MHSSA Mental Health Infrastructure and Priority Needs:
2020-21 Countywide Report

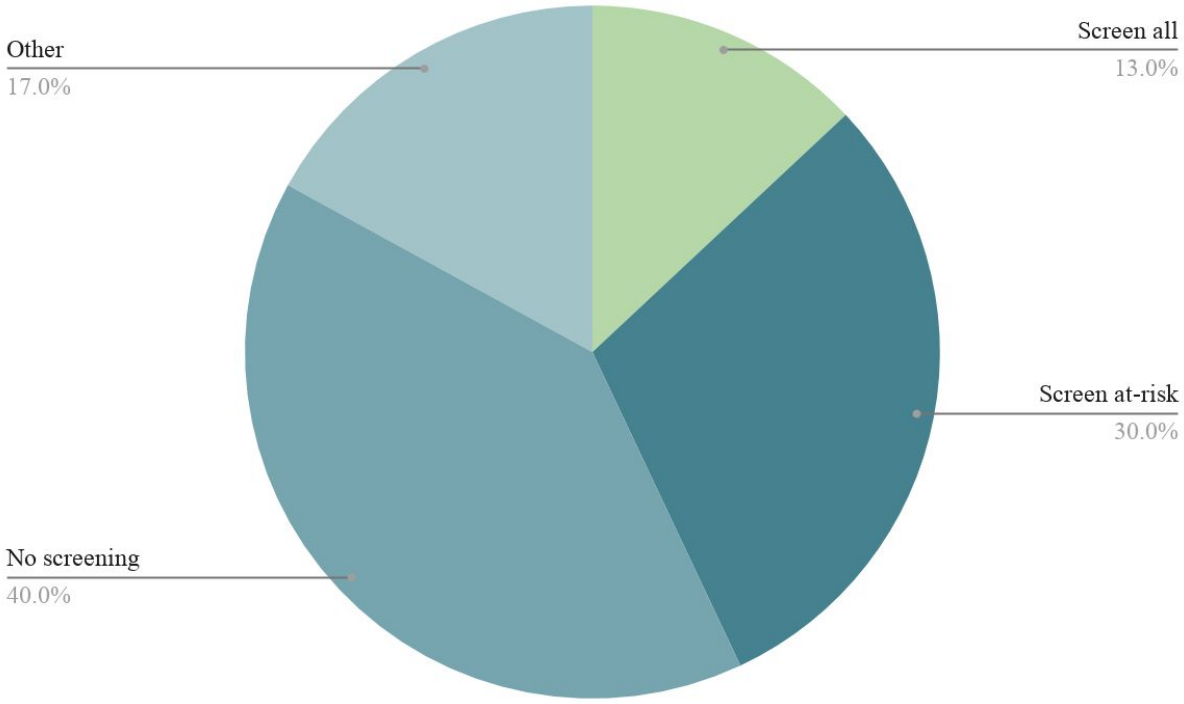
Results in this report are based on responses from all 27 Orange County school districts, OCDE ACCESS, OCDE Special Schools, and one charter school who are partners in the MHSSA program, for a total of 30 respondents. Throughout this report, any reference to Orange County school districts is based on responses provided by both MHSSA district and charter school partners.

MENTAL HEALTH INFRASTRUCTURE

Mental Health Screening and Linkage to Services

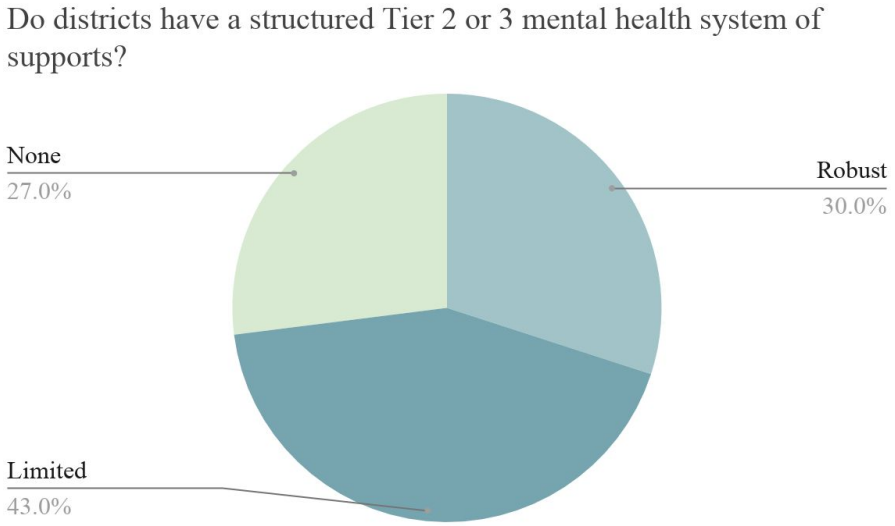
Mental Health Screening

Only four (4) Orange County school districts screen all students' mental health. Twelve districts have no mental health screening and about **one-third of the districts only screen at-risk students.** A few districts are working on developing universal screenings, or have them on hold during distance learning.

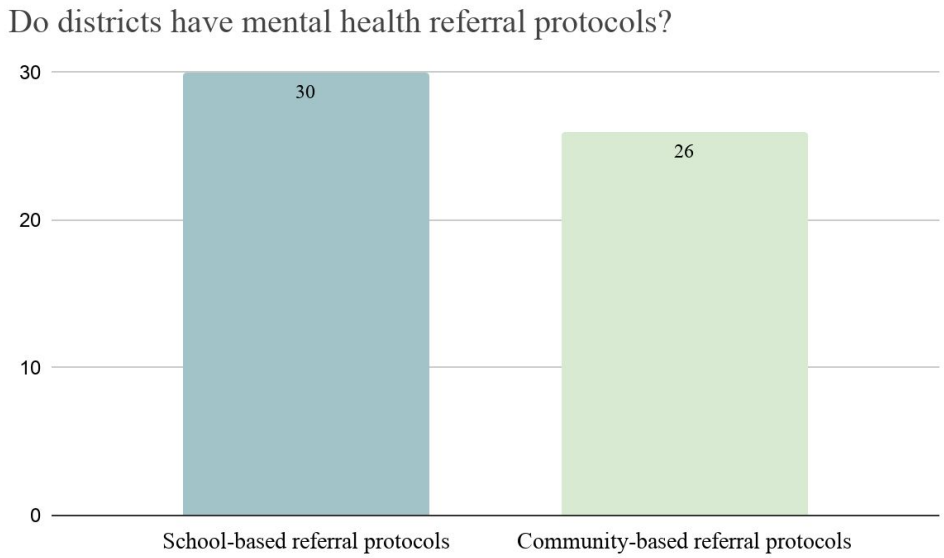


Mental Health Supports, Referrals, and Linkages

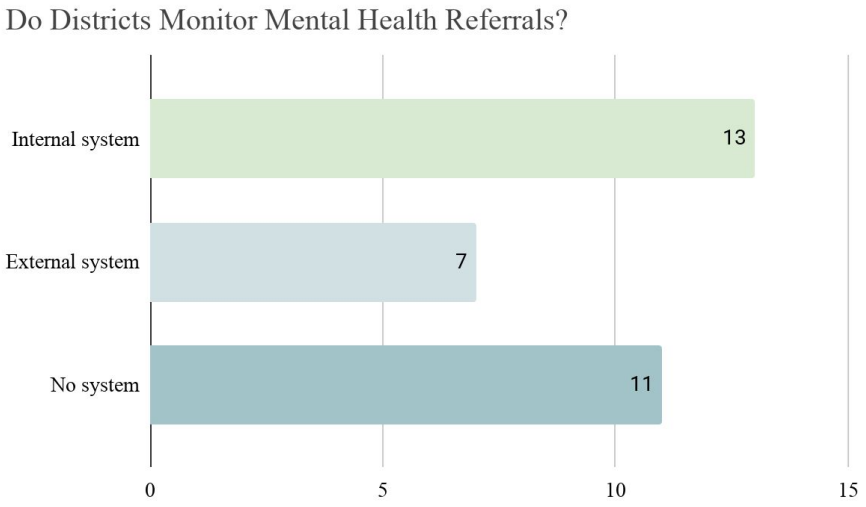
Nearly **three-quarters of districts** in the county **have a structured system of support for students needing Tier 2 and Tier 3 mental health supports.** Some districts have a more robust system than others, and eight (8) districts reported having no structured system in place to support students needing Tier 2 or Tier 3 mental health support.



