CONTRA COSTA
MENTAL HEALTH COMMISSION

CONTRA COSTA
MENTAL HEALTH
COMMISSION
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Mental Health Commission
Quality of Care Committee Meeting
Thursday, April 21st, 2022, 3:30-5:30 pm

Via: Zoom Teleconference:
https://cchealth.zoom.us/j/6094136195
Meeting number: 609 413 6195

Join by phone:
1 646 518 9805 US
Access code: 609 413 6195

AGENDA

I. **Call to order/Introductions**

II. **Public comments**

III. **Commissioner comments**

IV. **Chair comments**

V. **APPROVE minutes from February 17th, 2022 Quality of Care meeting.**

VI. **DISCUSS Site Visit Activity for March, 2022 – April 2022**
- **Crestwood Our House visit**
- **Hope House update**
- **Crestwood Bridge update**

VII. **DISCUSS the concept of campus Wellness Centers in high schools and some of the trends, challenges, and bright spots in supporting the mental health of students in Contra Costa County high schools, Graham Wiseman, CEO and Co-founder, BeingwellCA**

VIII. **UPDATE Committee on the Contra Costa County Wellness in School Programs (WISP) activities, Commissioner Laura Griffin.**

IX. **MENTION articles regarding children and adolescent mental health in the context of the COVID-19 pandemic (see articles in meeting packet)**

(Agenda continued on Page Two)

CONTRA COSTA COUNTY
MENTAL HEALTH
COMMISSION

Quality of Care Committee Agenda (Page Two)

Thursday, April 21st, 2022 ◊ 3:30 pm - 5:30 pm

X. DISCUSS Action Plan framework for outlining steps for achieving Committee goals, Lauren Rettagliata, Prior Mental Health Commission Chair and Chair of Quality of Care Committee, and Family Advocate

XI. DISCUSS Quality of Care mission statement: Keep or change?

- **Current: *"To assist Contra Costa County mental health consumers, family members and the general public in advocating for the highest quality mental health services and supports delivered with dignity and respect."***

XII. Adjourn

ATTACHMENTS:

A. California On Campus Wellness Centers from BeingwellCA website
B. "Children's Mental Health is in Crisis" from American Psychiatric Association website
C. "COVID Harmed Kids' Mental Health--And Schools Are Feeling It" from the PEW Charitable Trust website
D. "Adolescent Mental Health, Connectedness, and Mode of School Instruction During COVID-19" from ScienceDirect website
E. Report 262: COVID-19 and Children's Mental Health Addressing the Impact from Little Hoover Commission website
F. Opinion: What California can do to improve children's mental health Article in the East Bay Times
G. Mental Health Commission Quality of Care Committee "Action Plan" framework
H. "50 Top Mission Statements" from TOPNONPROFITS website
I. Mental Health Commission and Quality of Care Committee Mission Statements

CALIFORNIA ON CAMPUS WELLNESS CENTERS

WELLNESS CENTERS

Wellness Centers are designed to be a safe space where students can go to get support and information. These centers will: increase school attendance, improve employee and student support, provide access to mental health resources, decrease stigma around seeking help and help to coordinate care

Some of the benefits of on campus Wellness Centers are:

- Provide immediate access to support
- Allow students to remain on campus and return to class
- Reduce mental health use of Home and Hospital program *(65% for anxiety in a local district)*
- Deliver early intervention for mental health support
- Build awareness and reduce stigma on campus
- Engage the community in mental health awareness
- Improve coordination of services amongst nurses, counselors, support and administration

Wellness Centers work in collaboration with the Counseling Department and Health Office to expand support services for students, faculty and staff. These services include mental health counseling, outreach, peer support and case management:

- Staffed by district employees
- District Wellness Director – coordinate staffing and sites to meet student needs
- Wellness Coordinator – Licensed LCSW, PPSC
- Intake / Triage Specialist – to greet student, perform initial triage, referrals
- Interns – MFT or PCC Trainee, MSW Intern or similar
- Adjacent to or in close proximity to existing counseling services
- Comfortable furnishings such as couches and bean bags with neutral décor. Space should offer privacy but not hideaways
- Open during school hours – option to open after hours in crisis such as student death
- Integrated with Student Health Classes
  - Freshman orientation tour

- Mental Health Presentations by Wellness Center

Data collection process for reporting and assessment through district:

- Student name/ID number
- Number of visits
- Number of unique visits
- Referrals (internal/external)
- Evaluation linked to CHKS results

DAY TO DAY MODEL

Wellness Centers are open to students, faculty, staff, parents and community support groups. It provides immediate support for people experiencing stress, anxiety, depression, grief, suicide ideation or other mental health issues.
Students can self-refer or be referred by faculty/staff to Wellness Center. Upon arrival are greeted at the door, which preferable can be accessed independently of other school departments, by the Wellness advocate for triage. A student would sign in electronically with either name or student ID card and then be given an opportunity to share their situation. Triage options could include:

- 10 minutes to collect thoughts
- hot/cold beverage/snack
- One on one conversation
- Referral to: Wellness Coordinator, Counselor, School Psychologist, Assistant Principal, - immediate or by appointment
- Wellness Coordinator can refer to additional resources such as outside agency, community support group, etc.
- Referral to student club
- Crisis intervention – 5150 process
- Return to class with excused status
- “Handle with Care” status – Handle with Care is a collaboration between law enforcement and the school district. When law enforcement visits a home (for any reason) and school age children are present, the names and schools of the children. The Police would then notify the district who in turn would notify the school site that these students should be “Handled with Care”. The teacher would only be informed of this status to give the child some leeway. They have had a bad day/night.
- A student would not be returned to class until their immediate need is met

AMERICAN PSYCHOLOGICAL ASSOCIATION

2022 TRENDS REPORT (/MONITOR/2022/01/SPECIAL-EMERGING-TRENDS)

Children's mental health is in crisis

As pandemic stressors continue, kids' mental health needs to be addressed in schools

By Ashley Abramson Date created: January 1, 2022 8 min read

Vol. 53 No. 1

Print version: page 69

As the United States approaches 2 full years of the COVID-19 pandemic, mental illness and the demand for psychological services are at all-time highs—especially among children. While some children benefited from changes like remote learning (https://www.apa.org/monitor/2021/09/cover-remote-learning) , others are facing a mental health crisis. Prior to COVID-19, Centers for Disease Control and Prevention (CDC (https://www.cdc.gov/childrensmentalhealth/access.html)) data found 1 in 5 children had a mental disorder, but only about 20% of those children received care from a mental health

provider. Whether kids are facing trauma because of child abuse or loss of a family member or everyday anxiety about the virus and unpredictable routines, they need even more support now—all amid a more significant shortage of children's mental health resources.

In a 2020 survey of 1,000 parents around the country facilitated by the Ann & Robert H. Lurie Children's Hospital of Chicago (https://www.luriechildrens.org/en/blog/childrens-mental-health-pandemic-statistics/) , 71% of parents said the pandemic had taken a toll on their child's mental health, and 69% said the pandemic was the worst thing to happen to their child. A national survey (https://www.americaspromise.org/sites/default/files/d8/YouthDuringCOVID_FINAL%20%281%29.pdf) of 3,300 high schoolers conducted in spring 2020 found close to a third of students felt unhappy and depressed much more than usual.

Mental health crises are also on the rise. From March 2020 to October 2020, mental health–related emergency department visits increased 24% for children ages 5 to 11 and 31% for those ages 12 to 17 compared with 2019 emergency department visits, according to CDC data (Leeb, R. T., et al., *Morbidity and Mortality Weekly Report (https://www.cdc.gov/mmwr/volumes/69/wr/mm6945a3.htm)* , Vol. 69, No. 45, 2020).

Emergency visits could be mitigated with more widespread outpatient care, but even before the pandemic, kids often had to wait months for appointments (Cama, S., et al., *International Journal of Health Services* (https://journals.sagepub.com/doi/10.1177/0020731417707492) , Vol. 47, No. 4, 2017). Only 4,000 out of more than 100,000 U.S. clinical psychologists are child and adolescent clinicians, according to APA data. School psychologists are also in short supply, leaving kids without enough support at school. The National Association of School Psychologists (https://www.nasponline.org/research-and-policy/policy-priorities/critical-policy-issues/shortage-of-school-psychologists) (NASP) recommends a ratio of 1 school psychologist per 500 students; current NASP data estimate a ratio of 1 per 1,211 students.

The pandemic has also exacerbated existing disparities in mental health services. A 2020 technical report (https://www.umb.edu/editor_uploads/images/centers_institutes/birch/BIRCh_Technical_Report.pdf) from the University of Massachusetts Boston and University of Massachusetts Amherst

found that students who needed access to school-based services the most, particularly those with lower socioeconomic backgrounds, had lower rates of counselors and school psychologists in their districts.

While federal funding has provided schools with money to support students' well-being, psychologists have been seeking additional long-term solutions to address the mental health problems revealed and exacerbated by the pandemic, from building mental health into school curricula to training teachers in prevention strategies to support students based on psychological science.

Here are some of the most notable ways psychologists have worked to address students' mental health and what's ahead.

Bringing mental health into the classroom. The American Rescue Plan Act, passed in March 2021, included $170 billion for school funding, and many schools used the funding to hire mental health workers, including psychologists. Other federal and state funding is being allocated toward training more psychologists. For example, in Nevada, which has historically ranked last in U.S. mental health, the University of Nevada, Las Vegas, received a grant to train school clinicians in urban diversity and social justice, and Nevada State College received funding to create a new program to train school mental health clinicians, including psychologists.

While the field of psychology recognizes a shortage of mental health services for kids, addressing those needs may not be a realistic solution until the workforce grows. Relying on temporary funding to hire permanent staff isn't financially sustainable for lower-income districts, said Kenneth Polishchuk, APA's senior director for congressional and federal relations. As a result, Polishchuk said, many schools are hiring mental health providers on a short-term basis, as well as taking a preventative approach (https://www.apa.org/ed/schools/primer) focused on training teachers in psychological principles (https://www.apa.org/ed/schools/teaching-learning/top-twenty/principles) .

