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Mental Health Services
Oversight & Accountability Commission

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Responding to COVID-19: Meeting the Mental Health Needs of Schoolchildren July 2020

California's educators and mental health practitioners anticipate that anxiety and social isolation rules associated with COVID-19 are significantly increasing the mental health needs of children and youth, including a potential increase in suicidal behavior. This memo summarizes the Commission's understanding of those needs and opportunities for the State to support strong and enduring partnerships between county behavioral health departments and school districts that were important before the pandemic and are more valuable now.

Background and Conditions: The Pandemic Has Exacerbated a Student Mental Health Crisis

The pandemic has seriously disrupted the lives and significantly increased the stress on young Californians and their families. Physical distancing may be reducing the spread of COVID-19, but the strategy also has weakened or severed the link between families and school-based mental health supports. While online instruction has replaced classroom learning, the pandemic has amplified significant gaps and disparities in the educational system and public health infrastructure, further threatening the wellness of school-aged Californians and their families.

Children are at an elevated risk. Prior to the pandemic, one in five schoolchildren in California had a significant mental health need. The loss of established routines and social connections heightens the stress response of many students, particularly those who previously experienced trauma or have preexisting mental health needs. Parents and caregivers also are struggling with concerns about job losses and other impacts, contributing to rising domestic violence, substance abuse and mental health needs. Early indications are that these conditions are increasing "adverse childhood experiences." Vulnerable groups, such as LGBTQ and foster youth, are potentially at even greater risk.

The Role of Schools in Protecting Mental Health has been Disrupted

Social and emotional support structures have temporarily broken down. Educators cannot provide the same face-to-face human connection and teachers are struggling to provide emotional support in a virtual space as they develop online lessons. Schools are ramping up efforts for "virtual check-ins" and "telehealth," but many schools didn't have adequate staffing before the pandemic.

Schools typically connect families and communities to services. In addition to school-based services, schools are a vital mechanism to connect to an entire family, and to connect that family to the mental health and other services they need. Referrals to mental health and social support agencies are down at a time of heightened need, and many services cannot be provided under the isolation rules.

Teachers, who are often the primary protective factor for abused children, are not in close contact with their students. Several counties have reported a sharp decrease in the number of referrals to Children Protective Services, even while domestic violence cases have increased. Substantial numbers of students have not checked in with their teacher or school since the stay at home order was issued. There is some indication that students attending alternative schools are engaging in remote learning at a lower rate than students in traditional schools.

Already Increasing Suicide Rates May Escalate

Longstanding increases in suicide rates could escalate in the wake of the COVID-19 pandemic. Suicide is a complex public health challenge involving many biological, psychological, social, and cultural determinants. Major risk factors for suicide, such as health and mental health needs, substance use disorders and access to lethal methods of attempting suicide, may be exacerbated as care is disrupted or unavailable and people are confined to their homes with access to guns and other lethal means. Social distancing guidelines may worsen these risk factors, and some experts are predicting an increase in suicidal behavior as a result and suicide death as a result.

California may see an increase in the number of youth who die by suicide. Vulnerable child and youth may not have access to community and school-based supports and may be in unsafe home environments, including homes with easy access to firearms and illegal and legal drugs, with abuse and neglect, and family and caregivers who reject the sexual orientation and gender identity of children and youth.

Youth are Particularly Vulnerable and Need a Tailored Response

The stresses and risk factors for youth are distinct. Before COVID-19, 1 in 3 high school students felt chronically sad and hopeless. Almost 1 in 5 had seriously considered suicide in the past year. Sheltering at home may not be safe for youth, particularly those youth such as LGBTQ youth and foster youth who are at greater risk for parental rejection and abuse. These youth are less likely to check-in with their teachers, and more likely to develop mental health problems and drop out of school.

The emerging "best practices" are undermined by physical distancing rules. Safe places, at school and in the community, are particularly important for youth, but have been suspended by physical distancing orders. Youth are spending more time on social apps, which can enhance social connection, but may also be determinantal to their mental health.