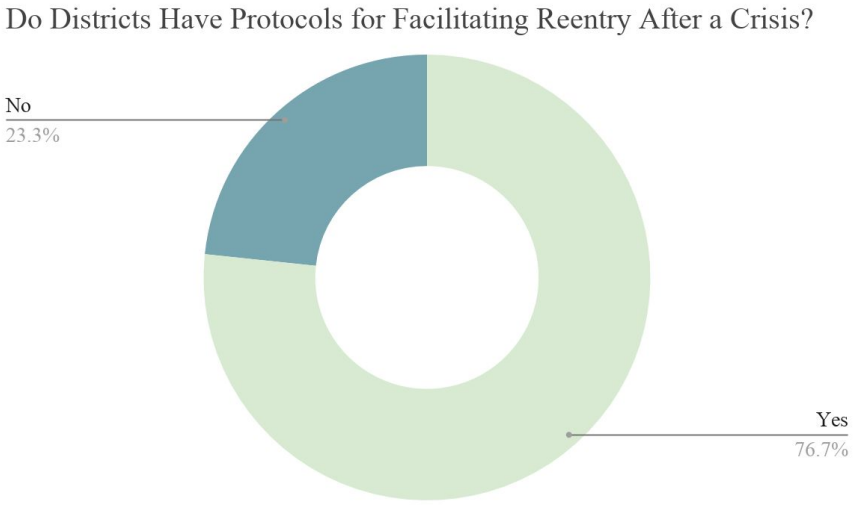
Referral protocols: All districts have protocols in place for referring students to school-based mental health services, and 26 districts have protocols for referring students to community-based resources. Nearly all districts (29) have Release of Information (ROI) forms and 10 districts have a Memorandum of Understanding (MOU) in place for exchanging student information with community agencies.



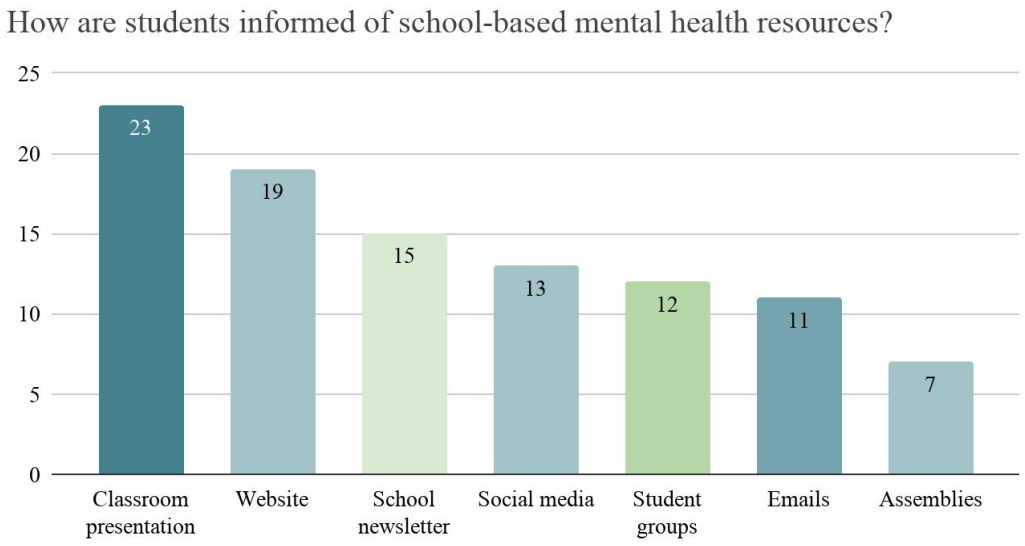
Monitoring mental health referrals: While nearly two out of three districts in the county monitor referrals, one-third do not. There is an opportunity to strengthen this process to ensure students access services to which they are referred and to ensure that students' needs are met.



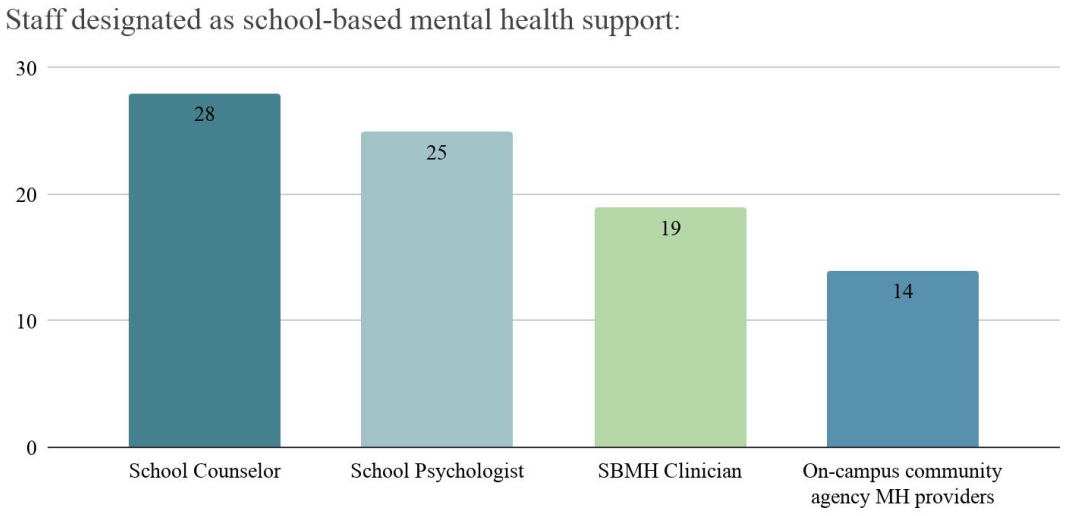
Reentry protocols after a mental health crisis, trauma, or psychiatric hospitalization: Twenty-three (23) districts have a protocol in place to assist students with reentry to school after a mental health crisis, trauma, or hospitalization. Most commonly, districts set up a meeting between designated staff members, the student, and the parent or guardian. Most schools set up this meeting via email, phone call, or an in-person conversation. While the majority of districts have protocols, **nearly one-quarter of the districts do not have a reentry protocol** in place.



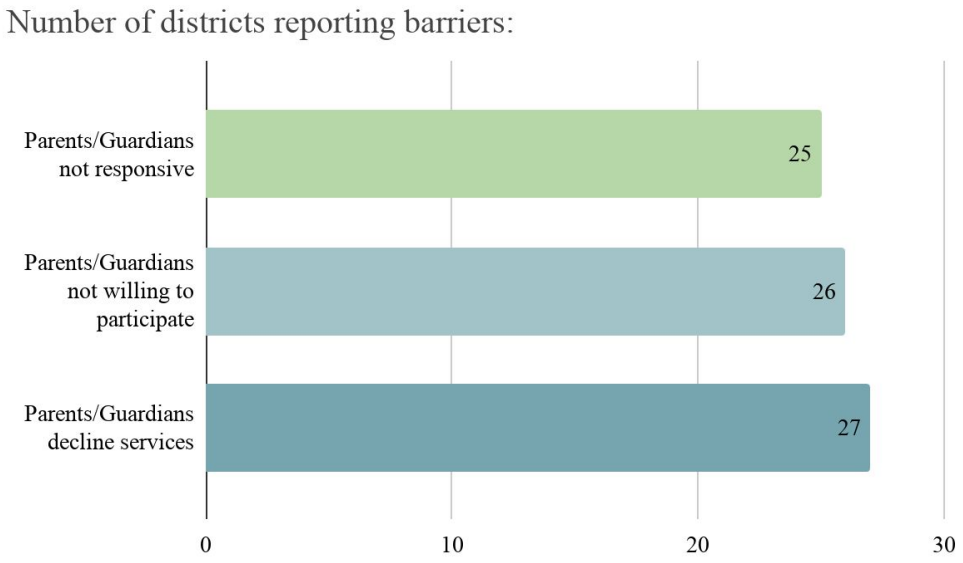
Informing students about school-based mental health resources: Most districts inform students about school-based mental health resources through classroom presentations or through their website. Other methods used to communicate with students about mental health resources include school newsletters, social media, student-run groups such as PAL or ASB, emails, and assemblies. Two-thirds of the districts **inform their students using at least 3 different methods.** However, it is important to note that **5 districts do not inform students through school-wide approaches,** but instead only inform students through teacher or staff referrals, and therefore no universal communications are provided to students.



Staff designated as possible school-based mental health support individuals: Most Orange County school districts have **school psychologists** and **school counselors** to support students' mental health. However, only 60% of districts have designated school-based mental health (SBMH) clinicians (MFTs, social workers), and under half have on-campus community mental health providers available to students.



