PART I
STUDENT MENTAL HEALTH INITIATIVE (SMHI)
Mental Health Services Oversight and Accountability Commission
May, 2010

In June 2007, the Mental Health Services Oversight and Accountability Commission (MHSOAC) voted to approve $60 million in statewide initiative funds for a Student Mental Health Initiative (SMHI) in response to the tragedy at Virginia Tech. While tragic incidents are rare, the urgency to take steps to prevent such incidents is undeniable. The purpose of this initiative is to strengthen student mental health.

At the time of its vote, the Commission heeded the request of the community, which asked to have more input on developing the specifics of the initiative, by approving the funding then convening stakeholder meetings to develop the details. This proposal is the result of that stakeholder process, which focused on both K-12 education and Higher Education, spanned three months and involved clients, students, parents, and representatives from over forty-five organizations. Stakeholders crafted the contents of this initiative and stakeholders should continue to be involved in crafting individual grant proposals.

Background

According to a 2006 report conducted by the University of California (UC), college students are presenting mental health issues with greater frequency and complexity. These issues have been reported to be equally urgent for the California State University (CSU) System and for students attending California Community Colleges (CCC). System-wide diminished funding has resulted in longer student wait-times, difficulty retaining staff, large student-to-counselor ratios and decreased services. These factors have resulted in a dearth of appropriate support for students who are facing significant developmental challenges, emotional stressors and mental health risks, leaving them at great risk to cope without preventative supports until they are in crisis.

Student Mental Health Needs Have Grown

Students have unique mental health needs that are growing in scope and complexity. One research study demonstrates that nationally, nearly half of all college students report feeling so depressed at some point in time that they have trouble functioning. In addition, late adolescence and young adulthood are periods of high risk for “first break” episodes of psychosis and other major mental illnesses as well as the onset of eating disorders and substance abuse issues. UC reports that in contrast to the past, about one in four students who seek counseling services have identified mental health issues and are receiving psychotropic medications. In the past 10 years, visits to the Student Health Centers have more than doubled, and UC Santa Barbara has experienced a seven-fold increase in crisis appointments. In addition, campuses have seen a dramatic increase in the number of students seeking disability supports on the basis of psychological or psychiatric services.

This heightened need to address students in crisis has diminished the ability for campuses

to provide assistance to other students whose problems are not so acute but who are dealing with concerns of a more "traditional" nature, such as homesickness, questions of identity, relationship issues and concerns over career choices. The greater numbers of students who need mental health services, along with the increased complexity of the issues they face, have overwhelmed the capacity of colleges and universities to respond appropriately. Much like the public mental health system, they must focus on crisis response rather than crisis prevention and promotion of well-being.

Students' Risk of Suicide Have Risen

For many college and university students, the lack of resources to address mental health problems puts them in serious jeopardy. The UC system has seen rises in student suicide, as well as significant rises in suicide attempts. Suicidal behaviors at UC San Diego have doubled over the past four years. A large survey in 2000 found that over 9% of students had seriously considered suicide. Only 20% of those students were receiving mental health services – *80% of students who were thinking of suicide received no mental health services at all* (University of California, 2006). Racial and ethnic minority, gay and lesbian, and graduate students are at particularly high risk because of the multiple challenges they face.

System Challenges of Meeting Student Mental Health Needs

Higher education institutions are doing their best to meet the mental health needs of their students. However, practical constraints exist.

Services are limited. For example, almost one in five community colleges has no on-site services. Of those that do, almost half have no mental health counselors. All systems report that available resources are stretched beyond capacity.

The target student-to-staff ratio in the UC system is approximately 1000-1500 students to one mental health professional, although the *Sacramento Bee* reported that some campuses are far more understaffed: UC Davis has one therapist per 2,500 students and California State University, Sacramento has only one per 4,000 (4/26/07). CCC reports similar difficulties in meeting the target ratio.