Psychologists in some districts are training teachers in basic social and emotional skills to help students cope with stress and anxiety in real time, said Kathryn H. Howell (https://www.memphis.edu/psychology/howell/index.php) , PhD, an associate professor of child and family psychology at the University of Memphis and chair-elect of APA's Committee

on Children, Youth and Families. Howell said equipping kids with coping skills in the classroom can prevent strain on school psychologists while also improving students' ability to learn.

"As psychologists, we don't just want to bring in interventions that only we as experts can deliver," Howell said. "We need to make it sustainable by teaching those on the front lines how to equip kids with the skills they need to thrive."

Some teachers are incorporating formal mental health lessons into their curriculum with help from psychologists. New York state requires basic mental health education in health classes, and Peter Faustino, PsyD, a school psychologist in Scarsdale, New York, said he's been receiving requests from teachers for help incorporating pandemic-relevant topics like anxiety, trauma, and warning signs of suicide into their classes. Other schools, he said, are investing in social and emotional health training programs for staff, such as Yale University's RULER program (https://www.ycei.org/ruler) , which teaches school leaders and teachers how to equip students with emotional intelligence skills.

Training teachers to address trauma. Along with more minor mental and behavioral health concerns, teachers are facing an unprecedented number of students with trauma, said Laurie McGarry Klose, PhD, president of NASP and director of the School Psychology Program at Trinity University in San Antonio, Texas. And many teachers don't feel equipped to handle their students' struggles: A 2020 survey (https://www.newyorklife.com/assets/foundation/docs/pdfs/key-findings-and-topline.pdf) by the New York Life Foundation and American Federation of Teachers found that only 15% of educators said they felt comfortable addressing grief or trauma tied to the pandemic.

As a result, psychologists are finding new ways to share their expertise with school personnel. For example, Samuel Song (https://www.unlv.edu/people/samuel-song) , PhD, a professor of school psychology at the University of Nevada, Las Vegas, and president of APA's Div. 16 (School Psychology), is working on a grant with colleagues to deliver a four-part web-based curriculum on trauma-informed practices. Such programs can help teachers identify signs of trauma in students and also cope with their own trauma, which Klose says are equally important. Teachers are more likely to dismiss trauma-driven behaviors as belligerence when they're under strain, so with proper resources and

training, they can better identify kids who are struggling and route them to appropriate support services within the school system.

Mental Health Primers (https://www.apa.org/ed/schools/primer) , developed by the Coalition for Psychology in Schools and Education, also provide information for teachers to identify behaviors in the classroom that are symptomatic of mental health and other psychological issues, with the goal of directing teachers to appropriate resources for their students.

“We know one-on-one therapy won’t be possible for every kid who’s struggling, so we need a multipronged approach to help build the capacity of teachers and staff to support kids in the classroom setting,” said Melissa Pearrow (https://www.umb.edu/faculty_staff/bio/melissa_pearrow) , PhD, a professor of counseling and school psychology at the University of Massachusetts Boston.

Resilience is built outside the classroom, too. Howell said psychologists and graduate students from her department at the University of Memphis are also working with local community centers to train leaders in emotional health principles. “We want to help provide mentors that can be present in kids’ lives beyond their parents, who are already dealing with a lot,” she said. “We have the expertise and scientific background, and they have expertise in working directly with families and systems, so how can we pair our expertise and learn from each other?”

Ensuring long-term resilience. While short-term crisis funding has helped many communities and schools hire mental health professionals and develop related programs, psychologists and policymakers continue to advocate for more permanent solutions. In a September 2021 address to the House Energy and Commerce Subcommittee on Oversight and Investigations (https://u7061146.ct.sendgrid.net/ls/click?upn=4tNED-2FM8iDZJQyQ53jATUdmaT7yvSQA9WuYYmEMj-2FLwV5pRDBg6Kj2p8Tn1Am1Q3K4OZK33MRjAxJxDLlnIXQtg8rYtEC-2F56NUUys4s3ow-2BWXBKrz3462R2-2FMEq6wtZbnhsp_KVyBcpjXADXifSWVpM8nQdv-2BTa-2BqjT8uKX9PTiQozEM6zPlCuGi4Kg-2Fkz-2FmhPmjgiRACHqNPvT5aD2c-2FQNrMeKcYd-2FwWh3rPQwtWw403-2FYclIPV-2Bt4dTQD9LyYq7rfhflKsV-2FavrYSH10LfcZvOuD6bvwjj0HGMbrYiupQfs-2BmxxmUS-2BknVnbiAkbLE93pyvO8BrXYifZGwQej4bgHhhj-

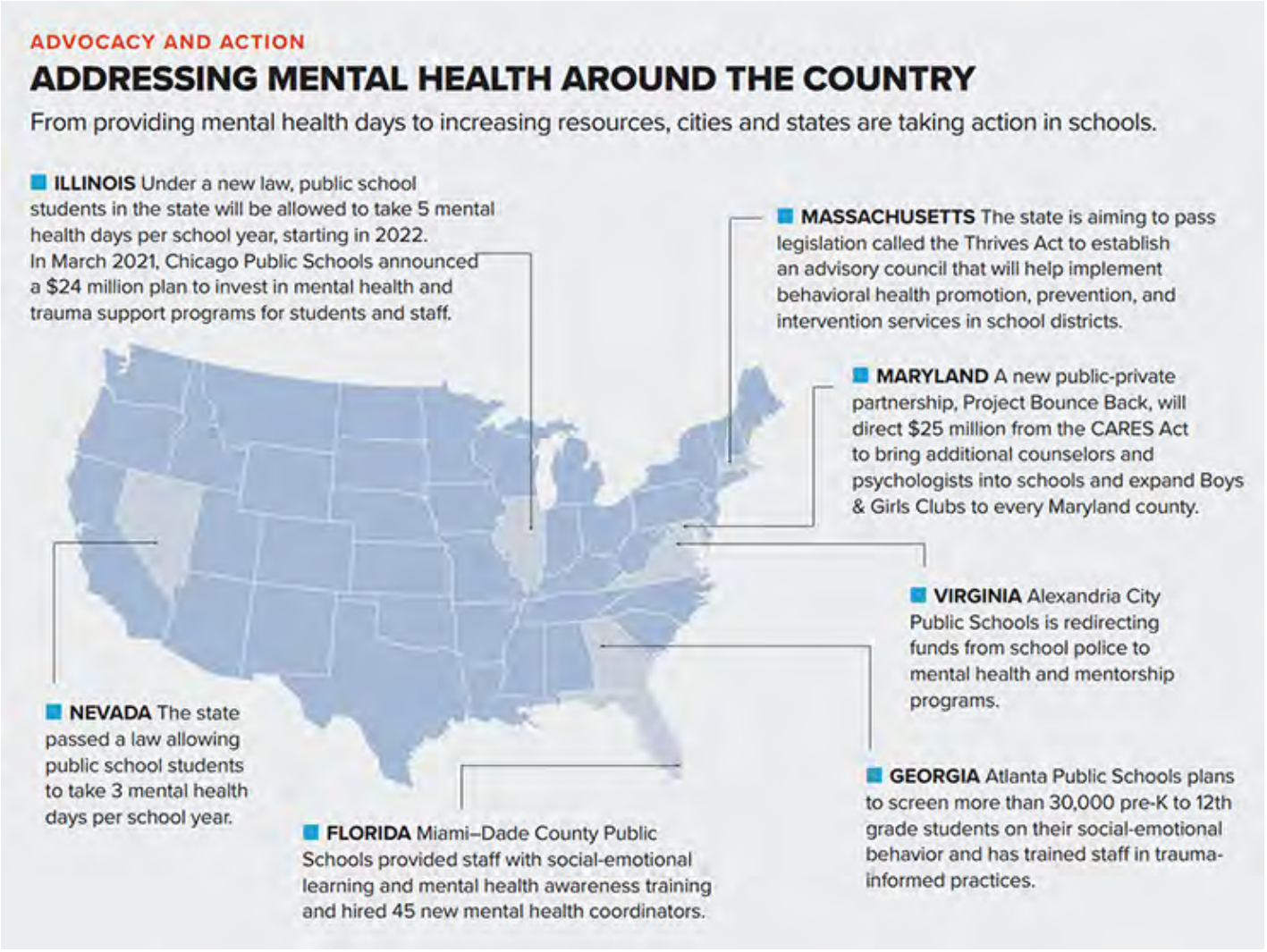
2Fox24IB0QQiii8lPj2Q3MJBb3RJk9JhltkQ9XJ148twDWhOBDiijUU8lYl7K99SLk9Lo7-2BQTnKx9v9qKW0s2ef5IIIDUmtyw7hjZxMR81hZUbd78ejM9Hfb6ji7No4rpIGHXkZsNK2xrXSAFSK6hCU-3D) , APA CEO Arthur C. Evans Jr., PhD, encouraged Congress to consider long-term investments in states' and school systems' mental health workforces and infrastructures. In October 2021, the Biden administration and U.S. Department of Education released new guidance (https://www2.ed.gov/documents/students/supporting-child-student-social-emotional-behavioral-mental-health.pdf) for schools to better help students' mental health needs.

Several bills could help protect kids' mental health in the long term. President Biden proposed an additional billion dollars to procure health care professionals—including mental health professionals—in schools. As of November 2021, the bill has passed in the House and will soon go before the Senate.

Also as of November 2021, bipartisan lawmakers are working to pass the Student Mental Health Helpline Act (https://newman.house.gov/media/press-releases/reps-newman-and-stewart-introduce-bipartisan-bill-create-and-support-student) , which would create a grant program to support existing and promote new statewide student mental health and safety helplines. The Comprehensive Mental Health in Schools Pilot Program Act, a bill referred to the House Committee on Education and Labor in May 2021, would provide resources for low-income schools to integrate social and emotional learning and evidence-based, trauma-informed practices into all aspects of the school environment. Also in May 2021, the House passed the bipartisan Mental Health Services for Students Act, which would build partnerships between schools and community-based organizations to provide school-based mental health care for students. It now awaits consideration by the Senate.

Until new laws go into effect, psychologists are committed to finding new ways to address children's mental health, not only for their own well-being but for the common good. "It's not only the right thing to do to make sure people can have as full a life as they possibly can," said Alan Leshner, PhD, the former director of the National Institute on Drug Abuse and former deputy and acting director of the National Institute of Mental Health, who has recently turned his attention to student mental health as a member of the National Academies of Sciences, Engineering, and Medicine Committee on Mental Health, Substance Use, and Wellbeing in STEMM Undergraduate and Graduate Education. "Young people are critical to the future of society, so it's in society's interest to

make sure we don’t lose the talent youth could contribute to a set of problems that can be alleviated.”



