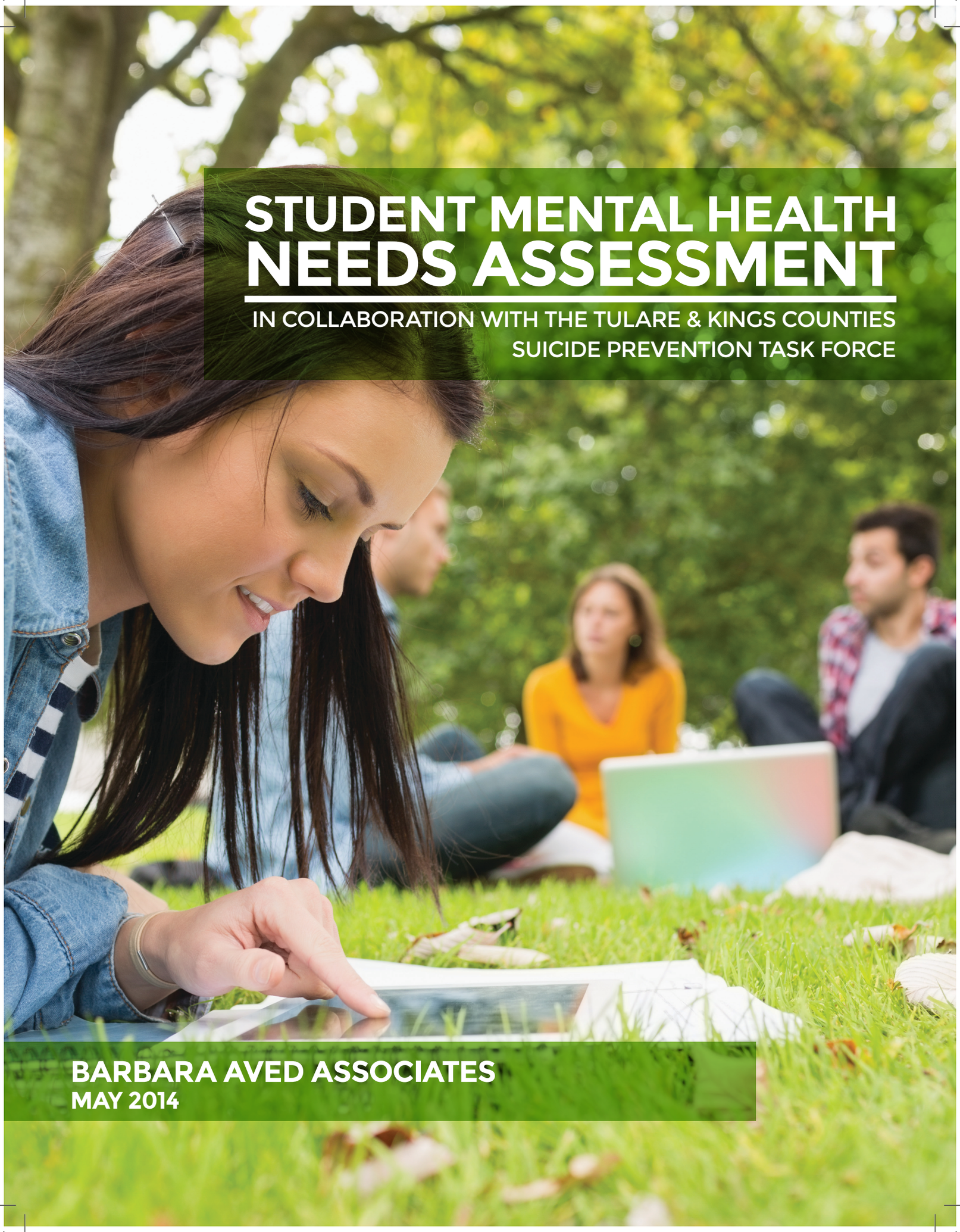

STUDENT MENTAL HEALTH NEEDS ASSESSMENT

IN COLLABORATION WITH THE TULARE & KINGS COUNTIES SUICIDE PREVENTION TASK FORCE

BARBARA AVED ASSOCIATES

MAY 2014

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EXECUTIVE SUMMARY

"I see kids all the time who are withdrawn and isolating themselves; some say, 'We're moving again so why should I get attached to anyone?' "
– High School Counselor

"Aggressive behaviors can look like so many other things at this early age, which is why the biggest mental health challenge is to truly be able to diagnose what's going on."
– Elementary school principal

INTRODUCTION

Research demonstrates that students with good mental health are more successful in school. Students who need and receive mental health support are also more likely to be successful as adults. When students experience mental health problems they often struggle to attend school, have difficulty completing assignments, and have more frequent conflicts with peers and adults. One-half of all lifetime diagnosable mental health conditions begin by the age of 14[1] and, increasingly, the school setting is recognized as the most efficient delivery system for students to receive mental health services.[2]

This student mental health needs assessment was undertaken by BARBARA AVED ASSOCIATES at the request of the Tulare & Kings Counties Suicide Prevention Task Force (SPTF) and its Student Mental Health Network to better understand and be able to respond to the mental health needs of students in Tulare and Kings Counties. The SPTF Executive Committee served as the steering committee for the study. Many voices contributed to thepicture of student mental health in Tulare and Kings Counties as will be evident below. The report is organized so that readers who have a special interest in the findings from certain stakeholder groups can easily locate those chapters.

METHODS

Data for the assessment were gathered from extensive interviews, focus groups, and written and online surveys with school personnel—principals and college administrators, teachers, psychologists and counselors—mental health providers, primary care physicians, parents and students (the "study sample"). Prior to data collection, a review of literature and existing data was completed to give context to the findings and considerations for implementation. Based on the assessment findings, suggestions for addressing unmet needs are presented that will require priority setting and action planning by the Executive Committee.

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[1] Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. (2005). Lifetime prevalence and age-of- onset distributions of DSM-IV disorders in the National Co-morbidity Survey replication. *Archives of General Psychiatry* 2005;62(6):593-602.

[2] Skalski AK, Smith AJ. Responding to the Mental Health Needs of Students. *PL* September 2006. http://www.nasponline.org

NEEDS ASSESSMENT HIGHLIGHTS

After evaluating all of the data collected from the needs assessment process, certain key findings emerged.

The Background

- Generally about half of the individuals contacted to participate in the study responded to the request. The only exception was private and religious schools; of the 11 sites contacted, none responded.
- The statistical projection of need for mental health services for student age groups are slightly higher in Tulare County than Kings County, but both are generally comparable to statewide estimates. The rates are higher among youth from lower income categories.
- Based on national data, there is likely a large gap between the need for mental health services by students who are military veterans and the use of those services.

Schools

- There were little differences among study participants in citing mood disorders, specifically depression and anxiety, as the most-commonly observed mental health concern among students.
- Although not the majority, many school personnel believe mental health concerns of students has increased in the last few years.
- 77% of K-12 administrators (compared to 69% of school counselors and psychologists) believed addressing student mental health needs was “a big part” of their role at school.
- Most (93%) K-12 schools did not conduct any type of routine, school-wide risk assessment on common mental health-related factors, though some think they should.
- On average, only about 20% of school personnel reported feeling fully confident in their ability to identify depression and anxiety. Teachers reported the lowest levels but were slightly more confident in being able to *respond* to these identified problems.
- Respondents generally were the least confident about identifying suicide risk and eating disorders.
- About 25% of the respondents who worked with preschoolers (children age 0-5) said they were not confident identifying concerns related to early childhood mental health.
- All of the school personnel and providers who participated in this project took the issue of suicide risk very seriously.
- Teachers were the most likely to indicate they were not aware of their school’s policies and procedures regarding responding to students’ mental/emotional health needs.
- Fewer than one-third of the administrators who were aware of the California Healthy Kids Survey said they reviewed the data *and applied findings to make needed changes*. Twothirds of the teachers were unaware of the CHKS.

Parents

- Most parents were willing to accept and engage in addressing their student’s mental health issues, but some schools reported denial or unwillingness by up to half of the families.
- When administrators expressed frustration at parental behaviors, they acknowledged parents’ personal problems, including substance abuse and their own mental health issues, as the main reason for their inability to help their children. Home environment was cited as the main barrier to student access to mental health services.

- Parents mentioned some important factors they thought might have made a difference to their child in preventing or reducing their mental health needs. In general, earlier assessment of problems and more available resources for intervention were key issues.

- Bullying was a major concern expressed by all groups but especially by parents and students. Despite school anti-bullying policies, some feel enforcement is inconsistent or lax, particularly parents and students.

- Parents felt their child's mental health issues were important to address at school, and most would support those services being implemented in their child's school.

- About half the parents with students on mental/behavioral health-related medications were still struggling with the need for a dosage adjustment "to get it to work" or getting the student to consistently take the medication.

- There was wide confusion and misperception by parents and students (and even some school personnel) about the role of school psychologists and availability to offer mental health counseling; the psychologists reported their main job was conducting assessments for special education.

- Wait times for mental health clinics and non-profit providers are mostly reasonable, but in some cases the "hoops" families have to go through before their student can actually begin therapeutic services adds upfront wait time that is frustrating for both parents and students.

Students

- A greater proportion of middle and high school students than college students (90% compared to 30%) identified a resource and know where to turn to if they had a mental health concern and wanted help.

- Students identified many specific prevention strategies that might have made a difference in preventing some of the mental health issues young people face, including *wanting* school personnel to take the initiative in asking students how they were feeling and alerting their parents to issues.

- The incidence of reported bullying at school associated with gender and sexual orientation is similar as the incidence related to race and ethnicity.

- Students noted awareness of suicide symptoms, but were most likely to say they would listen to a friend but not necessarily to report it.

- Despite preventive efforts, many college students "blow off" the information if they think the information does not apply to them. Stigma and asking for help, however, are major barriers to seeking care for young adults.

- The greatest majority of students who were involved in mental health treatment (and parents, once parents had overcome any barriers to get the student into a system of care), related positive experiences with services.

Physicians

- Family practice physician survey respondents were more likely to indicate confidence in identifying depression and anxiety and pediatricians were more confident identifying behavior management and substance abuse problems. However, among both types of primary care respondents, 36% felt "very little to no confidence" in their ability to identify student patients with sexual orientation/ gender identify issues; 28% of family practice physicians and 13% of pediatricians indicate they neither treat nor refer when these issues are of concern.

- Lack of available resources (and unawareness about available resources) and lack of time to address concerns are the 2 main barriers that limit physician diagnosis and management of student mental health issues.

- On the whole, physician respondents generally do not work with school personnel to confer or coordinate care when there are mental/emotional health issues among their young patients; pediatricians report higher levels of school involvement than family practice physicians.

- There was little difference in findings between Tulare and Kings Counties based on geography except for the availability of resources (especially mental health providers trained in early mental health and therapists with expertise in addressing LGBTQ issues) which are fewer in Kings County.

Community Mental Health Providers

- There was little difference in findings between Tulare and Kings Counties based on geography except for the availability of mental health providers (especially providers with expertise in early mental health, LGBTQ issues, and crisis mental health) which are limited in Tulare County and often very scarce in Kings County.

- Mental health providers praised the efforts of the MHSA prevention and early intervention programs and noted that the effects are being seen in increased community awareness about mental health needs and resources. This has led to increased demand for services. With the changes from the Affordable Care Act, access has been opened, but the availability of public and private mental health providers is not expanding.

Conclusions and Considerations for Implementation

Study participants indicated a great deal of understanding of the many positive efforts that have been undertaken in Tulare and Kings Counties to expand school-based prevention strategies, draw greater attention to the topic of suicide and adopt formal policies for bullying. Nevertheless, there is enormous and varied mental health needs among students and real limitations of the existing resources.

The following 9 considerations (in no particular order of importance), which reflect the input of all study participants, tie most closely to the identified needs and warrant priority attention for focusing resources in student mental health. Some of these solutions can be addressed in the short term while others will require more long-term planning to implement. This report does not present a timetable for implementation.

- Expand mental health prevention and treatment services for students in more school districts and college campuses, especially in Kings County.

- Increase awareness among college and adult trade school students of available mental health services.

- Expand the Mental Health First Aid training program for all teachers.
- Facilitate a greater understanding about the implications of bullying on students' mental health.
- Increase support for early childhood mental health programs.
- Support increased community and parent awareness around the stigma of mental health.
- Offer periodic mental health education programs for community primary care physicians and other providers for children and youth.
- Share and use the findings from this needs assessment as opportunities to improve mental health efforts in Tulare and Kings Counties.
- Encourage the engagement of private religious schools in community-wide efforts to meet all student mental health needs in the two counties.

Tulare & Kings Counties
SUICIDE PREVENTION
Task Force
www.sptf.org

MENTAL HEALTH SERVICES ACT
PROPOSITION 63
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Tulare & Kings Counties Suicide Prevention Task Force
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Kings County Behavioral Health
450 Kings County Drive, Suite 104
Hanford, CA 93230
Phone: 559-852-2444
Re: SPTF

INTRODUCTION

"Students don't want to fail their friends and family. They want to be a success, so they are all trying to do something; there's a lot of stress."
– College student interview

"When I went into teaching it was going to be all about teaching. But, these mental health issues are becoming more and more part of what I'm having to do. These last couple of years have been huge."
– Junior High Principal interview

Of all sectors, schools play the largest role in serving children and youth with mental and emotional disorders. This is primarily because under federal special education law schools are mandated to help children with emotional disturbance. It is also because schools increasingly understand and have begun to focus on the connection between emotional wellbeingand school performance as pressure for academic achievement has risen. The tragic events on school campuses have called even more attention to the mental health needs of students.

Students' unmet mental health needs can be a significant barrier to student academic as well as personal social success. Students with untreated mental health issues can develop significant barriers to learning, with many of these students eventually dropping out of school. For instance, more than 62% of students who withdrew from college with mental health problems did so for that reason, according to national survey data.[3]

Schools are often one of the first places where mental health crises and needs of students are recognized and initially addressed[4] as one-half of all lifetime diagnosable mental health conditions begin by the age of 14.[5] Research indicates that 20% of students are in need of mental health services, yet only 1 out of 5 of these students receive the necessary services.[6] Students of color and those from families with low income are at greater risk for mental health needs, but are even less likely to receive the appropriate services.[7]

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[3] College Students Speak: A Survey Report On Mental Health. National Alliance on Mental Illness, 2011. http://www.nami.org/Content/NavigationMenu/Find_Support/NAMI_on_Campus1/NAMI_Survey_on_College_Students/collegereport.pdf

[4] Froeschle, J., & Moyer, M. (2004). Just cut it out: Legal and ethical challenges in counseling students who selfmutilate. *Professional School Counseling*, 7, 231-235.

[5] Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. (2005). Lifetime prevalence and age-ofonset distributions of DSM-IV disorders in the National Co-morbidity Survey replication. *Archives of General Psychiatry* 2005;62(6):593-602.

[6] Kaffenberger, C., & Seligman, L. (2007). Helping students with mental and emotional disorders. In B. T. Erford (ed.) *Transforming the school counseling profession* (2nd ed.) (pp. 351-383). Upper Saddle River, NJ: Pearson.

[7] Vera, E. M., Buhin, L., & Shin, R. Q. (2006). The pursuit of social justice and the elimination of racism. In M. G. Constantine and D. W. Sue (Eds.) *Addressing racism: Facilitating cultural competence in mental health and educational settings*, (Hoboken: Wiley), pp. 271-287.

School performance is often a casualty for children with mild to severe disorders. Of all children with disabilities, those with serious emotional disturbance have the highest high school drop out rate. They also have the highest likelihood of landing in jail.[8] The presence of mental illness in children and adolescents, if not properly diagnosed and treated, increases the likelihood of significant health issues for them as adults and greatly limits their ability to become productive members of society.[9]

Severe mental illness is more common among college students than it was a decade ago, with more young people arriving on campus with pre existing conditions and grappling with depression and anxiety disorders.[10] On a more positive note, the number of college students who acknowledge they have thought about suicide—the third leading cause of death among all teens and young adults[11]—within 2 weeks of counseling intake has decreased from 26% in 1998 to 11% in 2009. This decline may reflect general improvements in suicide prevention education and outreach and greater awareness of available assistance.

According to the first comprehensive examination of the mental health of U.S. children and youth, such illnesses cost about $247 billion annually in decreased productivity, juvenile justice, special education and treatment.[12]

Background and Purpose of the Study

In 2012, the Tulare & Kings Counties Suicide Prevention Task Force (SPTF)—funded through a multicounty collaborative resulting from the 2004 Proposition 63 known as the Mental Health Services Act[13]—created the Student Mental Health Network (SMHN) whose goals include increasing collaboration and strengthening relationships among mental health providers, schools, students and parents. This comprehensive assessment of current and emerging student mental health needs is a document the SMHN can move forward with as it builds the platform to meet those goals.

The needs assessment is intended to be useful to leaders, organizations, advocates, community members and other audiences involved in addressing the mental health needs of students and their families in Tulare and Kings Counties by:

1. providing documentation for decision-making;

2. presenting the community with an overview of the state of mental health-related needs from which to gauge progress;

3. directing future efforts towards the highest-priority mental health needs for students and their families.

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[8] Koppelman J. Children with Mental Disorders: Making Sense of Their Needs and the Systems That Help Them National Health Policy Forum Brief No.799, June 4, 2004.

[9] Wu P, Bird, HR, Liu X. et al. (2006). Childhood depressive symptoms and early onset of alcohol use. *Pediatrics* 2006;118(5):1907-1915.

[10] Guthman JC, Iocin L. Increase in Severity of Mental Illness Among Clinical College Students: A 12-Year Comparison, paper presented at the 118th annual convention of the American Psychological Association, August 12, 2010. Accessed at https://www.apa.org/news/press/releases/2010/08/students-mental-illness.aspx

[11] Koppelman J. op cit.

[12] Perou R et al. Mental Health Surveillance Among Children—United States, 2005–2011. Morbidity and Mortality Weekly Report (MMWR) Centers for Disease Control and Prevention. May 17, 2013 / 62(02);1-35

[13] Reports and other material detailing progress in implementing local Mental Health Services Act funds in Tulare County and Kings County, respectively, can be found at the following websites: http://www.tularehhsa.org/tasks/sites/default/assets/File/MHSA%205Y%20FINAL%2006-04-12%20WEB3.pdf and http://www.kingscountybehavioralhealth.com/pdf/mhsa_plans/2011/1112AnnualUpdate%20(2).pdf

Organization of the Report

After considering how best to present the results of the needs assessment (whether by mental health topic or by survey group), we decided the report would have greater utility if readers could more readily see how each group viewed and was impacted by the student mental health needs addressed in the study. Thus—at the risk of some unavoidable repetition—sections II-VII of the report present the findings according to each major stakeholder group: school personnel; parents; students; physicians; mental health providers. The Conclusions section draws out and highlights differences and similarities among the groups as well as provides a general summary that lead to the considerations for implementation.

Acknowledgements

The consultants wish to thank the many people of Tulare and Kings Counties who took the time and interest to complete surveys and participate in focus groups and interviews, sharing their views about student mental health needs and solutions that made the statistical data more meaningful. We are particularly appreciative of the schools and college campus that hosted us during the interviews with parents and students.

We appreciate the guidance and suggestions of the Tulare & Kings Counties Suicide Prevention Task Force Executive Committee members for facilitating the needs assessment process and contributing to the utility of this document, especially their careful review of the early version.

We also wish to recognize the assistance of the Tulare County Medical Society that graciously facilitated our access to pediatricians and family practice physicians in Tulare and Kings Counties by mailing our survey and sending a letter of introduction.

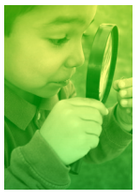
Consultant Team

BARBARA AVED ASSOCIATES (BAA), a Sacramento-based consulting firm serving health and human services organizations since 1986, carried out the student mental health needs assessment between May 2013 and May 2014. The consultant team included Barbara M. Aved, RN, PhD, MBA, Mechele Small Haggard, MBA, and Emelina Flores-Bauer. Shirley Colón and Michael Funakoshi from BAA provided office support.

PROCESS (METHODS)

"We don't have a fine-tuned way of knowing what our students' mental health needs are."
– College Administrator

The Tulare & Kings Counties SPTF Executive Committee (see Attachment 1 for a list of members) served as the steering committee and provided general guidance for this project including reviewing the data collection forms. After an initial meeting with the Committee to finalize the scope of the study, a broader group of about 25 representatives from schools and local organizations involved in student services, including mental health, met with the consultant team. The group provided useful feedback about the proposed needs assessment approach, helped to refine the study parameters and offered to facilitate access for data collection.



DATA SOURCES

Personal and small-group interviews and focus groups as well as written and online surveys were the primary methods used to gather the data from the sources described below. These stakeholder and constituent groups (the "study samples") are described in the next section of this report. Prior to the primary data collection, a scan with selected inclusions of existing background data and a review of literature were completed to give context to the findings and suggestions.

Principals and Other Administrators

The Executive Committee provided representative lists from both counties of K-12 school districts, private and religious schools, and colleges/adult schools from which samples were drawn for participation in the study. All of the sample K-12 district superintendents and colleges received a letter from HHSA to introduce the study and consultant firm. The consultants followed with a letter that provided more detail and requested support and participation by the schools. The K-12 superintendents who agreed to participate (Attachment 2) provided a list of principals and other administrators who they thought would be willing to be interviewed; these individuals were then contacted by email, provided details about the study and invited to participate in an interview.

A list of general and tailored interview questions was developed concerning administrators' perspectives about mental health, roles and responsibilities, and considerations for improvement. (The core questions were also used in interviews with other groups so that perspectives about these issues could be compared across groups.) The telephone interviews lasted between 30 and 60 minutes and were conducted between May and August 2013. All interview notes were coded, analyzed and summarized for inclusion in this report.

Parents and Students

School personnel and mental health providers identified lists of parents and junior-senior high school students who agreed to participate in interviews. Some of the students/families were involved in some way in school-based mental

health services while others were part of a club (e.g., Gay Student Alliance) or simply interested in participating in an interview after learning about the study. (For example, all college students self selected to participate in the study.) The majority of the parent interviews and all of the student interviews were conducted in person. To access college students, a table with signage about the study was set up on the College of the Sequoias campus on two separate days inviting interviews; students often volunteered singly or in groups of 2 or 3 for a personal interview after they saw the sign. Parents and college students were offered their choice of a $20 gift card to Save Mart/ Lucky Stores or Starbucks as a thank-you for their participation. Interview questions focused on commonly observed mental health problems and needs, perspectives about contributing factors and ways in which earlier intervention might have made a difference, and recommendations for improved student mental health services. (Attachment 3 contains a list of the interview questions.)

Teachers, Counselors, Psychologists and Other School Personnel

A comprehensive written survey (Attachment 4) on a range of mental health issues—matching the telephone and in-person interview questions where relevant—and roles and responsibilities and capacity, was developed and made available online during the month of November 2013 to school personnel through their participating school districts and colleges/trade school administrators. We were dependent on these sources to make school personnel aware of the survey and encourage all staff to participate. One reminder email was sent to the superintendents and college administrators half-way through the survey period to promote usage. A sample of school psychologists also participated in in-depth telephone interviews, particularly to follow on with some of the findings in the online survey.

Community Mental Health Providers

Representatives from a sample of Tulare and Kings Counties mental health agencies and private therapists provided by the Executive Committee participated in telephone interviews. The interview questions focused mainly on commonly-observed mental health problems and needs, perspectives about contributing factors, perceptions about family involvement, service capacity and considerations for improvement.

Physicians

The Tulare County Medical Society mailed a supportive cover letter and our survey (Attachment 5) to all pediatricians and family practice physicians in Tulare and Kings Counties. The goal was to learn how these physicians—who are the primary care providers students are most likely to see—view their roles and responsibilities and what their experience has been vis-à-vis their young patients' mental health needs. To increase the response rate, physicians who faxed in a survey and provided contact information were offered a $15 gift card for Starbuck's or Sees Candies.

DEFINITIONS

The following definitions were used in this needs assessment:

- *Mental Health (MH)* = a catch-all term used in this report to refer to the emotional, mental, and behavioral issues that can impede success in school.

- *MH problems/issues and needs that were included as part of this study* = depression, anxiety, anger, bullying, eating disorders, gender identity/sexual orientation issues.

- *Problems/issues that were excluded as outside the scope of the study as some limitations had to be applied* = autism, ADD/ADHD, developmental disabilities.

- *School* = any school/educational institution in Tulare and Kings Counties, i.e., preschool, K-12, college, adult/trade school.

- *Student* = anyone enrolled in a school/educational institution in Tulare or Kings counties.

- *Therapist vs. counselor* = except where there is a direct quote, "counselor" is used generally to refer to school personnel whose primary role is related to furthering students' academic achievement; "therapist" refers to mental health providers who provide mental health prevention and treatment services (which can include mental health counseling).

IDENTIFICATION OF PRIORITY CONSIDERATIONS

Based on the extensive project findings, considerations for addressing student mental health needs were developed for consideration by the Executive Committee. As the next step, the Committee, after sharing these results with broad stakeholder groups, will need to determine the priority short- and long-term implementation strategies to undertake, and plan the necessary strategies, action steps, timeline and partnerships for successful implementation. This report does not present a timetable for implementation.

BACKGROUND DATA

"Now that schools have the responsibility for student mental health it creates a whole new and interesting environment."
– Tulare County mental health service provider

"I think the community has more expectations about us [the school] than schools can deliver."
–Tulare County school district administrator

Publicly available mental health data at the county level are limited for counties with relatively small populations. Although some of the sample sizes are small, the Tulare and Kings Counties' background data presented in the next several pages provide a mental health picture that offers a context for understanding some of the underlying mental health issues that can impact a student's overall well-being and academic achievement. Where available, local data were used in this section of the report.

To understand the scope of mental health problems, estimates of need for mental health services are made using demographic data with a consistent, general relationship to mental health.[14] The prevalence rates for children ages 0-17 is based on estimates of serious emotional disturbance. Predictably, prevalence varies with income level with higher levels among youth from the lower income categories. The estimations for Tulare and Kings Counties for the general range of student ages[15] addressed in this assessment are shown in Table 1 on the next page. While the rates are slightly higher in Tulare County than in Kings County, both counties are generally comparable to statewide estimates.

[14] http://www.dhcs.ca.gov/provgovpart/Documents/CaliforniaPrevalenceEstimates.pdf. The statistical method relies on an indirect estimate (which is complex) projected on to the populations of interest. This approach assumes that demographic variation is more important than geographic variation. The mental health need prevalence rates for children below 18 years of age are primarily based on poverty levels.

[15] Although the age range of the college population varies widely, the American College Health Association estimates that the vast majority of college students (87%) are ages 18-24.The higher age range in the table is to accommodate veterans who are often older than the median age of students.

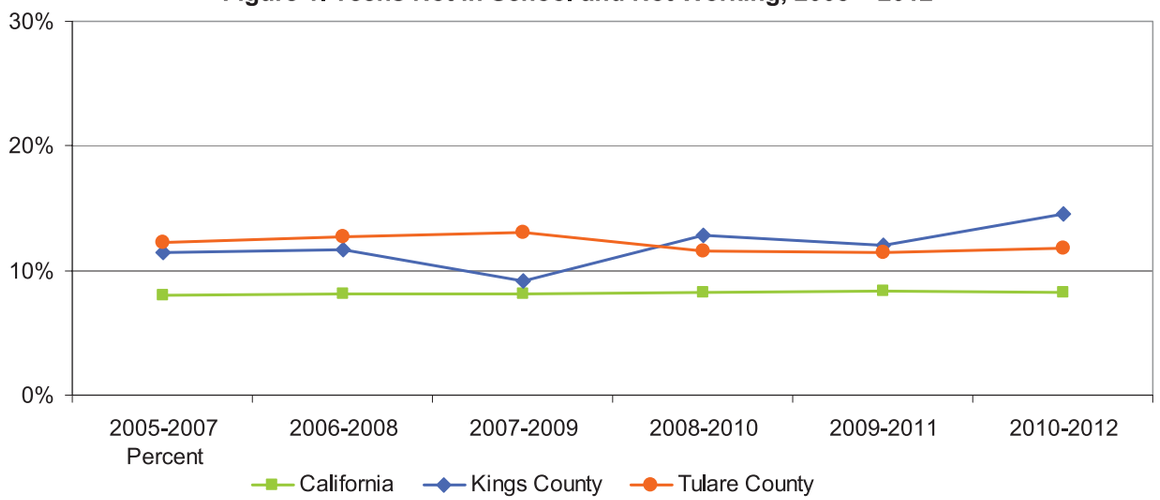
Table 1. Estimates of Need for Mental Health Services, Selected Ages, SMI Definition*

	Total Population		Households <200% poverty	
	Cases	Percent	Cases	Percent
Tulare County, Selected Ages				
Age 0-5	4,198	8.33%	3,081	9.07%
6-11	3,799	8.24%	2,779	9.05%
12-17	3,555	8.09%	2,328	9.07%
18-20	481	2.29%	306	2.7%
21-24	1,158	4.63%	880	6.18%
25-34	4,357	7.23%	3,277	9.77%
Kings County, Selected Ages				
Age 0-5	1,238	8.10%	874	8.93%
6-11	1,040	7.99%	688	8.89%
12-17	1,036	7.96%	677	8.89%
18-20	176	2.38%	86	2.77%
21-24	677	5.85%	316	6.35%
25-34	2,458	9.34%	920	9.64%
Total Youth Age 0-17				
California	714,431	7.56%	367,257	8.91%
Tulare County	11,552	8.23%	8,188	9.06%
Kings County	3,314	8.02%	2,238	8.91%

*Severe mental illness (SMI) is any mental illness that results in substantial impairment in carrying out major life activities.
Source: 2010 U.S. Census; California Department of Finance.

The Packard Foundation for Children's Health organizes selected published data on the health and well being of children in communities across California. Although the numbers for Tulare and Kings Counties are relatively small, 3 emotional health indicators from that source related to this assessment are presented below: teens who drop out of school, particularly those without a job (which can increase the risk for mental health); hospitalizations for mental health issues; and youth suicide. In both counties, the percentages of teens who drop out of school and are not working are higher than the statewide average in the last 6 years (Figure 1).

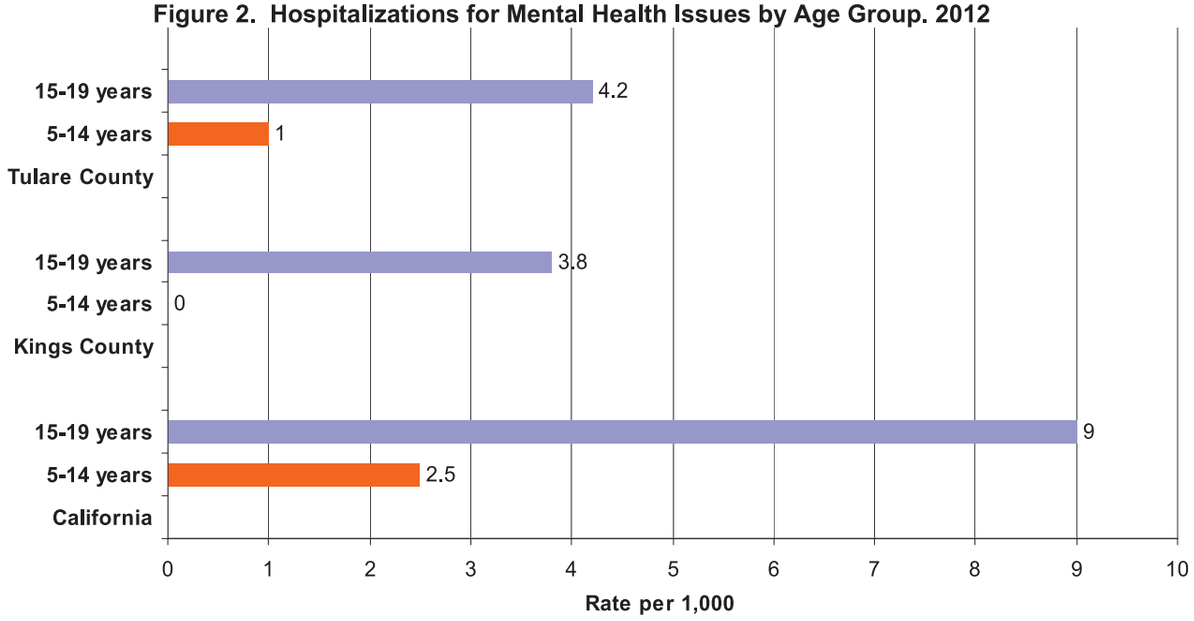
Figure 1. Teens Not in School and Not Working, 2005 – 2012



Source: U.S. Census Bureau, American Community Survey. As cited on kidsdata.org

Although the rate of hospitalizations related to mental health issues for ages 5-19 are lower in Tulare and Kings Counties than in California as a whole (Figure 2), this may speak more to the availability of resources than to prevalence. (Note that data by county for non-fatal Self-Inflicted Injury Hospitalizations are not available for Tulare and Kings Counties dues to LNE, Low Number Event, which refers to rates that have been suppressed because there were fewer than 20 cases.)

Figure 2. Hospitalizations for Mental Health Issues by Age Group. 2012



Source: Special tabulation by the California Office of Statewide Health Planning and Development (Nov. 2013); California Department of Finance, 2000-2010 Estimates of Population by Race/Ethnicity with Age and Gender Detail and State and County Population Projections by Race/Ethnicity and 5-year Age Groups, 2010-2060. As cited on kidsdata.org.

The pattern of youth suicide is relatively consistent in Kings County between 2007 and 2011 but clearly more variable in Tulare County during that period (Table 2), with a marked high in 2007.

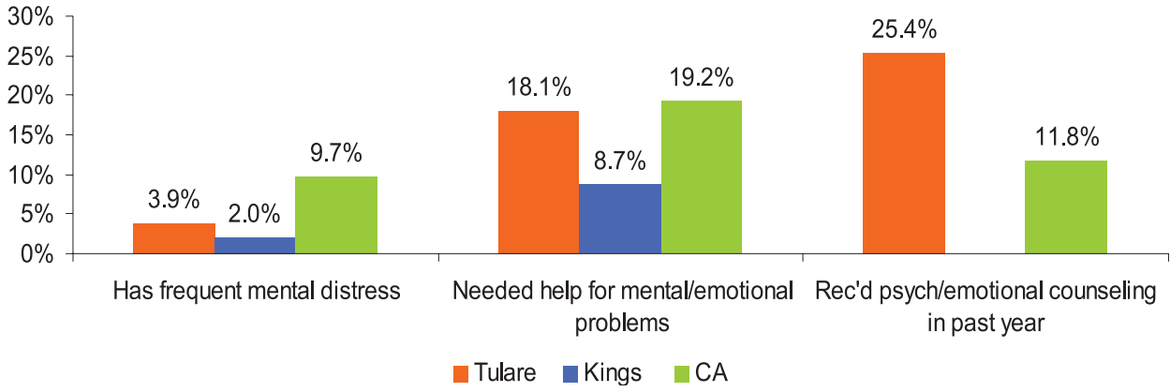
Table 2. Number of Youth Suicides by Age, 2007 - 2011

Tulare County	Number				
Age	2007	2008	2009	2010	2011
5-14 Years	0	0	1	0	0
15-19 Years	4	2	2	3	2
20-24 Years	8	2	3	4	0
Total for Ages 5-24	12	4	6	7	2
Kings County	Number				
Age	2007	2008	2009	2010	2011
5-14 Years	0	0	0	0	0
15-19 Years	0	0	0	0	2
20-24 Years	1	2	2	2	0
Total for Ages 5-24	1	2	2	2	2

Source: As cited on kidsdata.org, California Dept. of Public Health, Center for Health Statistics, Death Statistical Master Files; Centers for Disease Control & Prevention, Underlying Cause of Death 1999-2010.