Workforce retention issues contribute to the problem as they do in the public mental health system. The entire UC system lags behind the private sector in salaries for mental health professionals; in one six-month period in 2004-2005, UC San Diego lost 50% of its counseling and psychological staff largely because of salary concerns. These concerns are also barriers for the CSU and CCC systems.

Funding for mental health services poses a significant challenge. The majority of CSU campuses rely on state General Fund dollars to pay for these services, leaving them particularly vulnerable to state budget fluctuations. Services in the UC system are largely paid for through fees paid by students themselves, although they are also affected by funding in the state budget. According to UC, "Student services programs were

adversely affected by severe budget cuts during the early 1990's when the university was forced to make reductions due to the state's fiscal crisis. Those cuts have not been restored. In 2002-03, student services programs were again reduced by a mid-year reduction of $6.3 million." Some recommendations have focused on increasing student fees as a means to provide better mental health services. However, it may be worthwhile to consider whether the public has a vested interest in supporting the mental health of vulnerable college-age students and to invest in strategies that keep them from harm.

It is clear that mental health services in California's colleges and universities need to be given a higher priority and focus in order to prevent crisis and tragedy and to assist young people towards healthy and productive lives.

Student Mental Health Needs Begin Early

While the SMHI arose from an incident at an institution of higher education, "upstream" prevention is key to achieving positive mental health outcomes before they reach crisis levels. Practical experience and academic literature demonstrate that mental health problems that can lead to school violence begin early, in primary, middle and high schools. Fifty percent of all lifetime mental health disorders are evidenced by the age of 14 and seventy-five percent of all mental disorders are manifested by age 25.

Suicide is a present reality in school settings. The Youth Risk Behavior Surveillance (2005) indicated that 28% of youth nationwide report feeling a prolonged sense of depression or hopelessness over the past year. As high as 60% of California school children know someone who has attempted suicide and 20% know someone who has attempted suicide this year. Of the 8% of kids who reported making a suicide attempt over the past year, only one in four actually received mental health or emergency medical services. For every four students who attempt suicide, three get up and go to school the next day.

As such, the SMHI should incorporate strategies to identify students with potential mental health problems in K-12 settings and to support those with diagnosed mental illnesses as part of a comprehensive student mental health strategy.

Leadership to Support Student Mental Health

- **Launch MHSA Student Mental Health Initiative**
  In implementing the MHSA, the MHSOAC, the counties and the California Department of Mental Health agreed to fund key statewide projects, including prevention training, reduction of stigma and discrimination and suicide prevention. The total funding for all statewide prevention projects is $245 million over the first four-year period. At the end of this period, county will review evaluations of the effectiveness of the statewide initiatives and may consider renewing all, some, or none of them.

  In approving a $60 million SMHI from these statewide projects, almost 25% of the total funding for statewide projects, the MHSOAC intends these one-time

funds to quickly focus resources on the mental health needs of students and advance the collaboration between educational settings and county services, which should form the foundation for future MHSA programs.

- **Advocate for Policy**

  While resources for prevention and mental health services can be made available through SMHI and other MHSA programs, the MHSOAC should also provide leadership, collaboration and education in mental health to the higher education and K-12 systems. In partnership with stakeholders from the systems, the MHSOAC may consider making public policy recommendations to the Legislature on issues such as: appropriate handling of adult students' privacy; prioritization of student mental health issues in the state higher education and K-12 budgets; and standards and implementation of mental health education in the K-12 system.

PART II
STUDENT MENTAL HEALTH INITIAVE (SMHI)
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I. MHSA Prevention Program to Assist Students in Higher Education

Design and administer programs that will focus on three key strategic directions: training, peer support activities and suicide prevention. Any college, district, multicampus collaborative, or system within one of the three California public higher educations systems would be eligible. Successful programs will be based on demonstrated need and will emphasize culturally relevant and appropriate approaches, linkages to local community MHSA Prevention and Early Intervention plans and/or Community Services and Supports plans, and collaboration with mental health and substance abuse prevention partners. It is the intent of the MHSOAC that programs will be established in each of the three public higher education systems.