Additional resource

- Applauding the surgeon general’s December 7 advisory on ‘Protecting Youth Mental Health’ (https://www.apaservices.org/advocacy/news/protecting-youth-mental-health) (APA Services, Inc.)
- Take action: Join the APA Services call on Senate to address mental health in schools (https://www.apaservices.org/advocacy/actions/mental-health-schools)

2022 trends report

- This article is part of our 14 emerging trends special report. Explore our full coverage on how the pandemic era is changing attitudes toward science and mental health (/monitor/2022/01/special-emerging-trends) .

Related and recent

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Suggestions for providing meaningful instruction in the online classroom.

A hidden pandemic of COVID-19 (/monitor/2021/11/news-hidden-pandemic)

How psychologists are helping children who have lost caregivers to COVID-19

Stateline

COVID Harmed Kids' Mental Health—And Schools Are Feeling It

STATELINE ARTICLE

November 8, 2021

Updated: November 9, 2021

By: Christine Vestal

Read time: 6 min

Students wait for classes to start at a high school in Florida. Nationwide, children and adolescents are back in school and showing signs of stress from the trauma they have experienced during the pandemic.

Marta Lavandier/The Associated Press

After more than 18 months of school closures and social isolation, the nation's more than 50 million public school children are mostly back at their desks. But two months into the fall semester, teachers and students already are saying they need a break.

The grief, anxiety and depression children have experienced during the pandemic is welling over into classrooms and hallways, resulting in crying and disruptive behavior in many younger kids and increased violence and bullying among adolescents. For many other children, who keep their sadness and fear inside, the pressures of school have become too great.

According to the federal Centers for Disease Control and Prevention, emergency department visits for suspected suicide attempts among adolescents jumped 31% in 2020, compared with 2019. In February and March of this year, emergency department visits for suspected suicide attempts were 51% higher among girls aged 12–17 than during the same period in 2019.

Last month, the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, and the Children's Hospital Association declared that the pandemic-related decline in child and adolescent mental health has become a national emergency.

On top of social isolation and family instability, the medical groups said, "more than 140,000 children in the United States lost a primary and/or secondary caregiver, with youth of color disproportionately impacted."

"Nearly every child in the country is suffering to some degree from the psychological effects of the pandemic," said Sharon Hoover, co-director of the University of Maryland-based National Center for School Mental Health. "Suddenly everyone is talking about mental health. Parents, teachers and students are openly discussing it."

The pandemic may subside, but its mental health effects will be around much longer, Hoover and other experts say.

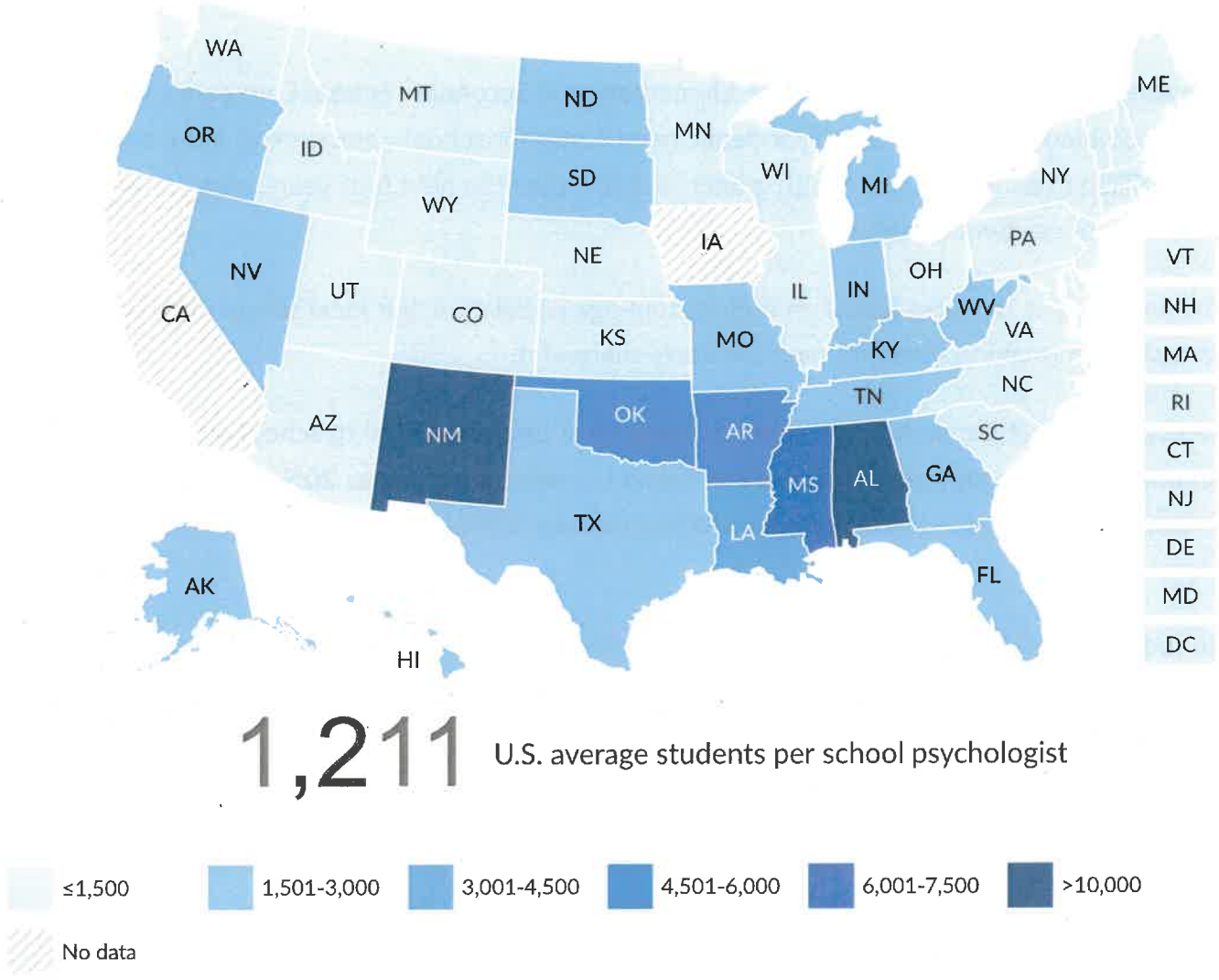
"That's why schools need to invest now in the mental health and well-being of our kids in a broad and comprehensive way—not just for children with learning disabilities and diagnosed mental health conditions, but for all students," Hoover said.

Share

Embed

A Shortage of School Psychologists

The National Association of School Psychologists recommends one professional for every 500 students. Maine is the only state that meets that standard.



Show Data Table

Source: National Association of School Psychologists analysis of 2020 U.S. Department of Education data

One good thing to come out of the pandemic, Hoover added, is that it lowered the stigma

around mental health. "We're all feeling it, so it's OK to talk about it."

School administrators and school principals know that the only way to get students back on track academically is to reduce the mental health barriers to learning, Hoover said. "They're as eager to invest in mental health resources as anyone. That wasn't always the case."

The pandemic also prompted the federal government to provide historic levels of relief funding for education.

New Investments

The American Rescue Plan Act and the Elementary and Secondary School Emergency Relief Fund, combined with other 2020 pandemic relief funds for schools, amounts to more than $190 billion in education and health grants available over the next four years, some of which can be spent on mental health.

The money goes to states based on their school-age population, but local school districts have decision-making authority over the lion's share of it.

Ninety percent of the money allocated to states must be re-allocated to school districts. Schools have wide discretion over how to spend the money, as long as 20% or more is spent on programs to address learning loss, including summer school and after-school academic programs.

No federal grants are specifically earmarked for mental health, but according to Hoover, nearly all states are spending part of their share of federal relief money on mental health and encouraging school districts to do the same.

Ohio, for example, is recommending that school districts invest in partnerships with community mental health providers to offer students mental and behavioral health services virtually or in school buildings that can be billed to Medicaid or private insurers.

Georgia is directing schools to use federal dollars to train counselors, social workers and nurses to identify students with substance use and mental health needs as they return to the classroom, then refer them to community mental health and local substance use providers.

Arizona is spending federal relief funds to hire more counselors and social workers in K-12 schools to improve the student to mental health professional ratio.

And Maryland is developing a school mental health response team to address the needs of students who have experienced trauma during the pandemic and are stressed beyond their ability to cope. The teams would quickly respond to local schools as needed.

New Laws

In addition to new investments in school mental health, states also are enacting a variety of new laws aimed at relieving pandemic-related stress on students and teachers and improving overall school mental health and academic success.

Arizona, Colorado, Connecticut, Illinois, Maine, Nevada, Oregon and Virginia enacted statutes this year and last that allow K-12 students to miss a certain number of school days for mental health reasons.

In addition, some school districts this fall called time outs for teachers and students to help release some of the pressures of trying to make up for lost time in the first two months of in-person learning.

In Chapel Hill and Carrboro, North Carolina, public schools gave teachers and students a full week off for Thanksgiving to support their mental health. And Richmond, Virginia, schools gave teachers and students a week-long mental health break around Election Day.

Tennessee enacted a law requiring schools to conduct mental and behavioral health screenings during the 2021-22 school year for all students in kindergarten through eighth grade to evaluate the effects the pandemic has had on their mental health. Utah enacted a law allowing schools to conduct mental health screenings for students whose parents consent.

A 'River of Referrals'

In most schools, it is the school psychologist who is responsible for working with counselors, social workers, nurses, teachers and principals to develop a school-wide mental health plan and to promote well-being for all students.

School psychologists also are called on to provide one-on-one counseling for students with mental or behavioral health needs and identify students with developmental and learning disabilities who may need a special education plan.

But this fall, long-term planning has largely gone by the wayside as school psychologists respond to what one called "a river of referrals." In an internal survey conducted by the National Association of School Psychologists in September, a substantial number of school psychologists reported sharp increases in the number of requests they were receiving to provide students with mental and emotional health supports.