Mental health-related data from the 2011-12 California Health Interview Survey (CHIS) for adolescents, while statistically unreliable for counties the size of Tulare and Kings due to small sample sizes, are still of high value as an information source. Adolescents who reported 14 or more "mentally unhealthy" days to CHIS are considered to have frequent mental distress (FMD). As shown in Figure 3, the counties' incidence of FMD is reported to be lower than the statewide average. However, Tulare County teens mirror California teens in the need for help related to mental and emotional problems (defined as "feeling sad, anxious or nervous during the last 12 months"), but received psychological or emotional counseling in the past year at slightly over double the proportion of the statewide average (Figure 3). Utilization rates for Kings County are not available from this survey.

Figure 3. Teen Mental/Emotional Health and Well-Being and Utilization, 2011-2012

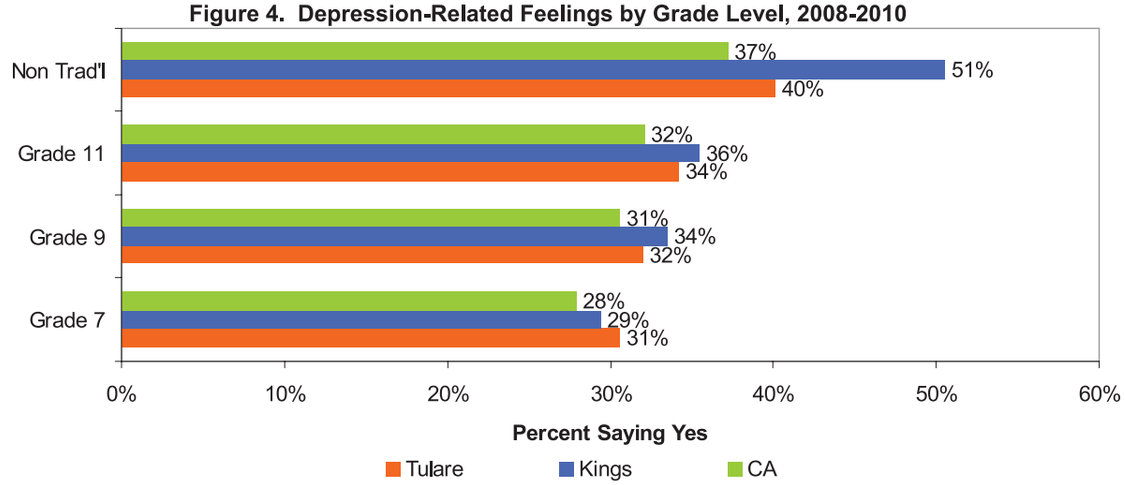


Source: 2011-12 California Health Information Survey

The California Health Kids Survey (CHKS), the largest statewide survey of resiliency, protective factors, and risk behaviors in the nation, has led to a better understanding of the relationship between students' health behaviors and academic performance. School districts that administer the CHKS have the option to request that their data be reported at the school level for a small fee, if they surveyed a sufficient number of students in their schools. These reports are not publicly posted. Selected indicators for Tulare and Kings Counties' schools publicly available at the county level from California Department of Education, are displayed in Figures 4-6 and Table 3 on the next 2 pages.

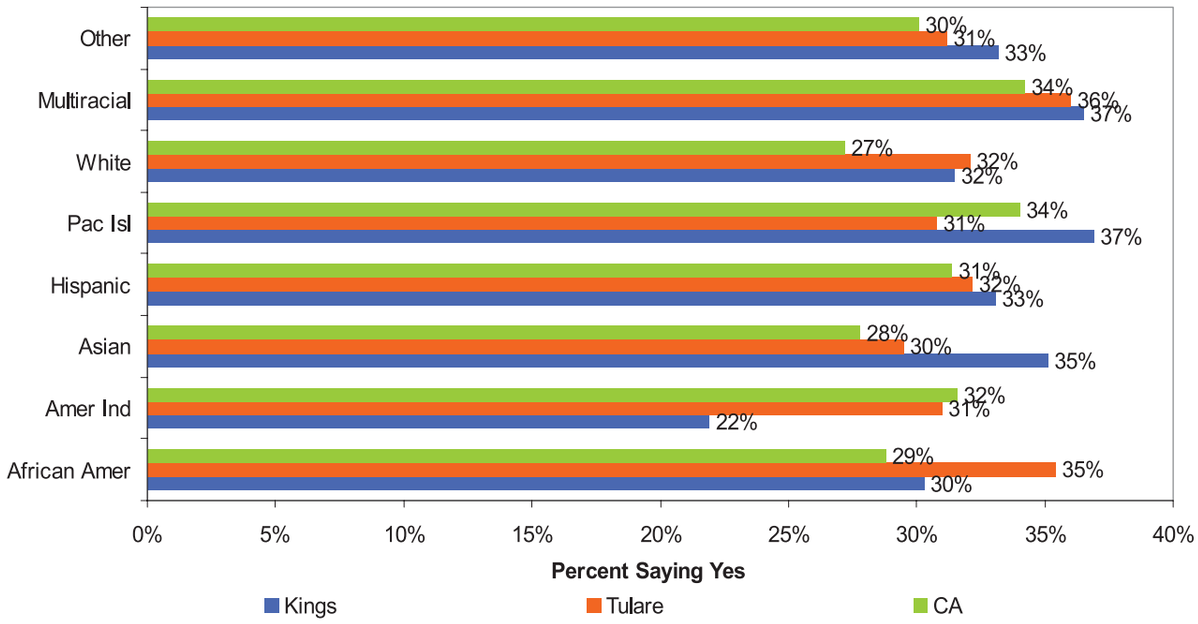
These 3 graphs show depression-related feelings reported by students by grade level, by ethnicity and by the degree to which the students feel connected to school. Except for grade 7 (where Tulare County exceeds both Kings County and California), Kings County students report higher feelings of depression than the statewide average and Tulare County. Although students with "high" levels of connectedness to school report lower feelings of depression overall, reported feelings of depression among these students from Tulare and Kings Counties are slightly higher than the statewide average.

Figure 4. Depression-Related Feelings by Grade Level, 2008-2010



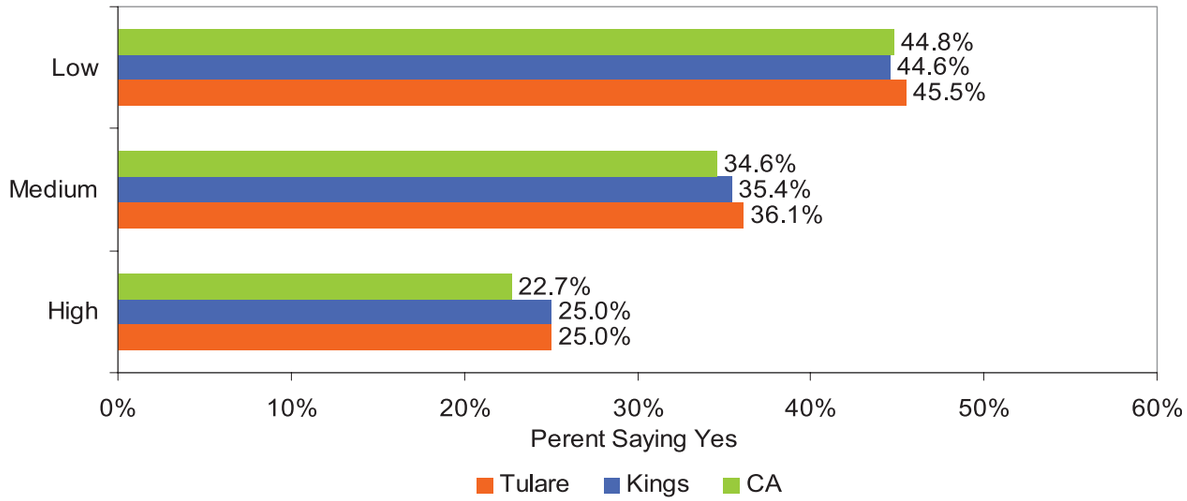
Definition: Percentage of students in grades 7, 9, and 11 reporting whether in the past 12 months, they had felt so sad or hopeless almost every day for two weeks or more that they stopped doing some usual activities
Source: California Department of Education, California Healthy Kids Survey (WestEd). http://www.wested.org/chks

Figure 5. Depression-Related Feelings, by Race/Ethnicity Grades 7, 9, & 11, 2008-2010



Definition: Percentage of students in grades 7, 9, and 11 reporting whether in the past 12 months, they had felt so sad or hopeless almost every day for two weeks or more that they stopped doing some usual activities
Source: California Department of Education, California Healthy Kids Survey (WestEd). http://www.wested.org/chks

Figure 6. Depression-Related Feelings by Level of Connectedness to School, 2008-2010



Definition: Percentage of students in grades 7, 9, and 11 reporting whether in the past 12 months, they had felt so sad or hopeless almost every day for two weeks or more that they stopped doing some usual activities, by level of connectedness to school. School connectedness includes being treated fairly, feeling close to people, feeling happy, feeling part of, and feeling safe at school.
Source: California Department of Education, California Healthy Kids Survey (WestEd). http://www.wested.org/chks

On average, about one-third of middle and high school students reported incidents of harassment when at school. Table 3 illustrates that the incidence of bullying associated with a student's gender and sexual orientation was nearly as similar as that for race and ethnicity.

Table 3. Selected Reasons for Harassment on School Property, Past 12 Months

	Tulare County (2008-2009)[1]			Kings County (2009-2011)		
	7th Grade	9th Grade	11th Grade	7th Grade	9th Grade	11th Grade
Race/Ethnicity						
0 times	82%	82%	86%	88%	83%	86%
1 time	8%	8%	6%	6%	7%	6%
2 or more times	10%	10%	8%	6%	10%	8%
Gender						
0 times	88%	90%	93%	92%	92%	92%
1 time	5%	4%	3%	4%	3%	4%
2 or more times	6%	6%	4%	4%	5%	4%
Sexual Orientation[2]						
0 times	88%	88%	88%	91%	89%	93%
1 time	5%	5%	3%	5%	4%	3%
2 or more times	7%	7%	4%	5%	7%	4%
Any Other Reason						
0 times	71%	79%	85%	79%	79%	85%
1 time	12%	7%	6%	6%	7%	5%
2 or more times	17%	14%	10%	15%	14%	11%
Any harassment	43%	35%	28%	33%	34%	29%

Question: During the past 12 months, how many times on school property were you harassed or bullied for any of the following reasons?

[1] 2009-2011 data not available for Tulare County.

[2] *The question read, "Because you are gay or lesbian or someone thought you were."*

College Students

College-age adults are especially vulnerable to mental health problems, in part because many mental health issues first emerge in the late teens or early 20s. An increasing number of college students are arriving on campus with psychological issues or developing problems once they're in school.[16] According to the 2006 National Survey of Counseling Centers, 92% of college directors believe that the number of students with severe psychological problems has increased in recent years, representing a major concern for their centers.[17]

Overall, about 27% of young adults between the ages of 18 and 24 are estimated to have diagnosable mental health problems. Suicide, the eighth leading cause of death for all Americans, is the second leading cause of death for college-age individuals.[18]

Stigma remains the number one barrier to students seeking help according to a college survey sponsored by the National Alliance on Mental Illness.[19] Survey respondents also cited busy personal schedules as a significant barrier to accessing care, showing the importance of having flexible service hours. When asked to explain what made their colleges' Disability Resource Center helpful or not, many of the students reported that DRCs focus primarily on physical health conditions and not enough on mental health conditions.

A national study of college freshman revealed that nearly 20% of first-year male students reported feeling frequently overwhelmed by what they had to do, as did more than 35% of first year female students. Although a fear of seeking help is common on college campuses where the need to fit in is strong, close to 7% of both males and females reported feeling there was "a very good chance" they would seek personal mental health-related counseling while attending college.[20] Projecting this likelihood of need for mental health services on the estimated number of students enrolled in colleges in 2010 in Tulare and Kings Counties, 21,899 (which is likely an undercount), suggests at least 1,540 local college students would seek mental health counseling.

Student Military Veterans

Some students are more vulnerable to mental health concerns than others, particularly veterans, active duty military members and members of the National Guard and reserves. Many veterans returning from Iraq and Afghanistan, for example, are facing mental health and substance abuse issues, and many wind up in the criminal justice system instead of getting the help they need. The Department of Veteran Affairs (VA) estimates that approximately 3% of undergraduate college students are veterans, and 1% are service members who are currently on active duty or in the reserves. In 2007-2008, the VA estimated that 40% of the military service members were using the education benefits available to veterans. In 2009, veterans' education benefits expanded with the passage of the Post 9/11 GI Bill.

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[16] "Mental Health Issues in College on the Rise." American Psychological Association. Education Leadership Conference, December 2013, Vol. 44, No. 11.

[17] Gallagher RP. National Survey of Counseling Center Directors. The International Association of Counseling Services, Inc; 2006.

[18] http://www.nami.org/Template.cfm? 3/25/14.

[19] College Students Speak: A Survey Report On Mental Health. National Alliance on Mental Illness, 2011. http://www.nami.org/Content/NavigationMenu/Find_Support/NAMI_on_Campus1/NAMI_Survey_on_College_Students/collegereport.pdf

[20] http://www.gseis.ucla.edu/heri/norms_pr_01.html as reported in SAMHSA's Resource Center to Promote Acceptance, Dignity and Social Inclusion Associated with Mental Health (ADS Center). Mental Health: What a Difference Student Awareness Makes. http://promoteacceptance.samhsa.gov/publications/collegelife.aspx. 3/25/14.

In 2008, RAND released a report about the mental health needs and service gaps for veterans. This report was not focused on student veterans, but rather on all service members returning from Afghanistan and Iraq. They found approximately 18.5% of U.S. service members who returned from Afghanistan and Iraq currently have post traumatic stress disorder or depression; and 19.5% report experiencing a traumatic brain injury during deployment.[21]

As part of another RAND study conducted to describe the student veteran and their use of the new educational benefits, surveys and focus groups were completed by current student veterans asking about their experiences adjusting to student life. The study reported that "a small subset of focus group participants described relatively smooth transitions….however, a majority of respondents described several challenges they faced in adapting to student life."[22] In addition to the challenges of "managing service-connected injuries, including traumatic brain injury (TBI) and post-traumatic stress disorder (PTSD)," other concerns were the difficulties meeting academic expectations, balancing family and other responsibilities with academics and relating to other students.[23]

In 2012, the Department of Veterans Affairs published the Suicide Data Report.[24] Their conclusions included the fact that a majority of veteran suicides are among those age 50 years and older, and that the numbers of veterans who die from suicide has remained relatively stable over the past 12 years.[25]

In the study of veteran students using the new GI bill, the participants who described the struggles they had adapting to life on campus reported using many resources. Of those resources, the most helpful support they had received was from other veterans.[26] Though it was noted in the RAND report that there has been an increase in mental health resources available to veterans through the Department of Defense and the Veterans Administration, there is still a large gap between the need for mental health services and the use of those services.[27]

The key barriers to using mental health services that were identified by those who participated in the study included:[28]

- The medications that might help have too many side effects (45%)

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[21] Tanielian T and Jaycox LH, eds. Research Highlights of "Invisible Wounds of War: Psychological and Cognitive Injuries, their Consequences and Services to Assist Recovery". RAND Corporation, p. 1. Accessed at http://www.rand.org/pubs/research_briefs/RB9336/index1.html, 03/17/14.

[22] Steele, J, Salcedo N, and Coley J. "Service Members in School: Military Veterans' Experiences Using the Post-9/11 GI Bill and Pursuing Postsecondary Education." RAND Corporation, p. x. Accessed at http://www.rand.org/content/dam/rand/pubs/monographs/2011/RAND_MG1083.sum.pdf, 03/17/14.

[23] Ibid.

[24] Kemp J, Bossarte R, "Suicide Data Report, 2012" Department of Veterans Affairs, Mental EHalth Services, Suicide Prevention Program. Accessed at: http://www.va.gov/opa/docs/suicide-data-report-2012-final.pdf, 03/17/14.

[25] Ibid, pp. 51-52

[26] Steele, J, Salcedo N, and Coley J. "Service Members in School: Military Veterans' Experiences Using the Post-9/11 GI Bill and Pursuing Postsecondary Education." RAND Corporation, p. x. Accessed at http://www.rand.org/content/dam/rand/pubs/monographs/2011/RAND_MG1083.sum.pdf, 03/17/14.

[27] Tanielian T and Jaycox LH, eds. Research Highlights of "Invisible Wounds of War: Psychological and Cognitive Injuries, their Consequences and Services to Assist Recovery". RAND Corporation, page 4. Accessed at http://www.rand.org/pubs/research_briefs/RB9336/index1.html, 03/17/14.

28 Ibid, table on p. 4.

- It could harm my career
- I could be denied a security clearance (44%)
- My family or friends would be more helpful than a mental health professional (39%)
- My co-workers would have less confidence in me if they found out (38%).

Demographically, 73% of the students veterans are male and 27% are female. Females make up only 10%-12% of the military personnel and are thus over-represented in post-secondary education. The students are older than the average student: 15% are 18-23 years old; 31% are 24-29; 28% are 30-39; and 25% are 40 and over. Almost half (47%) have children, and the same proportion report being married. Most of the student veterans are enrolled in a two-year public institution (43%).

Using these projections and U.S. Census data, Table 4 shows the number of student veterans estimated in Tulare and Kings County who could be using the education benefits.

Table 4. Estimated Number of Student Veterans in Tulare and Kings Counties

	Number of Veterans[29]	Percentage of Veterans in Population[30]	Estimated number of Veterans using education benefits[31]
Tulare County	18,558	4%	7,423
Kings County	11,072	7%	4,428
California	1,952,910	5%	781,164

Source: Please see footnotes.

[29] This column reflects the "Veterans 2008-2012" data in the Quick Facts for Tulare County, Kings County and California. Source: U. S. Census Bureau, American Community Survey, 5-Year Estimates, US Census. Accessed at http://quickfacts.census.gov/ , 03/17/14.

[30] Ibid, this column reflects the "Population, 2012 estimate" for Tulare County, Kings County and California. (Number of Veterans/2012 Population Estimate).

[31] Estimated using the VA figure stating that 40% of veterans use educational benefits. (Number of Veterans * 40%) from "Characteristics of Student Veterans" VA Campus Toolkit Handout, April 6,2012, unless otherwise noted. Accessed at: http://www.mentalhealth.va.gov/studentveteran/docs/ed_todaysStudentVets.html, 03/17/14.

ASSESSMENT RESULTS

"They [MH organization] educated me, too. I never knew these childhood problems could last into adulthood. I'm not afraid anymore after our experience with counseling."
– Parent of high school student

This section of the report summarizes the remainder of the findings from the student mental health needs assessment process. The perspectives presented below are the observations, opinions, remarks and suggestions of the study sample participants in response to interview and survey questions. The section is organized into 7 sub-sections that address the following key questions:

- Who participated in the study?
- What are the most common mental health issues identified among students in Tulare and Kings Counties, and what changes have been observed in recent years?
- How do perspectives about a range of student mental health issues vary among the stakeholders who provided input in this assessment?
- What are schools' and providers' experience with families, and what are the family challenges that promote or impede successful outcomes for their children?
- How are mental health issues typically identified and addressed by schools?
- What is the role of the primary care provider in early identification and coordination of care for mental health?
- What are the available mental health resources for students in Tulare and Kings Counties, and what are the main resource challenges and barriers to addressing the needs?
- What improvements or changes are needed to address the unmet mental health needs of students in Tulare and Kings Counties?

DESCRIPTION OF THE STUDY SAMPLE

PRINCIPALS AND ADMINISTRATORS

A representative sample of 20 K-12 school districts, 11 from Tulare County and 9 from Kings County, were pulled from a larger list of districts identified by the Executive Committee and invited to participate in the study. On average, 65% of district superintendents from each county agreed to participate and sent lists of principals from preschools to high schools who were considered likely to be willing to be interviewed (Table 5). Approximately half of the principals who were contacted agreed to an interview (though a couple did not keep the appointment). Representatives of 4 of the 7 college/trade schools contacted participated in an interview.

None of the 11 private and religious schools responded to the request for an interview when contacted by email or left a phone message.

Table 5. Principal and Administrator Sample (Public Schools)

	K-12 School Districts			Colleges/Trade Schools	
	Superintendents Invited to Participate	Superintendents Who Agreed to Participate*	Principals who Followed Through with an Interview	Administrators Invited to Participate in an Interview	Administrators Who Participated in an Interview
Tulare County	11	7	14	4	2
Kings County	9	6	10	3	2
Total	20	13	24	7	4

*Agreement = submitted names of principals to contact for an interview.

TEACHERS, COUNSELORS, PSYCHOLOGISTS AND OTHER SCHOOL PERSONNEL

A total of 243 school personnel in various roles from different school settings in both counties responded to the online survey. Although only 195 (79%) completed the entire survey, none of the survey responses was omitted from the analysis. The non-responses were partly due to skip patterns and to respondents' free will in answering the questions. The district superintendents notified their individual K-12 school administrators who in turn were to make faculty and staff aware of the opportunity to participate. It was not possible to know how many of the college administrators notified their personnel about the survey.

In Tulare County—which represented about two-thirds of the responses—the majority of personnel reported they worked in high schools (79%) and/or were teachers (69%). Kings County respondents were more evenly distributed across elementary schools (32%), middle schools (27%), and high schools (31%), and again the majority indicated they were teachers (61%).

Table 6. Characteristics of the School Personnel Sample (with fully completed Survey) (n=195)

Characteristic	Tulare County (n=124)	Kings County (n=71)
Type of School		
Elementary school	12%	32%
Middle school or junior high	1%	27%
High School	79%	31%
K-12	6%	3%
District-wide or county-wide	2%	3%
Adult/trade school	0%	4%
Role in School		
Classroom Teacher/Teaching Faculty	69%	61%
School Counselor (non therapist)	7%	3%
School Psychologist	3%	1%
School Nurse	1%	0%
Administrator	14%	14%
Other (Office Staff, Teachers' Aide, etc.)	10%	25%

PARENTS AND STUDENTS

A total of 85 junior and senior high school and college students and 33 parents participated in individual or group interviews. Just over 21% of the high school students were from Kings County (Table 6). Grades 7-12 students were identified by a teacher or administrator, provided an explanation of the interview purpose and given the option of participating on campus during school hours. The students were described as being part of a club, campus support group, someone known to be at higher risk of needing or receiving some sort of counseling services, or "just your basic kid."

College student interviewees were self-selected from those who saw the sign on our table on the college quad (set up over 2 days for about 3 hours each time) and who stopped and volunteered to participate.

The parent interviewees were identified through various school personnel; about half had a student involved in a K-12 or other early childhood mental health program. The interviews were held in English and Spanish. For convenience, some parents requested a phone interview from home in the evening; the other interviews were held in person at the school site.

Table 7. Parent and Student Samples

	Students		Parents/Other Caregivers**
	Junior/Senior High School	College	
Tulare County	51	23*	23
Kings County	11		10
Total	62	23	33

*College student residences unknown. All college interviews took place on the COS Visalia campus.
**In at least a couple of cases these were other family members who identified themselves as raising the children.

MENTAL HEALTH PROVIDERS

To understand the perspective of mental health providers in Tulare and Kings Counties, 22 providers were contacted with a request for an interviews and 14 (64%) agreed to participate. Five mental health providers in Tulare County and 9 providers in Kings County completed an interview.[32] All of these providers served junior and senior high school students, and most also (71%) served children in elementary school (Table 8). At least half provided mental health services on a school campus.

Table 8. Mental Health Provider Interview Sample (n=14)

Characteristic	Frequency	Percent
County of Primary Service		
Kings	9	64%
Tulare	5	36%
Focus of Service		
Prevention	4	29%
Early Intervention	2	14%
Treatment	11	71%
Population Served		
Young Children, age 0-5	8	57%
Elementary	10	71%
Middle School	14	100%
High School	14	100%
Adult (College, trade school)	6	43%
Service Location		
Office	11	79%
School Campus	7	50%
Public/Private Type Organization		
Clinic or public agency	11	71%
Private practice	3	21%

PHYSICIANS

About one-quarter (24%) of the 151 pediatricians and family practice physicians mailed a survey completed and returned it. All except one chose to identify their name and address in the survey (which was necessary to be mailed a gift card incentive). Of the physicians who answered the demographic questions, the sample was almost evenly divided between pediatricians (45%) and family practice physicians (55%) (Table 9 on the next page). Three physicians did not indicate their specialty area. The majority (94%) of physicians who reported their practice location indicated Tulare County; 2 respondents left this question blank.

[32] It should be noted that a few of the mental health providers who had participated in an interview did not respond to follow-up emails or telephone calls requesting clarification or additional information.

Table 9. Characteristics of the Physician Sample (n=36)

Characteristic	
Type of Physician (n=33)	
Pediatrician	15 (45%)
Family Practice	18 (55%)
Primary Practice Location (n=34)	
Kings County	2 (6%)
Tulare County	32 (94%)

While the physician sample provides an interesting and perhaps useful picture of primary care providers' opinions about student mental health, it may not be fully representative of pediatricians and family practitioners in Tulare and Kings Counties. Pediatricians and Tulare County doctors are markedly over-represented in the sample.

Pediatricians responded to the survey at about 3 times the proportion as family practice physicians (37% compared to 13%). Close to one-third (29%) of physicians with main practice locations in Tulare County who were mailed the survey completed and returned it compared to 5% who responded from Kings County.

PERSPECTIVES OF PRINCIPALS AND OTHER SCHOOL/COLLEGE ADMINISTRATORS[33]

"What do you serve—the academics, which is why we're here, or the behaviors that are so disruptive?"
– Middle school principal

"It's a scary thing as a principal that I have to put on a face that everything's fine when I'm scared too [about the threat of violence]."
– Middle School Principal

Most Commonly Observed Mental/ Emotional Health Problems Among Students

Mood disorders, specifically depression, was cited by a large majority of principals and other K-12 and college administrators as the most common mental/emotional health issue observed among their students. Depression was described as both intense introversion/social isolation and as students becoming "overly emotional" (e.g., crying). Bullying behaviors—including cyber-bullying—was nearly as frequently mentioned by K-8 administrators as depression. Among high school and college students, "stress" and anxiety—generally related at the lower ages to family and social situations and at the older ages to grades and careers—were very highly ranked concerns as well (Table 10).

Table 10. Rank Order of Most Common Student Mental Health Issues Observed

Issue	K-12 Principals		College Administrators
	K-8 / JrH	HS	
Depression	1	1	2
Anxiety; stress	3	2	1
Aggression (verbal/physical)[2]	2	3	3
Cutting	4	5	5
Other[3]	5	4	4

[1]Rank order "1-5," with "1" being the most common.
[2]Includes bullying.
[3]Most common: eating disorder, sexual orientation issue.

College administrators described the majority of their students as working (many full time) while trying to go to school and being under-prepared for class which along with lack of sleep added to their stress ("it's a vicious circle"). The colleges also mentioned some of the students with learning disabilities had curricula changed for them in high school and when they get to college the "reasonable accommodation" colleges make doesn't seem like enough for them and they get

[33] To respect the anonymity of the interviewees we generally do not mention the name of the schools.

very frustrated. They said these students (and others) "need counseling for all kinds of coping skills, but we can't provide it." Some of their students were said to be homeless, so financial hardships were at the basis of their anxiety and depression. PTSD was mentioned as contributing to a host of mood disorders among veterans.

Most of the K-12 principals remarked that bullying generally started out as verbal, especially with girls. While they take it seriously, several middle and high school principals cautioned that it was "sometimes hard to tell what constitutes bullying on a continuum of 'normal' teenage behaviors." Family feuds ("that take place in small communities") that spill over into aggressive behaviors between effected students were described by a couple administrators as being "pervasive and generational," which they've tried to address in parent sessions.

Anger (with and without obvious provocation exhibited by verbally lashing out and/or with physical threats—sometimes carried out in assaults (typically student-to-student, not student-to teacher)— was also commonly cited by the administrators. Both middle and high school administrators say they are seeing more "outbursts" among students in their districts. Principals of lower grades commented that "aggressive behaviors can look like so many other things at this early age, which is why the biggest mental health challenge is to truly be able to diagnose what's going on."

Anger was also cited as an issue by the administrators in reference to older students, including adult students. Intense anger ("more students more irate than ever before") was the consensus of college administrators who identified aggression as a common mental health concern. One college administrator commented on changes the school felt it had to make in securing the financial aid office desk because of the "rage" and potential for assaultive behavior that was occurring over the loss of student financial aid (from failed grades), which was said to be an important source of income for some families.

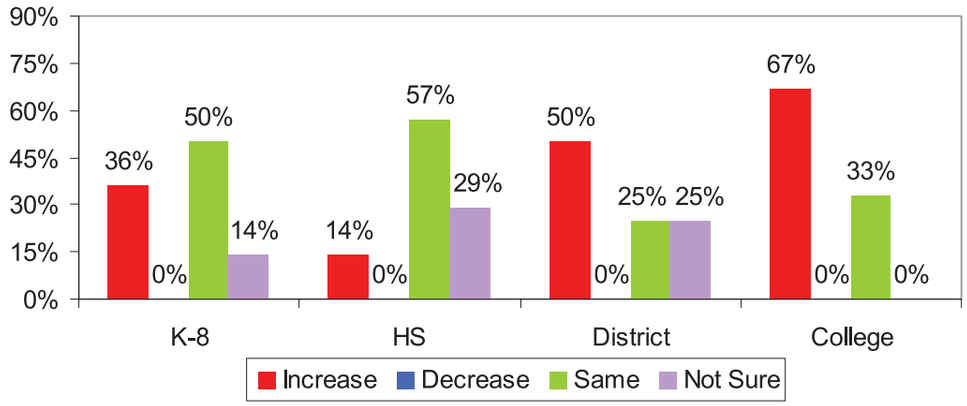
Representative principal and administrator comments include the following:

- *"Some of these kids just want to escape; they're essentially saying 'this is beyond my ability to process right now' so they sort of go unresponsive or zone out, some with alcohol drugs, some by isolating themselves."*
- *"The stress of wanting to fit in, whether it's athletically or in band/choir, or clubs, we see is so high among these kids."*
- *"Some of these kids [middle school] are so angry from morning until afternoon they have trouble conversing without anger. They have limited social skills or just decide to not use the ones they have."*
- *"The young ones especially just aren't able to share their feelings in an acceptable manner, not able to communicate their needs. Maybe they haven't seen this modeled well."*
- *"If these kids aren't able to work through their negative experiences when they're young they only escalate into bigger problems when they're older—and they act on these issues when they themselves become parents."*

Perceptions About Change in Mental Health Issues in Recent Years

College administrators were the most likely to indicate that MH concerns are increasing for students (67%). Those working directly in K-12 were most likely to report no change in MH concerns (50% for K-8 and 57% for high school (Figure 7). No one reported observing a decrease in these mental health concerns.

Figure 7. Administrators' Perceptions About Mental Health Changes in Recent Years



What has changed, according to nearly all administrators, is the attention schools are paying to issues like bullying. A few of the principals commented that while the amount of bullying behaviors has pretty much remained the same, the "means have shifted because of technology to more cyber bullying." Schools also reported increasing their attentiveness of "loner" kids and "the introvert who makes inappropriate remarks" in light of recent tragic school violence in the U.S.

School-wide Assessments and Individual Student Assessments

Because risk factors—biological factors or psychosocial experiences—can negatively impact a student's mental health, we asked administrators whether the district or school had conducted any type of assessment on common risk and stress factors (e.g., student exposure to crime, violence, substance abuse), and if so how long ago and how were the results applied.

- Twenty-five (93%) of the 27 administrators said they had not conducted any assessments; 2 added, "we should, though."

- One school creates a "watch list" which is an informal ongoing list of students they think are at higher risk and "use word of mouth among school personnel walking around all day long doing serious supervision" to direct their efforts.

- Four of the K-12 administrators referenced their schools' California Healthy Kids Survey (CHKS) results as assessments and described how they applied those results. Another school administrator said if the district nurse (whose position had been vacant this school year, however) brings anything to their attention from the survey they "pay attention to it." (See page 56 for more discussion about use of the CHKS.)

- The 2 schools that conducted all-student assessments were a Family Resource Center preschool and a Tulare County school district. In the former, behavioral therapists assess the children for signs and symptoms of early mental health issues and plan interventions.[34] In the latter example, the school district representative stated their Director of Student Services assesses each student every year using a non-anonymous self-report "depression inventory." Based on the responses, he develops a risk status for each student and shares the "alert list" with other personnel each month. Their April 2013 survey yielded 35 (5.4%) alerts of the 650 students assessed.

One high school administrator explained they do an individual student "threat assessment" any time they feel a student has posed a serious threat to others; he explained the administrative staff have been trained to do this. They pose a series of

[34] This program may be supported by a grant from First 5 Tulare.

questions that leads to a risk status for knowing the level of seriousness and follow the protocol (e.g., referral) for handing the results of the assessment.

The response from one of the college interviews was particularly noteworthy. The interviewees said they were "afraid of opening Pandora's Box because once you identify problems, such as with a risk assessment or depression inventory, aren't you obligated to do something about it?" They seemed ambivalent as on the one hand wanting to be of help to student but on the other hand not having adequate resources for making student mental health "more of a priority on the campus."

Experience with Families

While the administrators expressed a great deal of frustration at parental behaviors, they acknowledged that parents' personal problems—their own mental health issues, substance abuse, unemployment, domestic violence, issues and language barriers, in that order—or "being focused on their own needs," accounted for the majority of families' inability to help their students. One administrator noted "parents don't see the connection between their behaviors and their kids' needs/behaviors."

Willing Families.

While we don't have enough information to generalize about the following impression, it seemed the K-12 administrators who worked in Tulare and Kings Counties for a long time *and* were from small towns (some of whom volunteered they'd graduated from one of the local high schools), indicated they experienced a fairly high trust factor between parents and the school, and family resistance to help was low.

Charter schools with a "3 strikes you're out policy" said most parents understand this is a "last resort" school situation for their child and are thankful to have the school help in any way. Bringing the parent into the picture by requiring them to attend with the student once a week has helped to improve student behavior at these schools.

Family members other than parents who are raising students (as high as 30% according to some of the interviewees) are considered a little more engaged to help, perhaps because they have taken over the care of the child *because* there was a serious issue with the parents.

In the interviewees' experience, from preschool to high school, generally about half of the "willing" families still end up not following through. Parents were said to "drag their feet" and "come up with all kinds of excuses every time [we] check" even when they give the impression in the beginning they are ready to work with the school on these issues. An elementary school administrator summed it by saying, "you can only go so far in pushing parents to do something."

Resistant Families

Not counting funding issues, poor parent support was unanimously identified as the number one challenge for schools in addressing student mental health needs.

Lack of initial parental engagement was estimated by the principals and other K-12 administrators as being somewhere between 30% and 60% of families when a problem is identified. They estimated about half to two-thirds of families were eventually willing to work with them, and parent resistance became less of an issue ("most parents 'get it' that their kid is going through emotional turmoil"). Other parents were viewed as "set in their ways, not going to change in attitudes," sometimes even when a district psychologist got involved. According to a few of the high schools, unless there was a major threat of violence and the campus police were called, parents were not engaged unless mandated by the school to get involved. Some principals said they "try to be less judgmental and just present the facts, especially when they're in denial."