System-wide programs will be developed to address student mental health needs statewide. Campus based programs may be developed as replicable projects. Programs across systems and/or campuses may be combined. Administrative costs associated with these programs would be limited to 15% for any entity implementing the program. These funds shall not be used to supplant any existing mental health services, funds or programs. Programs are encouraged to leverage other resources. The term leveraging is used broadly and may be accomplished in numerous ways such as:

- Cash match
- Federal reimbursements in the health system
- "Readiness" to implement PEI programs by training staff and covering release time, creating supportive policies, etc.
- Use of facilities and other resources
- Coordinating existing prevention programs with new PEI-funded early intervention programs

There must be an evaluation of each program. The evaluation will cover both performance and outcome measures. Performance reviews will evaluate how much of the program was delivered. Outcome reviews may be guided by the DMH “Potential Outcomes of PEI Strategies” resource document or evaluate increased knowledge of suicide or its risk indicators, reduced incidents of suicide or suicide attempts, reduced stigma and discrimination related to mental health, increased assess to services, increased linkages with community resources, reduced disparities in access to services, and students’ own satisfaction with access and care.

Key Strategic Directions of MHSA SMHI Programs for Higher Education:

Eligible programs should cover the following strategic directions. Though every strategic direction need not be in each program, the programs must address one or more components from the following list.

1. Training

The program would fund training activities for students, faculty, staff or administrators to raise awareness of issues of mental health and wellness on college campuses. The training would be designed to improve recognition and responses to students experiencing mental distress, to reduce stigma and discrimination against persons who become identified with mental illness, and to promote a campus environment that enhances student success providing hope, supporting resiliency, and creating a healthy learning community.

2. Peer-to-Peer Support

These activities would focus on mutual support, promoting acceptance of cultural diversity, disability, empowerment strategies, and reduction of the stigma associated with mental illness. Peer-to-peer services instill hope while teaching successful coping strategies and relaying information about how to navigate health and mental health systems. Such programs could also effectively address issues of trauma, loss, identity, relationships, homesickness, and achievement pressure and would provide mental health and emotional support that are defined useful by students themselves.

3. Suicide Prevention

These programs would be designed utilizing the resources and best-practices of the MHSA suicide prevention efforts or knowledge of the assigned workgroup but would focus specifically on addressing the unique needs, vulnerabilities and risk factors of university and college students, and would bring suicide prevention resources directly onto campuses to raise their profile among students and to make them as accessible, relevant and effective as possible.

Annual Funding for SMHI Higher Education	$8.5 Million
Total Four-Year Funding:	$34 Million

Each county's allocation for the SMHI shall be spent in the same proportion for higher education and K-12 educational programs as the statewide amounts.

II. MHSA Prevention Program to Assist Students in K-12

Design and administer programs that address the systemic challenges in providing a comprehensive approach to addressing student mental health. Successful programs will take the variety of discrete school-based mental health interventions and programs that have been proven effective and combine them into a comprehensive student mental health program.

Replicable programs may focus on a single school, a cluster of schools, or an entire district within its jurisdiction provided that they use SMHI funds to fill in service gaps and establish new systems, policies and education/training to create a comprehensive student mental health program.

Ideally, at least one program would address needs in each of the eleven county superintendent of schools service regions. Administrative costs associated with these programs would be limited to 15% for any entity implementing the program. A county superintendent or his or her designee should be involved in the application. These funds shall not be used to supplant any existing mental health services, funds or programs. Programs are encouraged to leverage other resources. The term leveraging is used broadly and may be accomplished in numerous ways such as:

- Cash match
- Federal reimbursements in the health system
- "Readiness" to implement PEI programs by training staff and covering release time, creating supportive policies, etc.
- Use of facilities and other resources
- Coordinating existing prevention programs with new PEI-funded early intervention programs

Successful programs will be based on demonstrated need, emphasize culturally relevant and appropriate approaches, focus on families who have historically experienced disparities in access to care, link to local community MHSA Prevention and Early Intervention plans and/or Community Services and Support plans, and collaborate with mental health and substance abuse prevention partners.