"We've seen a huge increase in the need for mental health services for both adults and children," said Andria Amador, director of behavioral health services for Boston Public

Schools.

"All of our schools are struggling to make up for learning loss," Amador said.

"But the schools that are the most successful are those that are focusing first on re-creating the school community," she said. "Schools that are focusing purely on academics without helping kids feel like things are back to normal, are really struggling."

School psychologists, in short supply nationwide, also are receiving more requests than in previous years to run a battery of tests required by federal law to determine whether a child has a learning disability or physical or mental health condition that requires a special education plan.

Known as individual education plans or IEPs, about 14% of K-12 students in 2019 were deemed in need of federally funded special education accommodations under the 1975 Individuals with Disabilities Education Act. It's not yet clear whether an apparent increase in IEP testing this year will result in more students receiving special education supports.

"School psychologists are being swamped with referrals for just about everything," wrote Katherine Cowan, director of communications for the school psychologists' association, in an email.

Anecdotal evidence from *Stateline* interviews and media accounts indicates that violence and other behavioral challenges, including truancy, bullying, anxiety, depression and suicide risks, were up this fall in K-12 schools.

National data is not available on mental health related absences and referrals for mental health services in K-12 schools this year. But data from child mental health specialists on the effects of the pandemic is dramatic, said Dr. Carol Weitzman, director of developmental-behavioral pediatrics at Yale School of Medicine.

An estimated 16.5% of children ages 6-17 had at least one mental health diagnosis in 2016, according to data from the National Survey of Children's Health. According to the CDC, 7.1% of children ages 3-17 had a diagnosis of anxiety and 3.2% had a diagnosis of depression.

"Then came the pandemic," Weitzman said in an interview with *Stateline*. "We don't know a lot about how it has affected children's mental health yet. We're just starting to learn. But we do know that about one-quarter of all kids are showing up with symptoms of depression and one-fifth with symptoms of anxiety.

"That's millions more kids than before the pandemic."

STATELINE ARTICLE

November 8, 2021

Updated: November 9, 2021

Topics: Education & Health

Places: United States

Top State Stories 11/5

Top State Stories 11/8

AUTHOR

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Stateline

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Original article

Adolescent Mental Health, Connectedness, and Mode of School Instruction During COVID-19

Marci F. Hertz, M.S. *, Greta Kilmer, M.S., Jorge Verlenden, Ph.D., Nicole Liddon, Ph.D., Catherine N. Rasberry, Ph.D., Lisa C. Barrios, DrPH, and Kathleen A. Ethier, Ph.D.

Centers for Disease Control and Prevention, Division of Adolescent and School Health, Atlanta, Georgia

Article history: Received June 23, 2021; Accepted October 14, 2021
Keywords: Adolescents; Mental health; COVID-19; schools

A B S T R A C T

Background: Because COVID-19 was declared a pandemic in March 2020, nearly 93% of U.S. students engaged in some distance learning. These school disruptions may negatively influence adolescent mental health. Protective factors, like feeling connected to family or school may demonstrate a buffering effect, potentially moderating negative mental health outcomes. The purpose of the study is to test our hypothesis that mode of school instruction influences mental health and determine if school and family connectedness attenuates these relationships.

Methods: The COVID Experiences Survey was administered online or via telephone from October to November 2020 in adolescents ages 13–19 using National Opinion Research Center's AmeriSpeak Panel, a probability-based panel recruited using random address–based sampling with mail and telephone nonresponse follow-up. The final sample included 567 adolescents in grades 7–12 who received virtual, in-person, or combined instruction. Unadjusted and adjusted associations among four mental health outcomes and instruction mode were measured, and associations with school and family connectedness were explored for protective effects.

Results: Students attending school virtually reported poorer mental health than students attending in-person. Adolescents receiving virtual instruction reported more mentally unhealthy days, more persistent symptoms of depression, and a greater likelihood of seriously considering attempting suicide than students in other modes of instruction. After demographic adjustments school and family connectedness each mitigated the association between virtual versus in-person instruction for all four mental health indicators.

Conclusion: As hypothesized, mode of school instruction was associated with mental health outcomes, with adolescents receiving in-person instruction reporting the lowest prevalence of negative mental health indicators. School and family connectedness may play a critical role in buffering negative mental health outcomes.

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IMPLICATIONS AND CONTRIBUTION

Adolescents receiving virtual instruction reported more stress, mentally unhealthy days, persistent depression symptoms, and likelihood of seriously considering attempting suicide than students in other modes of instruction and may need additional support. School and family connectedness buffered these relationships.

Since the World Health Organization declared COVID-19 a pandemic on March 11, 2020, all 50 states in the U.S. closed schools for in-person learning at some point in time, with extended school closures from March 2020 through the end of the school year (May–June 2020) in 48 states [1]. In total, nearly 93% of U.S. students engaged in some form of distance learning during Spring 2020 [2]. In many cases, these closures continued into the fall of

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2020 or winter of 2021, with large portions of students receiving fully virtual modes of learning, some in hybrid (i.e., partially in-person and partially virtual) and a smaller portion going to school fully in-person [3]. Mental health indicators tracked in the nationally representative Youth Risk Behavior Survey and the National Health and Nutrition Examination Survey identified a trend of declining youth mental health prior to the pandemic. For example, on the Youth Risk Behavior Survey, more youth in grades 9–12 reported being sad or hopeless over the past 2 weeks, reported that they stopped doing usual activities [4], and reported their mental health over the past 30 days was "not good" [5]. These declines in youth mental health may have been further exacerbated by the COVID-19 pandemic and associated school closures [6,7]. More recently, analysis of national trends in emergency department visits found increases in suicide-related visits among youth during the pandemic, with significantly greater increases among girls. The mean weekly number of emergency department visits involving suspected suicide for girls ages 12–17 was 50.6% higher in February–March 2021 compared to February–March 2019, with a 3.7% increase among boys of the same age during the same time period [8]. These results are consistent with two international longitudinal studies that also found associations between COVID-19 and youth mental health challenges. An Australian study reported increases in youth depressive symptoms and anxiety and significant decreases in life satisfaction over the course of the pandemic [9]. These negative mental health effects were predicted by COVID-19-related worries, online learning difficulties, and increased conflict with parents, and were reduced by feeling socially connected, defined as feeling connected to those close to them, and society more broadly. The second study, conducted in China with baseline collection in November 2019 (prepandemic) and follow-up data collection 6 months later during the pandemic, found significant increases in nonsuicidal self-injury, and suicidal ideation, plans, and attempts [10].

In prepandemic research, protective factors, like feeling connected to family or school, have demonstrated a buffering effect and moderated negative mental health outcomes, such as depression and anxiety [11] and may present opportunities for building resilience during and following the COVID-19 pandemic. School connectedness has been defined in a myriad of ways, but generally includes the subconstructs of student academic engagement; sense of belonging and fairness; engagement in school activities; positive peer relations; feeling safe at school; and feeling supported by teachers [12]. Family connectedness, or feeling loved, cared for, valued, and respected by one's parents or caregivers, is also critically important, and is similarly associated with buffering against poor mental health. Youth who report feeling close to their parents are less likely to experience depressive symptoms, suicidal ideation, nonsuicidal self-injury, and conduct problems [13]. Research has demonstrated the long-term benefits of both school and family connectedness, with adolescents with high levels of school and family connectedness having lower odds of many negative adult health outcomes, including emotional distress [14].

Research about the protective effects of school or family connectedness specific to youth and COVID-19 is scarce. One U.S. study found that parent-reported youth "positive adjustment" (interacts positively with siblings or family members, has positive social or peer relationships, talks about plans for the near or far future, hopeful or positive, etc.) buffered some negative mental health outcomes [15]. Research with adults on connectedness during COVID-19 and mental health indicates that overall social connectedness can protect against negative mental health, with more robust social connections associated with lower levels of distress and fatigue during the pandemic [16].

This manuscript is grounded in the social–ecological theory that views child and adolescent development as reciprocal processes that evolve over time as an adolescent interacts with individuals and environments including home, school, community, and broader society. Social–ecological theory has been suggested as a theoretical foundation to inform school psychological efforts because of its emphasis on promoting the mental health of all students [17]. During the course of the pandemic, youth may have experienced stress in their home and school environments and in their relationships with peers and family due to changes in school mode or to modifications to in-person school settings. Simultaneously, adolescent access to social support networks such as peers or extended family may have also shifted as a result of school closures and travel restrictions. These changes in the environments in which adolescents live, work, and play, may have influenced their mental health and well-being. Thus, this study investigates: (1) the association between mode of school instruction and mental health challenges, including symptoms of depression, mental health quality of life, stress, and suicidal ideation; (2) how the association between poor mental health and mode of school instruction varies by race/ethnicity, age, sex, and poverty level; and (3) how school and family connectedness influence the relationship between mental health and mode of school instruction.

Given the lack of data on the relationship between mode of school attendance and mental health challenges during the COVID-19 pandemic, the purpose of this study is to address this gap by describing: (1) the association between mode of school instruction and mental health challenges, including symptoms of depression, mental health quality of life, stress, and suicidal ideation; (2) how the association between poor mental health and mode of school instruction varies by race/ethnicity, age, sex, and poverty level; and (3) how school and family connectedness influence the relationship between mental health and mode of school instruction.