Familiar negative responses administrators hear from parents or their students, some clearly illustrating denial, are:

- *"I don't want to be a snitch [and get my family in trouble]." (Student)*
- *"He's a chip off the old block; I was like that at his age. He's not going to change."*
- *"Oh, it's just a phase she's going through. All kids are like that."*
- *"She's just putting on an act, looking for attention."*
- *"He's done this before."*
- *"You're just trying to get rid of my kid [when the school suspended him]."*
- *"Are you calling my kid crazy?"*

According to the interviewees, most parents don't want their children on medication—or they think it's like an antibiotic you just take for a short while—and many take the student off the meds, so the student reverses improvement (which was also said in reference to college students). Other parents are scared and "think the kid will be crazy all his/her life."

Influence of Culture

The predominant ethnic group in the two counties reflects many family members from Mexico, and Mexican cultural beliefs about mental health are not always the same as for other students, nor well understood by schools, according to some of the interviews. One of the Hispanic administrators pointed out that "to be 'crazy' in the Mexican culture doesn't carry the same meaning as in other cultures because sometimes the family makes allowance for it by just saying 'they're just weird' or 'it's just who they are.' " Another pointed out that mental or emotional health concerns were especially hard for Mexican fathers because "they don't seek out professional services for this." The interviewee went on to suggest that if they can get the mother involved the father will often come along in his acceptance. Another administrator commented that the many agricultural workers in their community "depend on the school system to take responsibility for whatever a student needs," which would include a potential mental health concern, so bringing these parents along in the process can be challenging.

Influence of Gangs

Gang activity represents a particularly challenging and inevitable stress situation according to several urban and rural administrators, though gangs were said to be "a little less active now than in past years." The interviewees commented on their students at risk for developing conduct disorders (e.g., poor social skills, below-average achievement) and how they saw these issues leading increasing alienation from teachers and peers; these students become less interested in school and tended to seek antisocial peers, including gangs. The 9th and 10thgrade students were described as being more open about it, allowing administrators to be more aware of who was in a gang, than the older students "who've learned to be crafty and more lowkey about keeping their gang activity on the down low." It was explained that gang activity was more intense at the beginning of the school year "because of stuff that happens over the summer that carries over into the school year." One student told a principal who had tried to develop a one-to-one guiding relationship with him, "I have no choice but to be in a gang; this is my family. All my family is in a gang [parents too]." Another student mentioned he can't make friends at school because if he invites someone over "my family tries to recruit them into the gang."

School-Based (on Campus) Mental Heath Services

Pre-K – High School

All of the school districts employ school psychologists who are available to the individual campuses, but as is described in the interviews with school psychologists in the next section of this report, these staff are generally focused on academic-related access except when responding to a crisis. District representatives reported having crisis intervention teams that are very effective "when it works well and when staff are available to respond," but are too few in number. More than one administrator remarked that district psychologists were "generally in the office doing paperwork, not interacting with students." A number of them also stated that in many cases students would not be able to recognize the psychologists because "they are in schoolyard where kids can see them only about 4-5 times in a school year." According to the interviewees, academic counselors on each campus are generally the "first line of defense" in trying to assess what's going on with a student emotionally and "making the judgment call as to whether to involve the district psychologist or make a referral to an outside resource." One administrator remarked, "the academic counselors are to treat the 'whole child' but their focus is really on academic achievement."

Psychologists providing services to elementary schools are primarily responsible for completing Individual Education Plans (IEPs), according to the interviewees. One of the Family Resource Centers offers therapists as part of their early mental health program but the wait time for appointments was reported to be "very long."

Because of access to service issues such as transportation or work-related commitments that prevent families from taking the necessary time to bring their child to community providers, a number of school-based programs and resources are available to Pre-K–12 students in Tulare and Kings Counties. However, these are largely dependent on outside funding (e.g., Mental Health Services Act funds) and not consistently in place across all schools in the 2 counties. In Kings County, counselors from Behavioral Health (BH) come in to the schools (they have access to students' academic records) and work with high school counselors who help work with the students who've been identified with mental and behavioral problems. In some cases, they meet on a weekly basis 1-to-1 and in groups.

The BH counselors pull the students out of class for the sessions and "many are reluctant and balk because of the stigma and being made to feel different but 90% go," according to one principal who added, "about half of them have positive changes" which he identified as "better social adjustment, sometimes better grades." But, he acknowledged, "the social issues are easier to attack; the mental health stuff is so deep-rooted you're never going to be able to address that adequately in a group setting. The kids that open up get the most out of it." The BH counselors, who also try to develop rapport with the parents, go to all 3 high schools in the district so are stretched very thin (last year they served about 30-60 students per semester).

Kings View will also send counselors to the campus to meet with the students *who are their enrolled clients*, but the number of sessions may be limited. (All of these campus-based services from outside organizations are well regarded by the school personnel who are "grateful" for them but view them as "definitely not enough.") Another Kings County high school offers an every Friday noon "Girls' Talk" run by their School Resource Officer (SRO), attended by "girls who could go either way risk-wise," according to the principal who described this resource.

The administrators described other examples of ways schools have implemented preventive programs. A few of them are described here. Some participate in the SOS (signs of suicide) prevention program and Link Crew. The latter is a high school transition program that welcomes freshmen and makes them feel comfortable throughout the first year of their high school experience. It trains mentors from junior and senior classes to be Link Crew Leaders and positive role models who guide the freshmen to discover what it takes to be successful during the transition to high school and help facilitate freshman success. SOS teaches youth how to identify the symptoms of depression and suicidal ideation in themselves or their friends and encourages them to seek help through the use of the ACT technique (Acknowledge, Care, Tell). Some Tulare high schools have participated in CAST (Coping And Support Training), a suicide prevention program targeting youth 14-19 years old. CAST delivers life-skills training and social support in a small-group format (6-8 students per group). The program consists of 12 55-minute group sessions administered over 6 weeks by trained high school teachers, counselors, or nurses. CAST also serves as a follow-up program for youth who have been identified through screening as being at significant risk for suicide.

Last year, the Tulare County Office of Education (TCOE) offered a 2-day training called the Reduction and Elimination of Stigma through Art Targeted Education (RESTATE) program for some Tulare and Kings Counties schools, exposing a small group of juniors and seniors to the signs and symptoms of mental health. The program is part of a joint effort between the offices of education for both counties as well as local mental health organizations such as Kings County Behavioral Health. The Lemoore Union High School District and several districts in Tulare County are also participating in the program. Bright Futures offered by the TCOE has also had a regular presence on some campuses the last couple of years because of some “extreme cases” some of the schools have had to handle.

One of the Tulare middle schools is the first school in its district to implement Positive Behavioral Intervention and Supports (PBIS)—having just sent its administrative/leadership team to training in Fresno—and eventually the program will be district wide. PBIS is an evidence-based systemic approach to proactive, school-wide behavior based on a Response to Intervention (RTI) model. It applies programs, practices and strategies for all students to increase academic performance, improve safety, decrease problem behavior, and establish a positive school culture.

Some of the schools offer anti-gang programs in view of the problems gang involvement creates in the area. One Tulare County junior high offers Step Up, Team Success provided by a faithbased organization “that doesn’t proselytize,” and tries to target “pre-gang kids at risk.” They tell the kids, “gangs only take you to 2 places: a coffin and jail.” “The kids hear it but they don’t hear it,” remarked one of the interviewees. Another anti-gang program, one that involves parents and the community at large, is Parents on a Mission (POM), described by one of the Tulare County elementary principals at her school. POM is a 6-week curriculum for community leaders to develop parent leadership in neighborhoods. She reported it’s hard to get in because of limited enrollment and parents are reluctant to go at first but after they start attending they really seem to like it.

The charter schools have access to the district psychologist when needed (generally in an urgent situation, we were told), and their counselors are there for academic purposes only. However, only the students who need to use a computer come to the school site every day. The rest are required to only come once a week, with a parent, so onsite services are very limited.

One of the district-wide administrators we spoke with seemed to sum it up for the rest of the interviewees concerning student mental health when he stated, “anyone who wants to come onto our campus and offer anything our students need I welcome.” These K-12 administrators—at

least the ones who agreed to participate in this study—appear very open to expanding programs and services that support their students and enhance the learning environment.

College/Adult Schools

"Very little to none" was how mental health services at the 4 colleges were described by the college administrators, though all of them described great needs among their students as noted above. At College of the Sequoias, for example, the health center on the Hanford campus is open only a few hours a week and viewed as having "limited mental health counseling available." The Visalia campus offers more hours and more services and is trying to expand what they offer related to mental health (e.g., stress management activities). The Milan Institute—and similar adult/trade schools—doesn't offer on-campus health-related services; administrators, however, take the time to talk with students who seek them out and try to help with various referrals.

West Hills does not have a student health center on campus or offer counseling except academic-related. If a teacher is concerned about a student she/he can use an electronic early alert system and send a school counselor a message; this could be about academics or personal issues, and is the way they said they'd handle an urgent or crisis situation. If urgent, they'd "get a hold of a counselor who would generally be available to respond." (They do not have any therapists on call on campus.) The counselor could do the initial "talking them down/calming them/assessing what's going on" and then would suggest places in the community where they could go for help. They were very clear that their counselors "don't engage in any therapeutic counseling." The counselor could "stay with the student while he/she called a referral source to make an appointment in case they needed any help or support." They indicated that their counselors could not actually drive a student to these sources, but "could meet up with them there if necessary."

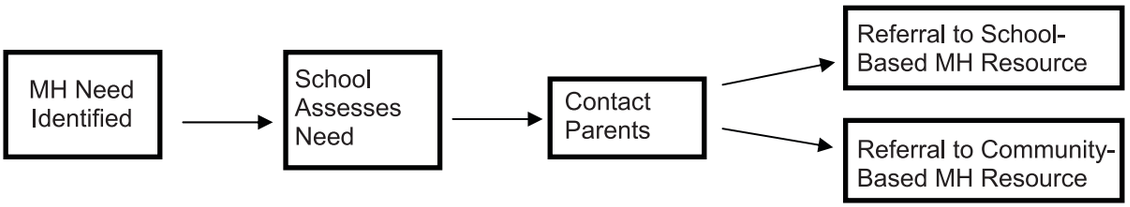
Because only 4 colleges and adult schools responded to the request for an interview it is not possible to know if these findings are representative of other colleges and private adult/trade schools in Tulare and Kings Counties, but it is reasonable to expect they could reflect the experience on most of the campuses. As an administrator told us, "colleges don't have the same obligation for students like a K-12.... although there are facilitative things we can do."

Referral Procedures

When students (including college students) with mental health concerns or abusive behavior come to the school's attention through a teacher, counselor, other staff person or other student, principals and other administrators generally take the following steps: sit down and talk with the student to try and get the student to open up so they can assess what's going on; depending on how that goes, they may do any or all of the following: make a referral to an outside organization/facility; call the parents to talk or require the parents to come in; bring the student back into the office for follow-up talks. In some cases, principals said teachers were also free to contact the district psychologists directly as a first step in the assessment/referral process. One middle school principal described using the Response to Intervention (RTI) system with its 4 tiers of multi-level prevention, screening, data-based decision making, and evidence-based intervention to achieve desired student outcomes.

The graphic on next page provides a general schematic for the typical referral process.

Figure 8. Typical Referral Process for Student Mental Health Needs



The principals, and in some cases school counselors, work with the district psychologists to make referrals to community providers such as Kings View in Kings County and Tulare Youth Service Bureau in Tulare County. One middle school principal expressed frustration about his experience referring students to Kings View who he felt needed more than an assessment: he stated that "99% of the time Kings View sends them back to school the next day with a letter saying the kid isn't at risk of harm to self or others" and was skeptical about this conclusion.

College administrators try to get their students in to see someone at the student health center (if there is one, and it's open) before referring—when a referral is given—to a community provider. Schools are not always aware of students' eligibility for services that require a student or family to qualify for the services. K-12 principals added that they needed parental permission to make a referral and these were not always granted. (When this is the case, one principal told us he says to the parent, "fine, we will take them, but you have to go pick them up.")

Referrals are sometimes also made to one of the Family Resource Centers in the two-county area. The school personnel give the FRC the name of the parents and the FRC contacts the family and invites them to an appointment for services, which in some cases can include counseling and parenting skills classes in addition to help with linkage to community services.

A couple of principals remarked they didn't refer out much "because families frequently fail to follow through." A couple others said they are trying to refer out or suspend students less often and provide more intervention with school counselors, "even though these well-meaning people have limited mental health training," as a means of trying to "handle more at the school."

Knowledge About and Referral to Community-Based Mental Health Services

The majority of interviewees could name at least 1 community-based mental health provider or program they or the district psychologists referred students to and/or that came onto the campus to provide services. (One principal said she was "still waiting to be told [by the district] who these were" after asking and getting an "I don't know" response from someone at the school district.) Kings View and Kings County Behavioral Health in Kings County, and Dinuba Children's Services and Tulare Youth Service Bureau in Tulare County were the community-based providers most commonly mentioned. Only 1 principal mentioned awareness of a tribal health center; he said he referred Native American students to Tule River Tribal Health Center when mental health concerns arose.

TYSB provides a wide variety of services to children and youth with Medi-Cal, and one of the principals mentioned that students who were undocumented don't qualify. In his experience, families who were undocumented were often afraid to go to YSB because they think their involvement could become an INS (immigration) issue. Some schools depend on the Counties' Behavioral Health staff and Offices of Education to help link students to outside referral sources.

One interviewee observed that until the last 3 years or so "no one was paying much attention to" student mental health but now because of outside organizations coming in to the schools to get involved—"probably because of funding"—it's been helpful to raise awareness among school personnel about mental health issues and problems.

Principals reiterated their uncertainty about how many families actually followed through with mental health services when parents were responsible for taking their student from the campus to the community provider. (Examples of exceptions were when there was self-injury such as cutting or other urgent situation.) A couple of the interviewees mentioned they happened to know someone who works at one of the community-based organizations or a private therapist and they help "fast track" families through those systems, especially as wait times for appointments can be long.

Interdisciplinary Meetings on Mental/ Behavioral Health

General communication among counselors and district psychologists and administrators happens informally. About half of the schools said they also hold student-specific conferences (referred to as "Student Study Teams") as issues arise ("when teachers/counselors/parents have concerns about a student's classroom performance"). In other cases, because the district requires it, SST meetings, which can be about both academic as well as behavioral issues and emotional concerns, are held monthly. Interdisciplinary meetings (such as among teachers, administrators, other staff, clinical team members, other youth-serving professionals) for planning new or reviewing current *mental health* programs and services, problem solving, information sharing, staff development and so forth were said to be held infrequently or mostly not at all.

Observations Specific to the Concern of Suicide

A number of the administrators said they had personally been involved in a student self-inflicted death at some point in their career. All of the principals and college administrators we spoke with expressed an appreciation of the seriousness of suicide, whether or not they thought the potential was significant for their students.

- When asked about how prevalent suicide concern was for the students they served, about half of those interviewed gave an estimate that was similar to the national figure for high school students (i.e., 12%-15%).[35]

- The other half estimated a significantly lower percentage among their students, 2%-3%. Their actual experience with grades junior high and up, on average, was an awareness of about 1-2 students in the last year or so with serious suicide indication or attempt.

- One middle school principal from Tulare County shared that last year 6 out of their 500 students had serious enough suicide-related situations to be brought to her attention (of these, there were 2 attempts, neither successful).

- Two high school principals, 1 K-12 district administrator, and 1 junior high principal stated they thought the potential for suicide was "not a very significant issue" on their campuses (though the junior high principal acknowledged a suicide attempt had occurred at the school the prior year). One of these principals added that "although the students are poor—and they know they're poor—they seem to be pretty happy on the whole. They just have to figure out how to survive."

[35] Trends in the Prevalence of Suicide-Related Behaviors National YRBS: 1991–2011. Youth Risk Behavior Survey http://www.cdc.gov/healthyyouth/yrbs/pdf/us_suicide_trend_yrbs.pdf

An elementary school principal described a situation where a first-grader "talked about an actual plan"—and drew a picture depicting herself running out in front of a moving vehicle." (This school and the family took the situation seriously and sought appropriate counseling.)

The administrators said there is much more attention being paid to the importance of this issue on their campuses, with more verbalizing among students, teachers and counselors. Teachers are more alert to what students write in essays, for example; some concerned students come forward to identify their at-risk friends. Some said they are "very aggressive" if they observe or suspect anything, and adopt a "better safe than sorry" attitude. Several of the interviewees mentioned implementing the Text-A-Tip program for high school students that lets them text and chat with administrators anonymously if their friends consider suicide (or are in trouble and have safety issues or they spot crimes).

Additional administrator perceptions related to suicide include:

- *"Kids that do talk about it is a cry for help but they aren't the ones who will follow through with it."*
- *"The cutters just want the pain to stop; that's what they're doing."*
- *"I'm only seeing or hearing about the unusual or more serious kids because principals are on an as-need-to-know basis."*
- *"We listen for things like 'I don't want to be here.' "*
- *"Some are students hearing voices telling them to hurt themselves—or it's the devil talking to them—and they had to be hospitalized [before they could do anything harmful to themselves]."*
- *"It's probably a lot bigger problem than the referrals we've gotten for those who've attempted."*

Concerns Related to Underserved Populations

Returning Veterans

Because more student veterans are pursuing higher education and face unique challenges as they transition from service into college life, we asked the college administrators about any particular concerns or unique support services their campus had for these students. None of the 4 administrators we spoke with said they offered veteran-specific *mental health* programs or services on their campuses. (We note, however, that the support groups of one campus' VA center and the camaraderie were considered by the *students* we interviewed there as mental health support.)

A Veterans Coordinator from one of the colleges shared the following observations:

- **Anger.** Veterans can get very angry (caused by many underlying factors) and have outbursts in the classroom if other students (often younger students) interrupt their learning environment. Many veterans with PTSD experience anger when placed in high stress situations.
- **Depression.** Returning to the civilian world creates a lot of uncertainty for veterans and they have to define themselves as civilians. Many veterans experience depression but few seek counseling due to the stigma attached to having depression and many often avoid seeking counseling if they might consider returning to the military.
- **Suicide.** PTSD, depression and the realities of the civilian world and job market all take a toll on veterans, and suicide is a greater risk for this student group.

- **Drop Out.** While not directly related to mental health, it was noted that veterans can have a high drop-out rate due to a higher need to provide for a family than to obtain an education, because they are at risk of homelessness, and because of the toll that PTSD and other service-related disabilities have on their ability to focus in school.

COS reported they referred to the Veterans Administration as the source of services for veterans to utilize. For example, the VA has a crisis line for suicide prevention and provides individual/group counseling for vets suffering with PTSD or depression. In urgent situations, COS said they try to connect the student with a counselor in the VA Hospital system. Another COS representative commented that veterans tend to take the police and fire academy classes. These are cohort models, which the students are used to from being in the military, "and while this means they 'support their own'—it can also mean the students don't want to make their mental health concerns known."

One of the college administrators remarked that returning veterans "have taken so much time and resources and these students have generally been disruptive in class." Another college administrator referenced their returning veteran population and the problem of PTSD and said "there's no place for them to go and while there've not been any incidents they should be considered a higher risk group."

The Milan Institute estimated about 5% of its students were veterans and "a couple every year" show PTSD symptoms. When the administration or teaching faculty becomes aware of a problem, their approach is to have the student take "personal time out" of the classroom to regroup and then go back in, which they said usually works.

LGBTQ Students

Mental health concerns and resources for LGBTQ (lesbian, gay, bisexual, transgender, and questioning) students were discussed with K-12 principals and colleges only to the extent of asking for a sample of names of GSA Club sponsors for student interviews. For results related to this area, please see the following sections of this report: *Perspectives of Other School Personnel, Including Psychologists and Student Perspectives.*

Considerations for Improvement

All of the interviewees responded to the question "What additional resources are needed to help you respond to students' mental health needs?" and "What are your recommendations for improving the current system of school-based mental health services?" (We did not place any funding restrictions in our questions or task them with identifying *who* should execute the suggestions.) Table 11 on the next page summarizes their suggestions by order of mention.

By a wide margin, and without reservation, the majority of the administrators, from preschool to adult school, urged increasing the number of *mental health* staff available to students *on the school site*. They emphasized the need to distinguish between counselors whose main role was academic assessment and guidance from counselors/psychologists qualified to offer therapeutic counseling and group sessions. "Counselors like the old days with a case load" and "sort of like the old school nurse situation with a caring person," were the kinds of representative comments that were typical of the mental health resources that would be "fabulously helpful" to schools. One elementary school principal commented that while he was happy to do it when needed, "attending to children's mental health issues takes an inordinate amount of a principal's time and effort." In promoting more campus-based services, principals stressed the

point that parentsare familiar and comfortable with their children's schools and trust them.

One high school principal, who commented on the connection between depression or acting out in anger and academic failure and the need for preventive services, remarked, "our tendency is to just give out the punishment and deal with the consequences—that's certainly not a deterrent to the behavior not happening again." Many highlighted the need for more *prevention-oriented* programs and services.

While some of the interviewees expressed cynicism about the chances for success (and others said "it's still worth doing"), about half made suggestions centered on the need for more parent education/skill building regarding children's mental health—at earlier ages—and interventions to improve students' home environments ("parents are the road block in many cases"). At least one-third of the interviewees also advocated for more teacher and other staff training and said it should include how-to-handle strategies, "telling teachers not to be afraid but to deal with these things." One person observed that because the teacher turnover in their area tended to be low an investment in teacher training would be cost beneficial.

A number of administrators, including those from colleges, advocated for giving greater visibility to student mental health issues "to help keep people continuously focused on it and not just once in awhile in a big dose, which we forget about again until the next big dose."

Two administrators brought up the issue of teen pregnancy (Tulare and Kings Counties' teen birth rates are 58th and 56th worst, respectively, of 58 counties in the state),[36] and recommended mental health programs that could address this problem with more emphasis on students' self esteem, respectful relationships, healthy ways to cope, etc.

Table 11. K-12 Principal/College Suggestions for Improving Student Mental Health by Frequency of Mention (n=30)

- Hire more district psychologists. Re-focus their primary role from academic assessment and guidance to therapeutic mental health services for students.
- Bring more community-based mental health services and programs on to campus to increase access (and reduce parents' need to transport).
- Focus more on prevention which is often missed.
- Provide more training for all school personnel to increase awareness of signs/symptoms, and knowledge about and comfort using process for referring students with mental health concerns.
- Offer parent education specific to mental health; offer high-enough incentive to encourage attendance, particularly for "resistant" parents.
- Use creative outreach activities to parents to help improve students' home environments.
- Create ways to give greater visibility about student mental health issues and their affect on student's inability to learn and the long-term consequences of not "fixing" a problem.
- Give more attention to suicide prevention.
- Streamline access to community-based mental health services (e.g., shorten wait times, condense assessment process, link quicker to therapeutic services).
- Make school personnel, including college administrators, more aware of community-based mental health services: locations, hours of operation, eligibility, cost.

[36] 2103 County Health Profiles, California Department of Public Health.

Other important comments from principals and other administrators include:

- *"Our psychologists can come on campus when there's an acute situation but this isn't near enough of what we need."*
- *"Reaching out to families is so needed. Many know there's a problem but don't know how to deal with it, especially the Spanish-speaking. Some cultures don't believe in mental health."*
- *"Parents need as much help as the students."*
- *"A lot of students who aren't academically successful are because of mental health issues."*
- *"Once you connect with a kid they'll run through the wall for you. But, as a low-income school, we're often overlooked when it comes to these [mental health] resources."*
- *"Teachers need training with what these kids are going through because for the most part they're not from that world and can't relate to it."*
- *"We need to recruit serious role models/ mentors who've 'been there," like people who've left gangs and gone on to a successful life and know what they're talking about but who the kids and parents can relate to."*
- *A better crisis service aimed at kids and their families is needed—not like the typical way we do it now with law enforcement getting involved and taking the student to the ER for evaluation and then putting a 72-hour hold on them and releasing them without linkage to ongoing counseling." (Elementary school principal)*
- *"We need more early enrichment programs like what First 5 supports. The kids that come out of those programs do very well but they don't reach enough kids; we're missing too many kids here [Tulare County]."*
- *"The reason we need therapists is because kids want to talk to someone. It seems they don't get a lot of opportunity to do this at home."*

PERSPECTIVES OF VARIOUS SCHOOL PERSONNEL[37] AND DISTRICT PSYCHOLOGISTS[38]

"It's really concerning that kids think it's OK to 'confront' someone via social media—they can't seem to talk to each other anymore unless they're texting." – Tulare County High School Counselor

"Counselors should listen to the teachers when they have concerns instead of spending all their time worrying about meeting state standards and test results." –Kings County High School Teacher

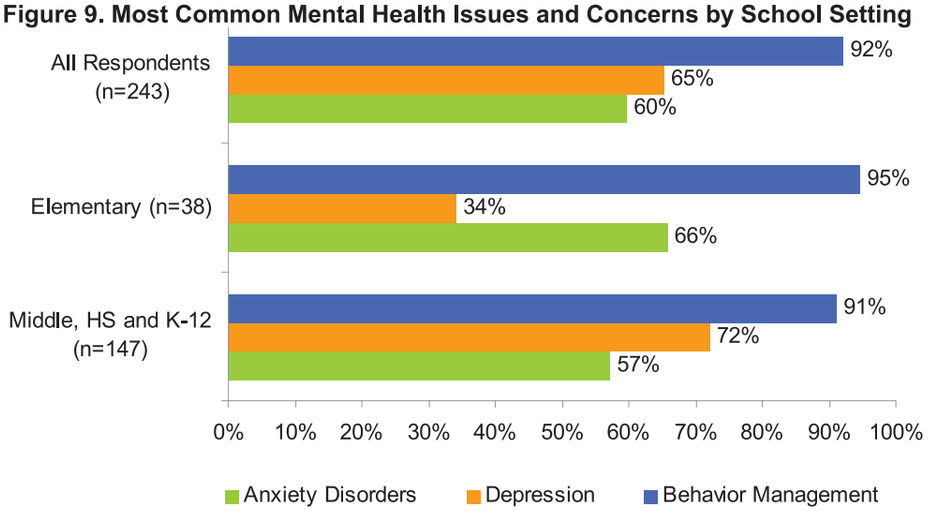
"When a kid starts to do something harmful to themselves—like not eating or cutting—it's not teenage angst." – School Psychologist

ONLINE SURVEY

Most Common Student Mental Health Concerns

Among all respondents to the online school personnel survey, the most commonly identified mental health concerns observed among students were behavior management (92%), depression (65%) and anxiety disorders (60%). Though the order varied by the age group of the students the personnel worked with, these issues remained constant for both elementary and older students (Figure 9).

Figure 9. Most Common Mental Health Issues and Concerns by School Setting

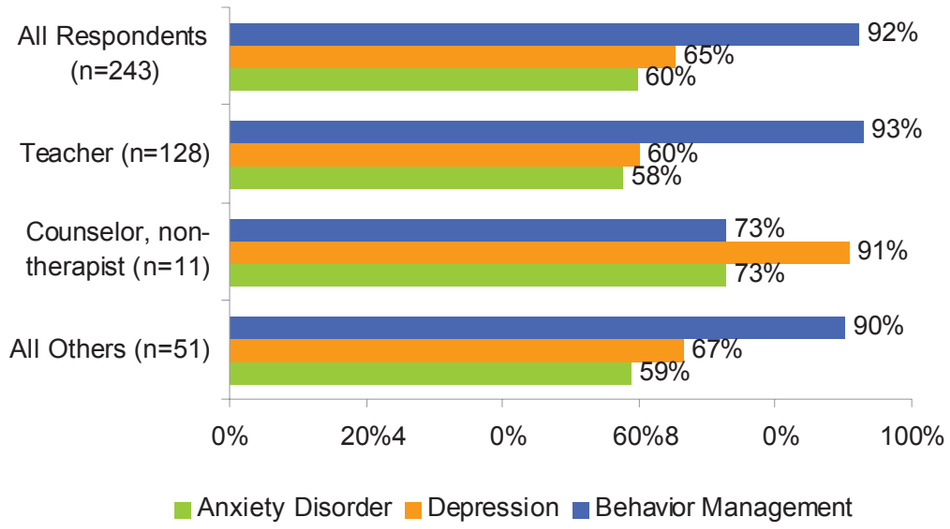


[37] Respondents to this survey who self-identified as administrators may include some of the principals who participated in in- depth interviews which were reported in the previous section of this report.

[38] In-depth interviews with a sample of district psychologists are included at the end of this section of the report.

Similar to teachers and other staff, school psychologists[39] were most likely to rank behavior management issues as the most common mental health concern among students, while respondents who identified as non-therapist school counselors were more likely to rank depression and anxiety as the top concerns (Figure 10).

Figure 10. Most Common Mental Health Issues and Concerns by Role at School



Confidence Identifying and Responding to Student Mental Health Issues and Concerns

Among the various mental health issues and concerns listed in the survey, school personnel reported being most confident in being able to identify behavior management problems (confidence about *responding* to these identified problems is discussed next). Though depression and anxiety were also ranked the most common concerns, only 23% and 19% of the respondents, respectively, indicated full confidence in their ability to identify these 2 concerns (Figure 11 below). Respondents generally were the least confident about identifying suicide risk and eating disorders. About one-quarter of the respondents who worked with preschoolers (children age 0-5) said they were not confident identifying concerns related to early childhood mental health.

[39] Note that while the total number of school psychologist survey respondents was relatively low, the importance of their role in student mental health justifies showing these data as a separate category here and elsewhere in this report.

Figure 11. All Respondents' Confidence in *Identifying* Mental Health Issues and Concerns (n=229)

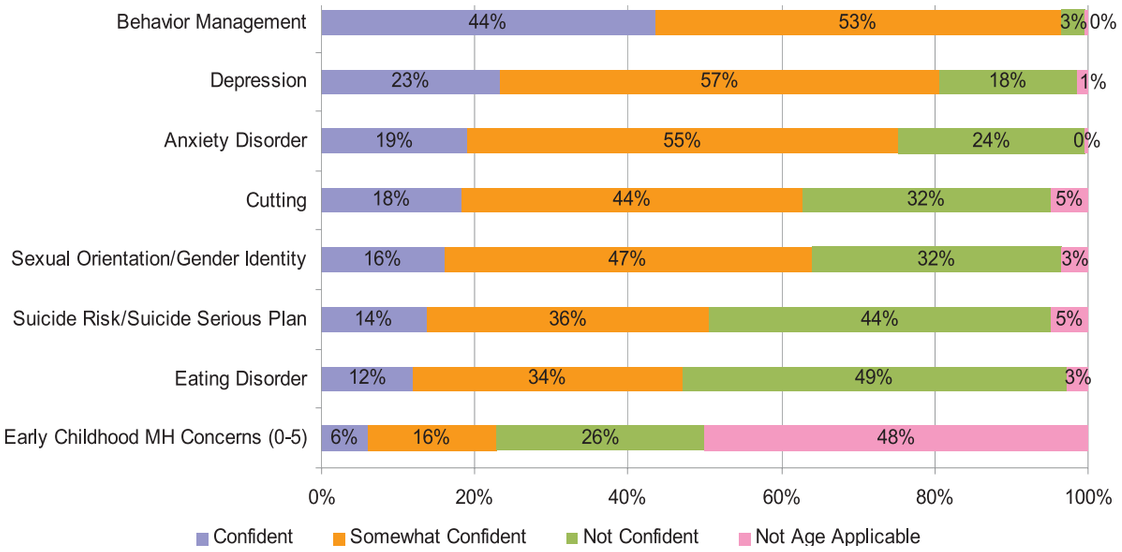


Table 12 displays details about the varying degrees of confidence in identifying mental health issues by respondent type. Not unexpectedly, those who identified as school psychologists reported the highest levels of confidence; as a group, teachers reported the least amount of confidence in being able to identify mental health problems among students, though like the other staff types they expressed a great deal of confidence regarding behavior management.

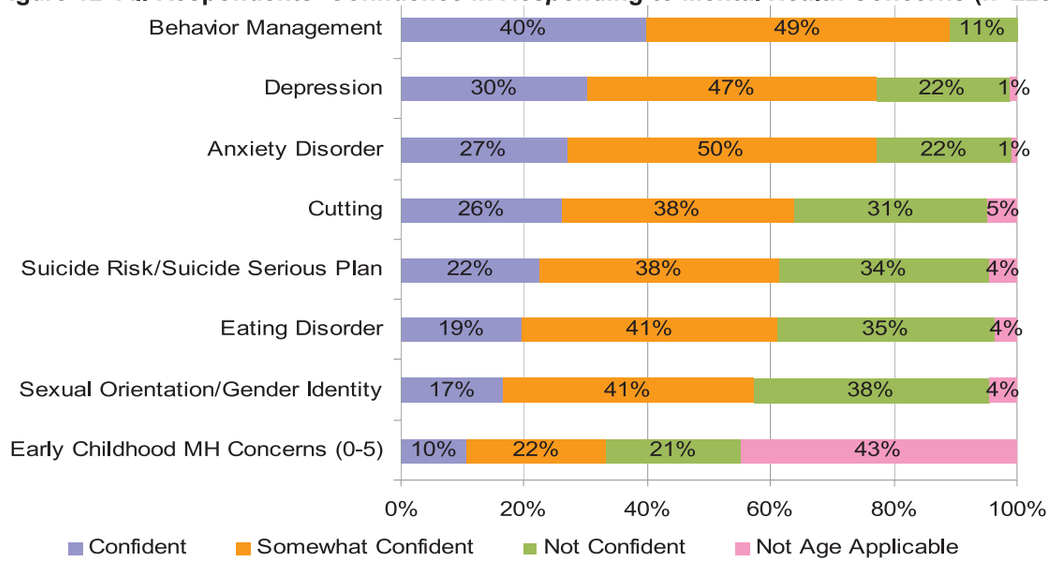
Table 12. Confidence in *Identifying* Mental Health Concerns, by Role at School

	Teacher (n=124)			School Counselor/ Non-therapist (n=11)			Psychologist/ Therapist (n=5)*			Others (n=48)		
Mental Health Concern	*Confident*	*Somewhat Confident*	*Not Confident*	*Confident*	*Somewhat Confident*	*Not Confident*	*Confident*	*Somewhat Confident*	*Not Confident*	*Confident*	*Somewhat Confident*	*Not Confident*
Depression	15%	65%	22%	82%	9%	9%	80%	20%	0%	31%	60%	8%
Anxiety Disorder	13%	61%	27%	45%	36%	18%	80%	20%	0%	25%	60%	15%
Eating Disorder	10%	29%	58%	9%	64%	27%	60%	20%	20%	17%	42%	40%
Cutting	14%	40%	43%	45%	55%	0%	60%	40%	0%	21%	56%	19%
Behavior Management	41%	58%	3%	64%	36%	0%	80%	0%	20%	52%	50%	0%
Sexual Orientation/ Gender Identity	13%	47%	37%	36%	36%	27%	60%	20%	20%	17%	60%	21%
Suicide Risk/Suicide Serious Plan	7%	35%	54%	64%	36%	0%	80%	20%	0%	15%	40%	40%
Early Childhood (0-5) MH Concerns	6%	14%	27%	18%	9%	18%	0%	40%	0%	6%	23%	25%

*Note: Caution should be used when interpreting or generalizing results for this category because of its small sample size.