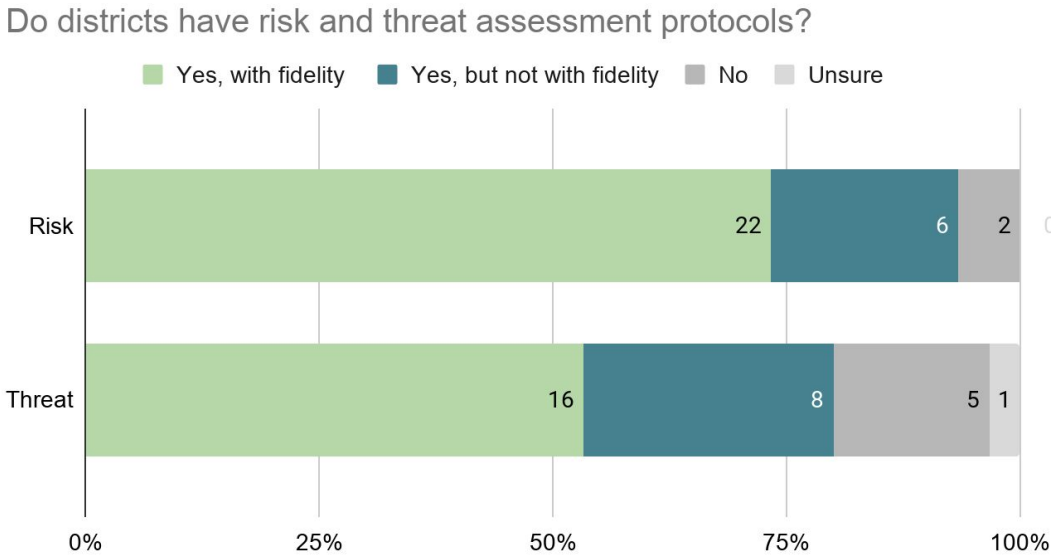
The majority of districts report that school site teams face **barriers when attempting to collaborate with parents/guardians about their student's school mental health services.**



Crisis Assessment and Response

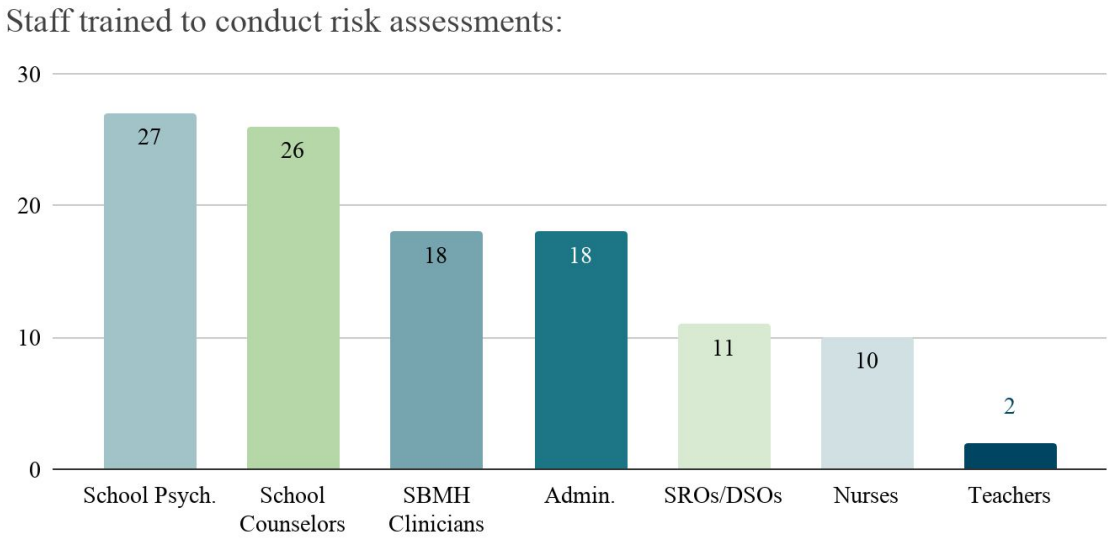
Risk and Threat Assessments

The majority of districts have district-wide risk and threat assessment protocols. However, in several districts, protocols are not implemented with fidelity at all schools, and some districts do not have these protocols. There are opportunities to strengthen these protocols, through support from MHSSA Regional Mental Health Coordinators (RMHCs) and other OCDE programs.

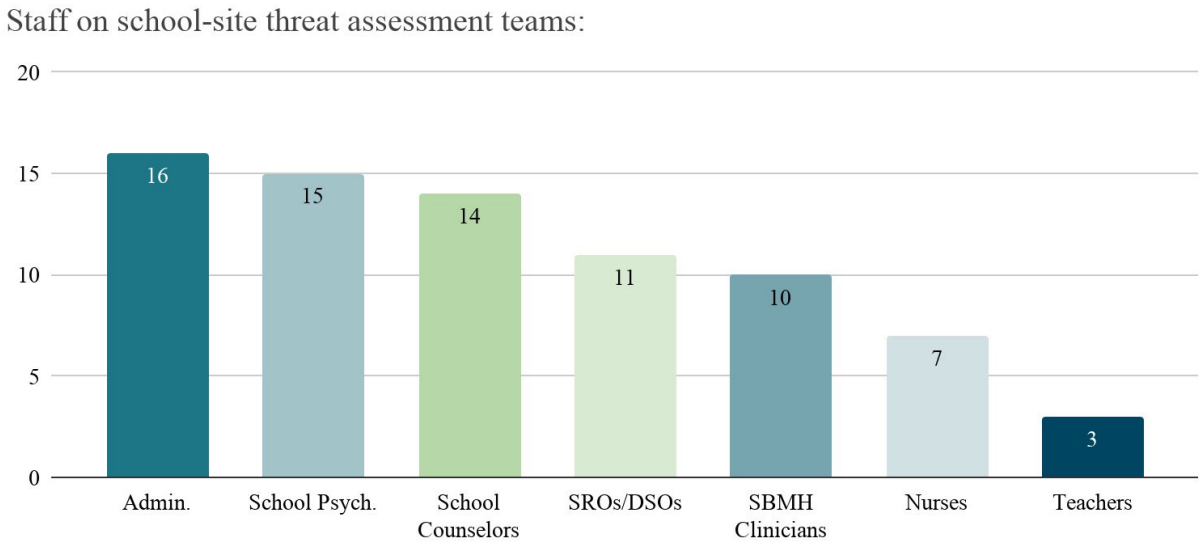


Parents and students across Orange County are largely unaware of district risk and threat assessment protocols. Only five districts reported parents and students being aware of risk assessment protocols and only three districts reported parents and students being aware of threat assessment protocols.

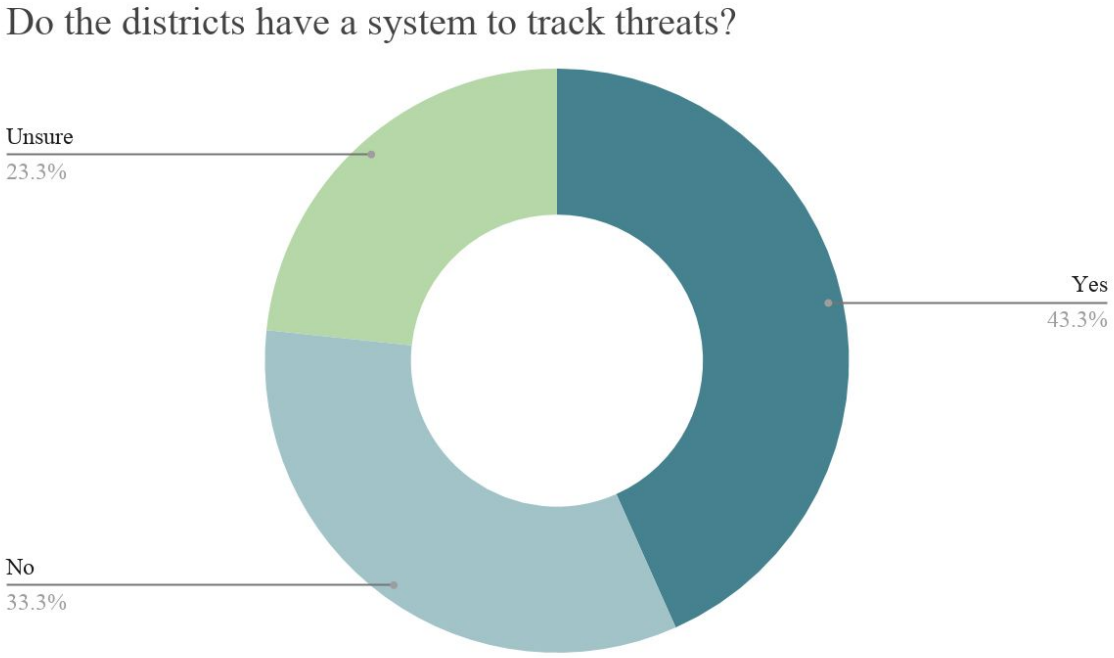
Staff trained to conduct risk assessments: School counselors and school psychologists were the most commonly-identified staff to be trained in conducting student risk assessments. Additionally, over half of the districts also have school-based mental health clinicians or administrators who are trained, and one-third have School Resource Officers (SROs) or District Safety Officers (DSOs) trained, to conduct risk assessments.



Threat Assessment Teams: Twenty (20) districts reported having school-site threat assessment teams. Administrators, school counselors, and school psychologists were the most common team members. One-third of districts also include SBMH staff and SROs/DSOs on these teams.