Methods

The COVID Experiences nationwide survey was administered online or via telephone from October 16 to November 6, 2020 in adolescents ages 13–19 using National Opinion Research Center's AmeriSpeak Panel, a probability-based panel of approximately 40,000 households recruited using random sampling from an address-based sample, to examine the relationship between adolescent mode of school instruction (i.e., in-person only [hereafter, in-person], virtual-only [hereafter, virtual], or both virtual and in-person [hereafter, combined]), for example, attending school in-person a few days a week and virtually a few days a week. Nonresponse follow-up was conducted via mail, e-mail, Internet, telephone, and in-person. The following groups were recruited for survey participation if they were English-speaking: (1) AmeriSpeak Panel members (ages 18–19); (2) AmeriSpeak Teen Panel members (ages 13–17); and (3) adolescents ages 13–17 residing with an adult AmeriSpeak Panel member but not participants in the Teen Panel. AmeriSpeak invited a single adolescent, randomly selected among all eligible within the household, to the study. Participants age 18 or older provided informed consent for survey participation. For

Table 1
Demographic characteristics by mode of adolescent's school instruction[a]—COVID Experiences Survey,[b] United States, October 16 to November 6, 2020

	Overall (n = 567)		Mode of school instruction, no., % (95% confidence interval)						*p* value
			Virtual only[c] (n = 313)		Combined[d] (n = 141)		In-person only[e] (n = 113)		
Total			313	56.3 (51.0–61.4)	141	24.4 (19.2–30.3)	113	19.4 (15.4–24.0)	
Respondent demographics									
Age (years)									.339
13–15	326	60.3 (55.7–64.8)	174	54.9 (47.3–62.2)	77	22.1 (16.2–29.4)	75	23.0 (16.4–31.3)	
16–19	241	39.7 (35.2–44.3)	139	58.4 (46.9–69.1)	64	27.8 (18.0–40.4)	38	13.8 (8.2–22.3)	
Sex									.699
Male	272	51.1 (45.8–56.4)	150	54.3 (44.6–63.7)	69	26.4 (18.3–36.5)	53	19.3 (12.3–29.0)	
Female	292	48.9 (43.6–54.2)	161	58.4 (50.8–65.6)	71	22.1 (17.6–27.4)	60	19.5 (15.1–24.9)	
Race/ethnicity									.007
White, non-Hispanic	308	50.0 (41.2–58.8)	137	48.1 (40.6–55.7)	90	27.8 (22.3–34.0)	81	24.1 (18.6–30.5)	
Black, non-Hispanic	78	13.5 (8.7–20.1)	60	68.2 (47.0–83.9)	8	12.2 (4.6–28.9)	10	19.5 (6.0–47.8)	
Hispanic	119	26.7 (20.8–33.6)	83	69.0 (57.5–78.5)	24	21.3 (11.6–35.9)	12	9.7 (4.9–18.3)	
All other races, non-Hispanic[f]	62	9.8 (7.4–13.0)	33	46.8 (31.1–63.2)	19	31.8 (20.5–45.7)	10	21.4 (10.5–38.7)	
Poverty level[g]									.046
At or below poverty	132	29.9 (21.3–40.3)	83	65.5 (56.8–73.4)	21	13.7 (7.1–24.8)	28	20.8 (12.2–33.0)	
Above poverty	435	70.1 (59.7–78.7)	230	52.3 (45.2–59.3)	120	28.9 (22.7–36.1)	85	18.8 (14.7–23.7)	

NORC = National Opinion Research Center.
[a] Table shows unweighted numbers, weighted overall and row percentages, and weighted 95% confidence intervals.
[b] See technical overview of the AmeriSpeak Panel: NORC's Probability-Based Household Panel retrieved from https://amerispeak.norc.org/Documents/Research/AmeriSpeak%20Technical%20Overview%202019%2002%2018.pdf.
[c] Virtual indicates 100% virtual school instruction in the 14 days prior to the survey.
[d] In-person indicates 100% in-person school instruction during the 14 days prior to the survey.
[e] Combined indicates a combination of in-person and virtual instruction in the 14 days prior to the survey.
[f] Other race category includes Asian, American Indian or Alaska Native, Native Hawaiian or Pacific Islander, some other race, or selected more than one race category.
[g] Poverty level was approximated using the midpoint of a categorical income variable and household size, inclusive of family and nonfamily household members. Based on 2020 poverty guidelines https://aspe.hhs.gov/2020-poverty-guidelines.

participants under age 18, parent consent and teen assent was obtained. Among adult panelists qualified to go through the nomination/consent for a teen, the completion rate for the consent survey was 69.2%, with 874 teens given consent to be invited to the COVID Experiences survey and 605 adolescents participating in the screening process. The screener completion rate for the parent consenting survey was 39.2%. The incidence rate, the percentage of qualifying respondents, was 69.8%. The interview completion rate for 18- to 19-year-olds was 41.1%. Due to the requirement of enrollment in middle or high school, only fourteen 18- to 19-year-olds are included in this analysis. The median duration for survey completion was 20 minutes; respondents were offered the cash equivalent of $20 for completing the survey. This activity was reviewed by Centers for Disease Control and Prevention and conducted consistent with applicable federal law and Centers for Disease Control and Prevention policy; the study was also reviewed and approved by National Opinion Research Center's Institutional Review Board. In total, 727 adolescents ages 13–19 completed the survey. Respondents not enrolled in grades 7–12 (n = 134) and those reporting home school or "other" (e.g., schools that do not usually offer in-person classes and those that selected "other" for school type) as their mode of instruction in the past 14 days (n = 26) were excluded. The final analytic sample included 567 adolescents, 51.1% (272) of whom were male, 48.9% (292) female (Table 1).

Measures

Four indicators of mental health challenges were assessed: (1) stress levels in four areas (at school, home, work, and with friends) given response options low/moderate/high/very high; responses were coded for high or very high stress in at least one area (hereafter "high/very high stress"); (2) mental health-related quality of life, assessed by number of the past 14 days (response options: 0, 1 or 2, 3–6, 7–14) with mental health not good, dichotomized with a cutoff score of ≥7 days (hereafter, ≥7 days not good mental health); (3) seriously considering attempting suicide (hereafter, considering suicide) in the past 12 months (response options: yes/no); and (4) persistent symptoms of depression over the past 2 weeks, assessed by the Patient Health Questionnaire 9-item adolescent [18], with students experiencing ≥3 symptoms on more than half of the past 14 days (response options: 0, 1 or 2, 3–6, 7–14) considered to have persistent symptoms of depression (hereafter, persistent symptoms of depression). Links to mental health resources and a toll-free national suicide prevention hotline were provided to all respondents.

Scales were used to assess both school connectedness and family connectedness. School connectedness was measured using the six questions from the National Longitudinal Study of Adolescent Health's School Connectedness Scale, including items such as "I feel like I am a part of this school" and "The teachers at this school treat students fairly" [19]. Standardized Cronbach's alpha = .89. Family connectedness was measured using responses to five questions assessing parental monitoring, parent–adolescent communication, and emotional support such as "How often do you and a parent/caregiver eat dinner together" and "How comfortable do you feel talking to a parent or caregiver about how you are feeling (for instance, stress, anxiety, and depression)?" The standardized Cronbach's was alpha = .70. As continuous variables, school connectedness ranged from 6 to 30 and family connectedness ranged from 6 to 20. Low connectedness was defined as at or below the 25th percentile (≤16 for school connectedness and ≤13 for family connectedness).

Table 2
Mental health indicators by mode of school instruction[a]—COVID Experiences Survey,[b] United States, October 16 to November 6, 2020

	Overall (n = 567)		Mode of school instruction, no., % (95% confidence interval)						*p* value
			Virtual only[c] (n = 313)		Combined[d] (n = 141)		In-person only[e] (n = 113)		
Mental health variable									
High or very high stress,[f] past 14 days									.005
Yes	238	41.0 (35.5–46.9)	146	44.7 (38.1–51.6)	59	44.8 (33.3–56.8)	33	25.0 (17.3–34.7)	
No	318	59.0 (53.1–64.5)	162	55.3 (48.4–61.9)	79	55.2 (43.2–66.7)	77	75.0 (65.3–82.7)	
Number of days mental health not good, past 14 days									.003
7–14 days	67	10.8 (7.9–14.5)	45	14.5 (10.0–20.7)	16	7.6 (4.1–13.5)	6	3.9 (1.7–8.7)	
<7 days	499	89.2 (85.5–92.1)	268	85.5 (79.3–90.0)	124	92.4 (86.5–95.9)	107	96.1 (91.3–98.3)	
Seriously consider attempting suicide, past 12 months									.021
Yes	63	10.3 (7.3–14.4)	42	13.5 (8.5–20.8)	14	8.4 (4.1–16.4)	7	3.8 (1.8–7.8)	
No	453	89.7 (85.6–92.7)	239	86.5 (79.2–91.5)	116	91.6 (83.6–95.9)	98	96.2 to rep (92.2–98.2)	
Persistent symptoms of depression[g]									.005
Yes	101	15.9 (12.0–20.8)	70	19.1 (15.0–24.1)	22	15.3 (9.3–24.0)	9	7.6 (3.2–17.1)	
No	457	84.1 (79.2–88.0)	240	80.9 (75.9–85.0)	113	84.7 (76.0–90.7)	104	92.4 (82.9–96.8)	
Connectedness variable									
School connectedness									.006
Low levels of school connectedness[h]	143	26.8 (22.2–32.0)	101	34.8 (26.7–43.9)	27	19.1 (10.9–31.4)	15	13.3 (8.6–20.1)	
Mid-high levels of school connectedness[i]	417	73.2 (68.0–77.8)	209	65.2 (56.1–73.3)	111	80.9 (68.6–89.1)	97	86.7 (79.9–91.4)	
Family connectedness									.212
Low levels of family connectedness[h]	152	24.0 (19.4–29.3)	89	27.4 (21.1–34.7)	38	21.2 (14.8–29.4)	25	17.6 (10.0–29.1)	
Mid-high levels of family connectedness[i]	398	76.0 (70.7–80.6)	214	72.6 (65.3–78.9)	98	78.8 (70.6–85.2)	86	82.4 (70.9–90.0)	

NORC = National Opinion Research Center; PHQ-9, Patient Health Questionnaire-9 item.
[a] Table shows unweighted numbers, weighted overall and column percentages, and weighted 95% confidence intervals.
[b] See technical overview of the AmeriSpeak Panel: NORC's Probability-Based Household Panel retrieved from https://amerispeak.norc.org/Documents/Research/AmeriSpeak%20Technical%20Overview%202019%2002%2018.pdf.
[c] Virtual indicates 100% virtual school instruction in the 14 days prior to the survey.
[d] Combined indicates a combination of in-person and virtual instruction in the 14 days prior to the survey.
[e] In-person indicates 100% in-person school instruction during the 14 days prior to the survey.
[f] Experiencing high or very high stress in at least one area of life: at school, home, or work, or with friends.
[g] Experiencing at least three symptoms of depression in the teen PHQ-9 more than half the days in the past 2 weeks.
[h] Low levels of school and family connectedness are defined as at or below 25th percentile.
[i] Mid-high levels of school and family connectedness are defined as above the 25th percentile.