When asked how confident they were *responding* when they become aware of students' mental health issues, personnel reported being most confident responding to issues they had marked earlier as most-commonly observed concerns, i.e., behavior management, depression and anxiety (Figure 12). Respondents expressed relatively more confidence in addressing suicide risk and eating disorders than sexual orientation/gender identity, in contrast to their comfort identifying these concerns. One out of 5 respondents who worked with the youngest children said they were not confident responding to concerns related to early childhood mental health.

Figure 12. All Respondents' Confidence in *Responding* to Mental Health Concerns (n=229)



Teachers were slightly more confident in *responding* to identified problems, overall, than they were in their ability to identify them. As would be expected, psychologists reported high confidence levels to addressing problems when they were identified.

Table 13. Confidence *Responding* to Mental Health Concerns, by Role at School

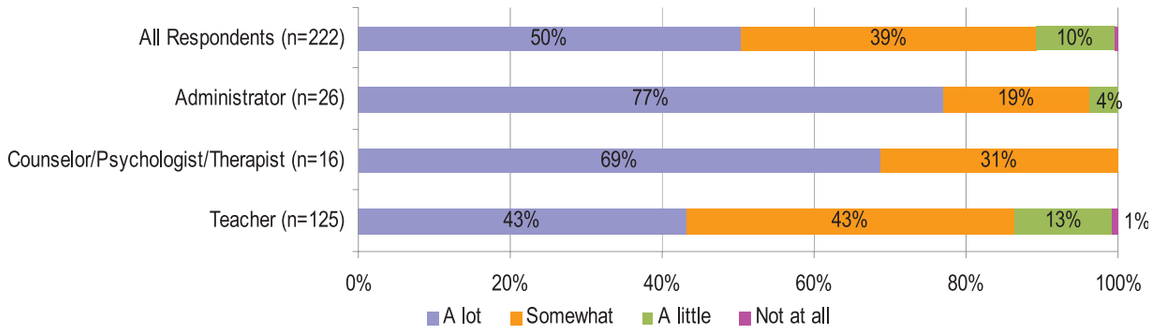
	Teacher (n=128)			School Counselor/ Non-therapist (n=11)			Psychologist/ Therapist (n=5)*			Others (n=51)		
Mental Health Concern	*Confident*	*Somewhat Confident*	*Not Confident*	*Confident*	*Somewhat Confident*	*Not Confident*	*Confident*	*Somewhat Confident*	*Not Confident*	*Confident*	*Somewhat Confident*	*Not Confident*
Depression	25%	48%	26%	64%	27%	9%	80%	0%	20%	33%	47%	14%
Anxiety Disorder	21%	53%	24%	45%	45%	9%	80%	0%	20%	33%	39%	20%
Eating Disorder	16%	42%	36%	36%	45%	18%	80%	0%	20%	24%	31%	37%
Cutting	19%	39%	37%	64%	27%	9%	80%	20%	0%	31%	33%	25%
Behavior Management	34%	53%	11%	64%	36%	0%	80%	20%	0%	47%	39%	10%
Sexual Orientation/ Gender Identity	13%	41%	41%	27%	55%	18%	80%	0%	20%	20%	35%	35%
Suicide Risk/Plan	19%	35%	41%	55%	45%	0%	80%	0%	20%	24%	37%	27%
Early Childhood (0-5) MH Concerns	6%	22%	23%	18%	9%	18%	20%	20%	0%	16%	18%	22%

*Note: Caution should be used when interpreting or generalizing results for this category because of its small sample size.

Perception of Role

The school personnel were asked to what extent they believed addressing students' mental health needs was part of their role at the school. Half indicated "a lot" of responsibility for dealing with student mental health needs (Figure 13). This was somewhat more the case for administrators (77%) than for those who identified as counselors/ psychologists/ therapists (69%). Teachers were slightly less likely to see having a large role to play in addressing these concerns than other personnel. (Only one respondent, a teacher, believed they had "no role" to play in dealing with student mental health concerns.)

Figure 13. Role at School in Addressing Student Mental Health Needs



School Policies and Procedures

Fewer than half (46%) of the respondents indicated that the school's policies and procedures help them adequately respond to student mental health concerns. Teachers were the most likely to indicate that the policies are *not* adequate (33%), or that they were not aware (31%) of their school's policies and procedures regarding responding to students' mental/emotional health needs (Table 14).

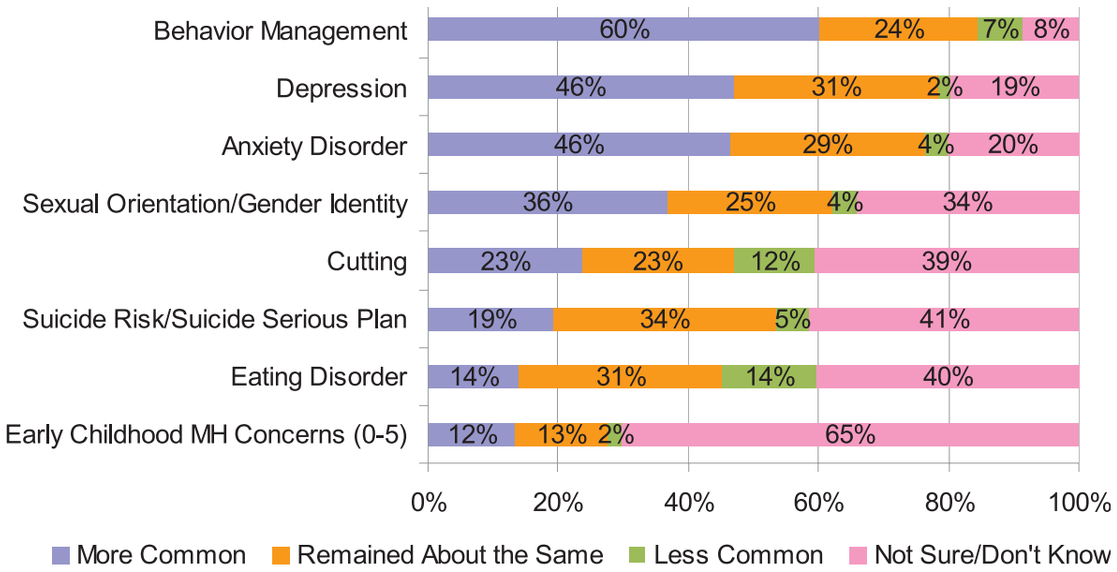
Table 14. Helpfulness Regarding the School's Policies and Procedures to Adequately Respond

	All Respondents (n=223)	Teacher (n=126)	Counselor, non-therapist (n=11)	Psych/ Therapist (n=5)	All Other Staff (n=49)
Yes	46%	37%	73%	100%	65%
No	30%	33%	27%	0%	24%
I'm not totally aware of my school's policies and procedures	24%	31%	0%	0%	10%

Change in Occurrence of Mental Health Issues

Overall, between one-quarter and one-third of respondents reported no discernible changes "in the last few years" in the occurrence of the mental health issues of concern for students age 6 and older (Figure 14). However, close to half of the respondents perceived the mental health issues noted as being most-often observed to be more common now. About 40% were unsure about any change in frequency in cutting, suicide risk, and eating disorders, and 65% were unsure about changes in early childhood mental health concerns. About the same proportion (one-third) who thought concerns related to sexual orientation/gender identity were more common now said they were unsure.

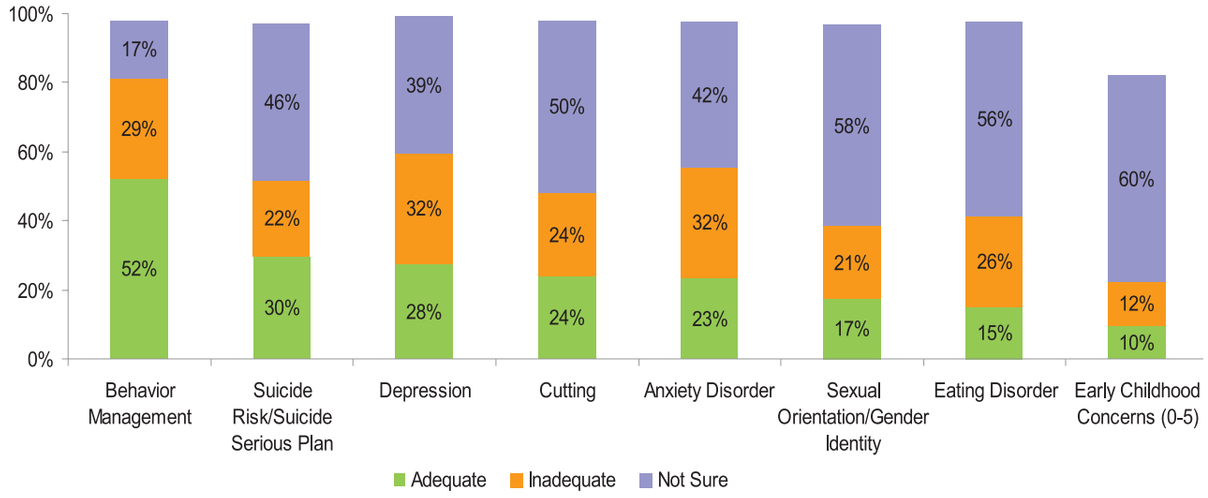
Figure 14. Perceived Changes in Student Mental Health Concerns



School-Based Mental Health Resources

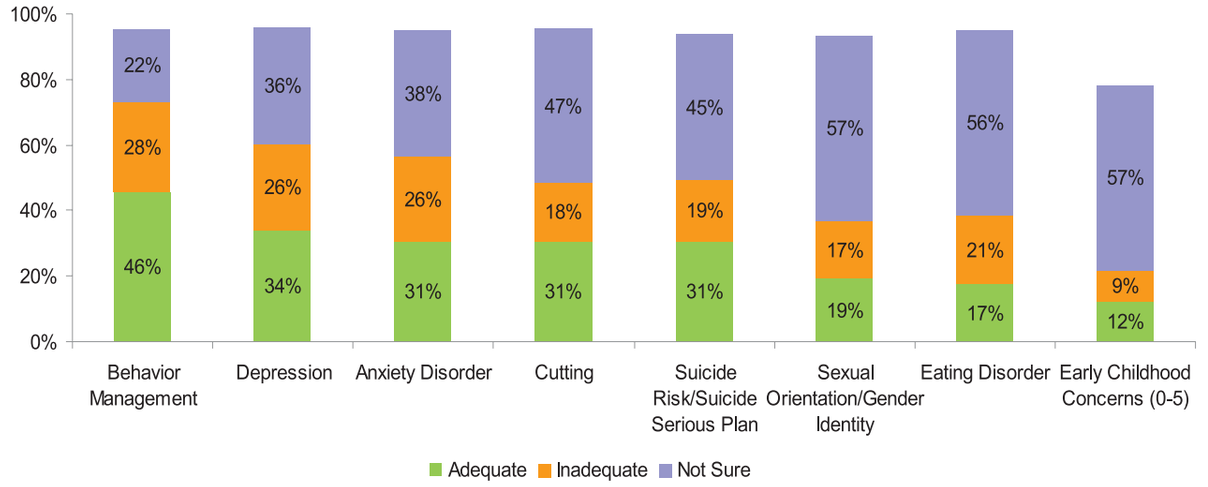
Except for the school-based prevention resources related to behavior management problems, which most personnel rated as adequate, respondents were largely unsure about the adequacy of the school's resources for prevention of student mental health issues (Figure 15 below). Between about one-quarter and one-third of the respondents rated the resources related to prevention services for all of the issues except early childhood mental health concerns as inadequate.

Figure 15. Perceived Adequacy of School-Based Mental Health *Prevention* Resources (n=213)



On the whole, respondents viewed their school as having more adequate mental health resources for dealing with mental health problems than for preventing them. School-based services for these issues were rated slightly more adequate for treatment than for prevention (the area of behavior management was the exception). However, a notable proportion of respondents indicated treatment related to depression and behavior management was inadequate (Figure 16).

Figure 16. Perceived Adequacy of School-Based Mental Health *Treatment* Resources (n=213)



Tables 15 and 16 below display respondents' views about the adequacy of *school*-based prevention and treatment services by respondent type (Figures 17 and 18 which follow show their views about *community*-based prevention and treatment services). This detail is intended to illustrate how perspectives about school-based mental health resources vary by staff role, which may have implications for future staff awareness and training. Overall the respondents agreed that the treatment resources are more adequate than the prevention resources and that overall teachers were the least likely to rate the resources (for prevention or treatment) as adequate.

Table 15. Perceived Adequacy of *School-Based Prevention* Resources, by Role at School

	Teacher (n=125)			School Counselor/ Non-therapist (n=11)			Psychologist/ Therapist (n=5)*			Others (n=48)		
Mental Health Concern	*Adequate*	*Not Adequate*	*Not Sure*	*Adequate*	*Not Adequate*	*Not Sure*	*Adequate*	*Not Adequate*	*Not Sure*	*Adequate*	*Not Adequate*	*Not Sure*
Depression	22%	31%	46%	36%	27%	36%	60%	40%	0%	38%	35%	27%
Anxiety Disorder	18%	30%	50%	36%	27%	36%	60%	40%	0%	33%	40%	27%
Eating Disorder	12%	22%	65%	18%	27%	55%	20%	60%	20%	21%	38%	42%
Cutting	20%	20%	60%	45%	27%	27%	40%	60%	0%	35%	35%	29%
Behavior Management	50%	31%	18%	73%	9%	18%	80%	20%	0%	60%	31%	10%
Sexual Orientation/ Gender Identity	15%	18%	65%	18%	9%	73%	20%	60%	20%	27%	31%	42%
Suicide Risk/Suicide Serious Plan	25%	21%	53%	55%	18%	27%	80%	20%	0%	38%	29%	33%
Early Childhood (0-5) MH Concerns	5%	13%	64%	9%	0%	73%	0%	20%	80%	21%	13%	54%

*Note: Caution should be used when interpreting or generalizing results for this category because of its small sample size.

Table 16. Perceived Adequacy of *School-Based Treatment* Resources, by Role at School

	Teacher (n=125)			School Counselor/ Non-therapist (n=11)			Psychologist/ Therapist (n=5)*			Others (n=48)		
Mental Health Concern	*Adequate*	*Not Adequate*	*Not Sure*	*Adequate*	*Not Adequate*	*Not Sure*	*Adequate*	*Not Adequate*	*Not Sure*	*Adequate*	*Not Adequate*	*Not Sure*
Depression	25%	31%	44%	55%	18%	27%	60%	40%	0%	57%	17%	26%
Anxiety Disorder	22%	28%	49%	45%	27%	27%	40%	60%	0%	54%	22%	26%
Eating Disorder	13%	20%	66%	18%	18%	64%	20%	60%	20%	28%	28%	46%
Cutting	25%	15%	60%	45%	18%	36%	60%	40%	0%	48%	26%	28%
Behavior Management	39%	33%	28%	55%	18%	27%	80%	20%	0%	67%	24%	13%
Sexual Orientation/ Gender Identity	15%	16%	67%	27%	9%	55%	20%	60%	20%	30%	22%	50%
Suicide Risk/Suicide Serious Plan	24%	20%	53%	64%	9%	27%	80%	20%	0%	41%	22%	39%
Early Childhood (0-5) MH Concerns	8%	11%	60%	9%	9%	64%	20%	0%	80%	22%	7%	63%

*Note: Caution should be used when interpreting or generalizing results for this category because of its small sample size.

The primary reasons respondents gave for ratings of inadequacy of school-based prevention and treatment resources were lack of services, lack of training for school staff and lack of information about what is available.

- *"I don't think the school's emphasis is on mental health, and I don't think individuals [school staff] are trained to identify signs and symptoms. I'm unsure of whom to go to if I have concerns which means I'm sure the students have the same problem."* (Tulare County School Counselor)

- *"As far as I know there are no prevention or treatment resources for any of the issues provided by the district except some for behavior management that started last year."* (Kings County Elementary School teacher)

- *"Counseling is only permitted for extreme cases which were identified the year before. When situations arise in the current year there is no immediate help available. One counselor for 600 is not servicing their needs. Only loud behavior problems seem to get the help. Young kids have problems too."* (Kings County Adult/Trade School Teacher)

- *"I do not believe a school is equipped to deal with many of the mental health issues students have."* (Tulare County High School teacher)

- *"I don't know of any programs in place to prevent or deal with these issues."* (Kings County Elementary Teacher)

- *"I'm unaware of any prevention policies we have for depression or anxiety, as well as gender issues, so therefore it's inadequate. The treatment we have that I know about is our GSA club, but that is only a support group. Not sure how adequate that is."* (Tulare County High School Teacher)

Student : Counselor Ratios

Three of the 5 psychologist/therapist survey respondents indicated the student: counselor ratios for the schools where they worked. They were:

- Elementary School: 400:1 (n=1)
- Junior High/Middle School: 500:1 (n=1)
- High School: 300:1 (n=1)

Community-Based Mental Health Resources

When asked about the adequacy of the *community-based* resources to prevent and treat student mental health concerns, the respondents were less likely to rate the resources as adequate for the most common concerns, including behavior management, depression, suicide risk, anxiety and cutting. The ratings were approximately even with the perceptions about school-based resources of adequacy for sexual orientation, eating disorders and early childhood mental health concerns (Figures 17 and 18).

Figure 17. Perceived Adequacy of Community-Based Mental Health *Prevention* Resources (n=188)

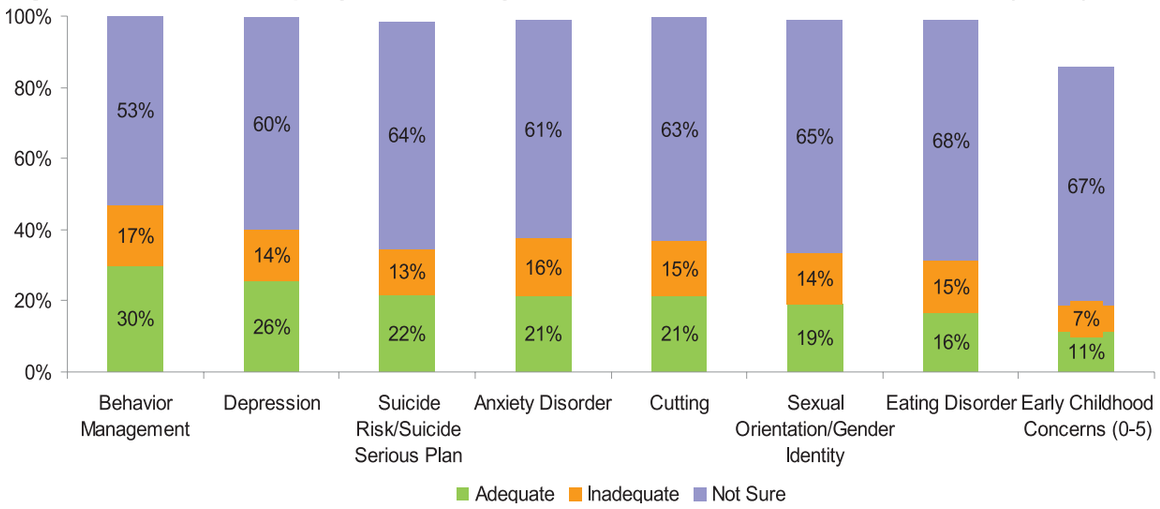
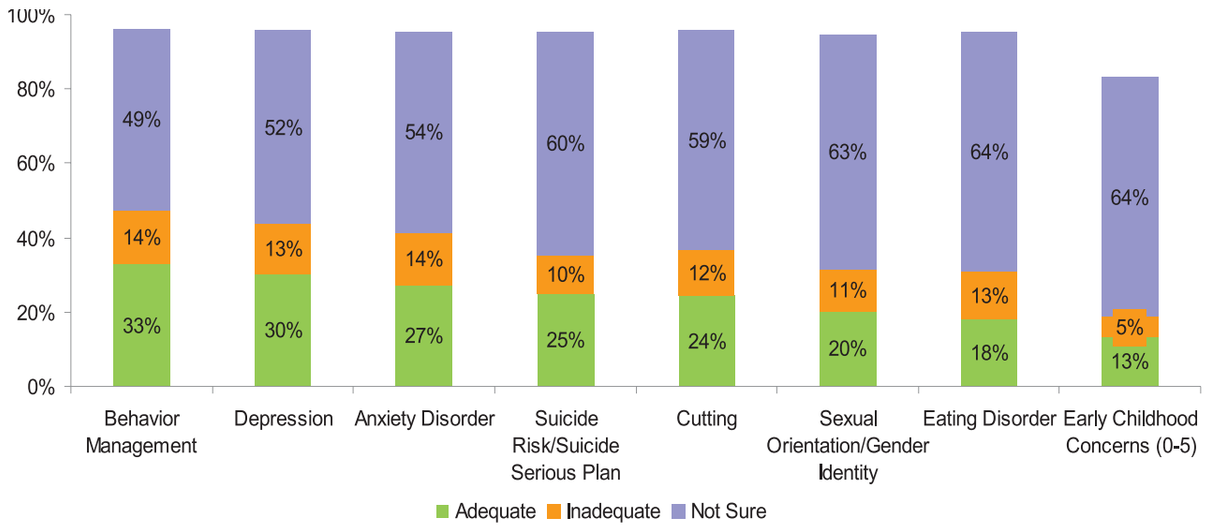


Figure 18. Perceived Adequacy of Community-Based Mental Health *Treatment* Resources (n=188)



Similar to the detailed tables above about the adequacy of school-based mental health services, views about the adequacy of *community*-based prevention and treatment resources illustrate the variances by staff role and between the types of mental health concerns. Respondents were less sure about community resources for prevention than treatment services, but overall they perceive treatment resources in the community to be slightly more available than prevention services.

Table 17. Perceived Adequacy of *Community-Based Prevention* Resources, by Role at School

	Teacher (n=112)			School Counselor/ Non-therapist (n=11)			Psychologist/ Therapist (n=5)*			Others (n=48)		
Mental Health Concern	*Adequate*	*Not Adequate*	*Not Sure*	*Adequate*	*Not Adequate*	*Not Sure*	*Adequate*	*Not Adequate*	*Not Sure*	*Adequate*	*Not Adequate*	*Not Sure*
Depression	17%	12%	71%	45%	9%	45%	60%	40%	0%	40%	21%	40%
Anxiety Disorder	12%	14%	73%	36%	18%	45%	60%	40%	0%	38%	21%	42%
Eating Disorder	11%	11%	78%	18%	9%	73%	60%	40%	0%	25%	25%	50%
Cutting	12%	12%	77%	45%	9%	45%	60%	40%	0%	35%	25%	40%
Behavior Management	23%	14%	63%	45%	18%	36%	60%	40%	0%	42%	23%	38%
Sexual Orientation/ Gender Identity	14%	9%	76%	27%	9%	64%	40%	60%	0%	27%	25%	48%
Suicide Risk/Suicide Serious Plan	13%	9%	76%	55%	9%	36%	60%	40%	0%	31%	21%	48%
Early Childhood (0-5) MH Concerns	7%	4%	74%	18%	0%	64%	20%	20%	60%	17%	15%	52%

*Note: Caution should be used when interpreting or generalizing results for this category because of its small sample size.

Table 18. Perceived Adequacy of *Community-Based Treatment* Resources, by Role at School

	Teacher (n=106)			School Counselor/ Non-therapist (n=11)			Psychologist/ Therapist (n=5)*			Others (n=47)		
Mental Health Concern	*Adequate*	*Not Adequate*	*Not Sure*	*Adequate*	*Not Adequate*	*Not Sure*	*Adequate*	*Not Adequate*	*Not Sure*	*Adequate*	*Not Adequate*	*Not Sure*
Depression	19%	15%	66%	73%	0%	27%	60%	40%	0%	51%	11%	38%
Anxiety Disorder	15%	15%	69%	64%	0%	36%	60%	40%	0%	49%	13%	38%
Eating Disorder	12%	10%	76%	45%	0%	55%	60%	40%	0%	23%	19%	57%
Cutting	13%	11%	75%	64%	9%	27%	60%	40%	0%	43%	13%	45%
Behavior Management	25%	16%	59%	73%	0%	27%	60%	40%	0%	49%	13%	40%
Sexual Orientation/ Gender Identity	15%	9%	75%	27%	0%	64%	40%	60%	0%	32%	13%	55%
Suicide Risk/Suicide Serious Plan	15%	9%	75%	73%	0%	27%	60%	40%	0%	38%	11%	51%
Early Childhood (0-5) MH Concerns	8%	5%	74%	36%	0%	55%	20%	20%	60%	21%	6%	57%

*Note: Caution should be used when interpreting or generalizing results for this category because of its small sample size.

The reasons respondents wrote in for inadequate resources in the community were similar to the reasons for how they viewed school-based resources as inadequate, and also included the additional barriers that families face in seeking services off of the school campus.

- *"For families dealing with poverty, getting mental health services is a difficult process with multiple hoops to jump through and few appointments."* (Kings County High School Administrator)

- *"I am well-versed on school and community resources and again, there are just not enough. Also, you get what you pay for. If you can't pay, you get sub-standard care."* (Tulare County High School Teacher)

- *For most families, the culture frowns upon mental health needs even being mentioned. More education is needed for parents to understand that mental is an illness."* (Kings County District-wide staff)

- *"It is too difficult for students who do not have insurance to get into the mental health program. The parents often do not follow through because they have to do so many steps in order to get the help their student needs."* (Kings County Middle School Teacher)

- *"The agencies are overwhelmed with the number of people who need help."* (Kings County High School Administrator)

- *"Unless the parent is willing (doesn't want to be identified as an abuser, etc.), and able (has transportation) to make a trip [out of town] to get diagnosed, and is on Medi-Cal, my understanding is there are no community-based resources.* (Kings County Elementary Teacher)

- *"What the community-based mental health agencies do is not shared. They are visible on campus but their effectiveness is not evident or unable to be determined. I am not involved with most of their students. In some of our most difficult cases, they have not been effective."* (Tulare County Elementary Teacher)

Coordination of Care with Other Professionals

Significant evidence points to the key role of other caring and skilled professionals in promoting the mental health and well-being of the children and youth in their care. Of these 5 survey respondents who indicated they were school psychologists or licensed counselors, four responded to the questions about coordinating mental health care with physicians and clergy. Three of the respondents noted they "usually" (n=1) or "sometimes" (n=2) coordinate care with a student's primary care physician, and all 4 indicated they "rarely" (n=2) or "not at all" (n=2) work with churches/religious organizations with which a family is affiliated.

Barriers to Services

Survey respondents were asked to think about the students they worked with and then rank a list of the most important or biggest barriers for students to access to mental health services. Family resistance or low engagement regarding getting help and the student's home environment were the barriers most likely to be ranked first or second as the highlighted areas in Table 19 shows. Other common reasons were the families' inability to pay for communitybased services and the shortage of mental health staff in the schools.

Table 19. Barriers to Student's Access to Mental Health Services in Rank Order (n=181)

Barrier	Ranking*								
	1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*
Family resistance or low engagement to help	53	52	17	15	14	13	3	5	4
The student's home environment	51	50	26	18	15	4	7	5	4
Family inability to pay for services when referred to outside resource	21	21	48	26	17	18	18	7	5
Shortage of school psychologists/counselors for time on non-academic purposes	19	16	18	30	30	22	23	11	5
Lack of awareness of mental health issues among school staff	10	17	23	29	30	24	15	23	4
Shortage of community-based mental health providers	9	10	16	18	30	32	27	29	6
Transportation	6	10	23	22	15	38	43	20	3
The times that services are offered	6	6	7	14	22	17	33	64	11
Other	2	0	1	2	1	2	1	0	18

*Ranking = "1" is most important; "9" is least important.
Shaded areas reflect the highest rankings for each barrier.

Other factors that respondents identified as barriers included:

- *Student's resistance to help.*
- *Stigma surrounding mental health issues.*
- *Services that are offered are not a publicly known commodity to teachers or students or community.*
- *Lack of knowledge that there is something mentally wrong/bothering their student.*
- *Early intervention and identification.*

Parent Engagement

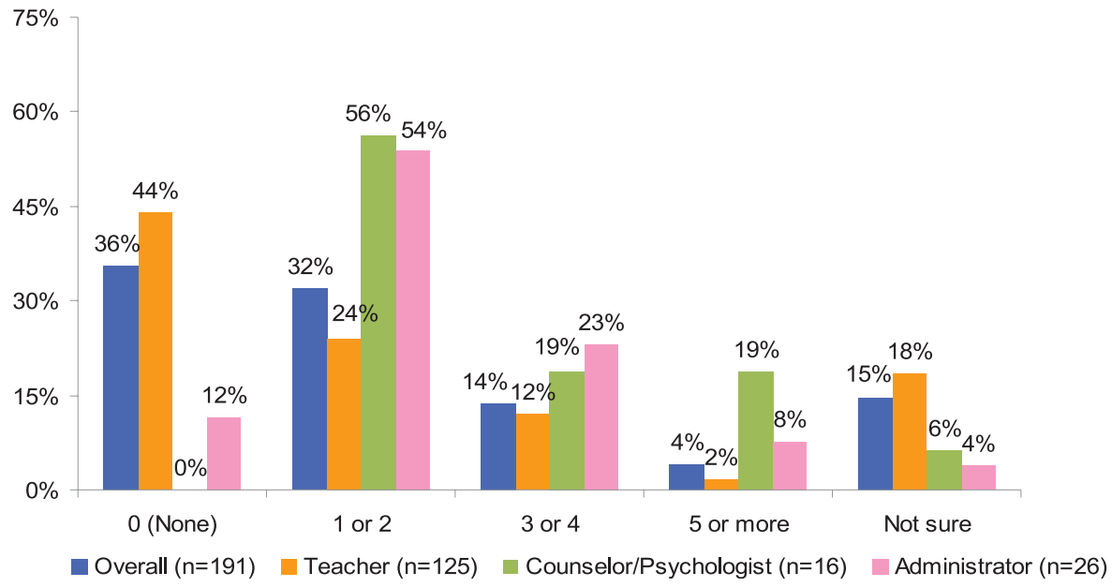
Because parental engagement is so important to a student's success we also asked if there were certain mental health issues in which parents were particularly supportive/engaged or in which they were not particularly supportive. About one-quarter (27%) of the respondents indicated there was more parental engagement in specific mental health issues. This observation varied somewhat by respondent type with administrators and counselors/psychologists/therapists more likely to note a difference in level of parent response (48% and 63%, respectively) and teachers less likely to report a difference (17%) depending on the issue.

- The most commonly noted issue that got parents' attention among all respondents (21%) was bullying. This observation seemed to particularly resonate with teachers.
- Counselors indicated that behavior issues and depression were the most likely to engage parents.
- Administrators reported that suicide was the issue that parents were most likely to respond to.
- One-third of the respondents reported observing lower parental engagement for certain issues, specifically behavior issues (17%)—particularly noted by teachers and psychologists—and depression (15%).
- Teachers were most likely to indicate sexual orientation/gender identity as an area where parents were less likely to engage (21%); the rest of the respondents did not indicate this issue.
- Counselors were the only group to indicate that suicide was an area in which parents did not engage (20%).

Suicide

The survey provided another valuable opportunity to query Tulare-Kings Counties' school personnel about the issue of suicide. About one-third (36%) of the respondents overall indicated they did not know of any students in the past 2 years who demonstrated serious signs of suicide intent or actual attempts (Figure 19). Teachers were the most likely to be in this group (44%). Another third (32%) noted they knew of 1 or 2 students who had demonstrated signs of suicide intent or made attempts in the past 2 years. Counselor/psychologists and school administrators were the most likely to be familiar with students who had demonstrated suicide risks (56% and 54%, respectively).

Figure 19. Number of Students Known About with Serious Signs of Suicide Intent or Actual Attempt in the Last Two Years (n=191)



Use of California Healthy Kids Survey Data

The California Healthy Kids Survey (CHKS) is a large statewide survey of resiliency, protective factors, and risk behaviors, taken by students at selected grade levels. It allows schools and districts to monitor whether they are providing the critical developmental supports and opportunities that promote healthy growth and learning. Respondents who indicated they worked at middle and high schools were asked about their awareness of and use of the CHKS data.

Of the 157 respondents who completed this section of the survey, 38% indicated they had at least some familiarity of the data (Table 20). Awareness was most common for administrators (79%) and counselors/ psychologists/therapists (44%). Teachers were the most likely to indicate they were not aware of the CHKS results (69% had no familiarity).

Table 20. Level of Awareness of California Healthy Kids Survey Data

	Overall (n=157)	Teacher (n=99)	Counselor/ Psychologist/ Therapist (n=16)	Administrator (n=19)
Aware/familiar	10%	2%	31%	37%
Somewhat aware/familiar	28%	29%	13%	42%
Not aware/familiar	62%	69%	56%	21%

Those who had some awareness or the survey or familiarity with the data were asked how they *used* the information. The responses were fairly evenly distributed among those who generally did not review the data (33%) and those who reviewed the data for their own interests (31%). One in 5 respondents (21%) reviewed and shared the findings with others, and another 12% reported reviewing, sharing, and *applying* the findings to make changes in their school (the administrators were the most likely to be in this last group). Teachers were the least likely to state they reviewed CHKS data (45%).

Table 21. Use of California Healthy Kids Survey Data

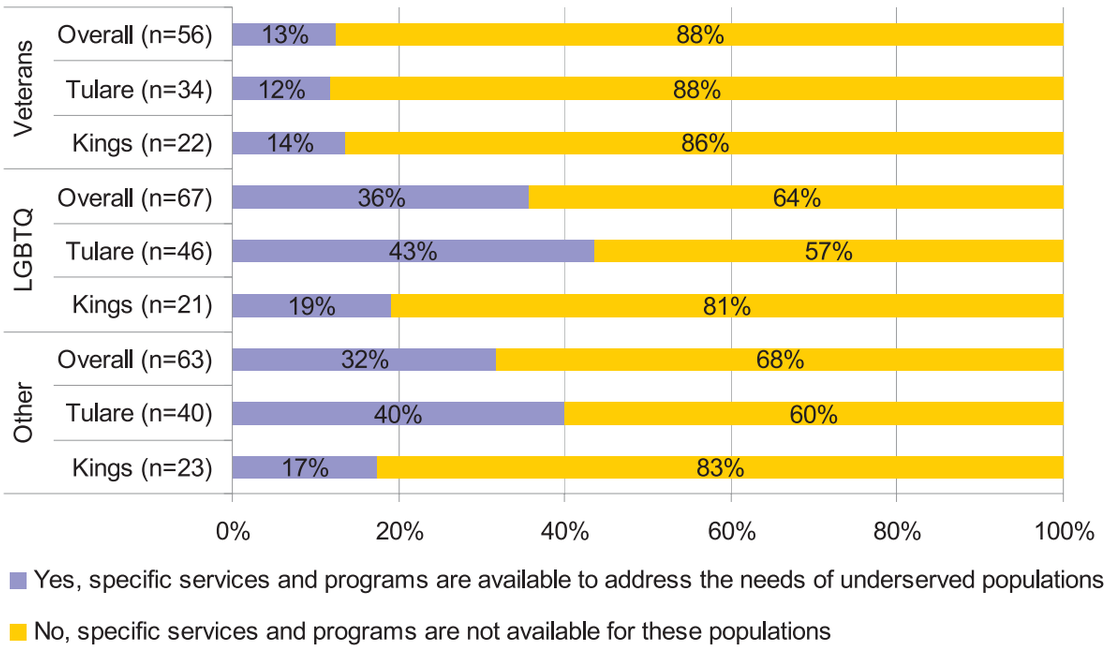
	Overall (n=58)	Teacher (n=31)	Counselor/ Psychologist/ Therapist (n=7)	Administrator (n=15)
I am aware of the California Healthy Kids Survey but don't generally review the data	33%	45%	14%	7%
I review the data for my own curiosity	31%	35%	29%	20%
I review the data and usually share or talk about some of the findings with others	21%	10%	43%	40%
I review the data, often share findings with others and apply findings to make changes	12%	6%	14%	27%
Other	3%	3%	0%	7%

Special Student Populations

School personnel were also asked if they had any particular services and programs available to address the needs and concerns of underserved students to make them feel welcome and safe on campus. Services for veterans appear to be evenly distributed between Tulare and Kings Counties (Figure 20). Respondents from Tulare County were twice as likely as Kings County respondents to indicate that their campus had services for LGBTQ and Other populations. The following campus services and programs were noted:

- Services for Veterans were described as ROTC programs, Veterans' Day Activities, Veteran Appreciation Days, and programs that focus on inclusive cultures.
- Services for LGBTQ were noted to be Awareness Week, Student Clubs (including the Gay-Straight Alliance) and restroom and locker room accommodations for self-identified transgendered individuals.
- Services for Other Populations noted Student Clubs (Be the Change, MECHa, Student Voice), Challenge Days, Suicide Prevention Screening, on-site counselors and Support Groups.