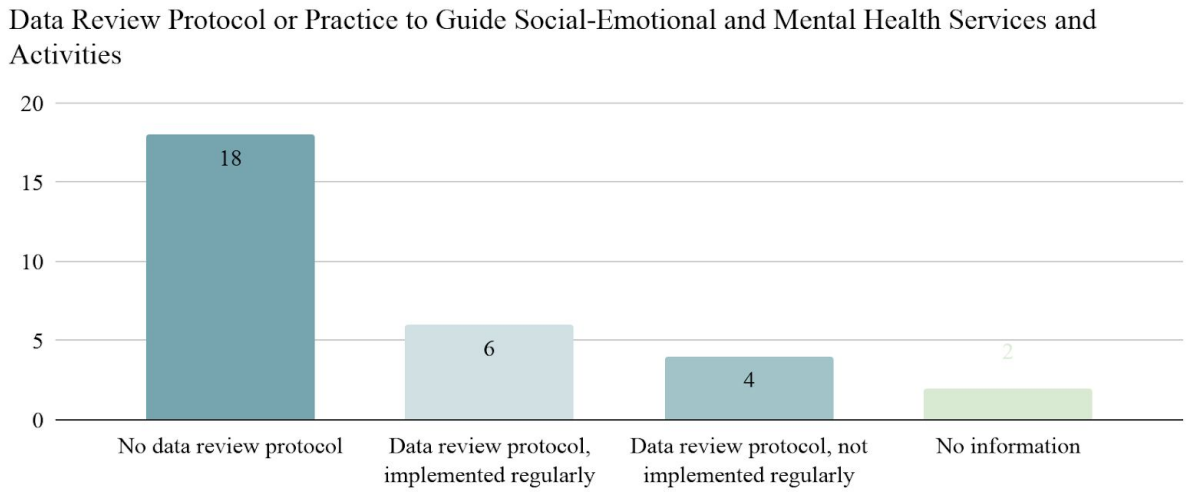
Tracking Threats: Only 13 districts reported having a system in place to track threats. Many district representatives were unsure whether their district has a system to track threats, and 10 reported having no system in place. Opportunities exist to establish school-site threat assessment teams, and to improve threat tracking systems for districts in the county.



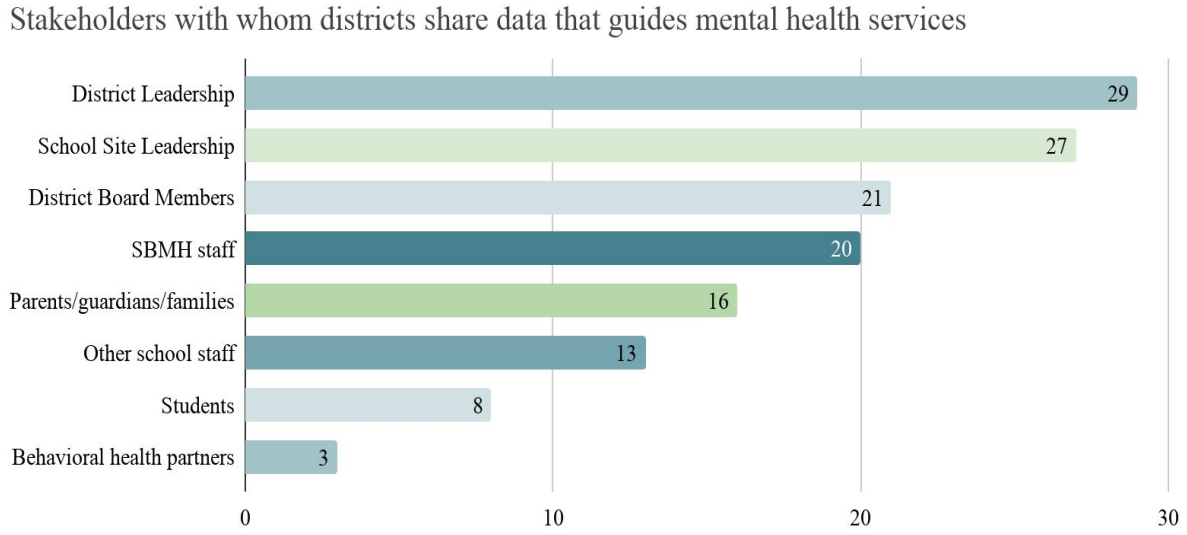
Evidence-Based Threat Assessment Models or Guidelines: While 17 of the districts said they use an evidence-based model or guidelines for threat assessment and response, only 13 districts identified an evidence-based model or guidelines. The most common model used is Dr. Dewey Cornell's Comprehensive School Threat Assessment Guidelines (CSTAG) model, but other districts mentioned the National Association of School Psychologist (NASP) threat assessment model, Association for Student Conduct Administration (ASCA), and the Secret Service Threat Assessment Model.

Data Review Protocols

Most districts in the county do not have a data review protocol or practice to guide social-emotional and mental health services, and many that have one do not implement it regularly. The most commonly-used data sources are the California Dashboard and California Healthy Kids Survey (CHKS). There is little consistency in use of other data across districts. These data are most commonly shared with District and School Site Leadership, but also with District Boards, school staff, and about half share these data with parents/guardians and families.



Data sources reviewed when setting priorities to address student population social-emotional and MH needs	**Number of districts using each data source to set priorities:** • 24 use California Dashboard data • 20 use CHKS data • 12 use Vulnerable Student Populations data • 8 use district surveys of students, parents, and/or staff • 6 use behavioral, academic,and/or mental health referral data • 5 use validated SEL student surveys (Panorama, CORE SEL, or Covitality survey) • 3 use validated mental health screeners (SRSS, BEISY) to help guide priorities • 3 use LCAP surveys



Mental Health Funding

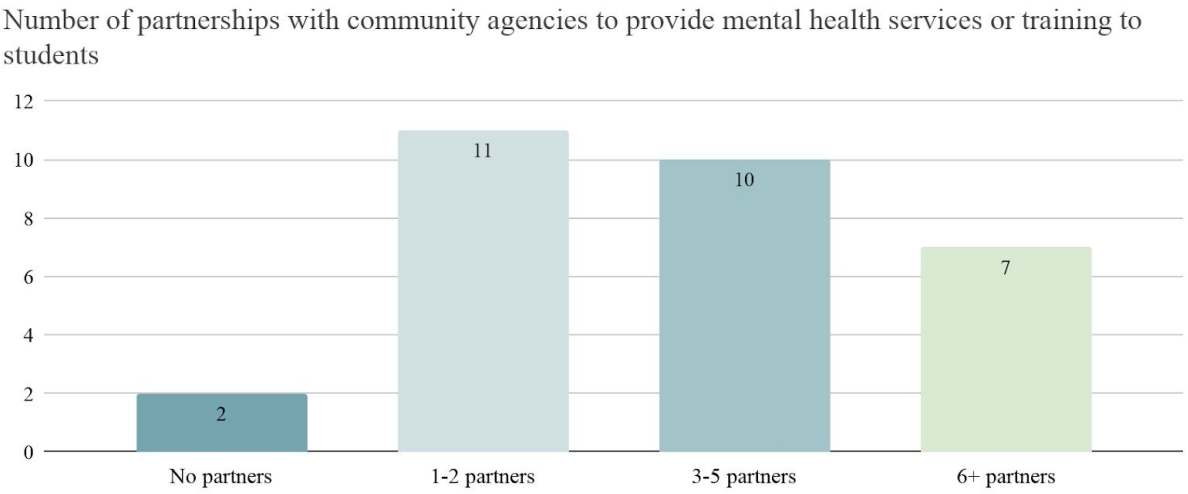
Approximately half of the districts in the county use LEA Medi-Cal reimbursement, Medi-Cal Administrative Activity (MAA) funding, Title I, and/or CARES Act funds to support social-emotional and mental health programs. **One-quarter receive no Medi-Cal reimbursement or MAA funding**. Some districts reinvest Medi-Cal reimbursement funds into mental health assessments and referrals, prevention activities, crisis services, or counseling. One-quarter do not reinvest Medi-Cal or MAA funding mental health services. **Eighteen districts expressed interest in getting RMHC support to establish or expand Medi-Cal reimbursement or MAA funding.**

Funding Topic	Number of districts
Sources of funding used to fund social-emotional and mental health programs	**Number of districts with funding source:** 17 LEA Medi-Cal Reimbursement 15 Medi-Cal Administrative Activity (MAA) 15 Title I 14 CARES Act (ESSER Fund) 6 Local foundation funds (e.g., donations) 4 General funds 3 Other funds (e.g., LCFF)
School-based MH support services on which district reinvests Medi-Cal reimbursement funds	**Number of districts reinvesting in each service:** 10 Mental health assessments and referrals 9 Prevention 6 Crisis intervention 6 Counseling 2 Special Ed/IEP services 3 Other services

Partnerships

Community-Based Mental Health Agency Partnerships

Orange County school districts have a wide variety of partnerships with community agencies to provide mental health services to students. However, while some districts have multiple



partnerships, others have few or none. A goal of the MHSSA grant is to expand these types of partnerships. Expanding partnerships with community organizations was a priority identified by many districts during this needs assessment process. For more information, see the Priorities section of this report.