Analysis

Unweighted frequencies or weighted prevalence estimates and 95% confidence intervals (CIs) of demographic characteristics and mental health indicators and connectedness by school instruction mode were calculated. Chi-squared tests identified unadjusted associations by mode of instruction ($p < .05$). Adjusted prevalence ratios (aPRs) were calculated using predicted marginals in logistic regression, comparing mental health indicators by mode of instruction. The first model controlled for categorical demographic variables for age, race/ethnicity, sex, and poverty level. Subsequent models controlled for demographic variables in addition to continuous variables for school connectedness (Model 2), family connectedness (Model 3), or both school and family connectedness (Model 4). Connectedness variables were considered moderators if the aPR was closer to 1.0 in Models 2, 3, or 4 compared to Model 1. Findings were considered statistically significant if $p < .05$. The complex sample design was accounted for using SAS-callable SUDAAN (version 11.0; RTI International).

Results

Within the final sample of 567 adolescents, 460 (80.2%) reported enrollment in public school, 36 (7.1%) in private school, and 69 (12.6%) in some other type of school, for example, a school that is completely online all of the time, regardless of the pandemic. A majority (56.3%) of respondents received virtual instruction; 24.4% received combined instruction and 19.4% received in-person instruction. Virtual instruction was more prevalent among black (68.2%) and Hispanic students (69.0%) compared to white students (48.1%) (Table 1).

All four mental health indicators were associated with mode of instruction (Table 2). Students in virtual learning were more likely than students attending school in-person to report high or very high stress (44.7% vs. 25.0%). Students in virtual learning more frequently reported negative mental health risk on three indicators than students receiving combined or in-person instruction: ≥7 days not good mental health (14.5%, 7.6%, and 3.9%, respectively); considering suicide (13.5%, 8.4%, and 3.8%, respectively); and persistent symptoms of depression (19.1%, 15.3%, and 7.6%, respectively). When continuous variables for school and family connectedness were dichotomized (lowest quartile compared to the three upper quartiles), low school connectedness was more common for students attending virtually than those receiving combined or in-person instruction (34.8%, 19.1%, and 13.3%, respectively) and the association was statistically significant ($p = .006$). Reported levels of family connectedness did not vary significantly by mode of school instruction (27.4%, 21.2%, 17.6%, respectively) ($p = .212$).

Table 3
aPR for mental health indicators by mode of school instruction—COVID Experiences Survey,[a] United States, October 16 to November 6, 2020

	Model 1: adjusted for demographics[b]	Model 2: adjusted for demographics[b] + school connectedness[c]	Model 3: adjusted for demographics[b] + family connectedness[d]	Model 4: fully adjusted[e]
	aPR[f] (95% CI)	aPR (95% CI)	aPR (95% CI)	aPR (95% CI)
High or very high stress,[g] past 14 days				
Virtual[h] versus in-person[i]	**1.78 (1.26–2.53)**	1.26 (.93–1.71)	**1.58 (1.16–2.13)**	1.30 (.98–1.73)
Virtual versus combined[j]	1.03 (.77–1.39)	.88 (.69–1.11)	1.06 (.83–1.37)	.95 (.74–1.21)
Combined versus in-person	**1.72 (1.14–2.60)**	**1.44 (1.04–1.98)**	**1.48 (1.04–2.11)**	1.37 (.99–1.90)
≥7 days mental health not good, past 14 days				
Virtual versus in-person	**4.13 (1.61–10.55)**	**2.92 (1.15–7.37)**	**2.98 (1.21–7.34)**	**2.72 (1.08–6.86)**
Virtual versus combined	**2.10 (1.10–3.99)**	1.69 (.90–3.19)	1.87 (.93–3.74)	1.69 (.81–3.52)
Combined versus in-person	1.97 (.64–6.06)	1.72 (.58–5.10)	1.60 (.48–5.36)	1.61 (.48–5.39)
Seriously consider attempting suicide, past 12 months				
Virtual versus in-person	**3.52 (1.41–8.79)**	**2.72 (1.15–6.42)**	**2.45 (1.19–5.05)**	**2.45 (1.22–4.90)**
Virtual versus combined	1.40 (.57–3.42)	1.20 (.49–2.94)	1.25 (.50–3.10)	1.26 (.51–3.11)
Combined versus in-person	2.52 (.81–7.83)	2.27 (.73–7.02)	1.97 (.69–5.58)	1.95 (.69–5.52)
Persistent symptoms of depression				
Virtual versus in-person	**2.58 (1.13–5.88)**	1.69 (.86–3.30)	1.89 (.90–3.98)	1.58 (.82–3.02)
Virtual versus combined	1.39 (.89–2.17)	1.25 (.84–1.87)	1.29 (.76–2.19)	1.25 (.75–2.06)
Combined[i] versus in-person	1.85 (.74–4.62)	1.35 (.64–2.85)	1.47 (.59–3.65)	1.26 (.57–2.81)

aPR, adjusted prevalence ratio; CI, confidence interval; NORC, National Opinion Research Center; PHQ-9, Patient Health Questionnaire-9 item.
[a] See technical overview of the AmeriSpeak Panel: NORC's Probability-Based Household Panel retrieved from https://amerispeak.norc.org/Documents/Research/AmeriSpeak%20Technical%20Overview%202019%2002%2018.pdf.
[b] Adjusted for age, sex, race/ethnicity, and poverty level based on 2020 poverty guidelines, as described in Table 1.
[c] Adjusted for a continuous variable measuring a scale of school connectedness (range: 6–30, mean: 19.6).
[d] Adjusted for a continuous variable measuring a scale of family connectedness (range: 6–20, mean: 15.4).
[e] Adjusted for age, sex, race/ethnicity, poverty, school connectedness, and family connectedness.
[f] Each aPR is the ratio of the proportion of adolescents with a mental health indicator attending school with one mode of instruction relative to the other, adjusted for other characteristics in a logistic regression model. Bold font indicates statistical significance at $p < 0.05$.
[g] Experiencing high or very high stress in at least one area of life: at school, home, or work, or with friends.
[h] Virtual indicates 100% virtual school instruction in the 14 days prior to the survey.
[i] In-person indicates 100% in- person school instruction during the 14 days prior to the survey.
[j] Combined indicates a combination of in-person and virtual instruction in the 14 days prior to the survey.
[k] Combined indicates a combination of in-person and virtual instruction in the 14 days prior to the survey.

As shown in Model 1 (Table 3), adjusting for demographics, students receiving virtual instruction were more likely than those in-person to report the following: stress/high stress (aPR 1.78; 95% CI 1.26–2.53); ≥7 days mental health not good (aPR 4.13; 95% CI 1.61–10.55); seriously considering suicide (aPR 3.52; 95% CI 1.41–8.79); and persistent symptoms of depression (aPR 2.58; 95% CI 1.13–5.88).

School connectedness (Model 2) and family connectedness (Model 3) (Table 3), each independently buffered the relationship between mode of instruction and all four outcomes examined. Specifically, adjusting for demographics and school connectedness (Model 2) weakened the association and rendered three previously significant associations (Model 1) to nonsignificance; and two associations became weaker and nonsignificant after adjustment for demographics and family connectedness (Model 3). For mentally unhealthy days, controlling for school and family connectedness reduced the magnitude of the association for virtual versus in-person instruction from aPR 4.13 (95% CI 1.61–10.55) to aPR 2.72 (95% CI 1.08–6.86). Similarly, for persistent symptoms of depression, the magnitude of the association for virtual versus in-person instruction reduced from aPR 2.58 (95% CI 1.13–5.88) to aPR 1.58 (95% CI .82–3.02). Reductions also occurred for high/very high stress (aPR 1.78; 95% CI 1.26–2.53 to aPR 1.30; .98–1.73) and suicidal ideation (aPR 3.52; CI 1.41–8.79 to aPR 2.45; CI 1.22–4.90) for students attending school in-person versus virtual school attendance. For all other associations, the aPR was also reduced after controlling for school and family connectedness.

Discussion

To our knowledge, this study is the first to report adolescent data indicating those receiving virtual school instruction may be at increased risk of mental health challenges, including stress, symptoms of depression, and suicidal ideation compared to students attending school in-person or in a combined mode of instruction during the COVID-19 pandemic. Similarly, adolescents receiving combined school instruction may be at increased risk for mental health challenges in comparison to those receiving in-person instruction. However, these associations are significantly reduced when adjusting for feelings of connectedness to school or family. The social–ecological model describes an interrelated process by which positive and negative factors at all levels of the social ecology (e.g., home, school, neighborhood) interact and influence youth well-being. A prevention approach thus must address all of the contexts in which young people interact [20].

Schools remain an environment where most young people spend a significant amount of time. Given that most schools were closed for in-person instruction for a large portion of the 2020–2021 school year and the potentially broad impact of school closures on student mental health, a comprehensive, coordinated, multidisciplinary approach to promoting student mental health and well-being will be needed as students return to in-person learning. This approach could include engaging diverse partners across education, health, and mental health to plan for and meet the needs of students and their families, particularly

those who attended school virtually, is critical [21]. For some students, stressors related to COVID-19 and shifts in schooling may be exacerbated by pre-existing mental health challenges, including depression or anxiety, as well other, prior, or co-occurring traumas, such as witnessing domestic violence, child abuse or neglect, and financial or food insecurities [22,23]. These students may benefit from individual or family mental health services. Schools are one of the leading settings for delivery of mental health services, with 15.4% of students receiving mental health services in schools, surpassed only slightly by specialty mental health settings (16.7%) [24]. However, significant gaps remain between those who need mental health services and those who receive them. In 2019, nearly 57% of adolescents ages 12–17 with major depressive impairment did not receive any treatment in the year prior to the survey [24]. On average, U.S. school systems have only 1 counselor per 491 students and 1 psychologist per 1,400 students, far below recommended ratios [25]. Estimates prior to the COVID-19 pandemic project a potential dire shortage of school counselors, with a projected deficiency of more than 10,000 personnel, relative to projected need by 2025 [26]. This is particularly important given that students who feel like their school counselor knows them personally and responds effectively to their concerns are more likely to report feeling connected to their school [27]. As students return to school, efforts to increase the number of school counselors may be helpful, as they are trained to work with administrators to develop a comprehensive plan for mental health promotion, provide direct student services, and broker partnerships with community mental health agencies [28].

