinary practices, such as COSTs, to review aggregate and individual data regularly, identify strengths and needs, implement data-driven interventions, assess progress, and refine strategies;
- **ensure sufficient staffing and capacity building** to support inclusion of high-needs students in a general education environment; and
- **directly address issues of access and voice** through multidisciplinary decision-making structures and processes.

A Multi-Tiered System of Supports (MTSS) applies evidence-based practices that increase in intensity and individualization in response to student need. In Tier 1, all students receive high-quality, evidence-based instruction and support in core content, behavior, and social-emotional learning. Using data on student progress, students identified as needing more intensive support are provided with Tier 2 additional instruction and support, typically in small-group contexts, to address specific issues in core content, behavior, or social-emotional learning. Students in need of further support receive Tier 3 intensive instruction or other interventions.

With more than 60 percent of California's public school students enrolled, Medi-Cal can—and should—be used as a strategic part of a comprehensive districtwide strategy and approach to supporting behavioral health services. The California Children's Trust has identified several ways school districts may be able to access additional Medi-Cal resources through county health and human services departments to support and expand behavioral health services in schools using existing resources.[17]

For example, school districts can hire and employ their own clinical staff, mostly to ensure that students receive services as required by the federal Individuals with Disabilities Education Act (IDEA). A recent change at the state level now allows school districts to bill for more services and serve more students.[18] However, even though a school district can bill for Medi-Cal services on its own or in partnership with its county health department through the LEA Medi-Cal Billing Option Program (BOP),[19] the full responsibility of comprehensive, sustainable implementation must be shared across health system actors, including the following:

- **Community-based organizations (CBOs)** can colocate services on school sites under formal memorandums of understanding (MOUs) with schools/districts. In this model, CBOs act as both the clinical provider of staff and services as well as the contract holder for administration and billing of Medi-Cal services.
- **A Special Education Local Plan Area (SELPA)** can hold the Medi-Cal contract for a single school district or for multiple school districts, supporting administrative and billing functions for the contract. SELPAs will often contract out the clinical services to local CBOs rather than manage their own staff.
- **The county office of education (COE)** can hold the Medi-Cal contract for a single school district or for multiple school districts in the county, acting as an intermediary between the schools and the county health department. In this model, the COE can provide the clinical service as well as professional development of support staff, site coordination, and other health and wellness services.
- **County health departments** (behavioral health, public health, health care agencies) can hold a Medi-Cal contract for specific school sites or districts within their counties, acting as both the payer for and provider of services. County health departments will often contract clinical services out to local CBOs or LEAs. There is usually already a relationship between school districts and county health departments for other prevention, nursing, and health services.

School districts can determine the most sustainable funding strategy and potentially bill the three dominant Medi-Cal payers in schools—managed care organizations (MCOs) or managed care plans (MCPs), mental health plans (MHPs), and the LEA BOP—to support the continuum of services in schools. Across all of these approaches, there are few incentives for specific funding sources (and the institutions they represent) to engage with schools proactively, or even to provide prevention or early intervention services for children.[20] System leaders must ensure that those dollars do not reinforce a fragmented model in schools.

Scaling Healing-Centered Community Schools: Recommended Actions for Leaders at All Levels of the System

The level of need for healing-centered community schools and the amount of funding available to districts to implement community school strategies are unprecedented. And there is still considerable room for improvement, alignment, and accountability across education and health systems.

Education Leaders, Policymakers, and Influencers

Educators have already begun to understand and adopt whole child notions of student success yet often try to fit them into long-standing structures and systems that instead stymie collaboration and new ways of teaching and learning.[21] To support effective implementation of healing-centered community schools, leaders must take on significant systems-change work to do the following:

- **Prioritize collaborative leadership and adequate administrative capacity** to braid and blend funding, optimize cross-sector partnerships, and maximize dollars to provide fiscally sustainable whole school approaches.
- **Recognize that strengthening relationships and teaching is everyone's responsibility**, not just the role of support specialists or community partners. To that end, district curriculum and instructional leaders must understand that healing-centered strategies implicate and strengthen their work to support high-quality, student-centered pedagogy.
- **Reformulate district- and school-level work of "student support services."** Sometimes mental health and behavioral health specialists are best suited for one-on-one work with students and families. However, the work of professionals should also be part of Tier 1 strategies and Tier 2 early interventions, training, and support for teachers. In addition, districts should invest in peer-to-peer models so that young people, families, and teachers are able to lead healing work within their own peer communities.
- **Ensure that teachers and school leaders are trained and supported** to identify and disrupt patterns and behaviors that damage relationships with students, families, and communities. This means, for instance, paying explicit attention to confronting anti-Black bias, encouraging proactive partnerships with students and families, and modeling facilitative leadership that recognizes historical patterns of power and privilege.
- **Reexamine and redeploy existing funds or staff allocations** based on regular review of student outcomes and on conversations with students, families, teachers, administrators, and community partners. Districts and schools engaged in continuous improvement are familiar with Plan-Do-Study-Act protocols to address problems of practice. Healing-centered work also demands this level of attention, along with a willingness to listen to students and families as well as to retool strategies and resources to better address the realities in classrooms, hallways, and boardrooms.

- **Promote and model reciprocal accountability and partnership** among school boards, community leaders, and civic and institutional partners to ensure the success and sustainability of community school strategies. Beyond politically championing community school values of collaboration and partnership, this means making concrete investments in districtwide partnership strategies; ensuring appropriate human capital and staffing practices that prioritize equity; investing in embedded capacity-building supports; and developing usable data systems to support evidence-based decision-making at all levels.
- **Establish a cohesive and seamless continuum of learning and care**, starting from prenatal care through elementary, secondary, and postsecondary learning. This includes providing services and opportunities such as screenings, mental health services, literacy programs, early childhood education including dual-language immersion, early intervention, child welfare, social services, and legal services in one place that is accessible and molded to the unique needs of each community. Strategies like wellness hubs and family resource centers at school sites can leverage existing early childhood programs and braid funding from early education, child welfare, mental health, nutrition, and philanthropy.

COEs and other Capacity-Building and Support Partners

Since 2013, California has invested significant resources in a centralized system of support led largely through COEs, the California Collaborative for Excellent Education (CCEE), and partnerships with nonprofit and higher education experts. Scaling up healing-centered community schools will require aligning and leveraging existing capacity-building infrastructure and resources to do the following:

- **Support districts in building educator capacity.** It is important to strengthen the capacity of districts to implement healing-centered community school strategies, including explicit support around organizational culture, relationship-centered approaches to reform, distributed leadership, adult learning, child and youth development principles, trauma-informed classroom management, and restorative practices.
- **Proactively convene and coordinate county health and human services agencies and school districts**, especially in building out school-based mental health service systems. In this role, COEs can help to identify regional service gaps and available resources as well as prioritize and advocate for cross-sector improvement.
- **Support integration of healing-centered community school practices, principles, and systems building** into continuous school improvement supports and processes, including district Local Control and Accountability Plans.

State Board of Education, Governor's Office, and State Legislature

The 2021–22 state budget's record levels for education reflect an understanding of and commitment to whole child teaching and learning. However, sustainable and scalable healing-centered community schools will require a longer term financing and capacity-building strategy. State leaders should:

- **Prioritize and address the long-term, systemic budget gaps** facing public education. One-time recovery dollars or ongoing but limited amounts of targeted grant funding will not result in successful healing-centered community school strategies. California schools are facing massive and exponentially growing budget deficits due to pension liabilities,[22] rapidly eroding physical infrastructures,[23] looming fiscal cliffs,[24] teacher shortages[25] exacerbated by inadequate compensation and professional support, declining enrollment,[26] and underinvestment in entitlement programs such as special education coupled with growing numbers of students needing services.[27] Addressing these massive structural inequities makes it more likely that schools and districts will be able to invest short-term dollars to create the systems and partnerships needed to create and sustain healing-centered community schools.
- **Lead and support cross-sector and interdisciplinary policy reform.** Part of the responsibility of state- and county-level agencies and decision makers is to seek out the cross-sector strategies that lay the groundwork for funding and practice reform. Although there are many ways that K–12 schools can address and disrupt their practices of systemic racism, such awareness and responsibility must be held by other public systems of care—for example, early education, health and human services, housing, and public safety. Legislators can work to convene multiple agency leaders to coordinate, integrate, and streamline services across systems so that districts and schools are more readily able to access supports. This also means removing disincentives for health and human services to serve school communities, adapting funding streams, and aligning outcomes across public systems to support essential elements of healing-centered community school strategies.
- **Address policy and funding changes needed to support mental and behavioral health services** for children and youth. Deploying recovery dollars or competitive community school grant funds to build and strengthen community school strategies should not be conflated with the urgent need for mental health services reform. The legislature should continue to overhaul California's overall use of Medicaid—especially to provide mental health services.[28]
- **Reduce barriers to funding for healing-centered community school strategies** by streamlining and aligning application and reporting requirements for different funding sources when possible. For example, state plan amendments and changes within the Department of Health Care Services must reduce the barriers for school districts and their health partners to participate in Medi-Cal-funded programs and make it easier for