Figure 20. Percentage of Mental Health Services Geared Toward Students in Underserved Populations, by County of Respondent



Improvements by Type of Suggestion

A total of 104 respondents suggested "one thing that should change" in the current system of school-based mental health services in their school/district. The majority (56%) of the comments, such as those below, related to increasing the number of mental health staff and availability of services on the school site:

- *"Expand the [mental health] services and have staff on campus every day as opposed to occasionally."* (Tulare County High School Administrator)

- *"We need more [mental health] people so there can be more one-on-one counseling here at our school."* (Kings County Middle School Administrator)

- *"Add more mental health specific counselors or psychologists to deal with these type of issues."* (Tulare County High School Counselor)

These comments were followed by requests for staff training so school staff know how to identify and respond to mental health needs (13%), and more information about what services are available and how to access them (12%).

- *"Make [services] better known as well as ways to assist in the process of mental health with our students."* (Tulare County High School Teacher)

- "*More education for teachers about what services are available and what teachers can do to help."* (Tulare County High School Teacher)

- *"Make sure resources and information are available in poster or pamphlet format in all access areas of the campus."* (Kings County High School Teacher)

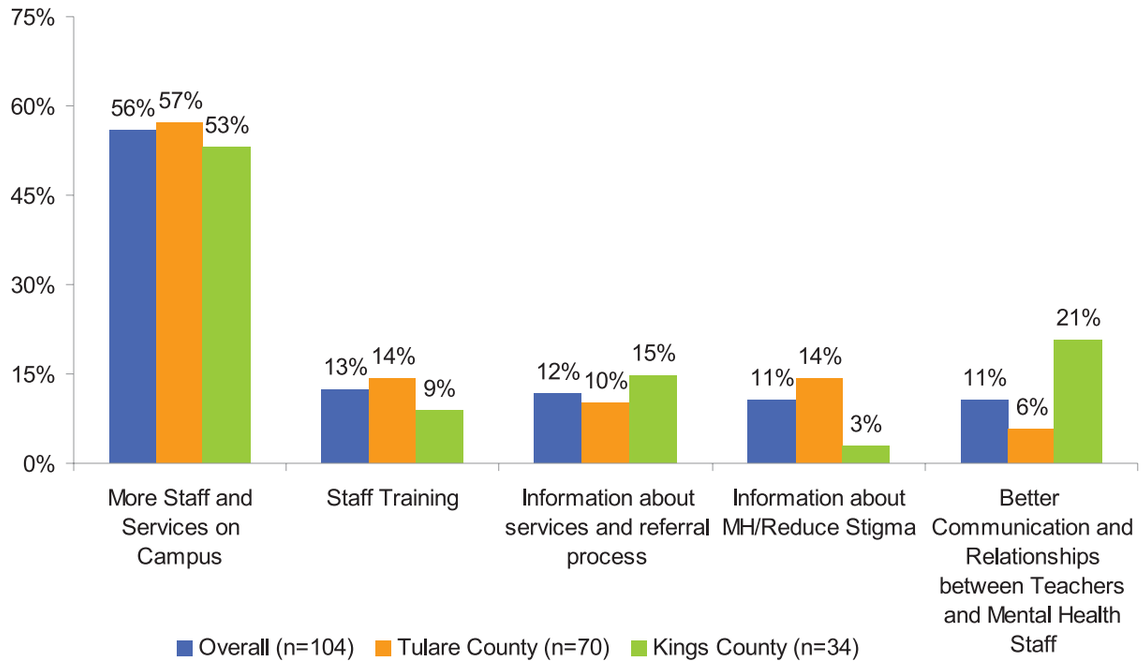
When the responses were viewed by county of respondent (Figure 21), information about mental health and reducing stigma were more commonly noted by Tulare than Kings County respondents (14% compared to 3%).

- *"There is a huge misconception of mental illness and what it can cause our students to do and the decisions they make."* (Tulare County, High School Administrator)

- *"Change the stigma that goes along with counseling."* (Tulare County, High School Counselor)

- *"Students feel embarrassed to talk about their mental health issues."* (College administrator)

Figure 21. Suggested Changes to Improve School-Based Mental Health Services, by County



Relationships between teachers and mental health staff and better communication was more likely to be reported by Kings County than Tulare County respondents (21% and 6%, respectively).

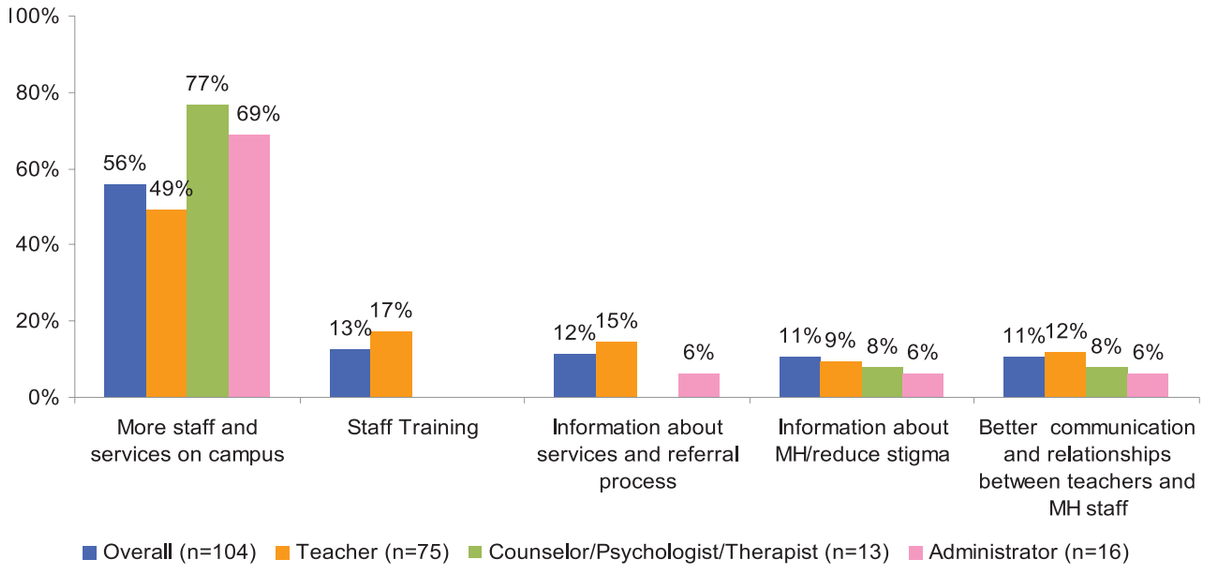
- *"Better communication with staff about students' progress and support systems for the staff to implement."* (Kings County Elementary School teacher)

- *"Counselors should listen to the teachers when they have concerns to tell them instead of spending all their time worrying about meeting state standards and test results."* (Kings County High School Teacher)

- *"Mental health personnel need to make themselves more available to staff to ask questions and offer support."* (Kings County High School Teacher)

The suggested changes were also analyzed by staff role at the schools. Those who selfidentified as counselors/psychologists/therapists or administrators were more likely to indicate they wanted more staff and services on campus than teachers (77%, 69% and 49%, respectively). Teachers were the primary group requesting more staff training (17%) and more information about the available services and the referral process (15%). See Figure 22.

Figure 22. Suggested Changes to Improve School-Based Mental Health Services, by Role



INTERVIEWS WITH DISTRICT PSYCHOLOGISTS

Seven school district psychologists (3 serving the high school level, 2 at the junior high level, 1 at Pre-K-12, and 1 at elementary) of the 9 who were contacted participated in a telephone interview. The interviews were conducted after the online school personnel survey results were analyzed to focus on key questions with the psychologists and gain greater understanding about specific student mental health needs and suggestions.

Role and Availability

The school psychologists have some discretion over how they schedule their work, such as spending one whole day a week at each school in their district, but every one of them felt "stretched to the max" and unable to take enough time with students who have mental health concerns. As one remarked, "if only we could clone ourselves." The student-to-psychologist district ratios were reported by the interviewees to be closer to 1:4000 as compared to the more favorable responses from the school psychologists who answered this question in the survey.

While interviewees said they offered *some* private meetings with parents these were limited to academically-oriented issues, that is, when behavioral or special education needs interfered with a student's ability to "access their education," and a written action plan was required. Other than crisis management in an acute situation, when social-emotional counseling is offered, it is for the purpose of assessment/triage and referral to a community mental health provider. The psychologists expressed frustration by the lack of opportunity to give individual attention to more students ("because they come with a lot of stuff") and hold groups as in the past, but recognized "there is no money for this anymore." A couple of the interviewees also made the point they are not trained as *clinical* psychologists, i.e., therapists, but as educational psychologists with a master's degree, usually in psychology or education, and a Pupil Personnel Services Credential. They stated the bulk of their job was "doing assessments for special education" and acknowledged there was a lot of confusion and misperception by parents and even some school personnel about this role when it came to their availability for student mental health counseling.

Common Mental Health Issues

Depression, although harder to pinpoint at a young age, was by far the mental health issue school psychologists observed among students, regardless of student age group. All agreed the reasons generally point back to the student's home environment: family life situation and illequipped parents. Besides social isolation, the most commonly observed response to depression is when a child internalizes, with the easiest symptom to identify being self-injury (e.g., not eating, cutting, suicide ideation). Other students and teachers when they are aware of it are "very good about" reporting these behaviors to someone who can help, according to the psychologists.

Additionally, as others have noted, the psychologists remarked that older students seem increasingly anxious—worried about their future and grades and getting into college and being able to earn a decent living. Some have seen the economic impact of unemployment on their families and many are "extra anxious" or "overwhelmed" because of it. Other comments of interest included:

- *"Kids know too much about their parents' lives. They see the turmoil and crashes and can't help but let it affect them."*
- *"More students are responsible now for their younger siblings. It puts a heavy burden on them they shouldn't have to shoulder at their age."*
- *"We're dealing with more "coming out" situations but I think kids are just more comfortable about this than before, not necessarily that more students are having sexual/gender identity issues."*
- *"I've personally had to deal with the issue of suicide at school and think personnel have realistic perceptions about the risk of it."*

Experience with Parents

The psychologists were somewhat mixed in their opinions about parent engagement and follow through when contacted by the school about a mental/behavioral issue involving their child. While some found parents to be receptive "when things were handled in private," and wanting help because they knew *something* was going on but didn't know what to do about it, the others described less supportive parental responses.

Most of the psychologists found the majority of parents (60%-70%) unable or unwilling to follow through when the school made a referral for a student mental health concern, even when it appeared they were initially supportive. The reasons for the lack of follow through were partly due to the common barriers of transportation/ child care/time off from work, but often due to lack of support (denial, shame, embarrassment, fear of disclosure about the family, dissimilar cultural beliefs, financial concerns about treatment). We've commented elsewhere in this report about family "secrecy" but it is worth mentioning here the psychologists' concerns about the impact on children of being the one "exposing family problems" and "getting parents into trouble" (which could result in some parents being removed from the home) and the fearfulness this causes in many children.

- *"Parents see us [the school] as part of the problem. They ask 'why aren't you doing what you're supposed to be doing for my child?' "*
- *"Kids aren't shown boundaries or appropriate discipline. How it's handled by parents makes such a difference."*
- *"Some parents are confused about their role; they want to be the child's buddy."*
- *"Getting parents to make that initial assessment visit [to a community provider] is the hardest part.*

- *"The mental health needs of students are on the back burner because counselors and administrators have their own ideas about what school is about—test scores."*

Experience and Relationships with Outside Providers

The psychologists generally believe "for the amount of resources they have, the communitybased mental health providers do a pretty good job" (a male therapist from Kings County was specifically named by 3 of the interviewees as being "very responsive"), and the psychologists have built good relationships with these outside providers. But some of the agencies are viewed as "not user friendly" and "very difficult to access" when they require the student to go to the agency because of wait times for appointments, how appointments are set up (multiple visits required before therapy actually starts), financial barriers, and lack of parent follow through. Nevertheless, according to one of the interviewees, these resources are seen as "safer" by the students because the therapists are non-school personnel. The number of sessions provided on-campus by the agencies is seen as not always being sufficient, and one psychologist worried whether the on-campus services would be sustainable if future funding was reduced.

Two of the interviewees from Kings County commented on the "intimidation" some families feel when they take their children to Kings View Behavioral Health. They say the families are uncomfortable because the "sketchy people in the waiting room make them nervous" and they don't want to go. (Some parents have suggested there be another room for children and teens in which to wait but there's been no change.) Another concern expressed was in regard to the approach taken by one of the counties' offices of education (COE) in how they look at a problem: rather than applying social learning theory, the COEs look through their own paradigm using applied behavioral analysis "in every situation" when multiple models are needed for K-12 students.

Those who commented on their relationship with a family's primary care medical provider (if there is one) said they generally don't work with the physicians, except perhaps to send or receive records, because they don't view them as involved and/or don't agree with their diagnoses.

Improvement Suggestions

The chart on the next page (Table 22) summarizes the considerations the seven school psychologists made to improve students' mental health in order of mention.

Table 22. School Psychologists' Suggestions for Improving Student Mental Health (n=7)

- Find a way to expand the number of district psychologists to 2 per campus.
- Bring more mental health services onto campus to increase access.
- Allow more time for school psychologists to have individual attention with students with emotional/mental health needs.
- Provide more training/in-service for teachers (especially older graduates who may not have had as much mental health training as more recent graduates) focused on what *teachers* say they need.
- Support cross-training of staff (which requires principal support for release time).
- Offer the same level of student mental health services support over the summer as during the school year.
- Focus more on prevention (e.g., hold groups, sponsor GSA Clubs).
- Minimize the parent component that is required by some providers to not block students' access to services.
- When students are referred to a community provider, do the intake on the *school campus*; parents are used to coming to the school and more likely to come.
- Try to recruit/hire someone with expertise in gender identity/sexual orientation issues.
- Offer more parenting classes specific to mental health; offer enough incentives to encourage attendance, particularly among the hard-to-reach parents.

STUDENT PERSPECTIVES

"I was 13 years old when I realized something was wrong. The adults [at school/home] told me I was wrong and just needed to shape up. I started to believe them. I mean, everyone was telling me to just stop it."
– High school student interviewee

"My mom was always closed off so I had to try to figure out things on my own."
– College student interviewee

"The teachers we trust are the ones who listen. Most are like 'I'm the teacher, sit down and do this.' Those are the ones we don't talk to."
– Middle school student interviewee

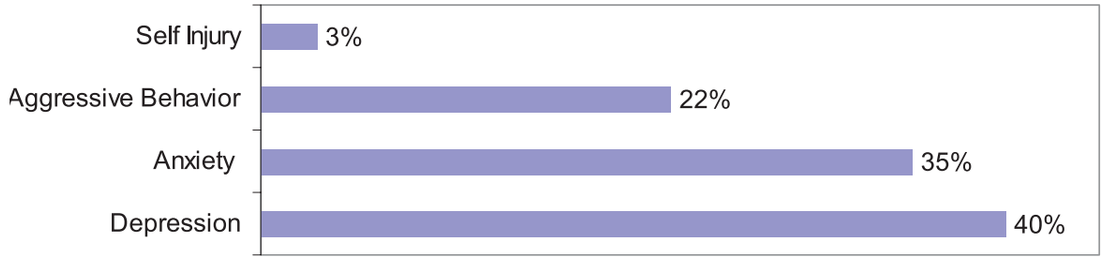
JUNIOR AND SENIOR HIGH SCHOOL STUDENTS

A total of 85 students (62 junior and senior high school and 23 college students) participated in an individual or group interview held on their school campus.

Common Mental Health Problems

When we established with the students that "all kids have issues—that's normal—but some have more than others," and asked about concerns, depression and anxiety were the 2 most immediate responses as the mental health problems students reported observing among their peers or experiencing themselves (Figure 23).[40] This was similar in general to what administrators and other school personnel as well as mental health providers identified among students. These conditions were mainly explained as worry about family issues, concerns about grades, confidence issues (beyond normal teen angst), trying to fit in (and "trying to fit into something you're *not*"), and trying to fulfill parents' expectations.

Figure 23. Relative Magnitude of Commonly Perceived Student MH Issues by Grades 7-12



[40] In about half of the group interviews responses were framed in the context of "a friend," a neighbor or another student. Personal disclosure of their own challenges and/or solutions were reported less than the anecdotes they shared about others.

Students overtly and subtly bullying one another (including cyber bullying) or feeling bullied by a teacher, and "acting violently" against one another in physical ways—which overlapped with their mention of its relationship to depression—deserves some discussion here because of the intensity of feelings students expressed when they talked about bullying, particularly how damaging it was being made fun of in front of others or behind one's back ("*the rumor spreading on Facebook is really the cruelest bullying*"). The students were aware of and acknowledged the importance of their school's various activities to reduce bullying, but some expressed skepticism about how successful these efforts had been. Specific comments included "*it's not reported enough or to the right people;*" "*when they try to do something about it the results are short term;*" and, "*the school's zero tolerance policy is just for show so they can say they have this because the administration wants a positive reputation in the community.*"

Students were very sensitive as to how some teachers came across in the classroom relative to bullying. While most felt teachers took it seriously, one student shared that "*when they showed a movie about it some kids laughed at some of the scenes, and actually so did the teacher.*" Another commented that "*some teachers turn a blind eye to it when they see it.*" And, one student had observed his teacher "*making a kid feel like a fool in front of the whole class and keeping on harping on them like they're a real dummy.*"

Self-injury was generally described by students to be cutting and thoughts about or attempts at suicide (discussed in the next paragraph). Eating disorders as a form of poor mental health/self injury were almost never mentioned. Students observed that when some students are lonely they often don't know what to do, they can't figure it out on their own, so they "try to hurt themselves" ("*to make the pain stop*"; "*to get attention*").

Additional comments from students that further demonstrate their concerns and issues include the following:

- *"The physical and emotional transitions we're all making are not acknowledged as hard transitions."*
- *Our parents and teachers are from a different generation. They were not online [when young] and didn't have to deal with social media where everyone just judges your life for you. In Tulare there are soooo many rumors."*
- *"We don't know how to do all of this and now that we're older our parents pay less attention to us." [College student]*
- *"Kids have too much responsibility. I know people who are being raised by drug addicts and are taking care of all their siblings. They're not ready for this."*
- *"We have to learn it all on our own and it isn't fair."*
- *"Human interaction is way down. When I was little we would all be outside playing together. Now all the kids in the neighborhood are inside playing video games....and having drama with people they haven't even met."*

Suicide-Specific Concerns

After a discussion about mental health concerns in general, we specifically asked students how much of a problem they thought the issue of suicide was among the students at their school and friends they knew, and whether they had heard of any kids seriously making plans or attempts.

About two-thirds of the interviewees thought suicide was "a huge issue," not necessarily because of the numbers but because of the seriousness of the outcome. A few of the students knew someone personally who had committed suicide.

- *"Some kids feel like they don't belong here, don't belong in the world, and they end up killing themselves or wanting to."*

- *"I think it's a bigger deal than the teachers think. A lot of the students have gone through this [thinking about making an attempt]."*
- *"A few people I know that say they are suicidal....they are always making notes of their last good-byes. I don't tell adults about it....I don't know if they're serious or not."*
- *"It can be a huge problem when parents are fighting because kids start thinking it's their fault."*
- *"No one really talks about suicide; they talk more about bullying that is happening a lot. Now it is drama all the time and everyone just wants to die."*

Contributing Factors to Poor Mental Health

What students experienced at home was more closely linked to their mental and emotional health status than the school environment according to these interviews. They identified the factors below, in order of importance, as the main contribution to poor mental health.

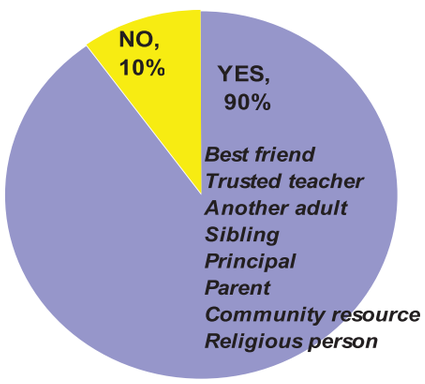
- parents "breaking up"
- having to move away from home (or moving home-to-home for foster kids)
- no support from parents or other caregivers/ being "harassed" by family about "everything"
- being "messed with" by other students/talking about you behind your back
- parents using/abusing drugs and alcohol
- being low-income and "not being able to figure out how to make it"
- sexual orientation/gender differences
- being stigmatized and being too scared to say when something feels wrong
- other people's insensitivity (and "not being taught boundaries") toward "any thing that is different than they are"

The topic of drug use (tobacco, alcohol, illegal substances) was infrequently mentioned by students in these interviews. When it was brought up, it was generally in the context of being an *answer* to a mental health issue ("*zoning out to where I feel safe*") never as a *contributing* factor to poor mental or behavioral health.

Knowing Who to Turn to

When we asked students if the kids they knew felt they might have a mental health problem would they know who to turn to for help, about 10% said no ("*some would have no idea where to go or even who they could talk to or trust*") but the majority (about 90%) believed students would know who to turn to if they wanted help (Figure 24 on the next page). Most would talk to a best friend—turning to a peer vs. an adult—but many stated they would seek help from a trusted teacher or the principal. Some of the students volunteered names of community resources they had heard about or were personally familiar with. Being able to count on someone and, most importantly, to have one's confidence protected were important factors for students. In naming these resources, they stated these individuals "are the ones who love you" and "they will keep your secret."

Figure 24. Does K-12 Student Know Who They can Turn to with a Mental Health Concern?



Many of the students remarked that "parents would be *way* down the list," validating school personnel's input in this assessment about non supportive home environments. Many students said "*parents don't understand*" (which is not an uncommon adolescent belief). One student remarked about the challenge of mental health problems and stated "*it depends on the parent; a lot of them really blame themselves and aren't equipped to deal with our problems; they feel weak and scared.*"

Perceptions About School-Based Mental Health Services

Attempts to Access Services

Nearly all of the students said they knew at least one student—or volunteered their own personal experience—who had received mental health services provided by or arranged through the school. These accounts were mostly positive and students felt they had been helped. For instance, one student shared that when his father had passed away he "*started getting into a lot of trouble, doing whatever, fighting. I went to a therapy guy. It was hard, but I'm not doing that [getting into trouble] anymore.*" Two students commented on how helpful their principal had been in "getting through to see the school counselor" and, in the other case, linking them to a community counselor.

The few students who felt they or a friend had not been successful in their attempts to access services included a student who volunteered they had tried to ask for help concerning transgender issues but felt while the school person they reached out to was supportive they were "not qualified" because they had not personally gone through the same experience as the student. Two students recounted not feeling the counselors they had been sent to were "trustworthy" but didn't elaborate further.

Supportiveness of the School

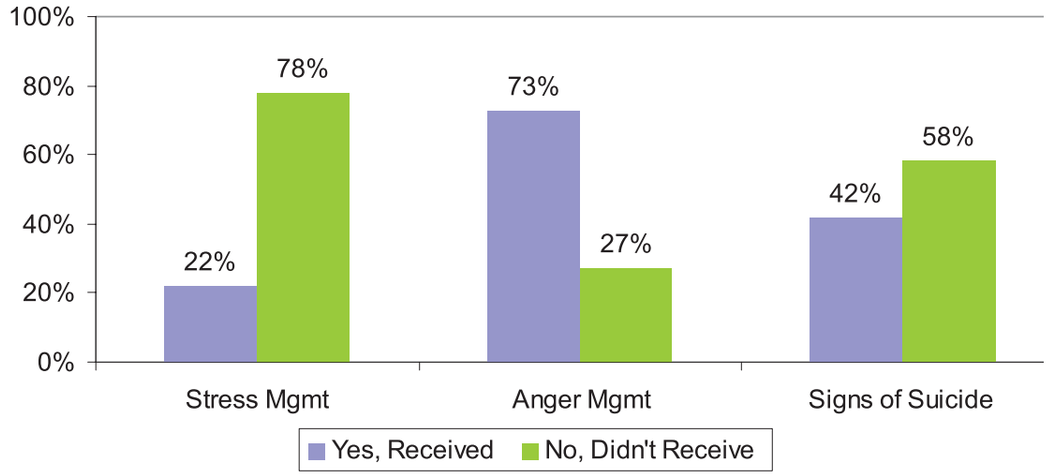
Students were split about 60/40 with the majority perceiving their school environment to be an emotionally safe and supportive place that promotes good student mental health. They based favorable opinions on personnel taking the time to talk with students when problems were identified, such as a principal or other administrator with an "open door" policy and an approachable teacher on yard duty. Only one person mentioned the availability of counselors. One student cited the peer mediators who are available during lunch and breaks "who are role models there to help you with problems."

Students who felt their school had not been supportive made the following comments: the school was not open-minded about students who were having a harder time; staff gave the impression that holding meetings about mental heath was a burden; teachers didn't take the school's anti-bullying policy seriously enough; and the school "pushed it off to the side" when a student brought up a problem and sometimes said "Oh, there's a problem? Here, let's put you in a program."

Prevention

We asked the students to indicate whether during the current school year they had been taught in any of their classes, including PE, about how to manage stress and anger in healthy ways, and about signs of depression and suicidal behavior. (We didn't define what the teaching needed to cover.) Their recollections and the comments they shared revealed that while they recalled being taught about appropriate ways of dealing with anger (primarily within the context of the school's anti-bullying efforts), most students did not believe they had received any education regarding how to manage stress. Close to 60% of the students reported receiving information about depression and signs of suicide and what to do "if a friend was thinking about it" (Figure 25).

Figure 25. Students' Recall of Receiving Education About Preventive Mental Health in Any Classes During the Current School Year



What Might Have Made a Difference

Students related things their school—or schools they attended in the past—might have done that could have made a difference in preventing some of the mental health issues young people face. Their main message was: "talk to me, ask me, and respect how I'm feeling." The following 2 comments by middle-school students express this well:

- *"The teachers we trust are the ones who listen."*
- *"Counselors need to not just jump in and out of their office, or take phone calls while you are with them. I saw a counselor for almost a year and he never remembered my name. He would read it off my chart every time."*

In addition to listening and talking with students, the 6 most important preventive strategies to students identified were:

- Be more sensitive to how students are feeling; ask students questions who appear "down."
- Give the impression, repeatedly, that school personnel have time and are open to students coming to talk.
- Call parents to alert them to issues.
- Get the student some "real" (i.e., not academic counselors) mental health help.
- Be more aware of, supportive, and intervene when someone is being bullied.
- Inform students, parents and teachers about LGBTQ issues and ensure safer school environment.
- Install cameras to watch bullying more carefully.

Suggestions for Improvement

The students offered many ideas and suggestions to change or improve the mental health services available at their school, many of the ideas overlapping and related to their previous comments. The following chart (Table 23) summarizes their main suggestions.

Table 23. Grades 7-12 Student Suggestions for Improving Student Mental Health (n=62)

- More training for teachers and other staff to better understand mental health-related issues.
- Start with the freshman not the senior year (HS) to implement "Success 101" and similar types of preventive curricula; repeat annually.
- Offer more school-based mental health (vs. academic) counseling—with a choice so students can find a "best fit."
- Intervene with unacceptable behavior ("don't let them get away with it") so students know they have to "stop it."
- Bring parents in ("make them come") when there are issues to have parent/student/school meetings.
- Teach more empowerment, more coping skills—especially for when students are on their own; teach "it's OK to fail sometimes."
- Promote a variety of music, sports, art, other ways, and encourage and help make it comfortable for "outcast" students to participate and mix.

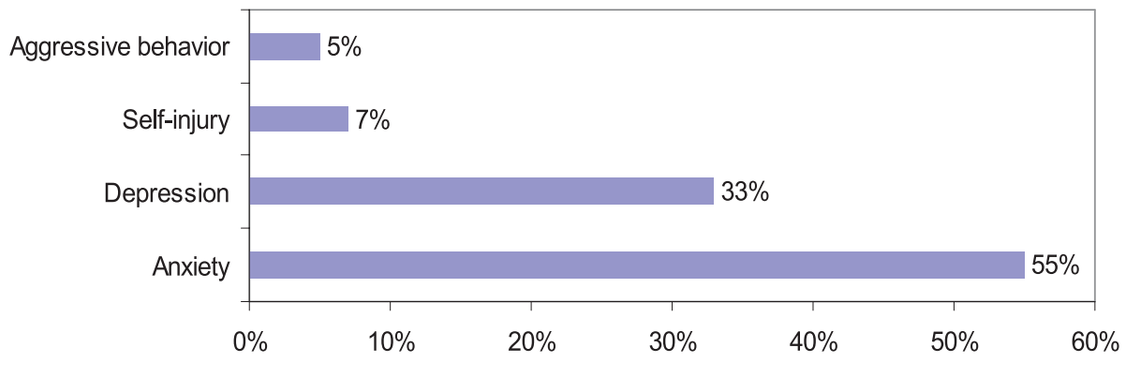
- *Make announcements every morning there are teachers, principals, peer mediators available to talk—then make sure it happens."*
- *When someone notices someone in a bad mood, come to them in a positive way and when no one is around so you don't put them 'on blast" [confidential conversation so others don't notice]."*
- *"Tell students you have their back."*

COLLEGE STUDENTS

Common Mental Health Problems

The college students who volunteered to be interviewed were a representative mix of gender and ethnicities and expressed many similar observations, candid views, and recommendations as the younger students. They spoke of the same need to be listened to, cared about, and helped with "life issues." The most common mental health concern they reported observing among other students or experiencing themselves was stress and anxiety—about grades, money worries, jobs or the lack of, relationships, and about what was going on with parents and other relatives, in that order. Trying to manage school along with "everything else, especially relationships," was largely related to the extent of depression they saw or experienced when these areas of their life weren't going well (Figure 26).

Figure 26. Relative Magnitude of Commonly Perceived Student MH Issues by College Students



Depression/anxiety was also a common response when students felt they weren't meeting parental expectations—which were generally high, even when parents didn't go to college— and letting the family down *("people don't want to fail their friends and family; they want to be a success"*"). Some of the pressure they felt to do well or "get a perfect GPA," students admitted, was self-imposed. Fear of their futures—from observing the hardships their families experienced, for example—was also related to students' anxiety and depression and viewed as a risk factor for suicide. They relayed that stress was commonly relieved by "self medicating with drug use [including alcohol] and lots of energy drinks."

Social isolation, not having friends, "feeling like a loner" was mentioned by about one-quarter of the students as a common mental health issue. Besides the issue of having someone to trust when there was a problem, some of the students believed that embarrassment or shame about a problem was a big factor for some students and contributed to their reluctance to approach anyone for help.

Additional illustrative observations and comments college students made about mental health concerns, including contributing factors, included:

- *"I was always the trophy child [first one to go to college] so any positive thing I do never gets acknowledged because it's expected of me. I feel hurt by this."*
- *"Some people have a terrible home life. They go through things and they can't trust other people—they don't know who to tell. It's really hard to trust someone with your problems."*
- *"People have unrealistic expectations that are being destroyed right in front of them."*
- *"Kids have trouble making the transition from high school to college. We need to abolish the 'feel-good A for effort' culture. Life is a struggle, getting a job is a struggle. There isn't always a reward for trying."*
- *"The people you think should know, don't. I went to a teacher I thought I could talk to; I even went to my priest, but they didn't understand my issues and where I was coming from."*
- *"The problems are there. But people just give up."*
- *"If I talk to a counselor and people find out they will think I'm crazy."*
- *"People don't want to appear weak. There's a lot of stigma for the macho/aggressive men on campus. Getting mental health services is seen as weak, like you're a loser." [Self-identified veteran]*
- *"The fear of losing control by seeking help essentially admits you are relinquishing control to someone else."*
- *"If I have a mental health issue and disclose it I can't get certain jobs, like law enforcement." [A fellow student in the group added, "...they lie about their mental health and still wind up in law enforcement, only now without treatment."]*

Suicide-Specific Concerns

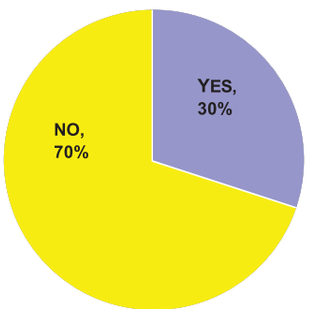
While some "had no idea," most of the college students felt the risk of suicide was "high" among college-age students and that it wasn't talked about enough (one student told the interviewer "you're the first person I've heard say the word on campus"). Between one-quarter and onethird of the students had personally known or heard about a fellow student seriously making a suicide plan or attempt. Nearly all of them who knew someone who committed suicide said "we never saw the signs" or that the person "seemed happy enough." One student commented that "the normalizing of depression hides the more severe kinds [of depression] so some people don't go and get help because everyone tries to make it sound normal."

At the same time, several students felt that the threat of suicide wasn't "really that real" because "students are always saying they're going to harm themselves [e.g., over a relationship], and try to think of something dangerous to do but they don't do it." Even so, most of these students reported they "try to calm someone down, let them know this would pass, tell them they would feel differently later" if a friend is considering harming themselves. Some of the students volunteered their awareness of a suicide hotline and of "a bookmark in the library that tells you where to go for help."

Knowing Who to Turn to

Approximately 7 in 10 college students (a significantly greater proportion than the younger students) said they and most other college students "probably *don't* know" where they could go if they had a mental health problem (Figure 27). One student asked, "you mean there's a resource on campus?"

Figure 27. Does College Student Know Who They can Turn to with a Mental Health Concern?



The majority of the students had not accessed mental health services on the college campus. Among 14 students, 13 reported they did not know the student health center offered free (up to 8 sessions) mental health counseling. Some students who didn't know where to go said they would "probably Google it" and others reported they were aware of a student health center on campus but unsure if it included free counseling services. The interviewee who self-identified as a veteran mentioned having a mental health screening at the campus veterans' services center. (He also reported that that it was "tricky" trying to schedule an appointment between classes because the center was open a limited number of hours.) Similar to the younger students, these college students would first turn to a friend or trusted adult if they *wanted* to reach out to someone because of a mental health concern. A couple of students said "here, they just go home" if they are depressed or can't cope with being at school.