Two-thirds of Orange County districts partner with Western Youth Services (WYS), nearly half partner with Olive Crest, and **one-third partners with Family Resource Centers (FRCs)** and **Seneca Family of Agencies** to provide mental health services or training to students.

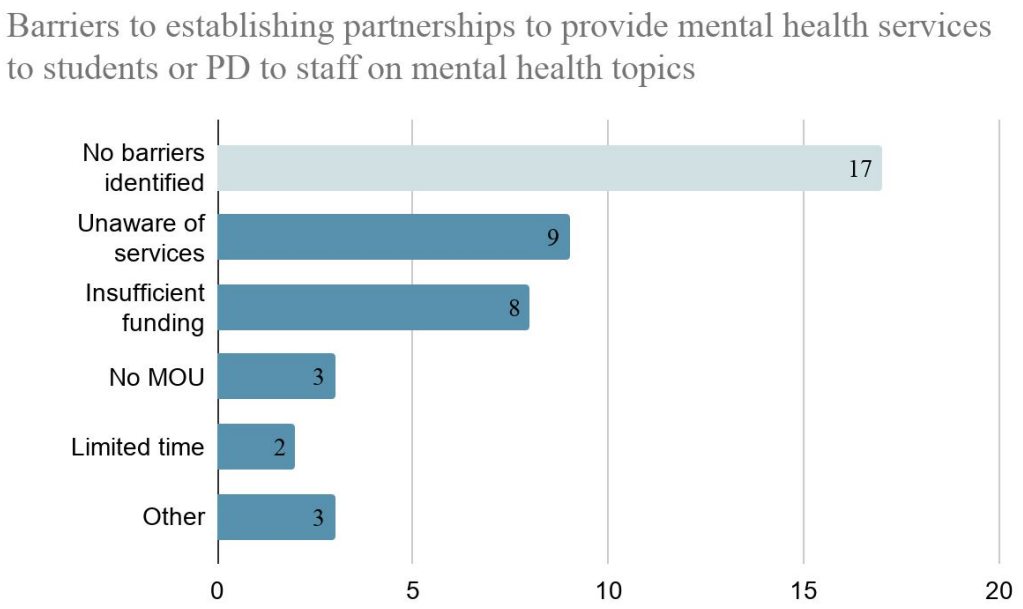
Districts reported having a total of 73 MOUs with community partners, to provide mental health services and/or training to students. They also reported **33 partnerships without MOUs**.

Districts are more limited in the number of partnerships they have to provide professional development (PD) to staff on mental health topics. **Only 11 school districts have a partnership with a community agency to provide PD to staff**. The table below shows the number of districts that partner with various organizations to provide mental health services or training to students and professional development to staff in mental health topics. RMHCs will work with districts to expand these partnerships, as needed.

Services/training for students	21 Western Youth Services 15 Olive Crest 12 Family Resource Centers 10 Seneca Family of Agencies 5 Project Kinship 4 Mariposa Women and Family Center 4 Care Solace 4 Pathways OC 4 Health Care Agency 3 CHOC 2 Phoenix House 2 Outreach Concern 2 Turning Point 18 Other agencies
PD for staff	7 Western Youth Services 5 Olive Crest 4 Seneca Family of Agencies 3 Family Resource Centers 3 Project Kinship 2 OCDE 2 CHOC 1 Mariposa 1 Phoenix House 1 Pathways 1 CHOC 1 HCA 4 Other

Staff responsible for community partnerships. Nearly all districts report that Administrators are primarily responsible for establishing community partnerships, with just over one-third reporting that family and community liaisons also establish these partnerships. To a lesser extent, school counselors and SBMH clinicians, or other district staff are responsible for establishing community partnerships.

Barriers. While more than half of districts reported no barriers to establishing community partnerships, many districts identified limited awareness of available services, insufficient funding, and other barriers to establishing these partnerships.

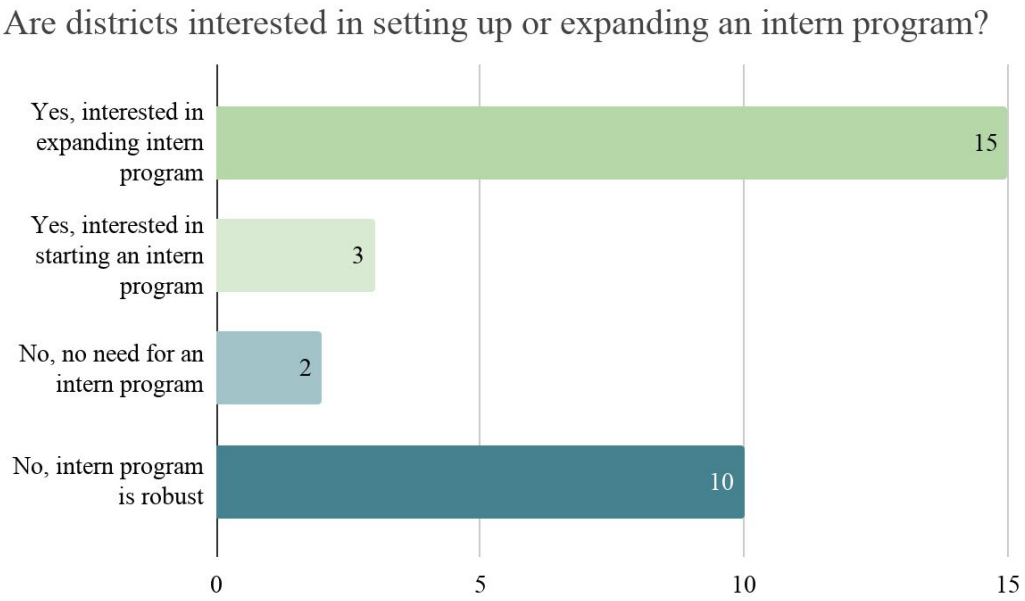


College/University Partnerships: Mental Health Interns

Twenty-five districts **have partnerships with colleges and universities to provide mental health services through intern programs**.

Partnerships with colleges or universities to provide MH services through interns	21 CSULB 17 CSUF 15 Azusa Pacific University 14 USC 12 Chapman 10 National University 6 CSULA 2 Concordia 2 Biola 11 Other Colleges/Universities

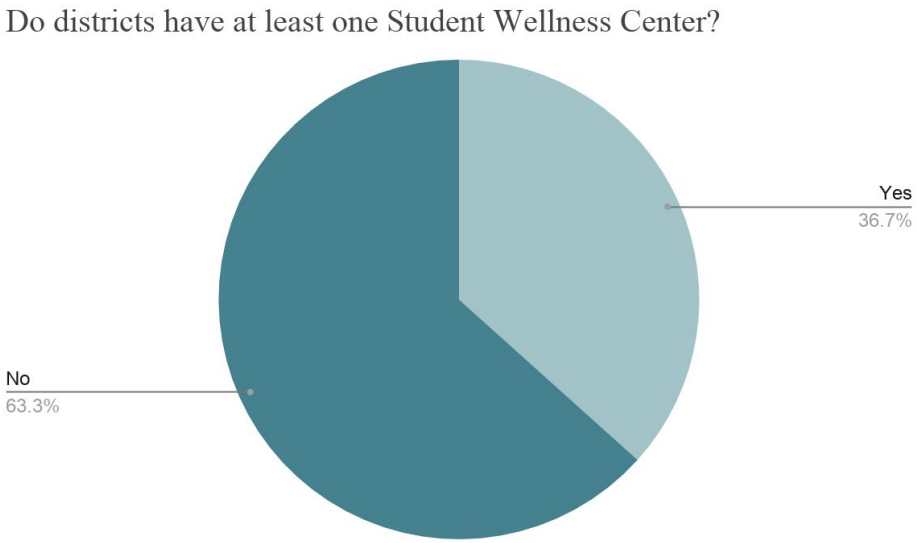
Eighteen districts **expressed interest in expanding or developing an intern program**, ten districts reported that their intern program is robust, and two districts reported having no need for an intern program.