more students to qualify for and access services when they need support.[29] In addition, policymakers should pay attention to issues of equitable access to competitive funding streams; small and rural communities are often without the grant development and evaluation capacity that larger districts have and are thus less likely to receive funding.

- **Invest in capacity building and technical assistance** to support effective implementation. For most districts and schools, there is an overwhelming sense of initiative overload and a confusing, incoherent array of implementation support and guidance on how to take on significant systems-change work. Implementation will require technical assistance across existing public and nonprofit capacity-building resources in areas such as family and community engagement; instructional support; trauma-informed, developmentally appropriate practice; expanded learning; and sustainable funding for health and wellness services.
- **Understand legislative proposals that address systemic barriers to collaboration and service provision.** Legislative actions should do more than provide one-time or competitive funding to support whole child strategies like community schools. In addition, legislators should take on long-term sustainability issues, including funding and data systems.

Philanthropy

Even now, when significant funds are available to strengthen comprehensive whole child approaches, philanthropy can still play an important role by strategically investing in the systems reform and capacity building that will be necessary to sustain transformative change. While the current influx of public dollars will likely support immediate implementation of programs and services, philanthropic partners should continue to do the following:

- **Advocate for adequate school funding**. Historically, foundations primarily funded community school programming and partnerships. COVID-19 relief funds and resources will help districts and schools get much-needed support and staffing, but funders will need to advocate for deep, transformative systems change across child-serving institutions.
- **Support efforts to understand and invest in addressing upstream challenges** of collaborative infrastructure, human capital, resource allocation, and sustainable leadership. It is far easier to count participation rates of direct-service programs than to invest in the longer term efforts of systems change. Without disrupting the systemic origins of inequity—for example, teacher and school nurse shortages, siloed public institutions, racially biased and anti-Black education and justice systems—schools and communities are left to string together crisis responses instead of holistic, systemic strategies that address the root causes of inequality.

- **Invest in technical assistance that emphasizes continuous improvement leadership practices and structures**, including comprehensive data systems and practices that directly address issues of access, engagement, and decision-making, particularly for youth and families. This means building trust with grantees and communities by modeling vulnerability, learning from failures, and engaging communities in meaningfully assessing the impacts of philanthropic efforts.
- **Provide resources to backbone organizations** and advocates working towards sustainable collaborative infrastructure. Collaboration does not just happen. To do it well, organizations and institutions need to develop new muscle memory that is often a departure from traditional roles and disciplines. While such collaborative efforts should eventually be built in and across public systems, foundations can serve as preliminary conveners in creating new, sustainable patterns and systems of cross-sector work.
- **Commit to systems change by insisting on continuity** instead of rapidly shifting initiatives. Systems change cannot happen without a constancy of purpose. Foundations must reflect a sense of urgency for change and strategically limit the number of initiatives to which grantees are expected to respond.

Conclusion

As we look towards the uncertainties that a new academic year will bring, schools will be the most consistent front line to address not only significant learning and opportunity gaps but also mental health impacts on children and youth of the pandemic and of national racially motivated violence. Now is the time to reinvent and redefine California's schools so that healing and relationships are explicitly recognized as fundamental tenets of quality teaching and learning. Healing-centered community schools are intentionally designed and organized to support student well-being as both a facet of learning as well as an ultimate goal.

Practitioners should be supported to leverage existing policy and funding mechanisms that can support at-scale implementation of healing-centered community school strategies. Policymakers and influencers must be guided to advance greater policy and systems integration across general education, special education, early education and childcare, mental health, and community development. The moment and opportunity demand a healing-centered community school strategy, and there is much urgent work to do.

Endnotes

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Author Biography

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Policy Analysis for California Education (PACE)

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