School-based mental health services may meet the needs for many, but not all students and families. Partnerships between health and mental health providers, while always important, may be of heightened importance in the coming months. Schools and healthcare providers can establish memoranda of understanding or other, less formal arrangements to assist students and their families in accessing youth friendly, culturally appropriate, and affordable mental health services, either on or off school property [25]. Health practitioners can also provide training for school staff and workshops for families to promote overall family functioning and enhance connections among caregivers, young people, the school, and health providers. Topics for these efforts may include how to improve communication between parents and youth; monitor behavior and well-being of youth in a developmentally appropriate manner; identify when external mental health assistance may be needed; and access community or school resources [29]. In clinic settings, healthcare providers can also implement practices to increase family connectedness. For example, they can incorporate questions about family and school relationships into routine visits and provide resources and referrals to improve the quality of communication, parental monitoring, and overall family and school functioning. They can also use interactions with parents to emphasize the importance of parent–child communication and encourage joint activities that foster family connectedness, such as eating meals together as a family [30].

However, the need for mental health support resulting from the collective experience of COVID-19 [31] for many students is so pervasive that services alone are necessary, but not sufficient, to promote recovery and well-being [32]. School connectedness represents a public health approach to mental health promotion [33] because of its potential to impact many students simultaneously and evidence of its relationship to promoting positive student mental health outcomes and buffering the impact of traumatic experiences [34]. Effective school connectedness strategies include classroom specific and school-wide programs, school climate change or management and disciplinary strategies, and activities within the broader community environment to promote with parent and family involvement [35]. Connectedness strategies may be increasingly important as students return to in-person instruction and can include practices such as creating decision-making processes that facilitate student, family, and community engagement; providing education and opportunities enabling families to be actively involved in their children's academic and school life; develop students' academic, emotional, and social skills to increase school engagement; implementing effective classroom management and teaching methods to foster a positive learning environment; and creating trusting and caring relationships that promote open communication among administrators, teachers, staff, students, families, and communities [36]. School connectedness approaches can be incorporated within existing school frameworks, such as the Multi-Tiered Systems of Support, and layered with other, universal approaches such as Social–Emotional Learning strategies.

Future research is needed to investigate the finding presented here that students of color were more likely to be in the virtual mode of school instruction compared to white students. It is important to understand how mode of school instruction may be influenced by prevalence of COVID-19 cases in these communities; whether or not these families had a choice in mode of school instruction; and how these disparities in in-person about school attendance may have been influenced by other factors, for example, financial or environmental. In addition, although sample size prohibited the exploration in this paper, future research is needed to assess if and how the relationship between mode of school instruction and mental health and other outcomes may vary by race/ethnicity and by sexual minority status. Finally, as this was a survey of individuals and we were concerned about their ability to accurately report school level data, we were not able to assess the relationship between other school level characteristics (e.g., school size, class size, teacher–student ratio) and student mental health. Additional research exploring school level characteristics that might influence school connectedness and student mental health would be informative for educational policies and practices.

Findings in this report are subject to several limitations. First, although data were weighted to approximate representativeness of U.S. household demographics, findings may not represent all U.S. students ages 13–19 years due to limited sample size and response rate and use of an incentivized, English-language survey. Second, self-reports are subject to social desirability and recall biases. Third, adolescents did not report the duration of in-person or virtual instruction or whether they had a choice in instruction method. Fourth, the study did not adjust for all potential confounders such as community COVID-19 transmission levels, some household characteristics (e.g., urbanicity or rurality), and prior mental health status. Finally, neither causality nor directionality (e.g., it is possible that students with poor mental health were more likely to choose virtual or hybrid instruction) between instruction mode and indicators can be inferred from this cross-sectional study.

As demonstrated by the study's findings, connectedness can play a critical role in buffering student stress experienced during the pandemic. Adolescents receiving in-person instruction reported the lowest prevalence of negative indicators of mental

health. Adolescents receiving virtual or combined instruction may benefit from additional support, including school and family connectedness activities and linkages to mental health services. Understanding the relationship among mode of school instruction, mental health, and connectedness is critically important as students return to school and begin to re-engage with healthcare providers, as the mental health impacts may not be as visible as physical impacts but may necessitate additional actions to reduce risk and foster resiliency.

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Author Contributions

Ms. Hertz, Drs. Verlenden, Rasberry, Liddon, Barrios, and Ethier conceptualized and designed the study, drafted the initial manuscript, and reviewed and revised the manuscript. Ms. Kilmer, carried out the analyses, and reviewed and revised the manuscript. All authors approved the final manuscript as submitted and agree to be accountable for all aspects of the work.

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LITTLE HOOVER COMMISSION

COVID-19 and Children's Mental Health: Addressing the Impact

Report #262 | August 2021

Milton Marks Commission on California State Government Organization and Economy

www.lhc.ca.gov

Dedicated to Promoting Economy and Efficiency in California State Government

The Little Hoover Commission, formally known as the Milton Marks "Little Hoover" Commission on California State Government Organization and Economy, is an independent state oversight agency.

By statute, the Commission is a bipartisan board composed of five public members appointed by the governor, four public members appointed by the Legislature, two senators and two assemblymembers.

In creating the Commission in 1962, the Legislature declared its purpose:

...to secure assistance for the Governor and itself in promoting economy, efficiency and improved services in the transaction of the public business in the various departments, agencies and instrumentalities of the executive branch of the state government, and in making the operation of all state departments, agencies and instrumentalities, and all expenditures of public funds, more directly responsive to the wishes of the people as expressed by their elected representatives...

The Commission fulfills this charge by listening to the public, consulting with the experts and conferring with the wise. In the course of its investigations, the Commission typically empanels advisory committees, conducts public hearings and visits government operations in action.

Its conclusions are submitted to the Governor and the Legislature for their consideration. Recommendations often take the form of legislation, which the Commission supports through the legislative process.

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August 23, 2021

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Governor of California

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and members of the Senate

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Senate Minority Leader

The Honorable Anthony Rendon
Speaker of the Assembly
and members of the Assembly

The Honorable Marie Waldron
Assembly Minority Leader

DEAR GOVERNOR AND MEMBERS OF THE LEGISLATURE:

Last year, the Little Hoover Commission initiated a review of the impacts of the COVID-19 pandemic to better understand the challenges facing California and identify how state government can support those impacted. The following report, the last in our series, focuses on the pandemic's impact on the mental and emotional well-being of children and adolescents, especially those under the age of 18.

The Commission learned that the COVID pandemic has had a major impact on young people's mental well-being and has been a source of stress, anxiety, and trauma. The Commission also learned that chronic stress and traumatic experiences during childhood can have a life-long impact on individuals' psychological and physical health, with substantial social and economic costs. However, the Commission found that California has long struggled to support children's mental and emotional health adequately.

In this report, we examine ways in which California can improve the state's system for supporting child mental health. Governor Newsom and the Legislature, together with state agencies, local governments, health plans, care providers, and stakeholders, are taking critical steps to overhaul and improve California's system for supporting child mental health, especially through the Children and Youth Behavioral Health Initiative. These ambitious and expansive efforts promise to transform California's child mental health system, but strong leadership and clearly defined outcome goals will be needed to ensure that they achieve their potential. To create lasting improvements in children's mental health care, the Commission recommends that the state establish centralized leadership to promote sustained and sustainable coordination, collaboration, and accountability around mental health.

While the pandemic has exacerbated an ongoing crisis in children's mental health, the Commission recognizes that it also presents a once-in-a-generation opportunity to improve children's mental health care. The Commission respectfully submits this work and stands prepared to help you address the impacts of the COVID-19 pandemic.

Sincerely,

Pedro Nava, Chair
Little Hoover Commission

Executive Summary

COVID and Children's Mental Well-Being

COVID confronts California with two pandemics of public health: the viral pandemic and a pandemic of mental health that has fallen most heavily on children and youth.

COVID created a perfect storm of stress, anxiety, and trauma, exacerbating a preexisting crisis in children's mental health. Many young people experienced social isolation and disconnection; some endured economic dislocation and the illness or loss of loved ones. There have been notable increases in anxiety, depression, and mental health-related emergency room visits. Experts further warn of a looming "tsunami" of unmet mental health needs among young people and suggest that some children and adolescents will need time, support, and investment to bounce back.

The pandemic's effect on children's mental well-being is likely to be uneven. It is probable that the pandemic will disproportionately impact the mental and emotional well-being of children from communities of color and low-income communities, which have borne the brunt of the pandemic's economic and physical health effects. Unless California responds robustly, trauma and sustained stress may also have long-term psychological and physiological impacts on some children.

Barriers to Addressing Children's Mental Health Needs

Early intervention and treatment can help to address COVID's impact on young people's mental well-being, but California has long struggled to meet the mental health needs of young people. Too few children receive care, and when they do, it often is too late. Children of color and children from low-income families, moreover, access mental health services at lower rates than their peers.

Systemic and structural barriers can prevent children from accessing mental health services. More than half of children and adolescents in California are on Medi-Cal and thus receive care through the state's public mental health system. That system is, however, decentralized and fragmented. It contends with capacity and workforce shortages, complicated and administratively burdensome funding mechanisms, and challenges around providing preventive and timely care. There is also considerable variation in school districts' focus on student mental well-being and in the availability of school-based services.

Addressing the Crisis

To address COVID's impact on children's mental health, California needs to build a larger, more diverse mental health workforce, establish a genuine continuum of care for children, emphasize prevention and early intervention, and center schools as hubs of mental well-being.

California is poised to facilitate access to mental health services through two major initiatives that have potential to transform children's mental health care:

CalAIM. The California Advancing and Innovating Medi-Cal (CalAIM) proposal reforms Medi-Cal service delivery and financing, reducing administrative burdens and removing diagnostic requirements that can prevent children from accessing timely mental health services.

Children and Youth Behavioral Health Initiative. The Behavioral Health Initiative provides more than $4 billion over the next five years to develop a comprehensive system of mental health for children and youth. It will create a statewide virtual platform for behavioral health services and invest in expanding school-linked mental health services, developing a larger, more diverse mental health workforce, building a continuum of care, and promoting public awareness.