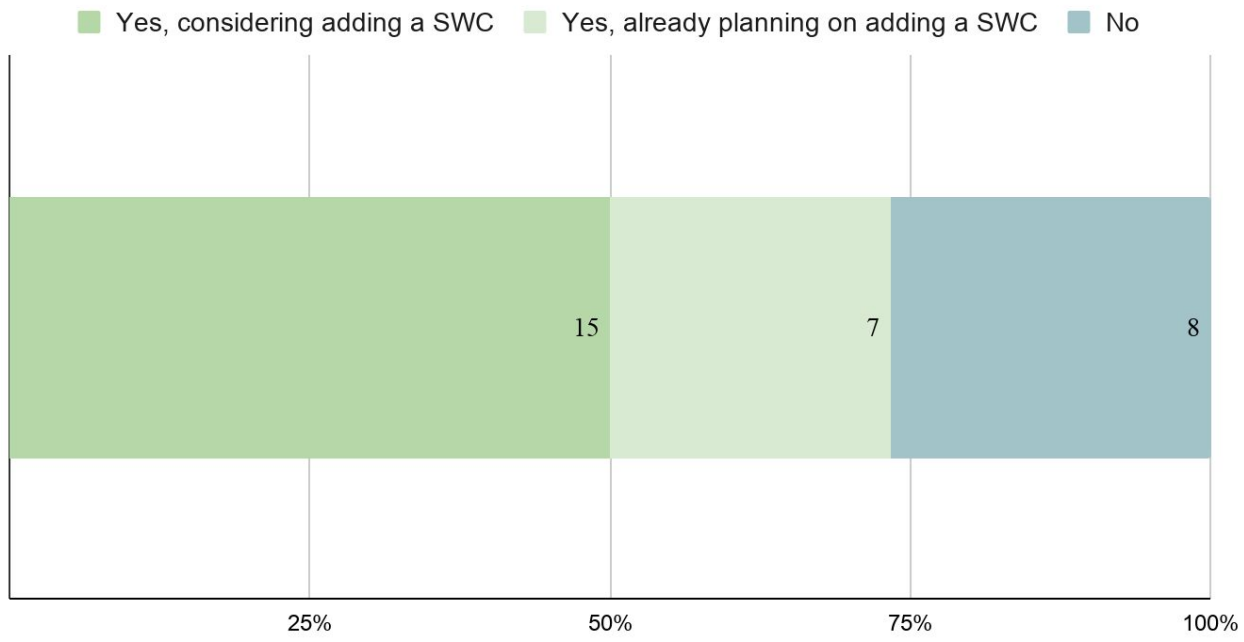


Districts report various barriers to expanding or setting up intern programs including insufficient staff, funding, and time. The most common barrier was insufficient staffing, with eleven districts reporting this barrier.

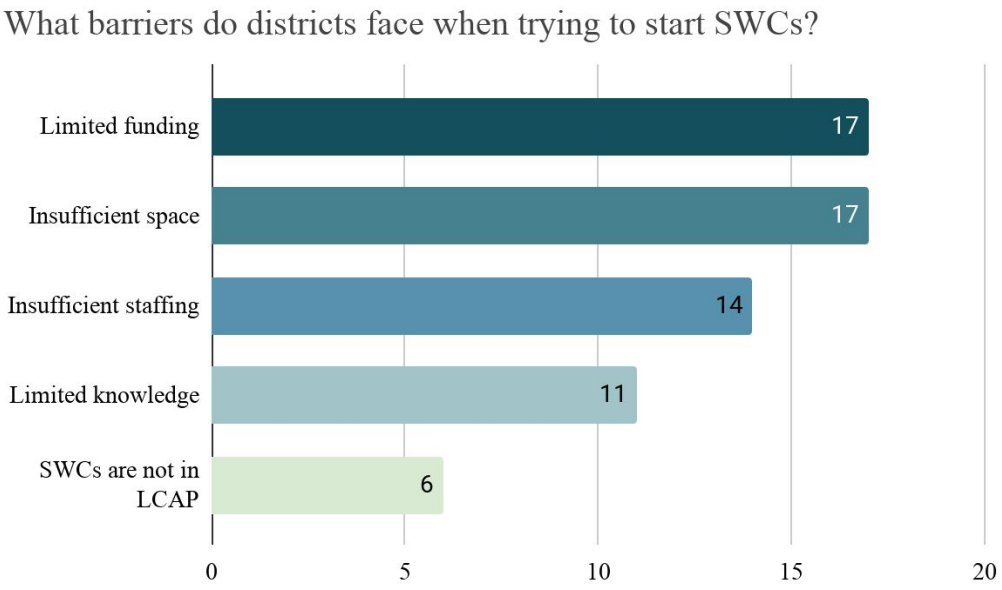
Student Wellness Centers (SWC)

Only 11 districts have one or more Student Wellness Centers. However, 22 districts are considering adding, or are already in the process of adding, one or more SWCs.

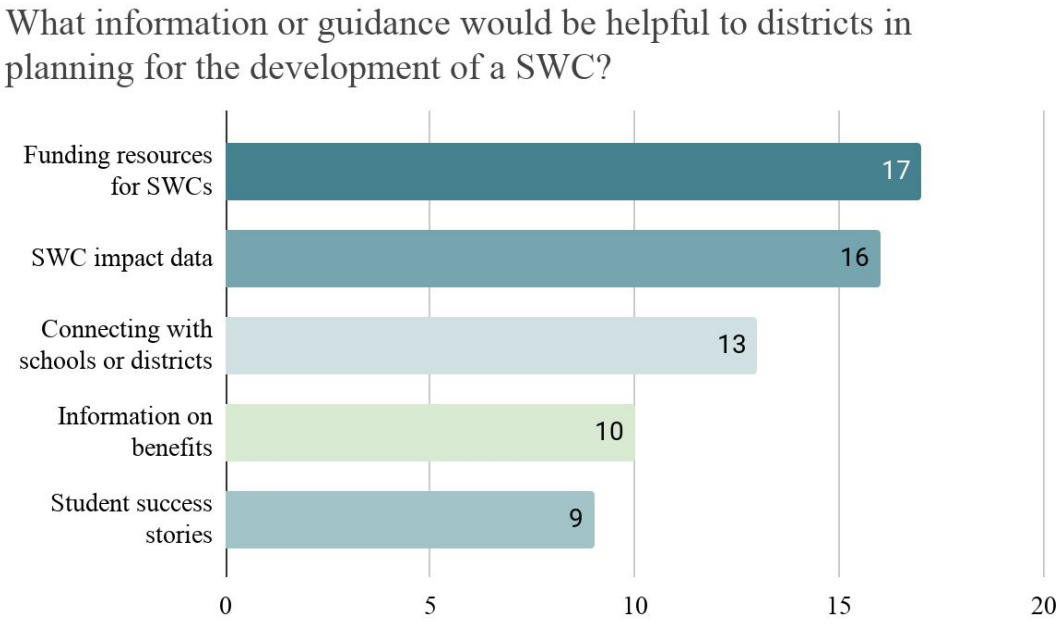




Many districts report facing several barriers when trying to start Student Wellness Centers. More than half of the districts identified insufficient funding and space as barriers to developing SWCs. Many also cited insufficient staffing and limited knowledge of how to set up a Student Wellness Center as barriers.



Helpful information or guidance in planning SWCs. More than half of the districts are interested in getting information or guidance on funding resources to help plan for the development of a SWC. Many districts are also interested in getting information on the impacts of Student Wellness Centers, the benefits of SWCs, and student success stories, as well as connecting with schools or districts that already have SWCs.



Existing Staff Trainings

Orange County district staff receive training on a variety of mental health topics. Nearly all districts have staff who receive training in mental health awareness, trauma-informed practices, suicide prevention, and self-care/mindfulness/stress and coping. SBMH clinicians are most likely to be trained in mental health topics, while teachers mostly receive training in mental health awareness, SEL, self-care, trauma-informed practices, and how to access on-campus mental health services.

Only one-third of the districts have staff trained in stigma reduction, and those that do, have limited staff trained in this topic. One-third of districts also do not have staff trained in screening for trauma. RMHCs will work with districts to improve access to needed mental health training.