Perceptions About the College's Supportiveness

While most of the college students "had no problem" with the supportiveness of the environment on campus, many referred back to how "unsupportive" they felt their high schools had been or the limited resources offered there. Although most weren't aware of the college health center mental health support services, they viewed the college to be "real supportive at the college level," commented on "some teachers willing to give you a break" and "it's in the handbook where we can go if we need [academic] help." For the most part, the students viewed their college teachers as "noticing and caring." They also identified programs like the Trevor Project[41] and places on campus such as the Disability Resource Center as being helpful for reducing stress along with accommodations for learning disabilities.

41 A national 24-hour, toll free confidential suicide hotline for gay and questioning youth.

Prevention-Related Presentations and Classes

At the college level, unlike lower grades, receiving education about coping with stress, managing anger, and signs of suicidal behavior was most likely to be received as part of an academic class with related curricula (for example, a health class, a psychology class), but this was "mostly as a side note." Although the majority of the students did not recall receiving this information in any of their classes in the past year, several students recalled receiving information "about stress" during freshman orientation. One student remarked that a life skills lab offered through the campus library emphasized triggers for anger but not how to manage it ("it wasn't practical advice").

A number of students, however, mentioned getting "little yellow cards" with information about depression and suicide but after the presentation students "blew it off" ("*you see all the cards thrown on the floor when people are leaving*"); they believed this was because students didn't think the information applied to them or to the people they knew. (They acknowledged, however, that "*some kid might actually look at and keep one of those cards without letting anyone else see that.*")

Suggestions for Improvement

The college students offered a number of practical suggestions to increase awareness and improve the availability of mental health services on their campus, many related to their previous comments about what they or their friends had observed or experienced. The chart below (Table 24) summarizes their suggestions.

Table 24. College Student Suggestions for Improving Student Mental Health (n=23)

- Create more opportunities for campus-based mental health counseling (and more affordable community-based counseling services).
- Increase awareness of campus- and community-based mental health resources.
- Anything that will reduce the stigma of having a mental health problem.
- Recognize and work with different abilities. Address unrealistic expectations; help students realize not everyone gets A's but you can still succeed.
- Teacher training to increase awareness of signs and symptoms of poor mental health.
- Require a personal management class to graduate college and teach about budgeting *("people are bad about it; they get their financial aid checks and spend them in 2 days").*
- Distribute more flyers with practical information and resources; post more Safe Zone posters (LGBTQ-friendly signs) on campus ("they help").
- Require everyone to be in at last one campus-sponsored club to address loneliness and encourage new friendships.

PARENT/GUARDIAN PERSPECTIVES

"Going to college for kids is a foreign concept for some families."
– Parent of a High School Student

"Schools are doing the best they can but they don't have the support services for kids they need. They really need social workers and mental health professionals at the school"
– Parent of a Middle School Student

"Some parents say 'it's just fate' and don't want to deal with it"
– School Psychologist

A total of 33 parents/guardians[42] (23 from Tulare County and 10 from Kings County)— representing students from preschool to high school (and some with older children)—were interviewed to gain parents' perspectives about student mental health. As described above, many of these individuals were identified because their student had a mental health concern. In nearly every case, we found the interviewees to be open and forthcoming about the child's (and some cases their own) mental and emotional health issues.

Most Common Mental Health Concerns

The mental health issue among students most commonly described by parents was anxiety regardless of the student's age; this was usually exhibited as a behavioral problem or becoming withdrawn. Although anxiety also meant being depressed for some students, others with anxiety were described as "still a happy person." The few foster parents we talked with stated that anger and depression were the most commonly observed issues among the students they were caring for.

In nearly all of the situations where a mental health concern was described, the parent commented that they had observed it relatively early in the child's life ("*we felt something wasn't right when she was young even if we didn't know what it was then*"). Schools were likelier to pick up behavioral issues earlier than mood disorders.

Contributing Factors

The vast majority of parents stated that "bad childhood experiences," and specifically being bullied, were largely responsible for their child's— or other students they knew personally— mental health concerns. In most of the cases the bullying was leveled at students who were deemed by others as "different," including differences related to sexual orientation/identity. "Different" also frequently meant struggling with self confidence, not forming friendships, not fitting in or only fitting in with "un-cool kids." Parents who described harassment of their child dealt with it in different ways, including getting help, contacting the school, "preparing them for life," and trying to minimize the impact without making light of the situation. A small number of Spanish-speaking parents of very young children mentioned their children encountering confusion and intimidation" over language-related issues.

[42] We use the term "parent" for simplicity but in some cases we were talking with step-parents, foster parents, grandparents and other relatives who were acting as guardians or raising the children.

- *"I taught my son to just accept everyone the way they are. If he gets bullied, I said just know there's somebody else around the corner that's not going to be like that."*

- *"It's just a simple fact that kids are mean. It's like a vulture mentality."*

- *"Someone made a fake Facebook page with her name…they said so many bad things about her that weren't true that I had to get her help."*

- *"My son likes to decorate, he cares about his appearance….the kids at school call him gay. My family thinks this makes him strange, and I think that other students do as well."*

- *"My son is less rough and tumble. My dad used to call him a faggot. Even when he was little…..he's grown now and seems happy….but they still will call him a swag fag sometimes."*

- *"He was bullied a lot for not being a 'man's man.' But he's into an anti-bullying group now so he's turning his negative into a positive."*

While supportive families can help students with mild impairments make it through school, poor home environments pose a risk to children's mental health. An unhealthy or dysfunctional home life was acknowledged by a few of the parents as a contributing factor to their child's mental health concerns, but more frequently it was the relatives who spoke of this in relation to the child they were raising. Typically these factors were exposure to in utero and current substance abuse and abusive environments. Other common reasons involved neglect, such as when all of the attention is focused on another child in the family, death or incarceration of a parent, and instability resulting from multiple moves or rancorous child custody situations.

- *"Everything begins at home."*

- *"Lots of families feel hopeless because they're poor and feel stuck in a rut without goals."*

- *"Kids are left alone too much because parents are too busy."*

- *"We argue a lot, my kids have no respect for me. They even reported, falsely, I was dealing drugs. When I tried to enforce rules my kid called up CPS and made up stories to get back at me. I think we're a dysfunctional family."*

- *"The whole family was focused on the child with [the chronic medical condition] so she never got focused on."*

- *"Her parents [grandparent speaking] were loaded out of their minds 24/7 when she was growing up….they never disciplined her. She's lived in various houses or hotels depending on what her parents could find, and she never had friends and got socialized."*

- *"….her parents did get her medication but I suspect they may have done that so they could get access to more prescription drugs for themselves."*

- *"Parents tend to think how it was when they were young. They have old-school values like 'we never would have done that or gotten away with that when we were young.' "*

- *"I was raised tough and I'm a very tough parent—'iron fist.' I don't tolerate most common things most kids get away with. It's a dictatorship here."*

Medication

Parents said medications were not always the hoped-for panacea when they were prescribed. About half of those whose students were on (or supposed to be on) mental/behavioral healthrelated medication were still struggling with needing to make adjustments to dosages "to get it to work" or getting the student to consistently take the medication ("*he doesn't think he needs it;*" "she says it makes her feel like a zombie and she hates that").

Impact of Mental Health Concerns

All of the parents reported some degree of negative social, academic and family life impact for students with mental health concerns.

Socially

About two-thirds of the parents reported some type of negative social impact when their child had a mental health issue. Mostly this was an inability to make friends, sometimes because of poor social skills, and to "get along with people," including teachers. These students were often ostracized by their peers (and sometimes withdrew socially), and frequently harassed in some way. Only a couple of parents mentioned feeling that some teachers had "ignored paying any attention to" their child *because* they had a mental health problem or "didn't fit the mold of the ideal student."

Academically

Nearly all parents reported some degree of negative impact on their student's academics This ranged from loss of interest in school to hit-and-miss attendance (with a resultant drop in grades) to having to change schools to, at the extreme, dropping out. On the other hand, a small proportion of the parents shared that their student was so anxious and stressed from the perceived need to "be perfect and get perfect grades" that this resulted in hyper attention to homework and tests and, hence, *high* scholastic achievement.

Students born to drug-addicted mothers were reported as especially hard hit. Parents shared that these students with prenatal drug exposure "had a lot of imbalances" and an inability to focus well enough to do homework, and at school to process information ("*can't get it fast enough*") and take tests; students then got frustrated and some became disruptive.

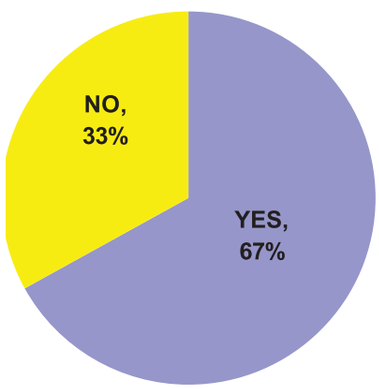
A number of parents who reported that their student's academics were declining "before the diagnosis" also shared that their attendance and grades had improved since the student began receiving mental health treatment services.

Perceptions and Experiences with Mental Health Services

Awareness of Services

About two-thirds of the parents affirmed that they would know who to turn to or where to go if their student had a mental health concern, though some weren't sure about the availability of the resource (Figure 28). For example, many who said they would first contact the school also stated they didn't know if any services were provided on campus ("*if they still have counselors with real mental health background; someone who is really qualified, not just with a degree but able to give feedback to my kid*").

Figure 28. Does Parent Know Who They can Turn to with a Mental Health Concern?



Access to Services

Three primary problems related to access were cited, none of which was said to be unique to either Tulare County or Kings County.

- The wait time for an appointment—and the intervening steps and wait time to actually begin mental health counseling—was the main barrier parents identified as a problem when trying to access community-based services. The wait could be due to a limited number of providers and/or the multiple required steps in the process.

- The second most common access issue involved the hours services were available: the inconvenience of having to take time off work to take a student to a community mental health provider during the day, and the lack of non-daytime hours ("*everything happens in the evening or on the weekend when no one is around or available*").

- A third important limitation parents reported was the lack of enough psychiatrists (in both counties) for diagnosing (even with the use of Telemed in one case)—which can add to the wait time for the initial counseling appointment—and prescribing medications.

Only 1 parent acknowledged not following up on a referral, and this was due to the attention she felt she needed to pay to another child in the family who had a chronic medical condition. Concerns about financial issues including lack of health insurance was not mentioned by parents as a barrier.

When their child was connected to a mental health prevention or treatment service, the resources most commonly identified by parents were on-campus support groups and Tulare Youth Bureau; they were particularly complimentary of TYB services and programs. The only barrier noted for these resources was for students who wanted to use TYB services and were turned away because of eligibility status (the students had private insurance not Medi-Cal).

- *"When this school [unlike previous school in another part of the state] did further research into her diagnosis, they made room for her. This county [Tulare] is much better for getting her mental health resources and schooling."*

- *"I don't think the counselors have mental health knowledge. They want to help your child, but it's about grades and the suspensions, things like that."*

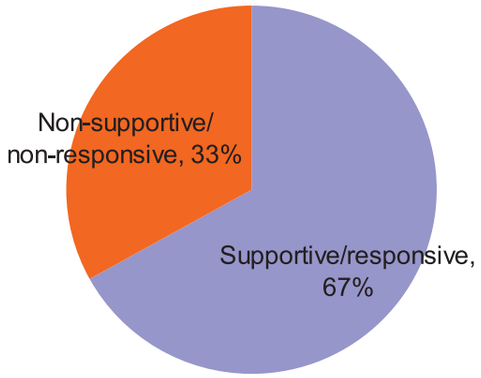
- *"Our [student] was matched with a very inexperienced counselor so he stopped going. But when they reassigned him it was a good match so the counseling was effective again."*

- *"When [student] got in trouble for smoking pot I freaked out and called YSB. It was a turning point for him. They drug tested him, and we all went through counseling together. I called them on my own [not through the school] after the police told me he was using drugs."*

Supportiveness of the School

Twenty-two parents disclosed during the interview that their child was receiving off-campus mental health counseling. Four (17%) of these families said they were unsure if the school knew their student was receiving the community-based services as they had sought help on their own (1 said they had "chosen to keep the school out of it"). Of the remaining 18 families, two-thirds felt the school had been responsive and helpful (Figure 29), though a few of the parents said they had been the one to initiate the request to the school for help.

Figure 29. Parent Views About School's Responsiveness (n=18)



When School was Aware of MH Concern

The sample of parents we talked with generally did not have a lot of resources (educational or financial), and the majority were grateful for the mental health services they had for their student. Spanish speaking (monolingual especially) families in particular have a very high reverence for the role of the teacher. It is typical that families expect the teacher, or "the school," is going to know exactly what is wrong and what to do and will inform the parents. This deference can be misinterpreted as indifference. But many parents we talked with expressed interest to understand more about what was happening in their child's classroom and on the campus.

- *"When this [mental health situation] first happened, I was so frustrated, it just felt hopeless. I wanted to put my head under the covers and not come out. We didn't think anything would change. But [name of school] have given us the tools we need to change the family situation. She's learning to use her support system and own tools....."*

- *"I'm very happy with how the school connected us to community services at the time of the suicide threat, and am still happy with both the school and the services."*

- *All the schools here—high school, middle schools, elementary—are all good but they are very limited in what they can do when a student is struggling [emotionally]."*

- *"It's so awesome to have counseling at the school. Everything happens at the same time in the same place."*

- *"Any teachers I've talked to have really been in tune."*

- *"My son's teacher looks out for the kids...but she's a teacher, not a counselor."*

- *"The school did all that they could [in the situation]."*

The parents who felt the school had not been responsive enough described situations where they felt their child had "fallen through a crack a mile wide"—their mood disorders were not recognized or were ignored—or a reported situation had not improved appreciably. Because many of the parents tied their child's anxiety or depression to being bullied, they were especially sensitive to how the school handled those complaints they had made. According to these interviews, it was

common for the principal or vice-principal, after receiving the complaint and talking with the family, to ask the coach to handle it. Coaches generally handled it by talking to the class as a whole; and, "*that was it*," complained a couple of parents whose students continued to be harassed. Some parents followed through if they felt things had not improved, but it seemed most did not ("*it doesn't matter, the school won't do anything anyway*" [when bullying resumed again]).

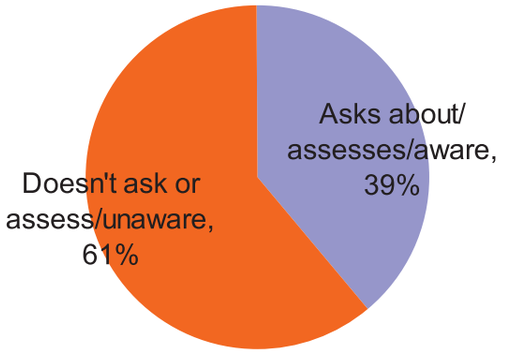
- *"When my son got bullied, the counselor believed the teacher rather than him. My son said the teacher didn't know. The day-to-day in the classroom was the same, nothing changed."*
- *"....The principal told us [after reporting continuous bullying], 'we can't watch every child."*
- *"I don't think the school thinks it's their responsibility to help kids with mental health problems or get them services. The focus is all on academics and they take an 'expel rather than deal with it' attitude."*
- *"Some kids forced my daughter to hide marijuana under our front door mat. They threatened her to not tell anyone or they would come and shoot her family. When I went to the principal and started crying and my daughter wouldn't name names, he said he didn't believe her."*
- *"I have a kid who attends a large high school. He had a therapist there but they were only there once a week. So if he was feeling emotional or needed to talk to someone on Monday they could only sign him up for the therapist for Friday; by Friday he isn't feeling that anymore, so it doesn't help.*

Although it was outside of the scope of this study to address law enforcement's role, relationships with local police departments were brought up by 7 or 8 of the families in the context of their child's mental/behavioral health concerns so we note it here. While about half of the parents were neutral in describing examples of police involvement, such when "stressed" students got into fights, used drugs, threatened suicide or ran away, some expressed fear and in a few cases resentment at their child or family being inappropriately "labeled," "profiled," "threatened," and "picked on for no reason." This area may need consideration for further investigation and/or planning.

Involvement of Primary Care Providers

About 6 in 10 parents whose child had a primary care physician and answered the question (n=23) said their child's primary care physician does not screen or ask questions about mental health issues (Figure 30). (Two additional parents said they were unsure.)

Figure 30. Parents' Report of Primary Care Physician Assessment/Awareness of Grades K-12 Patients' Mental Health Concerns (n=23)



Nearly all of the parents remarked that they *wanted* the primary care physician to inquire about their child's behavioral/emotional/mental health though they recognized how busy physicians were during well-child and other medical visits. Some of the parents reported leaving the office feeling frustration when doctors missed mental health issues (they apparently didn't feel comfortable bringing up the issue themselves). Because of parents' expectations about the role of their child's provider, a couple of them interpreted a referral elsewhere—which may have been reasonable for mental health concerns—as "just sending us away," "telling me 'there is nothing we can do here,' " and as physician indifference or "not dealing with it." A couple who had shared information with the doctor about their children's behaviors without resolution "felt ignored" or "crazy" themselves. Two parents, however, specifically mentioned their child's doctor had referred them to YSB which they viewed as positive and helpful.

When physicians were involved, it was generally for medication management, or when parents took the child to the office for a problem (in 2 cases this was because of cutting behaviors), and asked the doctor to document what was going on and intervene and these were said to be positive encounters.

Suicide as a Specific Concern

About two-thirds of parents who responded to the question said suicide might be a concern for their child. (Note: some of the parents identified to be interviewed were selected *because* there had been a serious suicide threat or attempt.) About half of these parents remarked that the concern was "*just a natural worry*" based on an apprehensive feeling, or because "*parents just think about this when they hear about others [doing it]*" and not because of an overt threat. The other parents offered remarks such as the following:

- *"My son disappeared...and when the police picked him up and took him to school he said 'I don't want to be here anymore.' The officer asked if he didn't want to be at school or didn't want to be alive and he said 'I don't want to be here, I want to be dead.' The police officer took him to the hospital and the YSB therapist met him there."*

- *"Against my better judgment I let her go downtown. A business owner called the cops because the kids were smoking pot and now she has a court date. She talked to a counselor at the school but started cutting herself again and said 'I wanted to kill myself because I didn't want to tell you I did drugs."*

- *"I heard her tell someone she wanted to go be with her mother" [who had recently died].*

- *"It's more of a concern for me [parent speaking] than my child because I feel what my child is feeling."*

Prevention

Parents mentioned some important factors they thought might have made a difference to their child in preventing or reducing their mental health needs (Table 25). In general, earlier assessment of problems and more available resources for intervention were key issues. Two parents identified a personal or home environment factor that might have made a difference in the child's mental health needs. One of these parents referred to a sexual identity issue (the only one to mention this topic in these interviews) in the context of wishing the student had trusted the parent more to have shared feelings. In reference to "other families" and what could make a difference for children, 1 parent commented that parents' use of alcohol and drugs was a consideration.

Table 25. What Parents Said Might Have Made a Difference to Their Child's Mental Health

- Effective interventions to permanently stop bullying once it is reported.
- Having mental health (non-academic) services readily available on the school campus.
- More understanding by teachers in how to identify a mental health concern vs. "bad" behavior.
- Having better parenting skills/the know-how to handle child's behavior and emotional issues.
- Having knowledge of what to look for, i.e., signs and symptoms.
- More direct intervention by teachers with the students who are struggling with (non-academic) "issues."
- Being informed earlier when students are having a hard time so parent can work with the school to resolve/share what's going on at home (e.g., death of a family member).
- More direct observation (especially during lunch) of what kids are up to, to be able to intervene.
- More "mental health testing" (risk assessment).

Suggestions for Improvement

The suggestions parents made to change or improve the current system of school-based mental health services ("What can schools do to help these kids?") reflected their experiences, and echoed what they had recommended as ways to prevent or reduce mental health problems and needs. In recommending more involvement by school psychologists, it is important to point out that many parents—along with others interviewed for this study—were confused about the role of these staff. As was pointed out above from school psychologists themselves, their training is as educational psychologists not *clinical* psychologists, and their primary role is assessment for special education not student mental health counseling.

The chart below (Table 26), summarizes parents' suggestions by frequency of mention.

Table 26. Parents' Top-Ranked Suggestions for Improving Student Mental Health (n=33)

- Bring more community-based mental health counseling services onto the campus.
- Give academic counselors enough training in mental health to be able to "pitch in" when mental health professionals aren't available.
- Provide training for teachers and other school staff to increase their understanding about student mental health (vs. "normal youth angst") and how to help, besides "just send them to the principal."
- Offer parenting skills workshops/training (including early mental health education programs) and make it easier (e.g., gas coupons, dinner) for them to attend.
- Give the psychologists more days to be on each campus.
- Shorten the wait time from referral to the first counseling session.
- Use constant awareness messages about stress/turning to someone for help in ways kids relate to, particularly social media.
- Use more peer-driven strategies (especially if peer had had positive mental health services experience) "because kids listen to each other."
- More preventive education about drug use and about sexuality/family planning.
- Have more yard duty supervisors (and monitor restrooms more) to keep an eye on things, especially bullying.
- Listen to and believe parents.

- *"If the kid never smiles but always used to be so funny, they [teachers] should be able to see what's going on and respond."*
- *"If they have a nervous tic or won't stop chewing their lip why doesn't the school notice this and pay attention to signs?"*
- *"I had no clue about ADHD and PTSD. I was like 'isn't that something that people get after wars?' "*
- *"You start to question yourself as a parent when you get the diagnosis. How could I not have known about this?"*
- *"This is a small town. There's a lot of violence. How do you deal with that?" [affect on students].*

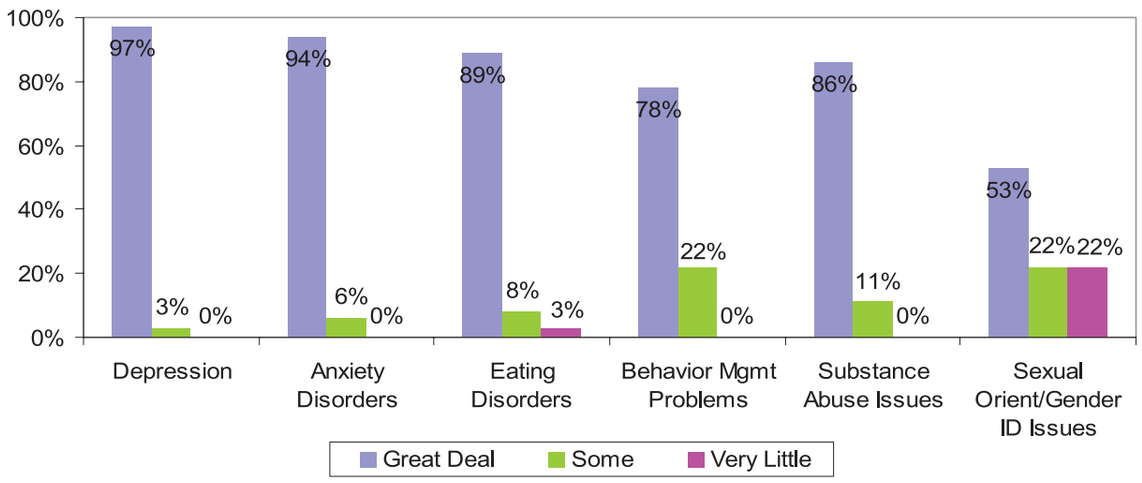
PERSPECTIVES AND INVOLVEMENT OF PRIMARY CARE PHYSICIANS

"There are cultural differences in child-rearing practices, and that extends to attitudes about mental health as well. "
– Tulare County pediatrician

Recognizing Behavioral and Emotional Issues

Physicians were asked about the extent to which they felt responsible for identifying various mental and emotional health issues among their student-age patients. Overall, they indicated that as physicians they felt a great deal of responsibility to recognize depression (97%), anxiety disorders (94%), eating disorders (89%) and substance abuse issues (86%). They were slightly less likely to indicate that they felt a responsibility to recognize behavior management problems (78%) and much less likely to indicate responsibility to identify sexual orientation/gender identity issues (53%) (Figure 31). The responses did not vary significantly between pediatricians and family practice physicians.

Figure 31. Physician Beliefs About Personal Responsibility to Identify Mental Health Issues (n=36)



Confidence Recognizing Mental Health Concerns

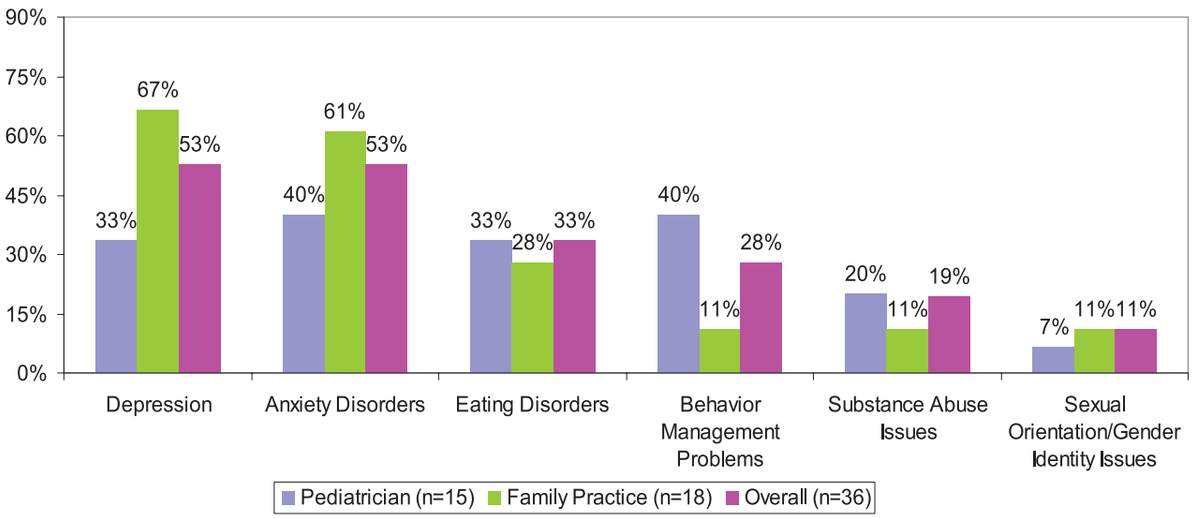
About the same proportion of physicians reported "a great deal" as reported "some" confidence in their ability to identify depression and anxiety disorders (53% and 47%, respectively), the 2 disorders, overall, they expressed the most confidence in identifying. They were less confident about identifying the other disorders, though at least two-thirds felt "somewhat" confident in identifying eating disorders, behavior management problems, substance abuse and gender identity issues (Table 27).

Table 27. Physician Self-Rating of Confidence In Identifying MH Issues, Total Sample (n=36)

Issue	A Great Deal	Somewhat	Very Little	None
Depression	53%	47%	0%	0%
Anxiety Disorders	53%	47%	0%	0%
Eating Disorders	33%	64%	3%	0%
Behavior Management Problems	28%	61%	8%	0%
Substance Abuse Issues	19%	69%	11%	0%
Sexual Orientation/Gender Identity Issues	11%	53%	33%	3%

When responses by type of physicians were compared, family practice physicians were more likely to indicate confidence in identifying depression and anxiety and pediatricians were more confident identifying behavior management and substance abuse problems (Figure 32). A higher proportion of family practice physicians than pediatricians expressed confidence in identifying sexual orientation/gender identity issues.

Figure 32. Physicians with "a Great Deal" of Confidence Identifying MH Issues, by Physician Type



Treatment and Referrals

Physicians were asked if they treated, referred, treated and referred or did neither when presented with a mental or emotional issue (Table 28). Overall, physicians were most likely to offer referrals rather than treatment for three concerns: behavior management problems (44%), substance abuse issues (58%) and sexual orientation/gender identity issues (47%). Family practice physicians both treat and refer for depression and anxiety but were less likely to refer without offering treatment for each of the concerns except behavior management problems and eating disorders. Substance abuse issues are mostly handled by referrals by both types of physicians.

Sexual orientation/gender identity issues among patients are usually handled by referring. However, it is important to note that 1 in 5 of all respondents (and 13% of pediatricians and 28% of family practice physicians) indicated they *neither treat nor refer* when these issues are of concern.

Table 28. Physician Treatment and Referral Practices (n=36)

Issue	Pediatrician (n=16)	Family Practice (n=20)	Total
Depression			
Treat	7%	28%	17%
Refer	53%	11%	31%
Treat and Refer	40%	56%	50%
Neither	0%	0%	0%
Anxiety			
Treat	13%	33%	22%
Refer	53%	11%	31%
Treat and Refer	33%	50%	44%
Neither	0%	0%	0%
Eating Disorder			
Treat	20%	0%	8%
Refer	27%	61%	44%
Treat and Refer	40%	39%	44%
Neither	0%	0%	0%
Behavior Mgmt			
Treat	20%	0%	8%
Refer	27%	61%	44%
Treat and Refer	47%	39%	44%
Neither	0%	0%	0%
Substance Abuse			
Treat	7%	0%	3%
Refer	67%	56%	58%
Treat and Refer	27%	44%	39%
Neither	0%	0%	0%
Sexual Orient/Gender ID			
Treat	0%	6%	3%
Refer	60%	39%	47%
Treat and Refer	27%	28%	31%
Neither	13%	28%	19%

Barriers for Physicians in Diagnosing and Managing Mental and Emotional Health Issues

Physician survey respondents were asked to rank common barriers to diagnosing and managing behavioral and emotional issues among their student-age patients. The barriers ranked the highest included "appropriate referral source not available locally" (31% ranked as most important barrier) and "not enough time" (25% ranked as the most important barrier). Lack of training and lack of awareness of local referral sources accounted for a somewhat high proportion of physician limitations on diagnosis and management of these issues (Table 29). A few physicians also noted that they were concerned about liability ("especially if the patient is suicidal or may hurt other people") and patient compliance issues such as not keeping appointments, not taking medications and "irresponsibility on the part of parents."

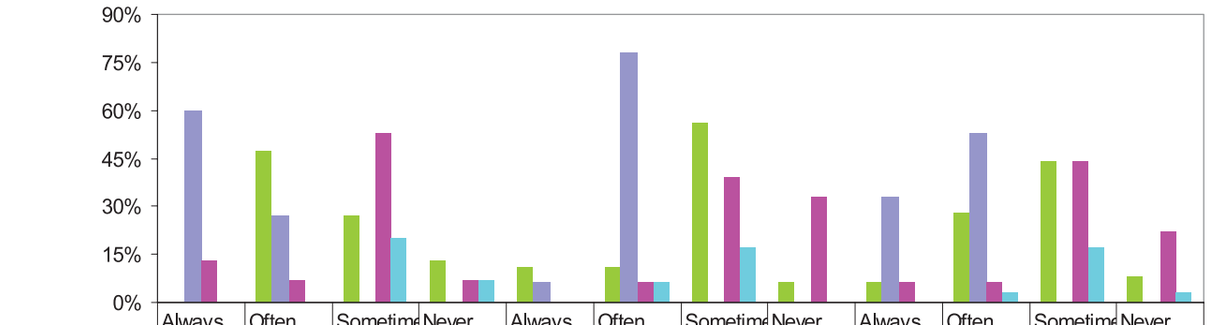
Table 29. Importance of Barriers that Limit Physician Diagnosis and Management of MH Issues

Reason	n	Rank					
		Most Important ◄ ► Least Important					
		1	2	3	4	5	6
Appropriate referral source not available locally	26	31%	17%	14%	11%	0%	0%
Not enough time	24	25%	11%	11%	8%	11%	0%
Lack of training or knowledge of issue	23	11%	22%	8%	14%	8%	0%
Unaware of local resources to refer	23	3%	19%	25%	14%	3%	0%
Lack of/inadequate reimbursement	18	11%	8%	6%	6%	19%	0%
Other	3	3%	3%	0%	0%	0%	3%
Liability of treating adolescent w/medication	1	3%	0%	0%	0%	0%	0%
Patient compliance	2	0%	0%	0%	0%	0%	3%
No Response	5						

Awareness of Mental or Emotional Health Issue

The physicians indicated they are most likely to hear about mental health-related issues from parents, followed by the patient and "someone else" (usually the school/college) (Figure 33). This pattern was more pronounced for pediatricians with 60% indicating that they "always" were made aware of the issue by the parent (compared to 6% of the family practice physicians). Thirteen percent of pediatricians compared to 6% of family practice physicians reported "never" being told by their patients when these issues are present.

Figure 33. Source of Physician Awareness About MH-Related Issues



	Pediatrician (n=15)				Family Practice (n=18)				Total (n=33)			
	Always	Often	Sometime	Never	Always	Often	Sometime	Never	Always	Often	Sometime	Never
Pt themselves	0%	47%	27%	13%	11%	11%	56%	6%	6%	28%	44%	8%
Parents	60%	27%	0%	0%	6%	78%	0%	0%	33%	53%	0%	0%
Someone else	13%	7%	53%	7%	0%	6%	39%	33%	6%	6%	44%	22%
Other	0%	0%	20%	7%	0%	6%	17%	0%	0%	3%	17%	3%

Coordination with Schools

On the whole, these physicians generally do not work with school personnel to confer or coordinate care when there are mental/emotional health issues among their young patients.

Pediatricians were most likely to indicate they "sometimes" initiate contact with the school or college (47%) when there are mental health concerns (Table 30). Family practice physicians were most likely to indicate they "never" coordinate care with the schools (39%).

Table 30. How Often Physicians Confer with/Coordinate Care with Schools

Frequency	Pediatrician (n=15)	Family Practice (n=18)	Total (n=36)
Always	13%	6%	8%
Often	20%	11%	14%
Sometimes	47%	28%	36%
Never	13%	39%	31%
No Response	7%	17%	11%

Of the 11 respondents who indicated that they "never" confer or coordinate care with the school/ college, 10 provided a ranking of common reasons. As Table 31 shows, the highest ranked reasons were "concerns about confidentiality and liability" (60%) and "other" (30%) not enough time" (20%). Liability generally centered around treating children and adolescents with medications.

Table 31. Reasons for Physician "Never" Conferring with/Coordinating Care with Schools (n=10)

Reason	Rank			
	Most Important ←			→ Least Important
	1	2	3	4
Concerns about confidentiality and liability	60%	20%	0%	0%
Not enough time	20%	10%	10%	0%
Unaware of where the patient goes to school	0%	10%	10%	10%
Lack of/inadequate reimbursement; carrier doesn't cover	0%	10%	10%	0%
Other	30%	10%	0%	0%
Didn't know who to contact	10%	0%	0%	0%
No follow through by school	10%	0%	0%	0%
Not aware of resources	10%	0%	0%	0%
Lack of resources	0%	10%	0%	0%

It is important to note that one physician with a "never" response and one with a "sometimes" response indicated the reasons as "no follow through by the school" and "no response to my letters or phone calls, regardless of which school," respectively.

Awareness of Where to Refer

Anxiety, depression and to a lesser extent behavior management issues were the most common mental health concerns the majority of physicians reported knowing a referral source for (Table 32). Overall, about one-third reported they were "not aware" of where to refer student-age patients with eating disorders or substance abuse issues. Sexual orientation/gender identity issues were areas the physicians knew least about for referrals; half (50%) of the family practitioners and 60% of the pediatricians responding to the survey were "not aware" of where to refer patients with concerns in this area.