Opportunities to Meet Immediate Needs and Continue Building the Foundation for the Future

The Commission has demonstrated leadership supporting local partnerships between schools and mental health agencies. For example, Fresno County is among a growing number of counties leveraging the strength of local partnerships to collectively respond to student mental health needs. *All 4 Youth* is a $110 million campaign involving the Fresno County Behavioral Health Department, the Fresno County Office of Education, and local school districts and schools. The goal is to increase access to mental health services for all children regardless of Medi-Cal eligibility and insurance coverage and place a mental health clinician in every school. Similarly, Sacramento County has launched a ground-breaking initiative to establish schools as "centers of wellness" with access to mental health clinicians on every school campus. The initiative, a partnership between the Sacramento County Office of Education and the Sacramento County Department of Health Care Services establishes a systemwide, continuum of care for mental health and wellness sustained on Medi-Cal funding, and with an emphasis on prevention and social and emotional learning.

For the past four years, the Commission has recommended ways to increase and improve school mental health, which informed legislative action on the Triage and Mental Health Student Services Act grants. A policy report has been drafted for the Commission's Subcommittee. This work informs the following options.

Accelerating and Focusing the Response

The State has a Foundation for Ramping up School Mental Health

California's recent investments in school mental health revealed the need and the ambition of community stewards to address this need. Educators, health professionals and children's advocates were already acting out of a sense of urgency to respond to the physical, emotional and developmental needs of children. They have been cobbling together the financial and professional resources and adapting emerging programs to support children and families and make learning possible. The response to the Commission's Triage and Mental Health Student Services Act grant programs indicates that local schools and county behavioral health departments are eager to invest in building and strengthening partnerships. The Commission received 38 applications for the Mental Health Student Services Act grant program – 20 applications to support existing partnerships and 18 applications to support new and emerging partnerships.

Many school-behavioral health partners are also working collaboratively in the absence of grant funding. The state could support that willingness by providing technical assistance on how to sustain cross-system partnerships through effective governance, strategic planning, blending and braiding funding streams, and data sharing and evaluation.

The State's investments also revealed the need for a systemic approach. Schools, county behavioral health departments and other partners have been developing programs based on existing relationships, available knowledge and funding, and political will. These disparate efforts could be significantly enhanced and scaled by

coordinated peer-based learning and the dissemination of research-based models that are sustainable, impactful and adaptive from design.

The System of Support for K-12 education could provide the infrastructure for developing models and professional skills. The new support structure is intended to help all schools close the achievement gap with levels of increasingly specialized support; including an emerging focus on social and emotional learning. With state leadership from the Superintendent of Public Instruction, the California Department of Education, the State Board of Education, and the Department of Health Care Services, this network could be deployed to reach all districts and help to identify gaps in capacity and funding to meet the elevated needs.

Coordination Would Increase Effective Suicide Prevention Practices

Suicide prevention efforts are occurring throughout the state and in different private and public sectors. The state strategic plan for suicide prevention completed by the MHSOAC in November calls for state leadership to coordinate efforts, send clear and consistent messages about best practices, monitor suicide and suicidal behavior data, leverage existing and seek new resources, and oversee state laws.

Public schools with students in grades K through 12 currently are required to develop a suicide prevention policy, including prevention, intervention, and postvention strategies. Some schools are expanding the use of suicide risk assessments and using this information to connect students to timely services based on level of risk. Several sites across California offer after-school programs designed to support the mental health of youth at risk of attempting suicide and other programs to safely transition youth from inpatient care back home and school, with monitoring, safety planning, and assessment. Formal agreements between health care systems, specifically hospitals, and schools should be established to safely and confidentially support students transitioning back into schools following suicide-related services, namely a suicide attempt.

Youth-led Innovations Provide a Foundation to Enhance State and Local Initiatives

Youth leadership is essential to effectively connecting to those in need. Youth leadership are effectively countering stigma and establishing the safe zones that allow other youth to open up, share their stories, and get connected to services. The Commission's Youth Innovation Project Planning Committee is developing concepts for youth-centered county innovation projects with the potential for significantly improving treatment and outcomes for youth. NAMI Campus High School clubs and Cal-HOSA chapters support youth leadership and mental health advocacy within schools and communities.

Youth are also playing a role in designing and leading mental health service delivery in California. Youth leaders have stepped up to educate their peers about mental health and shape school-community mental health programs. Santa Clara County's youth-led allcove center, for example, provides holistic services, including onsite mental health and substance abuse counseling, physical health care services, and linkages to education, housing, employment, as well as intensive treatment options.

Psypher, a youth-led organization, held a 14-day online workshop series called Wellness in Place to bring youth together to discuss difference aspects of wellness. Connecting youth to youth-initiated and directed programming can strengthen resilience and mitigate mental health crises now and in the future.