MH awareness/basics	**28 districts have staff trained on this topic** 26 - SBMH clinicians 21 - Nurses 20 - Teachers	19 - Administrators 11 - Support staff 6 - SROs/DSOs
SEL training	**25 districts have staff trained on this topic** 21 - Teachers 20 - SBMH clinicians	19 - Administrators 7 - Nurses 4 - Support staff

MH screening	**22 districts have staff trained on this topic** 21 - SBMH clinicians 9 - Nurses	9 - Administrators 8 - Teachers 2 - Support staff
Trauma screening	**20 districts have staff trained on this topic** 20 - SBMH clinicians 6 - Nurses	6 - Administrators 4 - Teachers 2 - Support staff
Trauma-informed practices/Understanding impacts of trauma	**27 districts have staff trained on this topic** 24 - SBMH clinicians 20 - Teachers	19 - Administrators 12- Nurses 9 - Support staff
Suicide prevention	**28 districts have staff trained on this topic** 27 - SBMH clinicians 23 - Administrators	21 - Teachers 18 - Nurses 11 - Support staff
Suicide screening, assessment, and response	**25 districts have staff trained on this topic** 25 - SBMH clinicians 15 - Administrators	8 - Nurses 3 - Teachers 2 - SROs/DSOs
Stigma reduction	**12 districts have staff trained on this topic** 12 - SBMH clinicians 6 - Administrators	4 - Teachers 3 - Nurses 2 - Support staff
Self-care/mindfulness/ stress and coping	**29 districts have staff trained on this topic** 25 - SBMH clinicians 24 - Teachers	23 - Administrators 11 - Nurses 10 - Support staff
How to access on-campus MH services	**25 districts have staff trained on this topic** 23 - Teachers 21 - Administrators 20 - SBMH clinicians	16 - Nurses 15 - Support staff 3 - SROs/DSOs
How to access community MH services	**24 districts have staff trained on this topic** 22 - SBMH clinicians 17 - Administrators 13 - Nurses	12 - Teachers 7 - Support staff 1 - SROs/DSOs

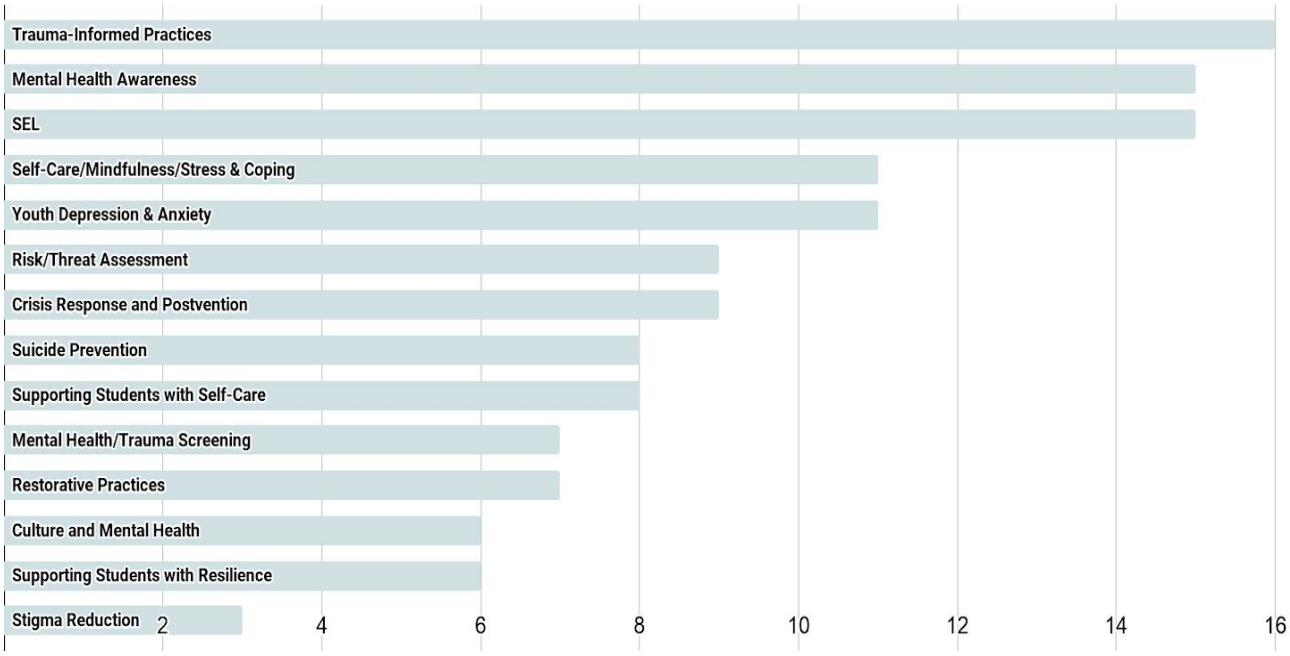
PRIORITIES

Mental Health Training Priorities

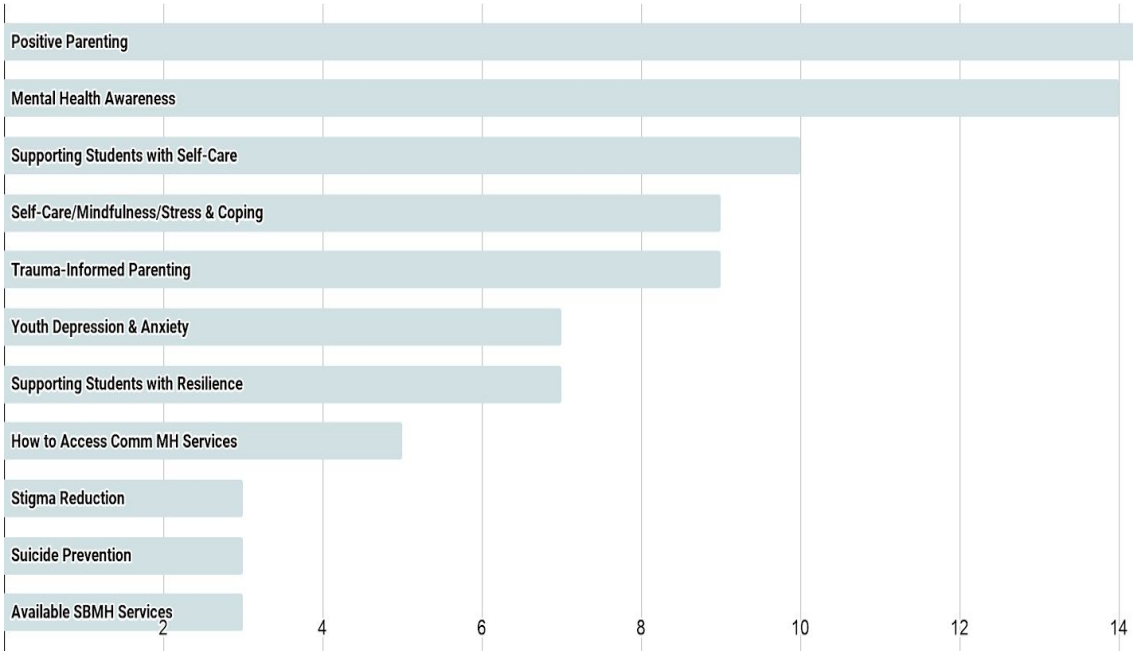
Mental health awareness and **self-care/mindfulness/stress and coping** training were identified as priorities for staff, parents/caregivers, and students by more than one-third of the districts.

Trauma-informed practices, social-emotional learning (SEL), and youth depression and anxiety were also priority training topics for staff, while **positive parenting and supporting youth with self-care** were identified as priority training topics for parents.

Staff Mental Health Training Priorities

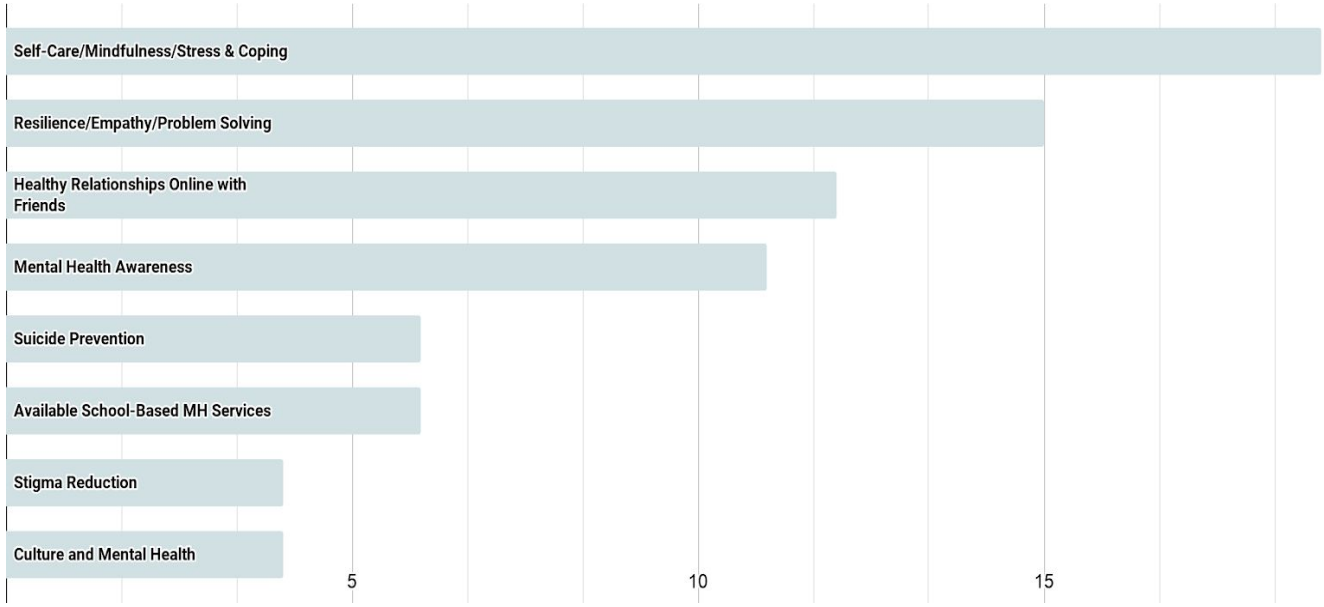


Parent Mental Health Training Priorities



In addition to mental health awareness and self-care, training priorities identified for students included **resilience/empathy/problem solving skills and developing/maintaining healthy relationships with friends online**.