Table 32. Physician Awareness of Where to Refer Patients for Mental Health Concerns

Mental Health Concern	Pediatricians			Family Practice			Total		
	Aware	Somewhat Aware	Not Aware	Aware	Somewhat Aware	Not Aware	Aware	Somewhat Aware	Not Aware
Depression	80%	7%	7%	33%	28%	22%	50%	19%	14%
Anxiety Disorders	67%	20%	7%	28%	33%	22%	42%	28%	14%
Eating Disorders	27%	20%	40%	6%	39%	33%	14%	31%	33%
Behavior Mgmt Problems	40%	47%	7%	11%	44%	28%	22%	44%	17%
Substance Abuse	27%	47%	20%	6%	33%	44%	14%	39%	31%
Sexual Orientation/ Gender Identity	20%	13%	60%	11%	22%	50%	14%	19%	50%

Important physician input in support of these findings include the following written-in comments:

- *"Resources [for these issues] may exist but good luck trying to get psychiatry services in a timely manner."*

- *"Inpatient care for children/adolescents is non existent. Crisis management for risk to self is poor—I have never heard anything [from a psychiatrist] other than 'there is no risk to self or others.' "*

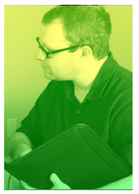
Attended Training

Most of these physicians do not seem to have recent training, which could include a lecture such as taking a continuing medical education course, related to mental and behavioral health. Of those who answered the question (and 17% did not), the majority (61%) had not attended a lecture or conference in the last 2 years where the main topic was child/adolescent mental or emotional health (Table 33). Pediatricians were twice as likely as family practice physicians to indicate that they had attended a recent training on this topic.

Table 33. Physician Attended Training on Child/Adolescent Mental Health in Last Two Years

	Pediatrician	Family Practice Physician	Total
Yes	33%	17%	22%
No	60%	67%	61%
No Response	7%	17%	17%

PERSPECTIVES AND AVAILABILITY OF COMMUNITY-BASED MENTAL HEALTH PROVIDERS



"Youth who are in the [mental health] program are at a lower risk than the kids with the same risks that are not in treatment. I am worried about those who aren't there "

– Community-based mental health provider speaking about suicide risk

Range of Mental Health Services Provided

Families turn to a variety of systems to get and help pay for care, yet they often face challenges in qualifying for and receiving the help that their children need. The 14 Tulare and Kings Counties mental health providers who were interviewed for this assessment worked in the areas of prevention, early intervention and treatment. Three providers also noted that they do training for school personnel and/or mental health providers who work with youth.

As noted earlier, all of the organizations work with students in middle school and high school, and half provide services on the school campus. Mental health services are also provided for students in juvenile hall. Services for families related to the student's mental health need are provided in the clinic/office setting, family resource centers and in the home. One provider noted that while they sometimes see families on the campus to provide treatment "*this is just in really difficult cases, and it is rare. I would love to see more of it. The schools have to be careful about who they let on campus, and it is usually after all the kids have gone home.*"

Financial Eligibility

One of the issues addressed through the needs assessment was the extent to which various barriers, particularly financial, prevent individuals from receiving mental health services. All of the public mental health programs and clinics accept Medi-Cal, and the majority of the students use Medi-Cal for treatment (60%-100% depending on the agency). (The increase in use of Medi-Cal funding represents a major shift in the predominate model by which public mental health services are funded and delivered.) Grant funding accounted for 5%-40% of the coverage for treatment services. All of the prevention services that were described by providers are grant-funded through MHSA and provided at no charge to the students.

Clinic settings also accept private insurance, and respondents noted that 5%-10% of the students had some form of private insurance. All 3 of the private practice providers accept private insurance and cash and 1 reported they will also occasionally see a few clients without a fee. Providers noted the recent changes in Medi-Cal will allow those who take Blue Anthem/Blue Cross will be able to serve Medi-Cal clients covered by this program.

Table 34. Type of Reimbursement Accepted by Mental Health Provider

Reimbursement Type	Provider Type	
	Private Provider (n=3)	Public Mental Health Provider/Clinic (n=11)
Medi-Cal	0%	60-100%
Grants	0%	10-100%
Private Insurance	0-100%	5-10%
Cash	10-100%	0%

Referral Process and System Capacity

The mental health providers were asked how soon a student who was not in a crisis situation but needed mental health care could receive services after a referral was received. There was no variation in wait time by type of reimbursement; the wait times they described were the same regardless of how the visit is reimbursed.

The public mental health providers and clinics reported a process for getting care. Generally the process begins at the point of referral and can take 2-6 weeks to see a therapist or psychiatrist. The wait can vary depending on the time of year, providers noted, with August/September (just after the start of the school year) and January/February (just after the school break) being the busiest times; the wait to see a therapist can be an extra week or so during those periods. One provider observed that the wait is shorter in the summer months.

The process of accessing mental health services for the first time can be slow because of multiple steps (Table 35 on the next page). In the community clinic setting, families have to go through their primary care doctor for a referral to mental health services; thus the wait can vary depending on how long it takes for the referral process from the physician. For the public mental health providers, there are appointments needed prior to seeing a therapist. The wait can also vary depending on the family's schedule and their ability to come to the initial appointments.

The quotes from public mental health providers that follow illustrate that the wait time varies depending on the systems in place at the provider and the families' ability to navigate the steps needed prior to getting mental health care.

- *"For a typical referral, we talk to them and they attend an orientation group (with parent permission). The groups are offered 4 days/week and once a week in Spanish. Parents sign kids up for services and we explain what to expect regarding services, confidentiality, etc. All of them ask the same questions, so we try to answer all the questions first. Most of the parents stay and allow their children to start treatment. Just a few leave. Usually the students are seen within 2-3 weeks."*

- *"At least half of the kids waiting are waiting because their parents don't come to the appointments or don't complete the paperwork. For a student with a regular risk (not urgent), it is 4-6 weeks before they see the MD."*

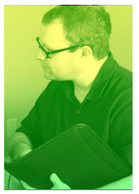
- *"We have time available for intakes each week. There is a process. First they enroll—this is when we are making sure they really want to be there. Next we do an assessment and finally they have a visit with the MD. It is usually about one week to enroll and about 2 weeks for the assessment and MD visit."*

- *"The wait is 2-4 weeks. It varies by the time of the year and the capacity of the staff (based on funding)."*

Table 35. Approximate Wait Time for Mental Health Treatment Services from Time of Referral

Steps to Getting Care	Approximate Wait Time From Referral		
	Public Mental Health Provider	Community Clinic Provider	Private Provider
Approval from primary care ⇨	n/a	1-2 weeks (Depends on wait for primary care appointment)	n/a
Orientation/ enrollment ⇨	2 days - 1 week	n/a	n/a
Assessment/treatment appointment with a mental health provider ⇨	1- 4 weeks	2-4 weeks	2-3 weeks
Medication visit with psychiatrist ⇨	2-6 weeks	3-4 weeks	n/a

n/a = not applicable.



Several providers volunteered that students experiencing an urgent mental health need are seen immediately, or within 24-48 hours, depending on the level of urgency. Those that provide campus-based prevention programs stated their ability to respond to referrals is dependent on the timing of the groups that are already in progress. Generally new groups start each semester and referrals are accommodated at that time. Therapists working in the schools reported seeing students within a week.

Of the 3 private providers interviewed, 2 were currently accepting new patients. They estimated a 2-3 week wait for an initial appointment. One of these providers noted that students can be seen sooner if parents have the flexibility to bring the student in during the day. The evening hours are the most popular so there is a limited amount of time available for these appointments.

One private provider remarked that the motivation to take on complicated cases was not high among this individual's private provider colleagues:

- *"There are not a lot of us that are going to jump on a referral for a depressed student who is suicidal. This will be a complicated case and it will take a lot of work. Some mental health providers are not trained and/or not comfortable with that type of case. There is plenty of work to do that is not as difficult or risky. These kids have often never had any referrals and no primary medical care. They see their doctor only for sore throats and ear infections. The schools are often the first ones to identify [the mental health need]."*

Though the above comment was made by one interviewee, it is a consideration in planning for how youth are able to access mental health services, particularly if they have complex mental health needs.

Coordination With Other Systems

All of the local youth services providers received referrals from schools, and in some cases there have been substantial efforts to coordinate the process of referral. For example, in Tulare County, Porterville Youth Services has been working for several months on a checklist that can be used by schools for screening youth for crisis mental health needs. The list is evidencebased and helps schools and mental health providers work more

closely. It is currently being piloted. The use of the checklist and referral process was described in the following example:

"*At 4:00 p.m., a principal calls and needs help right now. They have a female student in their office crying and she has evidence of past cutting on her arms. The principal thinks it is a crisis situation. The Youth Services Crisis Referral Questionnaire we created is a 20- question checklist which can help us to determine how to proceed and how to advise the referring school representative. The principals or counselors are asked to complete the questionnaire answering very specific questions (e.g., family history, psychiatric treatment, history of suicide, recent death or trauma, changes, family members with similar behaviors). The checklist gives the school representatives a way to ask these questions. They fax the checklist to us and a clinician reviews the form. We then speak by phone with the referring school representative. This process allows us to determine if the student should be sent directly to the ER, be brought in for an immediate appointment with the clinic or scheduled for a regular appointment. In the case listed above the client would most likely be seen immediately at the clinic.*"

In addition to schools, providers also indicated they coordinated with the Justice System (primarily the Probation Department), the foster care system, and Child Protective Services. The public mental health providers were more likely to note that they get referrals from these sources and refer to these systems.

Two of the 3 private providers noted that they received referrals from schools. One does not accept new patients and has not been able to take on new patients for the past 4 years ("*it is getting harder as there are not a lot of us practitioners that see children [age 0-18], and there are a lot of children in need of services*").

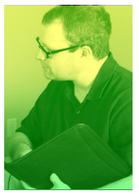
All private providers noted they are serving children and youth from families who are Englishspeaking, educated, and have a higher socio-economic status than the general population of children in the 2 counties. These parents are often able to advocate for and coordinate care for their child without the intervention of the mental health provider. Overall, they reported the students and families they serve have more resources to obtain care and follow-through with treatment than the general student population in need of mental health care or served by the public clinic system.

Mental Health Concerns

Similar to the other participants in this needs assessment, the mental health providers were asked which mental health concerns were the most commonly observed among students in Tulare and Kings Counties. In a slightly different order than others, depression, suicide and anxiety were the most highly-ranked responses (Table 36 on the next page), and these are the areas that providers prioritized when making suggestions for improvement.

Table 36. Student Mental Health Concerns Most-Commonly Observed by Mental Health Providers

Mental Health Concern	Frequency of Mention
Depression	79%
Suicide	43%
Anxiety	43%
Cutting	36%
Sexual Identity issues	21%
Bipolar	14%
Abandonment Issues/Lack of Parental Support	14%
Trauma History	14%
Adjustment Issues	14%
Conflict with Parents	14%
Co-Occurring Disorders/ Drugs and Alcohol	14%
Mood Disorders (general)	7%
OCD	7%
Emotional Abuse	7%
Gender Identity	7%
Sexual Abuse	7%
Child Abuse	7%
Anger/Bullying	7%



Observed Changes in Mental Health Issues

The majority (86%) of the providers believed mental health needs among student populations had increased in the last few years. Three providers noted suicide ideation and planning were increasing, 3 had observed a rise in depression, and an additional 2 had seen increases in cutting behaviors. Five (36%) providers remarked about changes in awareness of LGBTQ and noted that students are more open to identifying as LGBTQ, while a couple others commented on the influence of social media. An example of a change in LGBTQ resources was "*.... a group in place now at Hanford West High School for students who are questioning. This was not there 5 years ago.*" One provider related that students are confused about all the messages they get about sexuality and said, "*they come to me concerned, and I explain that just because 13-14 year old girls don't want to have sex with a boy doesn't mean anything. At that age, their sexuality is not even settled yet.*"

The providers who commented on the changing teen culture and focus on social media particularly mentioned issues of isolation and bullying ("*social networks and the connections can lead to anxiety and depression. The social isolation is a foundational part of suicide*").

About one-third of the providers reported that they are receiving more referrals from schools and parents and have more families seeking services due to outreach and awareness efforts of the Mental Health Services Act, Prevention and Early Intervention programs. They noted that "*referrals are up a bit, people are more aware as prevention efforts are taking hold. Schools are doing good work and changing the kid's sensitivity and openness. We are seeing the bounty of the anti-bully and anti-stigma programs.*"

Concerns Specific to Suicide

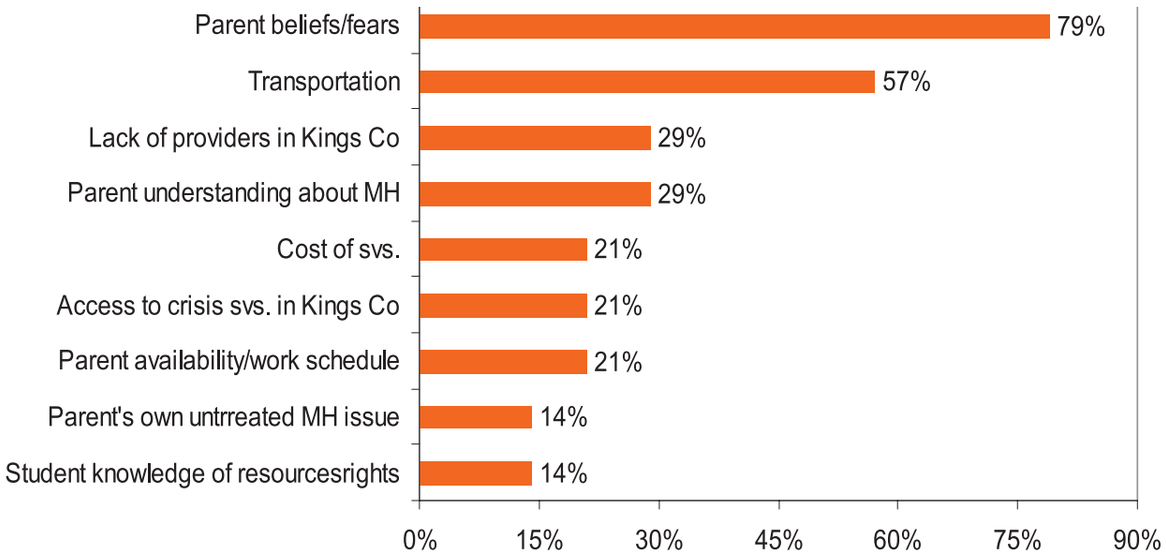
While the level of suicide risk varied among the students these mental health providers worked with, all of them recognized the serious extent to which they thought suicide was an issue for the student population in these 2 counties. Half of the providers reported about 2%-5% of their clients were suicidal during their time of treatment, while 2 providers estimated a risk of 5%- 10%. Six providers who served clients at higher risk for suicide estimated 30%-50% of their clients were at serious risk for suicide or suicide attempt. Despite the risk status of their current caseloads, one provider commented that "*youth who are in the program are at a lower risk than the kids with the same risks that are not in treatment. I am worried about those who aren't here.*"

Two of the mental health providers linked the suicide risk to self-harm and commented that cutting, something typically associated with borderline personality, is now something "so many kids are into" ("*....this type of mutilation can escalate to suicidal thoughts*").

Access

Providers were asked to describe the biggest barriers families faced in obtaining mental health services for their students in trying to access services. The most common barriers identified were family beliefs and fears about mental health, cited by nearly 80% of the providers, followed by transportation problems, especially in rural areas, mentioned by 57% (Figure 34).

Figure 34. Barriers Mental Health Providers Identified for Obtaining Student Mental Health Services, by Frequency of Mention



The following comments about parent beliefs and fears as a barrier for obtaining mental health services for K-12 students illustrate the importance of these factors:

- *"Getting parents in is the hardest part. Parents want to drop their kids off for fixing and then swing by and pick them up."*

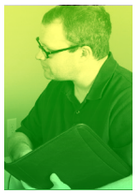
- *"The most common barrier is families refusing services because of stigma. Or, for some, they want to manipulate the process without making progress. They want the services, but they don't want to put in the work to stabilize the situation for the youth."*

- *"Sometimes the parents don't want a student to take medication, and they don't understand why it is important. I have spent hours explaining medication to parents and answering their questions. Hours just to get them to agree to try the medication for a short period to see if it helps."*

- *"You can have someone who is homeless and just got released from jail [served by the public mental health program] in the same waiting room sitting next to a 12 year old. This freaks out families with kids and they don't come back."*

The lack of awareness about the availability of services and eligibility, along with challenges in navigating the service system, was mentioned by at least one-third of the providers as significantly contributing to poor access and utilization ("*the information really needs to get to the parents. We need to teach the parents to be advocates and to be persistent*"). In identifying parents' and other family members' own untreated mental health needs as contributing to student mental health issues, one provider noted that "*kids show signs of mental illness that runs in families and it is identified as a behavior problem rather than an illness. Parents [and other caregivers] are identified by the schools as behavior problems as well.*"

The limited number and type of student mental health resources in Kings County was especially noted by the providers from that county. Four providers who practice in Kings County reported that the lack of mental health providers there, including psychiatrists, was the main barrier to receiving mental health services. Tulare County providers noted that Tulare County could use more psychiatrists, but affirmed a greater need for these services in Kings County.



- *"Eligibility has expanded faster than what can be supported. The barriers are not financial so much anymore because of Medi-Cal. The biggest issue is not enough qualified providers (especially psychiatrists)."*

- *"Psychiatrists have a low willingness to see children. Most will only see a certain percentage of their caseload as children. There are risk management issues when psychiatrists give medications to children. There are tens of thousands of kids in need and they are toughing it out without medication."*

- *"In Kings County, the overall availability of providers is low.... and some who are here prefer not to work with children and adolescents."*

Providers in Kings County also commented on the lack of *crisis* services in that county and provided the following examples of common access problems:

- *"We have no inpatient beds…the system of care and the options get really thin once the mental health issue gets really serious. We have to put a lot of energy into suicide prevention. There is no safety net."*

- *"When I want to have a patient hospitalized, I have to send them to the emergency room. At the ER, they do lab work to be sure the patient*

isn't using drugs. After that, Kings County Behavioral Health comes out to assess them and THEY decide if the patient goes to the hospital. As the child's therapist, I am totally capable of assessing if they are suicidal and if they need to be hospitalized. This process is a huge barrier. Once my client has been waiting in the ER for hours, then waiting for labs, the visit with the Kings County staff is not likely to open them up. Those providers don't have the same history with the client and it is unlikely they will know the same things I know about their mental health. So after all of that, the kids often get sent home. This happens for Medi-cal and private pay clients."

- *"I hate that the police will pick up a patient to keep them for a few hours while they settle down or the ER will hold them for a half day. We need crisis facilities and better handoffs between police, the ER and mental health."*

- *"In Tulare County, they understand suicide risks and they are trained to deal with the situation. They have the Crisis Intervention Training (CIT) and a crisis number with response to the home if needed. In Kings County, there are no CIT officers and the crisis number goes out of county."*

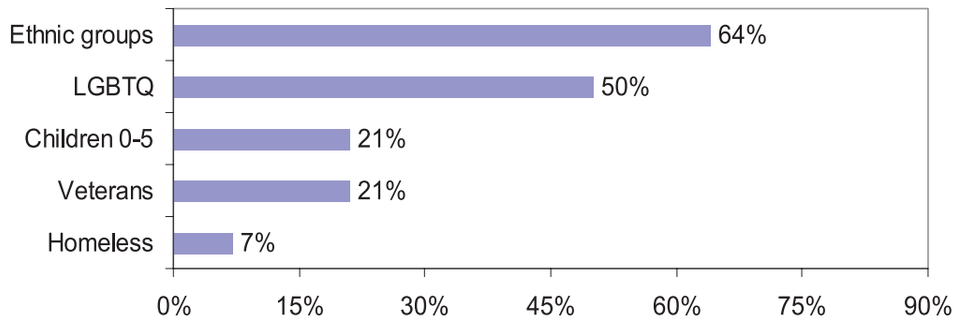
Access Problems for Under-Served Populations

Providers were asked to comment on which groups they felt had a harder time accessing services in Tulare and Kings Counties, and what barriers these populations encountered. Their responses are shown in Figure 35 below.

Ethnic Groups

Ethnic populations, and particularly Hispanics, have a harder time accessing services, according to two-thirds of the interviewees. (Note: while Hispanics represent the largest of the ethnic groups Tulare and Kings Counties they also comprise the highest proportion of the total population in both counties.) Besides limited English skills for many of these families, immigration and citizenship concerns were also noted.

Figure 35. Groups Mental Health Providers Thought Most Affected by Barriers in Obtaining Student Mental Health Services, by Frequency of Mention (n=14)



Other concerns related to serving students and their families in ethnic communities included lack of understanding about the mental health system and treatments in this country for recent immigrants; stigma as a significant cultural barrier for the Southeast Asian community; and a lack of African-American mental health providers and a greater need to connect with the churches to build trust in mental health services. A barrier noted for Native American students who live on a reservation or are connected to a tribe is their lack of Medi-Cal eligibility and limited access to mental health services through the tribe.

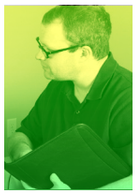
LGBTQ

Half of the mental health providers cited barriers to accessing mental health services for students who identify as LGBTQ. Examples of their comments about stigma and lack of resources describe some of these problems:

- *"We are a small county and it is very difficult for youth exploring sexual and gender identity. It is a sensitive area for parents and other adults."*
- *"There is a lot of stigma and it is hard for kids to identify themselves in a confident way. It is especially hard if the family doesn't know…on top of that, there is a lot of shame and ridicule from the community."*
- *"There is incredible support through the Trevor project, but it is very, very difficult for rural LGBTQ youth to get into treatment"*
- *"For LGBTQ, there are very few specialized services and no safe spaces community-wide for people to be out."*
- *"In Kings County there is training [about LGBTQ] for providers, but I haven't heard of any community resources."*

Veterans

The U.S. Department of Veterans Affairs provides medical care (including mental health care) throughout California. A VA medical center, located in Fresno, provides the most comprehensive mental health treatment, and the Tulare Community-Based Outpatient Clinic also provides outpatient mental health services to veterans.[43] The providers who reported additional barriers that veterans encounter when seeking services cited building trust ("*the door is open, but there is a lot of paranoia*"), co-occurring disorders, and unavailability of services within the counties ("*we do see veterans coming in for treatment, because Fresno is the closet Veterans Administration and it's too far for some to travel to*").



The College of the Sequoias has a Veterans Service Office at its Visalia campus. The office is staffed by veterans who provide support with education benefits. Since 2011, the office has included a Veterans Resource Center for student veterans to get help with academics and to socialize with other veterans. The Veterans Society Club provides mentors for veterans and helps them transition from the military to college.[44]

Families of Children Ages 0-5

Barriers unique to early childhood mental health were unfamiliarity with services/systems of care, including by organizations that service parents ("*childcare providers don't give parents the same mental health information they will get in Head Start or public preschool. Those children who are not in childcare are really out of the system*"), and by parent denial that there could be a mental health problem in such a young child.

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[43] Location information accessed at the US Department of Veterans Affairs Location Directory. http://www.va.gov/directory/guide/state.asp?State=CA&dnum=ALL, 03/17/14. Service descriptions are from the "Guide to VA Mental Health Services for Veterans and Families" Appendix A: Minimum Mental Health Services VA Medical Centers and Clinics are Required to Provide, pp. 22-23. Accessed at http://www.mentalhealth.va.gov/docs/MHG_English.pdf, 03/17/14.

[44] Information about the Veterans Services Office was accessed on the College of The Sequoias website: http://www.cos.edu/studentservices/studentsupportservices/veteranservices/Pages/default.aspx, 03/17/14.

Suggestions for Improvement

Providers were asked for their ideas or solutions to address the current mental health needs they identified and the barriers for accessing help. Table 37 summarizes their responses, which are described in more detail in the pages that follow.

Table 37. Suggestions by Mental Health Providers for Addressing Student Mental Health Needs (n=14)

Solutions and Strategies	Frequency of Response
Promote Education for Key Groups	100%
Teachers/schools	71%
Parents	57%
Students	43%
The general public	14%
Reduce Stigma	64%
Use peers in outreach	43%
Educate and decrease fear ("normalize mental health care")	43%
Better Identification and Referrals	43%
Identify students/families at risk	36%
Increase awareness about depression	7%
Improve referrals between schools and MH providers	7%
Increase Access to Services	71%
Provide services on campus/at family resource centers	50%
Improve crisis services in Kings County	14%
Raise cultural competency	14%
Recruit more providers to Kings County	14%
Reduce transportation barriers; increase service hours	14%
Help families overcome barriers to entering the system (e.g. paperwork)	7%
Establish a youth-only mental health clinic	7%
Collaboration	43%
Coordinate services/build more relationships	36%
Joint training ("everyone needs to be on the same channel")	21%

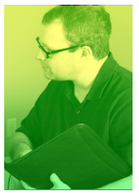
Education

Education about mental health—including how to identify needs and where to go when someone needs help—was the number one consideration by all of the mental health providers.

- *"Teach schools about how to have the conversation with families. Teachers are afraid to be involved and fearful of the reaction from parents, they don't want to offend anyone."*
- *"The teachers and administrators are overworked and it is the providers' responsibility to make them more aware of the services. They need to know we are here and know what's available."*
- *"Improve knowledge about resources. Mental health providers know what's available, but parents and schools don't always have the information."*
- *"Talk to the parents to explain what depression looks like, here are questions you can ask, here are things you can do."*
- *"I see the interested families who want to get better. If I go to the continuation high school, or certain neighborhoods, there is not that same interest from parents."*
- *"It could be a required class like their physical health class. It should be part of general education, not just for the students who are about to be expelled."*
- *"We need to help the community understand what mental health is."*

Nine (64%) of the providers spoke about the need to address the stigma around mental health,and 6 recommended using peer providers to decrease fears and "normalize mental health care."

- *"Reduce stigma with families, teachers and administrators—work toward making a discussion about mental health very matter-of-fact, just like anything else."*
- *"Some schools have wonderful peer counseling groups; we could use that in all of the schools."*



Identifying and Referring

The providers who offered solutions concerning better identification of those at risk and improved referrals from the schools to providers suggested the following:

- *"Before the transition out of elementary school, we need to identify the at-risk students, identify the high-risk family situations and identify the parents' mental health needs."*
- *"Less fear on the teacher's part is needed to speak up and say something [when they suspect or recognize a problem]."*
- *"There are kids who are not receiving intervention for mental health. They are not getting identified as mental health even though they are in other systems. They come to us with a co-occurring disorder and no mental health or substance use interventions. The issues are identified as behavioral problems rather than mental health issues."*
- *"Effective suicide prevention programs are depression-finding programs."*

Improved Access to Services

The most common consideration for addressing the access barriers that students and families face when they are trying to use mental health services was to bring the therapists to where the students are: the school campus and family resource centers, for example, which also reduce the barriers of transportation and stigma.

- *"The mental health resources need to go where the people are. Keep the professionals out where the kids and families are..... families are much more likely to follow through."*

- *"Some agencies will say that they work at a school, but they don't go out until there are a certain number of referrals, or they wait to be asked. [One agency] needs 5 students before they go to the school. We need to change that to say, 'if you can't make your appointment, I am coming to you.'"*

- *"School sites should have their own therapist on site. Someone who is anchored there and more accessible so it is really easy to get care."*

- *"Co-locate the services in rural areas. The services are much less stigmatized when the families are going to the family resource center than when they have to come to a big building that says 'Mental Health'."*

Other comments included improving cultural competency ("*in the Latino community, the Mexican-American immigrants have faith, community events and camaraderie. Bringing these opportunities into the conversation is more culturally validating. Many of the clients respond to bringing some of the 'old ways' into their treatment*"); having a youth-centered mental health clinic separate from the adult clinic in the public mental health system ("*....it would be more comfortable for youth to access services there*").

Recommended Practices

Seven (50%) providers recommended incorporating more promising and/or evidence-based practices for addressing student mental health needs. These included:

- Mental Health First Aid[45] for parents and educators. The ASIST program (Applied Suicide Intervention Skills Training) was mentioned as being very well done and should be continued.

- Developmental Assets developed by the Search Institute[46] and implemented regionally. This program trains parents to help other parents with parenting youth.

- Expanded community programs for youth including sports, theater, church, recreation centers, after-school and others programs that "give students a different way of seeing. things…something to capture their imagination....sometimes the best thing for a high-risk student."

Collaboration

Close to half (45%) of the mental health providers remarked that more coordination of existing services and more efforts put toward building relationships to work together were needed. The following examples provide a place to start:

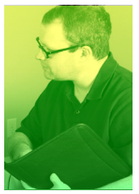
- *"We need better handoffs between the police, the emergency rooms, and mental health. There are pieces of the puzzle that need to be put together in this area and we need the energy and the leadership to address it."*

[45] More information can be found at their website: http://www.mentalhealthfirstaid.org/cs/

[46] More information about the program can be found here: http://www.search-institute.org/research/developmentalassets and here: http://www.familyleadership.org/the-40-assets/

- *"Everyone needs to be on the same channel and then the treatment comes together. Training and communication from everyone at the table."*

- *"I have seen a power struggle between the psychologist and the therapist around the diagnosis and treatment of a student. The education system has a set of diagnoses and the mental health system has another set of diagnoses. The only difference is in the training. The school psychologist is trained to look for and diagnose learning problems, the therapist is trained to look for and diagnose mental health problems. There needs to be more coordination and less power struggles. The school psychologist should not be diagnosing mental health concerns."*



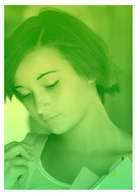
- *"It is time for the mental health providers to build trust and learn how to network, build relationships in communities and really create strong partnerships. This is a big shift from the current practice (which I am guilty of myself) of coming in and doing what you have to do and then leaving because your caseload is huge and you need to be in at least 3 other places today. A training on how to build those relationships and how to work together [with the school] as a team would be helpful."*

CONCLUSIONS

"Mental health issues among college students are more common than you'd think, but people aren't going to go around with a sign on their back advertising it."
– College Student Interview

"You start out by talking about one thing but it can sure lead to another pretty quick—these kids are emotionally raw."
– School Psychologist interview

"The majority of parents want a quick fix. Some are willing to work with you, some aren't."
– Junior High Principal interview



This needs assessment was able to shed light on a number of issues around the mental health needs and available resources for students in Tulare and Kings Counties. It identified challenges, such as a lack of confidence in the ability to identify mental health symptoms, lack of acceptance of these concerns by parents, and behaviors like bullying that can have a lasting impact on a student's long-term mental health, and identified opportunities for improving understanding about the stigma of mental health. The study also highlighted many positive efforts undertaken in these counties such as expanding school-based prevention strategies, drawing greater attention to the topic of suicide, and adopting formal policies for bullying.

The findings can provide guidance to those interested in developing or supporting existing effective programs and services. In determining how to apply the findings from this research, it is first important to understand the study's limitations. While the school personnel sample was broad, the assessment is not fully representative of all parents and students in the 2 counties but of those who were selected by the schools (or self selected in the case of college students). Similarly, the physicians and community mental health providers who responded to the survey and interviews, respectively, may reflect those who were more involved with or motivated to address mental health concerns than the pediatricians, family practice physicians and mental health providers who practice in these counties.

Schools

It is well known that mental health issues such as anxiety, depression, and family problems often are the root causes of poor academic performance, disciplinary issues and truancy. Colleges and PreK-12 schools, including some of those in Tulare and Kings Counties, have begun to play a central role in better meeting the needs of students with emotional, behavioral and mental health concerns that require intervention. These school districts recognized the value of

a more comprehensive approach in which a supplementary team of community mental health professionals had been integrated into their campus services.[47] Despite resource limitations, they appreciated that a comprehensive approach that includes education and prevention services, including for families, and on-campus treatment services is effective and evidence-based and removes barriers to accessing mental health services and improving coordination of care.

While schools are starting to embrace identifying mental health needs, resources for student mental health prevention and treatment varied among the study schools depending on the attention the schools or districts have paid to it. The majority of the schools seemed overwhelmed with responsibilities and competing needs and unable to more fully provide campus-based *mental health* (as opposed to academic counseling) services even when they were doing a good job of trying. It was a positive finding that once most families who were in the system and who got past all the barriers felt they got good treatment and were generally happy with it.

We noted that the definitions and criteria for anxiety, depression, anger and behavior problems—which have common characteristics—were not always clear as they were talked about almost interchangeably in many of the interviews. It would be helpful if everyone had a better understanding of what these conditions mean and how they affect students' academic, social and home life from a very early age as stakeholders continue to work on these issues. For example, because teachers (who were identified as being in the best position to observe student demeanor) were the least likely to be comfortable identifying and knowing what to do when a mental health need was suspected, putting training resources into the teachers to better identify and respond would be money well-spent in the current system. Increasing understanding of these issues beginning in early childhood also points to the importance of training providers in early mental health and supporting those already trained in working with young children.

Although all of the schools have adopted formal policies related to bullying prevention, the fact that a number of students and parents perceived enforcement as being lax or random or not enduring is troublesome and suggests an area to rapidly address. In small towns in particular where "everyone knows everyone's business," the lasting effects of school (and domestic) bullying incidents can be more severe than in larger cities where there is more diversity and anonymity. Parents spoke, for example, about excessive bullying leading to mental health concerns and some reported that their child's sexual orientation or the perception of their sexual orientation led to bullying at school and within their families. Most parents seemed very uncomfortable talking about LGBTQ issues directly, however.

Negative attitudes toward LGBTQ youth are particularly worrisome as LGBT youth are at increased risk for experiences with violence, compared with other students. Going to a school that creates a safe and supportive learning environment for *all* students and having caring and accepting parents are especially important, and in particular for students who are considered "different." Yet many school personnel indicated they were not confident in knowing how to identify or address LGBTQ concerns. Moreover, 1 in 5 physician survey respondents indicated they neither referred nor treated sexual orientation and gender identity needs, and 1 in 2 community mental health providers noted barriers for LGBTQ students, including stigma. Although many other study participants noted the needs of LGBTQ students and the impact of stigma and bullying on their mental health, few included additional resources specific to LGBTQ in their suggestions. The awareness of concerns, the inadequacy of

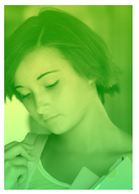
[47] See the graphic *A Comprehensive, Multifacted and Integrated Approach to Addressing Barriers to Learning and Promoting Healthy Development* in Attachment 6 as a suggested national model.

current resources to address the concerns and the lack of recommendations to address the needs and increase the resources suggest there is work to be done to increase sensitivity toward and support for LGBTQ students. This seems particularly true in Kings County.

While the community colleges also take student mental health conditions seriously, resources for campus-based mental health counseling are extremely limited. Yet mental health services are typically one of the most commonly sought services from student health centers. Because some college students said they "just leave and go home," cutting classes when they're overly stressed or depressed, they are less likely than younger students, who are more "visible" to campus personnel, to come to the attention of a faculty person who might be in a position of influence and express concern. College-age youth were also more likely than middle and high school students to report not knowing someone or feeling they had anyone to rely on or a resource to turn to when they were having "issues." Addressing the isolation and loneliness of college students with mental health concerns and the difference in their knowledge of what to do and where to go should be a matter for college administrators to consider. Even when student health centers cannot expand counseling support services they all need to have a formal link to and referral system for community-based care and a means for following up with referred students. Given the prevalence of mental health conditions among college students, including for returning veterans, this issue is of great importance.

It was clear that all of the school personnel and providers who participated in this project took the issue of suicide risk very seriously. Students noted awareness of suicide symptoms, but were most likely to say they would listen to a friend but not necessarily to report it, which suggests the need for more specific training for all students about what is a risk and how and when to take appropriate action.