The following four strategic directions should be incorporated into a comprehensive student mental health program funded by the SMHI:

1. **School-Based Programs**: Schools/districts funded under the SMHI should provide a continuum of prevention and early intervention services including:
    - Efforts that foster supportive school climates including bullying prevention, suicide prevention, stigma reduction, and cultural awareness.
    - Mental health educational programs for students that include a focus on stigma reduction, incorporate age-appropriate suicide prevention training

for the general student population, and are in alignment with state Health Education Standards.

- Early identification of students with mental health concerns who seek help, including universal voluntary screenings in partnership with families and caregivers.
- Linkages to services, either provided on campus or otherwise, through school health centers, county departments of mental health, special education programs, and community-based organizations.
- Outreach and education for families that are culturally and linguistically responsive and reduce the stigma associated with accessing and using mental health services.
- Consideration for youth from communities that demonstrate a high incidence of mental health problems or where research demonstrates a high risk for specific mental health needs, for example suicide risk among African-American and Caucasian males, Asian-American females, Hispanic males and females, LGBTQ youth and Native American youth.
- Training for those personnel, like teachers, most likely to first identify potential mental health needs, which includes resources for identification, referral, and non-stigmatizing responses.
- Use of appropriate youth peer-to-peer strategies.

2. **Systems and Policy Developments**: Programs funded under the SMHI should implement system and policy changes to sustain the school-based programs described above. Changes may include:

- Coordination and redirection of resources through school, district-wide, regional and/or statewide systems to create a cohesive and comprehensive system from prevention and early intervention to intervention and support for student mental health as opposed to fragmented programs.
- Development of relationships between school system and county mental health departments to ensure effective referral process of students between systems and effective use of resources to avoid duplication and fill gaps.
- Collaboration with community-based providers that enhance student success, for example health services, tutoring, after-school programs, or mentoring.
- Development of policies within the school/district/region/state that make mental health promotion an integral part of school operations and school improvement efforts, for example disciplinary policies that are therapeutic.
- Procedures for on-going assessment of student mental health and continuous improvement of school-based programs.
- Involvement of pupil services personnel, including credentialed school counselors, school psychologists, school social workers, speech-language therapists and audiologists, resource specialists, and school nurses where available, in the planning and executing of systems and policy changes.

- Meet current state curriculum mandates for health and wellness.

3.**Education and Training**: School/district personnel should receive education and training to support the successful implementation of specific school-based programs as well as the systems and policy changes needed to sustain these programs.

4. **Technical Assistance**: In order to support the effective development of comprehensive student mental health programs, the SMHI will include funding for technical assistance to support program development and implementation through the provision of resources on best practices, convenings to exchange and share information and lessons learned, and access to on-site consultation to increase the effectiveness of SMHI-funded programs.

SMHI funds are not adequate to support all elements of a comprehensive student mental health program. Successful programs will use this funding to braid existing resources that support student mental health and draw down new resources. Examples of these resources include, for example, MHSA, EPSDT, the Special Education Pupils Program (AB 3632), Safe and Drug Free Schools, Early Mental Health Initiative, Healthy Start, School Health Centers, Primary Intervention Programs, IDEA Early Intervening, and Student Assistance Programs (SAP).

Each program shall be evaluated. The evaluation will cover both performance and outcome measures. Performance reviews will evaluate how much of the program was delivered. Outcome reviews may be guided by the DMH "Potential Outcomes of PEI Strategies" resource document or evaluate increased school success, decreased school drop-out rates, reduced school suspensions and expulsions for behavior problems, increased identification of early signs of mental illness, reduced stigma and discrimination related to mental health, increased access to services, increased linkages with community resources, increase in parent or student awareness of available support resources, and students or families own satisfaction with care.

ALLOCATION OF FUNDING FOR K-12 EDUCATION PROGRAMS

Annual Funding:	$6.5 Million
Total Four-Year Funding:	$26 Million