Student Mental Health Training Priorities



Staff Certified to Provide Trainings in Mental Health Topics

Eighteen (18) districts have staff certified as trainers in mental health topics. Some of these topics include: trauma-informed practices (9 districts), restorative practices (6 districts), and/or suicide prevention and screening (5 districts). Fewer have staff certified to provide training in crisis response (3 districts), risk assessment (2 districts), threat assessment (2 districts), mindfulness (2 districts), and/or Cognitive-Behavior Therapy (CBT; 1 district).

Nearly all districts (29 of 30) are interested in getting staff certified to train school staff, parents/families, and/or students in mental health topics. RMHCs can help facilitate access to training resulting in certification, so that additional district/school staff can become certified to provide training in mental health topics. Further information will be gathered regarding the specific topics on which districts would like staff certified to provide training.

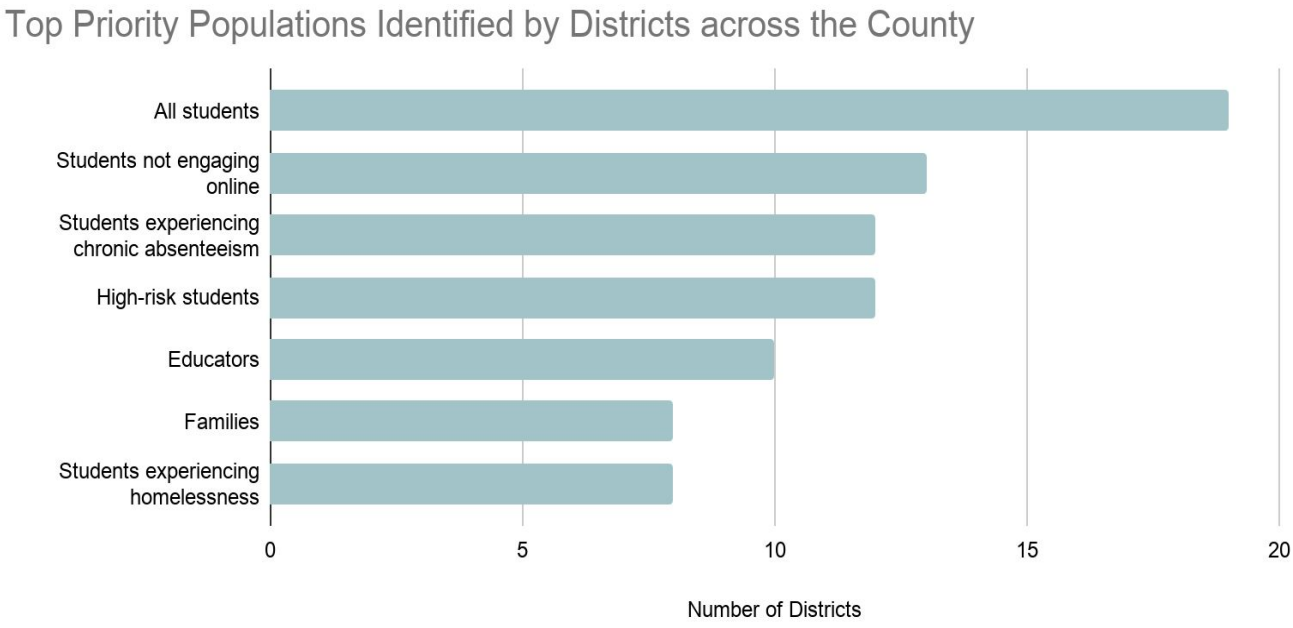
Interest in Getting Staff Certified as Trainers on Mental Health Topics

1	0	11	18
Not at All Interested	A Little Interested	Somewhat Interested	Extremely Interested

Priority Populations for Mental Health Services

Nearly two-thirds of districts in the county, 19 of 30 districts, prioritized **all students** for needing mental health services and support, suggesting a desire for **universal approaches to addressing mental health needs of students**. Additionally, many districts prioritized students not engaging online during distance learning, students experiencing chronic absenteeism, high-risk students,[1] and students experiencing homelessness. These priority populations suggest the need for some Tier 2 **targeted outreach and support**, and potentially Tier 3 services for some students as well.

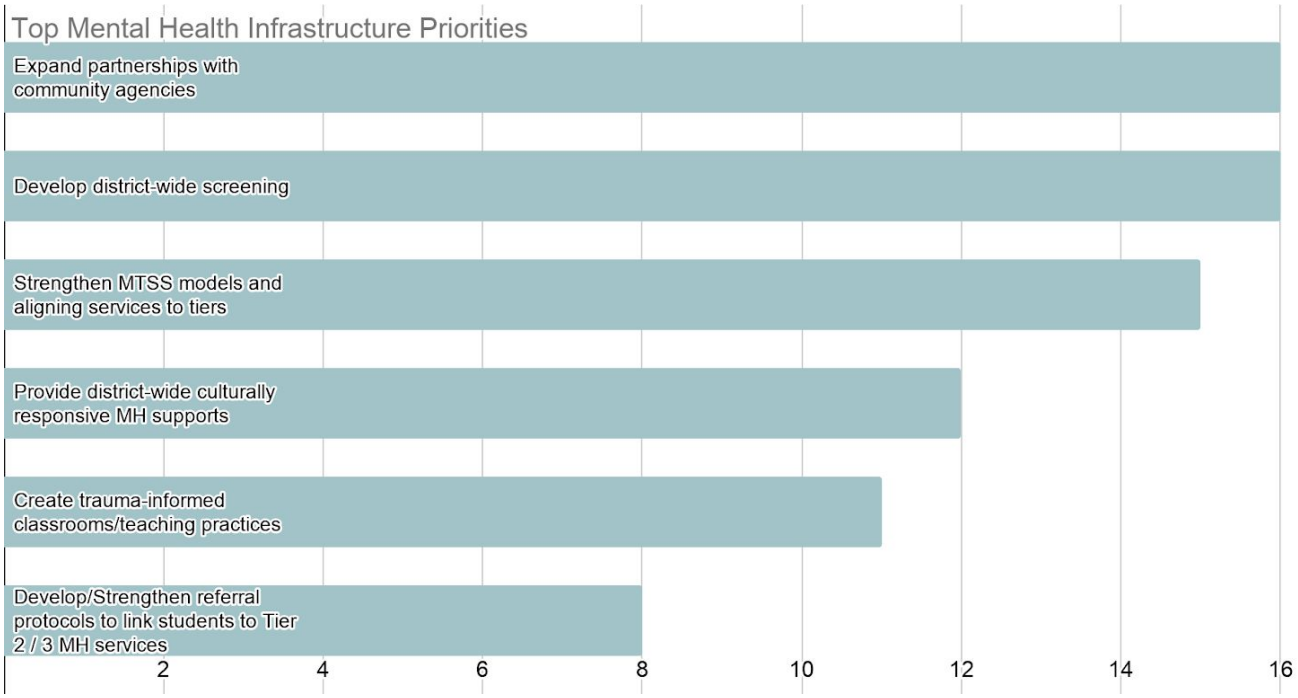
Many districts also prioritized **educators** and **families** of students as needing mental health services and support.



Mental Health Infrastructure Priorities

More than half of the districts identified the following as top infrastructure priorities: **expanding partnerships with community agencies to meet student mental health needs, developing a district-wide system and tools to screen students to identify mental health needs,** and **strengthening MTSS models and aligning services to tiers.** Other commonly-identified priorities included providing district-wide culturally-responsive mental health support for students through professional development and support to families, creating trauma-informed classrooms/teaching practices, and developing/strengthening referral protocols and processes for linking students to Tier 2 and Tier 3 mental health services and support.

[1] In this context, high-risk students are those with a history of suicidal thoughts/attempts, or who were previously hospitalized.



SUMMARY

Some of the main countywide district mental health infrastructure strengths and gaps are shown in the table below.

Countywide **Strengths**	Countywide **Gaps**
✓ Protocols for referring students to school-based and community mental health services/resources	✗ Universal mental health screening for all students
✓ Risk assessment protocols	✗ System to monitor mental health referrals to community agencies
✓ Threat assessment protocols	✗ System to track threats
✓ Partnerships with community agencies to provide mental health services/training to students	✗ Data-review protocols
✓ Partnerships with colleges or universities to provide mental health services through intern programs	✗ Partnerships with community agencies to provide PD to staff on mental health topics
✓ Training for variety of staff on mental health topics	✗ Reinvestment of Medi-Cal funds in mental health services
	✗ Few Student Wellness Centers
	✗ Stigma reduction training for staff

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