Parents and other groups who recommended school psychologists be given more days to be on campus might be a reflection of their confusion about roles. The psychologists are the school employees whose role is largely to diagnose learning disabilities and help in planning effective interventions. They are not the ones who are effectively addressing mental health concerns because they are not generally trained as clinical psychologists. Clarity about the roles of the school, the school psychologist, the therapist and the psychiatrist would be very helpful for those involved in serving students and their families.



Parents

Learned parenting styles, economic disparity, and the multiple challenges of fractured households, domestic stress/abuse and perceived and real lack of alternatives to resolve these conditions has presented many families in Tulare and Kings Counties with the challenges that impact their student's mental health. All of the parents whose child had an identified mental health concern felt the issues affected their child in a variety of ways, including academics, social life and family life.

Parents felt their child's mental health issues were important to address at school, and most would support those services being implemented in their child's school. They viewed schools as a positive support system for student mental health concerns, and generally believed the school was supportive of their child's mental health. Most agreed that training in mental health awareness and issues would be beneficial for school staff, students, and parents. These attitudes did not differ by county or by whether parents had a child with an identified mental health condition.

Relationships with schools were generally reported in a positive light. However, it usually sounded as reactive to the efforts of school personnel's outreach rather than parents reporting their personal proactive effort to get involved in their child's classroom or school events. Many

of their experiences in connecting with medical or counseling supports were individual actions, not augmented by any peer mentors or support groups.

When parents sought or were receptive to their student receiving mental health treatment the most common reported problems were basically the same ones they typically experience in accessing other health and human services, such as transportation difficulties, time to wait for an appointment, time getting off work, confidentiality, and stigma. This speaks to the very real need to expand campus-based mental health services, including offering family counseling at times that are more convenient for working family members.

While family attitudes and experiences varied, Spanish-speaking (monolingual especially) families tend to have a very high reverence for the role of teacher. It is typical that those families expect that the teacher or the school is going to know exactly what is wrong and what to do and will inform the parents. This deference can be misinterpreted as indifference, and these parents may need to be approached in different ways to engage more effectively with the school. Most of these parents expressed interest to understand more about what was happening with their student. Recruiting more bicultural and bilingual mental health counselors would be optimal.

Parent anecdotes about frustrations, confrontations and disillusionments with police and school district personnel were mostly based on a sense of perceived injustice (for example, authorities selectively focusing on their child's behavior and not pursuing the real source of the problem). The fallout from this is that when families lose their trust in authorities or feel victimized they reduce their level of communication rather than try and reconcile the situation. Including law enforcement personnel (particularly as they are first responders in a mental health crisis) in the conversations and in trainings around prevention education for student mental health may help alter some families' perceptions and increase their willingness to heal their feelings that they "don't matter." Examples of local organizations that can be part of the solution include Family Resource Centers and Family Services agencies as these are places that have garnered trust because of their accessibility and multi-resource function.

Mental Health and Primary Care Providers

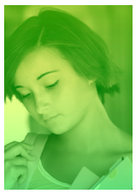
It was mentioned in many areas of this needs assessment that personal relationships were very important when addressing mental health needs. For example, school administrators with strong ties to the community were better able to encourage parents to seek treatment. Other references were made of being able to "fast-track" treatment access when the school personnel knew someone in the mental health agency, and some commented about the need to build relationships between schools and mental health providers. Nevertheless, the communication between schools, mental health providers and community physicians seemed sometimes confused. The schools reported not getting the "outcomes" they were hoping for from the mental health services (for example, providers not assessing or determining the level of risk the way the school thought they should, and returning the student to the school without treatment) and the physicians noted not getting responsive care from the mental health providers and in some cases the schools. Clarifying expectations about what happens after a referral and what the criteria are for risk (like the Porterville schools are doing with their Checklist) could go a long way toward better collaboration or at least building trust.

Although the wait times for some mental health clinics and non-profit providers were reasonable, the results were mixed. Some of the "hoops" families have to go through before their student can actually begin therapeutic services adds upfront wait time that is frustrating for both

parents and students. The statement that private therapists commonly lack motivation to take on complicated cases "because there's plenty of work to do that is not as difficult or risky," although made by only one therapist, deserves more examination and should be a consideration in planning for how youth are able to access mental health services, particularly for those with complex mental health needs.

The findings from Tulare and Kings Counties pediatricians and family practice physicians showed these providers agree they should identify patients for mental health issues, but too few expressed confidence in their ability to do so—as well as to treat/manage such concerns among student-age patients. It was disconcerting to learn these physicians generally do not work with school personnel to confer or coordinate care when there were mental/emotional health issues among their young patients. While schools have limitations in initiating contact with a student's primary care provider when there are mental health concerns, they bear a responsibility for at least being responsive when the physician contacts the school to confer or coordinate care. While the resistance of some parents to a mental health diagnosis for their child may present a challenge, parents are the key to the relationship because of consent issues, and each entity has to make sure the parent is brought into the picture as the hub from which to work to be effective. The primary care provider findings may have additional implications as in some cases physicians are the gatekeepers for access to other related services for students.

Summary



The many local individuals and organizations that participated in this needs assessment indicated a great deal of understanding of the enormous and varied mental health needs among students and the frustrating and real limitations of the existing resources. The recent work that has been done to improve prevention and early intervention, address bullying and illuminate the risks of suicide has brought increased attention, knowledge and ideas to the issues surrounding student mental health. As parents, mental health providers and schools continue the conversation, the need to clearly define each other's roles and expectations in addressing the identified concerns becomes paramount. It is hoped that this report and the description of the issues from the varied perspectives serves to encourage continued collaboration as the Tulare and Kings Counties communities work to improve mental health for all students.

For a copy of the full report, please contact:

Tulare County Health & Human Services
Tulare & Kings Counties Suicide Prevention Task Force
5957 S. Mooney Blvd.
Visalia, CA 93277
(559) 624-7474
community@tularehhsa.org

Kings County Behavioral Health
450 Kings County Drive, Suite 104
Hanford, CA 93230
Phone: 559-852-2444
Re: SPTF

CONSIDERATIONS FOR IMPLEMENTATION

"We don't necessarily ever get to the heart of the family stuff, what's going on at home, because it takes a long time for these kids to open up."
–High School Principal

"The funding type dictates who can be helped."
–Elementary School Principal

After evaluating all of the data collected from the needs assessment process, certain key findings emerged. While many important considerations were offered by study participants, certain suggestions rose to the top that tie most closely to the identified needs. Notwithstanding the challenges of poverty and the limitation of resources, we identify 9 considerations for implementation we believe warrant priority attention in Tulare and Kings Counties for focusing resources in student mental health. We recognize some solutions will be more attainable to address in the short term while others will require more long-term planning to implement.

Readers should note there is no particular significance to the order of these suggestions.

Promote conversations and education about mental health signs, symptoms and resources.

■ Support increased community and parent awareness around the stigma of mental health.

Despite decades of learning, mental illness is still perceived with stigma. It remains a powerful negative attribute in society and in familial relationships; negative attitudes can start as early as the preschool years. Stigma leads to lack of parental engagement once a mental health need has been identified, and prevents underserved populations from seeking care. To address stigma, peer-driven strategies that address mental health, particularly programs that use other parents, youth and/or representatives from underserved populations, should be implemented. The definitions and criteria for anxiety, depression, anger and behavior problems would be a good place to start conversations.

■ Increase student awareness of available mental health services on college and adult trade school campuses.

Although mental health counseling available through college student health services is very limited on most campuses (as are general student health services), more efforts need to be made to increase and maintain student awareness of what is available both on campus as well as in the community. At a minimum, maintain an updated list of providers and information about eligibility. Consider offering space and inviting community mental health providers to offer counseling services as part of the student health services program. The mental health services should be coordinated with other student health services and include preventive as well as intervention strategies.

■ Share and use the findings from this needs assessment as opportunities to improve mental health efforts in Tulare and Kings Counties.

Continue to use the Network and other strategic partnerships to operationalize the findings and suggestions from this report. Establish subcommittees, if appropriate, that involve schools and develop actionable next-steps with measurable outcomes where progress can be tracked. Bring into the process other interest groups and stakeholders (e.g., business, civic clubs, faithbased organizations) and use media outlets for messaging.

■ Encourage the engagement of private religious schools in community-wide efforts to meet all student mental health needs in the two counties.

It's not possible to know the potential interest of private religious schools in working together to better meet their students' mental health needs because of their lack of responsiveness to participate in this needs assessment. However, reaching out to them on an individual basis through Community Outreach and inviting them to be part of a community-wide effort around a specific education and prevention strategy may be an appropriate place to start.

Provide mental health trainings for professionals who are in a position to identify mental health needs in students.

■ Expand the Mental Health First Aid training program for all teachers.

Classroom teachers in every school district would benefit from receiving training from this national program. Participants are taught the skills to identify risk factors and warning signs for mental health and addiction concerns, strategies for how to help students in both crisis and noncrisis situations, and where to turn for help.

■ Offer periodic mental health education programs for community primary care physicians and other providers for children and youth.

This study suggests pediatricians and family practice physicians in the 2 counties would benefit by attending a periodic lecture or conference where the main topic is student mental health. Further training—with continuing

education (CE) offered—should be supported for identifying or treating/managing depression and other mental health problems in children and young adults. In addition to clinical-level curricula, practical information should be included about referral sources and ways to more closely coordinate care between physicians and mental health providers and school personnel when there are mental health issues among students.

Integrate mental health services into school settings.

■ Increase support for early childhood mental health programs.

There is a strong evidence base for the effectiveness of early childhood mental health that helps young parents at the very beginning to understand the factors that promote good mental health and readiness to learn. Increase support for the integration of mental health programs in all child-serving systems in the 2 counties, including child care resource and referral agencies, early care and education programs, special education services, Head Start and Early Head Start. When supporting workforce development strategies (e.g., expanding training opportunities for child care and preschool staff), ensure competencies and skills in early childhood mental health are integral to the curricula. Give particular attention to cultural values and beliefs, and language and literacy needs of families. Recognize the essential role that families play in their child's development and welcome their perspectives, engage them in planning, and solicit their feedback to promote the healthy social and emotional development of their children and the family.

■ Enforce and maintain zero-tolerance policies concerning bullying.

Every school should establish and maintain high expectations among students and faculty/staff concerning student exposure to bullying environments and behaviors and supply the support necessary to achieve the expectations. Prevention efforts should work at 3 levels: school-wide, classroom level and individual student. Parents need to know that the school will intervene more directly when they make a complaint about bullying of their child, and will maintain practical vigilance to ensure the bullying doesn't continue.

■ Expand school- and community-based mental health services–especially prevention–for students in more school districts, especially in Kings County.

School-based programs offer the potential for prevention efforts, as well as the promise of improving access to diagnosis of and treatment for the mental health problems. School districts and the colleges would benefit from teaming with community mental health providers to bring more mental health services onto the campus, ensuring the availability of private, confidential and comfortable space, and late afternoon and early evening counseling appointments. Make provision for mental health services to be offered during long school breaks and summer vacation.

Consider involving non-traditional stakeholders such as faith-based organizations and recreational programs and, where possible, integrating substance abuse and mental health services, family, individual, and group therapy, medication management, and case management into campus-based mental health services. When planning program and intervention strategies,

consider the risk and protective factors (i.e., personal characteristics or environmental conditions that have been demonstrated to increase or decrease the likelihood of problem behavior) for the student populations in Tulare and Kings Counties and how these factors should be modified to reduce risks.

Very importantly, roles of all the various mental health professionals who work on campus with students—including the district's school psychologists—should be clarified and defined so that they are understood by students, families, all school faculty and staff members, and the mental health professionals themselves and expectations are clear and realistic.

APPENDICES

"Families don't want to open up their lives to scrutiny. By the time we get to the families it's sometimes on the back end of the problem."
– High School Principal

"The education system has one set of diagnoses and the mental health system has another. There needs to be more coordination between the two and fewer power struggles." – Local Mental Health Provider

ATTACHMENT 1

Tulare & Kings Counties Suicide Prevention Task Force Executive Committee

The following individuals from Tulare & Kings Counties SPTF served as the Executive Committee for this study:

Executive Committee	Affiliation
Brenda Johnson-Hill	Kings View Counseling Services
Cheryl Lennon-Armas	Tulare Youth Service Bureau
Jackie Jones-Siegenthaler	Kings County Behavioral Health
Karen Haught, MD	Tulare County Health & Human Services Agency
Mary Anne Ford Sherman	Kings County Behavioral Health
Noah Whitaker	Tulare County Health & Human Services Agency
Project Support	**Affiliation**
Jan Winslow	Tulare County Health & Human Services Agency

ATTACHMENT 2

List of Participating Schools*

College /Adult (Dean/Provost)	School
Cindy Sandoval	Milan Institute
Kristin Hollabaugh	College of Sequoias (Hanford Campus)
Larry Dutto	College of Sequoias (Tulare Campus)
Sylvia Robinson	West Hills Community College
k-12 School District (Superintendent)	**School**
Carolyn Kehrli	Cutler-Orosi Joint Unified
Craig Wheaton	Visalia Unified
David East	Reef-Sunset Unified
Drew Sorensen	Woodlake
Joe Hernandez	Dinuba Unified
John Snavley	Porterville Unified
Paul Terry	Hanford Elementary School District
Rich Merlo	Corcoran
Sarah Koligian	Tulare Joint Union
Sherry Martin	Kings River
Steve Bogan	Armona Union
Thomas Addington	Central Union
Thomas Rooney	Lindsay Unified
William Fishbough	Hanford Joint Union
Principal/Other	**School/Other**
Chuck Gent	Corcoran High School
Cyndee Garcia	Cutler-Orosi FRC
Darin Parson	Hanford Joint Union
Dawn Crater	Bartlett Middle School
Eduardo Ochoa	John C. Fremont Elementary
Glen Billington	Woodlake School District
Helen Copeland	Cutler-Orosi Joint Unified
Irma Rangel	Woodlake FRC
Isidro Carrasco	Mission Oak
Jason Strickland	JFK Middle School
Joe Martinez	Dinuba Unified
Julie Berk	Linwood Elementary
Julissa Leyva	Santa Fe Elementary
Ken Spencer	John Muir Middle School
Kenneth Eggert	Woodrow Wilson Jr High
Laura Green	Porterville Elementary
Laurie Blue	Crossroads Charter School
Lucy Van Scyoc	Tulare Western
Melanie Stringer	LaJoya Middle School
Michele Borges	Sierra Pacific High School
Nancy Crawford	Lulu Blair Kress Preschool
Tina Smith	Reef-Sunset School District HS

*Names are in alphabetical order.

ATTACHMENT 3

QUESTIONS FOR PARENT/GUARDIANS INTERVIEWS

Tell me about your child's MH/emotional issues. How were these concerns first identified? By whom?

What do you think might be contributing to these concerns?

Has your child's MH concerns impacted them academically/socially, and if so, how?

How did the school respond to your child's mental health concern? Did you follow up on the referral? If you did not follow up on a referral, what kept you from following up?

Did your child get the help she/he needed, and was the experience satisfactory?

How involved is your child's doctor [or healthcare provider] in your child's MH needs?

Has suicide been a concern for your child? If so, did the school have a role in addressing the concern? How?

What might have made a difference to your child earlier in preventing or reducing his/her MH needs? What kind of difference do you think it would have made if some of these issues had been dealt with earlier? Why?

What one thing would you change to improve the current system of school-based MH services? What can schools do to help kids more?

QUESTIONS FOR PARENT/GUARDIANS INTERVIEWS

What are the most common mental/emotional health issues or problem you've seen among the kids you know? [Or yourself]

What are the main reasons for this? What do you think contributes to these problems?

If you felt [if the kids you knew felt.....] that you [they] had a MH problem, would you know who to turn to for help?

How supportive do you feel your school is with regard to students' MH needs/issues?

Have you or anyone you know ever tried to access MH services through your school? If so, what was that like?

During this school year, were you taught in any of your classes: how to manage stress in a healthy way? how to manage anger? signs of depression and suicidal behavior?

How much of a problem do you think suicide is among the kids at your school [other kids you know]?

What might your school – or schools you attended before – have done that could have made a difference in preventing some of the MH issues kids face [or that you've described]?

What one thing would you change to improve the MH services available to students at your school?

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* Introductory and other script not shown here. Note that all questions were always asked in every interview. The questions were modified and added to as appropriate for the interview (for example, when interviews were one-to-one or in a group setting).

ATTACHMENT 4

ONLINE SURVEY FOR SCHOOL PERSONNEL

Thank you for your help. The purpose of this anonymous survey—funded by Tulare and Kings Counties Mental Health—is to learn more about student mental health needs. Because schools are often where students' mental and emotional health issues are discovered and behavioral problems are identified that affect their learning, hearing from you is critical to improve services for students and their families.

This feedback will build on what we've already learned from talking with principals and other administrators from kindergarten through college who are supportive of this survey. Please note that this student mental health needs assessment is also going to include, with your help, interviews with a sample of parents and students.

Check with your district to obtain a copy of the final report in June 2014.

You may start and stop the survey and come back to finish it another time, but be sure to complete it before November 22! Thank you!

Here are a few terms to know about in this survey before you start:
Mental Health (MH) = refers to emotional, mental, behavioral issues
MH includes = depression, anxiety, anger, bullying, eating disorders, gender identity/sexual orientation issues
MH excludes = outside the scope of this survey are autism, ADD/ADHD, developmental disabilities
School = preschool, K-12, college, adult/trade school or school district
Student = any age of student in a school in Tulare or Kings County

1. What kinds of mental health issues and concerns have you MOST COMMONLY observed among the students you serve?
Of the following, check the 3 you think are MOST COMMON:
a) Depression
b) Anxiety disorders
c) Eating disorders
d) Cutting
e) Behavior management problems (anger, bullying)
f) Sexual orientation/gender identity issues
g) Suicide risk/suicide serious plan
h) Early childhood MH concerns (age 0-5)
i) Other [Please specify]

* The original format of this questionnaire has been modified slightly to fit the margins of this report.

2. How confident/comfortable are you in your ability to IDENTIFY the following conditions or concerns among your students?
[Check "Not Age Applicable" only if it applies to the students you are currently working with]

	Confident	Somewhat Confident	Not Confident	Not age Applicable
a) Depression	☐	☐	☐	☐
b) Anxiety disorders	☐	☐	☐	☐
c) Eating disorders	☐	☐	☐	☐
d) Cutting	☐	☐	☐	☐
e) Behavior management problems (anger, bullying)	☐	☐	☐	☐
f) Sexual orientation/gender identity issues	☐	☐	☐	☐
g) Suicide risk/suicide serious plan	☐	☐	☐	☐
h) Early childhood MH concerns (age 0-5)	☐	☐	☐	☐
i) Other	☐	☐	☐	☐

3. How confident/comfortable are you in your ability to IDENTIFY the following conditions or concerns among your students?
[Check "Not Age Applicable" only if it applies to the students you are currently working with]

	Confident	Somewhat Confident	Not Confident	Not age Applicable
a) Depression	☐	☐	☐	☐
b) Anxiety disorders	☐	☐	☐	☐
c) Eating disorders	☐	☐	☐	☐
d) Cutting	☐	☐	☐	☐
e) Behavior management problems (anger, bullying)	☐	☐	☐	☐
f) Sexual orientation/gender identity issues	☐	☐	☐	☐
g) Suicide risk/suicide serious plan	☐	☐	☐	☐
h) Early childhood MH concerns (age 0-5)	☐	☐	☐	☐
i) Other	☐	☐	☐	☐

Other - Please Specify

4. How confident/comfortable are you in your ability to RESPOND if you become aware of the following conditions or concerns among your students? (Note: "respond" can include referring, counseling, etc.)

	Confident	Somewhat Confident	Not Confident	Not age Applicable
a) Depression	☐	☐	☐	☐
b) Anxiety disorders	☐	☐	☐	☐
c) Eating disorders	☐	☐	☐	☐
d) Cutting	☐	☐	☐	☐
e) Behavior management problems (anger, bullying)	☐	☐	☐	☐
f) Sexual orientation/gender identity issues	☐	☐	☐	☐
g) Suicide risk/suicide serious plan	☐	☐	☐	☐
h) Early childhood MH concerns (age 0-5)	☐	☐	☐	☐
i) Other	☐	☐	☐	☐

Other - Please Specify

5. Do you think the policies and procedures of the school/district help teachers and students respond adequately to mental/emotional health needs?

a) ____ Yes
b) ____ No
c) ____ I'm not totally aware of my school's policies and procedures for these kinds of needs

6. How have these issues or concerns changed among your students in the last few years?

	More Common	Less Common	Remained about the same	Not sure / Don't know
a) Depression	☐	☐	☐	☐
b) Anxiety disorders	☐	☐	☐	☐
c) Eating disorders	☐	☐	☐	☐
d) Cutting	☐	☐	☐	☐
e) Behavior management problems (anger, bullying)	☐	☐	☐	☐
f) Sexual orientation/gender identity issues	☐	☐	☐	☐
g) Suicide risk/suicide serious plan	☐	☐	☐	☐
h) Early childhood MH concerns (age 0-5)	☐	☐	☐	☐
i) Other	☐	☐	☐	☐

7. To what extent do you believe addressing students' MH needs is part of your role? [Check only one]

a) ____ A lot
b) ____ Somewhat
c) ____ A little
d) ____ Not at all

8. A. Thinking about both prevention and treatment, how well do the SCHOOL'S OWN MH resources (e.g., school district personnel) address these issues among your students?

	PREVENTON			TREATMENT		
	Adequate	Not Adequate	Not Sure	Adequate	Not Adequate	Not Sure
a) Depression	☐	☐	☐	☐	☐	☐
b) Anxiety disorders	☐	☐	☐	☐	☐	☐
c) Eating disorders	☐	☐	☐	☐	☐	☐
d) Cutting	☐	☐	☐	☐	☐	☐
e) Behavior management problems (anger, bullying)	☐	☐	☐	☐	☐	☐
f) Sexual orientation/gender identity issues	☐	☐	☐	☐	☐	☐
g) Suicide risk/suicide serious plan	☐	☐	☐	☐	☐	☐
h) Early childhood MH concerns (age 0-5)	☐	☐	☐	☐	☐	☐
i) Other	☐	☐	☐	☐	☐	☐

Other - Please Specify

8. B. If you checked "inadequate" for any of the items above regarding your school's own resources, please explain the reason:

9. A. Thinking about both prevention and treatment, how well do the COMMUNITY-BASED MH resources (e.g., MH agencies or private therapists) in Tulare and Kings Counties address these issues among your students?

	PREVENTON			TREATMENT		
	Adequate	Not Adequate	Not Sure	Adequate	Not Adequate	Not Sure
a) Depression	☐	☐	☐	☐	☐	☐
b) Anxiety disorders	☐	☐	☐	☐	☐	☐
c) Eating disorders	☐	☐	☐	☐	☐	☐
d) Cutting	☐	☐	☐	☐	☐	☐
e) Behavior management problems (anger, bullying)	☐	☐	☐	☐	☐	☐
f) Sexual orientation/gender identity issues	☐	☐	☐	☐	☐	☐
g) Suicide risk/suicide serious plan	☐	☐	☐	☐	☐	☐
h) Early childhood MH concerns (age 0-5)	☐	☐	☐	☐	☐	☐
i) Other	☐	☐	☐	☐	☐	☐

Other - Please Specify

9. B. If you checked "inadequate" regarding community-based resources for any of the items above, please explain the reason:

10. Thinking about the students you work with, what are the most important or biggest barriers for students to access to mental health services? Put the following barriers in rank order, starting with "1" for the biggest, "2" for the next biggest, etc. until you've ranked EACH barrier from biggest to the least important barrier. (If you check the "Other" category, please include it in your ranking.)

a) ____ Family resistance or low engagement to help
b) ____ The student's home environment
c) ____ Family inability to pay for services when referred to outside resource
d) ____ Lack of awareness of MH issues among school staff
e) ____ Shortage of school psychologists/counselors for time on non academic purposes
f) ____ Shortage of community-based MH providers
g) ____ Transportation
h) ____ The time that services are offered
i) _____ Other [Describe_____]

11. Thinking about the students you work with:

A. Is there a MH issue in which parents are particularly supportive/engaged?

1) ____ No
2) ____ Yes [Which one(s)? Why?_____
_____]

B. Is there a MH issue in which parents are NOT particularly supportive/engaged?

1) ____ No
2) ____ Yes [Which one(s)? Why? _____
_____]

12. In the past two years, how many students are you aware of in your school/college who demonstrated signs of serious suicide intent or actual attempt? (Preschools please skip this question)

1) ____ 0 (None)
2) ____ 1 or 2
3) ____ 3 or 4
4) ____ 5 or more
5) ____ Not Sure

NOTE: In the Survey Monkey format, there will be an appropriate skip pattern for Qs 13-16)

For questions 13 and 14 ➔ Therapy staff (e.g., school psychologists) only. Others please go directly to Question 15.

13. How frequently do you confer with or coordinate care with a student's pediatrician or other primary care provider when there are MH health concerns?

a) ____ Usually
b) ____ Sometimes
c) ____ Rarely
d) ____ Not at all

14. How frequently do you connect with/bring into the picture in some way someone from the family's church religious organization (if you are aware they have such an affiliation), when there are MH issues with a student?

a) ____ Usually
b) ____ Sometimes
c) ____ Rarely
d) ____ Not at all

For questions 15 and 16 ➔ Middle school and high schools only. Others please go directly to Question 17.

15. How aware or familiar are you with the results (data) from your school's California Healthy Kids Survey?

a) ____ Aware/familiar
b) ____ Somewhat aware/familiar
c) ____ Not aware/familiar [Skip to Q 18]

16. Which response best describes what you generally do with the results from your school's CA HK Survey?

a) ____ Aware of the CA HK Survey but don't generally review the data
b) ____ Review the data for my own curiosity
c) ____ Review the data and usually share or talk about some of the findings with others
d) ____ Review the data, often share findings with others and apply findings to make changes.
e) ____ Other [Describe_____]

17. Do you have any special programs or services that address the needs and concerns of underserved students to make them feel welcome and safe on campus?

	Yes	No	Not Applicable
a) Veterans	☐	☐	☐
If yes, briefly describe _____			
b) LGBT	☐	☐	☐
If yes, briefly describe _____			
c) Other	☐	☐	☐
If yes, briefly describe _____			

18. What one thing would you change about the current system of school-based MH services in your school/ district?

19. In which county is the school/campus where you work located?

a) ____ Tulare County
b) ____ Kings County

20. In which school setting do you work?

a) ____ Preschool
b) ____ Elementary school
c) ____ Middle school or junior high
d) ____ High school
e) ____ K-12
f) ____ District-wide or county-wide
g) ____ College
h) ____ Adult/trade school

21. What is your primary role at this school/campus?

a) ____ Classroom teacher/teaching faculty
b) ____ School counselor (non therapist)
c) ____ School psychologist or counselor (therapist)
d) ____ School nurse
e) ____ Administrator
f) ____ School resource officer
g) ____ Other

Other - Please Specify

22. Added Question: What is your best estimate of the student:counselor ratio in the school(s) where you work? If you serve the entire district, please give an average for each level of school.

____ Not applicable
____ Elementary school
____ Junior high/middle school
____ High school
Feel free to add other comments or recommendations:

We will be talking with a SAMPLE of survey respondents in the next couple of months to follow up on some of the issues we'veasked about in this survey. If you're interested in possibly being contacted for a telephone interview, please complete the information below. Note that names will not be kept with the survey results and will not be reported; the survey is confidential.

Thank You!

If you have questions about the Tulare-Kings Student Mental Health Needs Assessment project or this survey, please contact Noah Whitaker, MBA, Community Outreach Manager, Tulare County Health & Human Services Agency, at (559) 624-7471, or Dr. Barbara Aved, BARBARA AVED ASSOCIATES, director of this study, at (916) 428-2847,

ATTACHMENT 5

SURVEY FOR PRIMARY CARE PROVIDERS

Dear Physician:

Pediatricians and Family Practice physicians are often the health professionals who regularly come in contact with children and adolescents. This survey—which has 10 questions—is part of the effort to assess and respond to mental health needs of students in Tulare and Kings Counties. If you fax back a completed survey you'll receive a gift card for See's Candies or Starbucks—your choice. Thank you!

1. How much responsibility as a physician do you feel it is to recognize the following behavioral and emotional issues?

	A great deal	Some	Very LIttle	None
a) Depression	☐	☐	☐	☐
b) Anxiety disorders	☐	☐	☐	☐
c) Eating disorders	☐	☐	☐	☐
d) Behavior management problems	☐	☐	☐	☐
e) Substance abuse issues	☐	☐	☐	☐
f) Sexual orientation/gender identity issues	☐	☐	☐	☐

2. How confident are you in your ability to recognize these behavioral and emotional issues?

	A great deal	Some	Very LIttle	None
a) Depression	☐	☐	☐	☐
b) Anxiety disorders	☐	☐	☐	☐
c) Eating disorders	☐	☐	☐	☐
d) Behavior management problems	☐	☐	☐	☐
e) Substance abuse issues	☐	☐	☐	☐
f) Sexual orientation/gender identity issues	☐	☐	☐	☐

→ PLEASE TURN SURVEY OVER TO NEXT PAGE

3. In your current practice, do you generally treat or refer (or do both or neither) for the following behavioral and emotional issues?

	Treat	Refer	Treat & Refer	Neither nor Refer
a) Depression	☐	☐	☐	☐
b) Anxiety disorders	☐	☐	☐	☐
c) Eating disorders	☐	☐	☐	☐
d) Behavior management problems	☐	☐	☐	☐
e) Substance abuse issues	☐	☐	☐	☐
f) Sexual orientation/gender identity issues	☐	☐	☐	☐

4. What are the main things that limit your diagnosis or management of these issues? [Put the items in rank order starting with "1" as the most important reason, "2" as the next most important, etc.]

a) ____ Not enough time
b) ____ Lack of training or knowledge of issues
c) ____ Unaware of local resources to refer
d) ____ Appropriate referral source not available locally
e) ____ Lack of/inadequate reimbursement
f) ____ Other (What? _____)

5. When you're made aware of an emotional or behavioral issue of one of your pediatric patients, how often do you hear it from:

	Always	Often	Sometimes	Never
a) The patient her/himself	☐	☐	☐	☐
b) The parent/guardian	☐	☐	☐	☐
c) Someone from the school/college	☐	☐	☐	☐
d) Other	☐	☐	☐	☐

6. How often do you initiate contact with the child's school/college to confer or coordinate care when your patient has an
emotional or mental health issue?
a) ____ Always
b) ____ Often
c) ____ Sometimes
d) ____ Never →

[If "Never," what are the main reasons? [Put in rank order starting with "1" as the most important reason, "2" as the next most important, etc.]
a) ____ Not enough time
b) ____ Unaware of where the patient goes to school
c) ____ Concerns about confidentiality and liability
d) ____ Lack of/inadequate reimbursement
e) ____ Other (What? _____)

→ PLEASE GO TO NEXT PAGE TO COMPLETE THE SURVEY

7. How aware are you of where in Tulare or Kings Counties you can refer children for these issues?

	Aware	Somewhat Aware	Not Aware
a) Depression	☐	☐	☐
b) Anxiety disorders	☐	☐	☐
c) Eating disorders	☐	☐	☐
d) Behavior management problems	☐	☐	☐
e) Substance abuse issues	☐	☐	☐
f) Sexual orientation/gender identity issues	☐	☐	☐

8. Did you attend a lecture or conference in the last 2 years where the main topic was child/adolescent mental or emotional health?

a) _____ Yes
b) _____ No

9. Physician type:

a) ____ Pediatrician
b) ____ Family Practice
c) ____ Other (What?)

10. Main practice setting:

a) ____ Kings County
b) ____ Tulare County

The following information is needed only if you wish to receive a gift card:

Please print clearly (or, use a dark inked rubber stamp or attach a business card)
Name _____ Address _____
City, State _____ Zip Code _____

Please send $15 gift card for: [check only one]
☐ See's Candies
☐ Starbucks

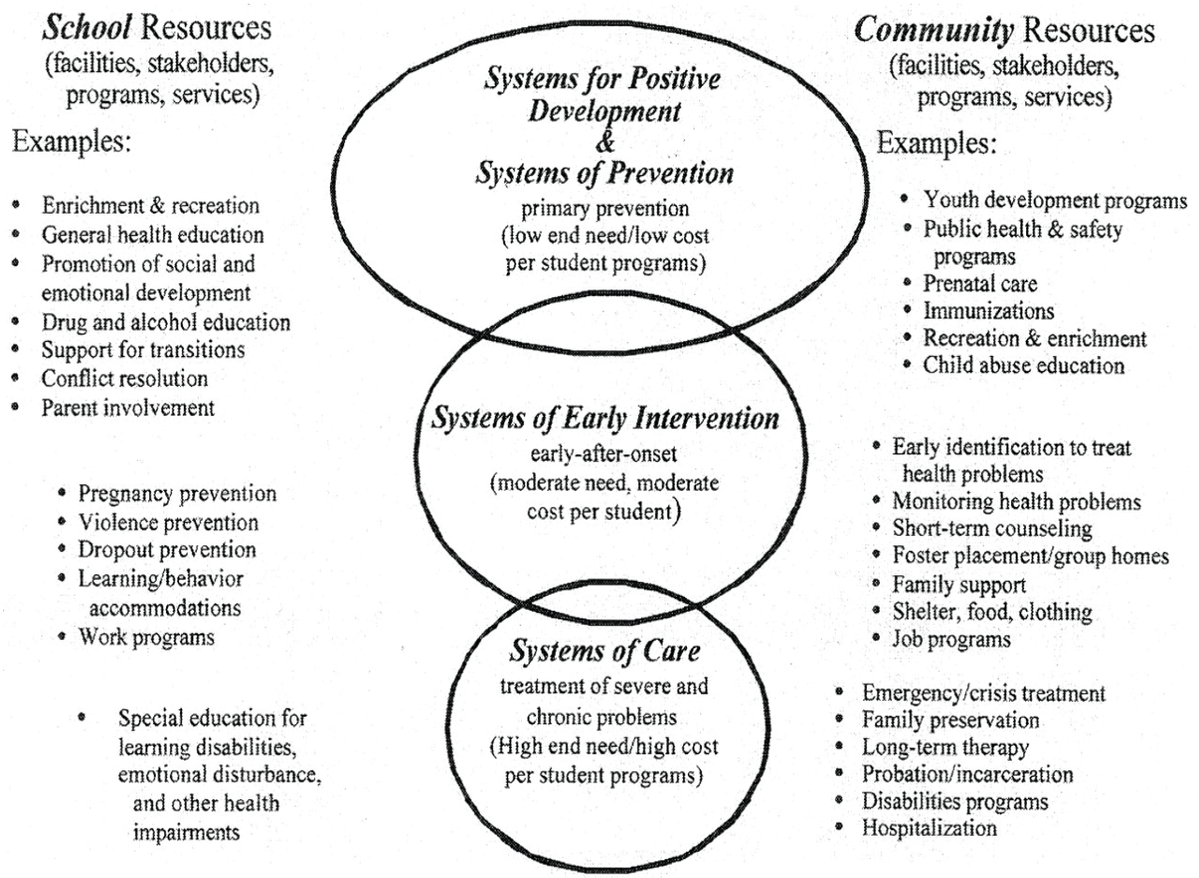
Fax survey by October 15, 2013

Fax to: Fran Hipskind at the Tulare County Medical Society at: (559) 334-0090

Thank you!

ATTACHMENT 5

A Comprehensive, Multifacted and Integrated Approach to Addressing Barriers to Learning and Promoting Healthy Development



Source: Committee on School Health. American Academy Of Pediatrics. Pediatrics 2004;113:1839-1845.