Steps Forward

California also needs strong structures to administer the Behavioral Health Initiative and achieve lasting improvement in children's mental health care. The Commission finds that there are three key elements for coordinating California's response to COVID's impact:

- California needs stronger, more coherent, and more cohesive state leadership around children's mental health, including common outcome goals and a single point of overall leadership.
- California must build capacity for statewide approaches to children's mental health, especially by expanding the ability of state government to provide support and technical assistance to health plans and local providers.
- Centering schools as hubs of mental wellness means bringing together systems of health and education and forging partnerships among entities that may have little experience working together. To foster effective partnerships, state government must support careful planning around intersystem collaboration, coordination of services, and use of data.

Recommendations

To improve the state's system for supporting child mental health, California needs leadership that promotes sustained and sustainable coordination, collaboration, and accountability around mental health.

Recommendation 1: The state of California should identify a central point of leadership for children's mental health. The Governor and Legislature should also initiate a review process to examine the creation of a new and robust Department of Behavioral and Mental Health, with coequal focus on child and adult mental health, which could exercise statewide leadership over mental health care and services.

Recommendation 2: In consultation with stakeholders, the Secretary of the Health and Human Services Agency should set statewide goals for child mental health based on key metrics related to overall mental well-being, access to care, and quality of services.

Recommendation 3: The Governor and Legislature should reserve a portion of Behavioral Health Initiative funding to provide a future tranche of additional funding to be competitively awarded to counties and health plans that effectively and efficiently implement successful reforms/programs and reach identified benchmarks.

Recommendation 4: The Department of Health Care Services should work with stakeholders to identify ways to increase the support and technical assistance it provides to counties, health plans, and other mental health providers.

Recommendation 5: The Governor and Legislature should leverage the Behavioral Health Initiative to encourage local educational agencies and their partners to develop comprehensive approaches to student mental wellness, including requiring grantees to establish actionable plans for coordinating services, for using and sharing data, and for integrating funding to create sustainable programs.

Recommendation 6: The Governor should establish a clear timeline for the development, testing, and piloting of the behavioral health services virtual platform, with vigorous oversight at every stage of development.

Introduction

COVID has confronted California with two pandemics of public health. The first is the viral pandemic, which has sickened millions and, at the time of this report, had led to the death of nearly 65,000 Californians.[1] The second is a pandemic of mental health that has hit children and adolescents especially hard. Surveys and reports suggest substantial increases in anxiety, depression, suicidal ideation, and mental health-related emergency room visits among young people. California and Californians are likely to feel the effects of the sustained anxiety and stress brought on by the pandemic for years to come.

COVID appears to have exacerbated and amplified what many experts call an ongoing crisis in children's mental health. Rates of adolescent suicide and self-harm were increasing even before the pandemic. Between an existing crisis in young people's mental health and COVID's impact, experts speak of a looming "tsunami" of unmet need.[2]

California has long struggled to support children's mental and emotional health adequately. Many young people with mental health needs do not receive any services; by some estimates, a majority of youth with some serious mental health conditions, like major depression, do not receive consistent care. Moreover, Ken Berrick, Founder and CEO of Seneca Family of Agencies, and Robin Detterman, Seneca's Chief Program Officer of Education Services, observed, "Too often, struggling students and families are not met with services until their needs rise to a crisis level."[3] California's child mental health system is extremely fragmented and suffers from severe capacity shortages. Additional demand for care and services as a result of COVID will further stress and strain this system.

Yet the COVID pandemic also presents a once-in-a-generation opportunity to improve children's mental health care. The pandemic's broad impact on Californians' mental and emotional well-being has raised awareness of the importance of mental health. Federal stimulus funding, together with an unexpected rebound in California's fiscal situation, will enable California both to make historic one-time investments in children's mental health and support ongoing work to improve coordination in delivering support and care.

State government must seize this moment. More than half of children and adolescents in California are on Medi-Cal and thus receive care through the state's public system of mental health. These young people come from the low-income families and the communities of color that have disproportionately

Impacts of the COVID-19 Pandemic

This report is the last in the Commission's series on the impacts of the COVID pandemic. The first two reports, *First Steps toward Recovery: Saving Small Businesses* and *First Steps toward Recovery II: Job Training and Reskilling*, examined the immediate economic impacts of the pandemic on small businesses and workers, focusing on how California can support small business recovery and job training opportunities for impacted workers.

This report studies the pandemic's impact on the mental and emotional well-being of children and adolescents, especially those under the age of 18. Literature around adverse childhood experiences suggests that chronic stress and traumatic experiences during childhood can have a substantial and life-long impact on individual's psychological and physical health, with substantial social and economic costs. This report examines how state government can respond to the pandemic's impact and better support children's mental well-being into the future.

borne COVID's economic and physical health impacts, and they are likely to be at higher risk to stress, anxiety, and trauma due to the loss of family income or the illness or death of family members. They have also historically been less likely to receive mental health services. California is, however, now poised to respond to young people's need for a stronger mental health system with the new Children and Youth Behavioral Health Initiative, which promises to build capacity, encourage new partnerships and collaborations, support prevention and early intervention, and expand access to care and services.

Still, key structural and systemic barriers remain. In previous reports, the Little Hoover Commission emphasized that California needs leadership that promotes sustained and sustainable coordination, collaboration, and accountability around mental health. In order to ensure that new initiatives achieve their potential and that California truly addresses the mental health needs of children, state government needs to take steps to institutionalize and sustain that leadership. State government also needs to set clear outcome goals that center on child wellness and that promote coordination around children's mental health care and services.

Section I: COVID and Children's Mental Well-Being

Dr. Tom Insel, former director of the National Institute of Mental Health, observed that the COVID pandemic has impacted populations differently depending on their age. Mortality from the pandemic is largely concentrated among adults beyond the age of 50. The pandemic's psychological consequences, however, have fallen most heavily on children and youth under the age of 25. Children and youth are more likely than other age groups to display moderate to severe anxiety and depression as a result of the pandemic.[4] Surveys and hospital data also point to spikes in mental distress among many children and youth. "It's important to understand," Dr. Insel explained, "that kids are resilient – they generally do well. But stress over time can overcome that resilience. And I think that is what we may be seeing here."[5]

The COVID pandemic's impact on young people's mental health is multifold. Children have endured long periods of social isolation and disconnection as measures to control the pandemic, including social distancing and remote learning, separated them from their friends, limited opportunities to make new friendships, and deprived them of their social routines. They missed out on major life events and milestones like graduations, birthday parties, and family reunions. They lost access to the sports, clubs, activities, and pastimes that connected them with friends and mentors, shaped their identities, and gave their lives meaning—and that let them be kids.

The pandemic created a perfect storm of stress, anxiety, and trauma. Some children grappled with stress stemming from economic dislocation and parents' loss of jobs or income.[6] Those whose parents or relatives are essential workers confronted daily anxiety over the safety of family members. Some also faced the illness or loss of family and loved-ones due to COVID. On top of all these stresses, young people dealt with the challenges of remote education, potentially struggling to log onto classes or to concentrate in shared rooms and crowded homes. Many coped with isolation through social media and increased screen time, which researchers link to disruptions in sleep patterns that can impact mental health.[7] In addition, the pandemic coincided with a significant and emotionally challenging national reckoning around racial justice.

Meanwhile, COVID affected the ability of young people to receive care and of the mental health system to deliver that care. For some children and adolescents receiving mental health services, the pandemic disrupted treatment. At the same time, it pushed care givers to their limit. California's Surgeon

Defining Children's Mental Health and Mental Health Disorders

According to the Centers for Disease Control and Prevention, "Being mentally healthy during childhood means reaching developmental and emotional milestones and learning healthy social skills and how to cope when there are problems." Mental health disorders, in turn, "are serious changes in the way children typically learn, behave, or handle their emotions, which cause distress and problems getting through the day."[8] Mental health exists on a continuum: children who do not have a mental health disorder may not be equally well; children with a mental health disorder can vary in how they are coping with that disorder.

The term "mental health disorder" is a broad term that encompasses mood and anxiety disorders, including depression, neurodevelopmental disorders like ADHD and autism, and mental illnesses like schizophrenia. Studies suggest that approximately 13-20 percent of children experience a diagnosable mental, emotional, or behavioral disorder in a given year; prevalence of mental health disorders among children and adolescents appears relatively similar around the world.[9] Estimates further suggest that 7-8 percent of children in California are likely to have a serious mental or emotional heath disorder, one which substantially interferes with their functioning in family, school, or community activities.[10] Approximately half of mental illnesses appear by a child's mid-teens.

Studies suggest that low-income children are probably at higher risk of mental health disorders. According to the California Health Care Foundation's review of 2014 data, 10 percent of children whose families fall below the federal poverty line have a serious emotional disturbance, compared to a California average of 7.6 percent of children.[11]

On the other hand, studies suggest that young people of color and White young people generally appear to experience mental health disorders at similar rates.[12] The California Health Care Foundation reports that approximately 8 percent of Black and Latino children have a serious emotional disturbance, compared to about 7 percent of White children.[13] The Public Policy Institute of California, meanwhile, finds that approximately 4 percent of both Black and White teens and 5 percent of Latino teens suffer from severe psychological stress, which correlates with severe mental health conditions like depression; the prevalence of suicidal thoughts was highest among White teens at 6 percent, compared to 4 percent for Black teens and 5 percent for Latino teens.[14] Studies generally show that children and adolescents who are foreign-born immigrants tend to have lower rates of mental health disorders than children born in the United States. There are, however, significant disparities in access to mental health services based on race, ethnicity, and immigration status.

General, Dr. Nadine Burke Harris, observed: "Our care givers were asked to do the impossible: continue working, while also supporting young children through e-learning. Even for those who were most well-resourced, this was a fairly untenable task, and many care givers lost jobs or had to quit in order to support their children who no longer had in-person school or child care options."[15]

The effect of pandemic-induced stress and anxiety on children's mental and emotional health is still unclear. The CDC reported that the number of pediatric mental-health related emergency department visits during the first six months of the pandemic, between March and October 2020, was largely the same as it was for the same period in 2019. Mental-health related emergency department visits constituted, however, a substantially greater proportion of all pediatric emergency department visits, probably reflecting both the impact of pandemic-related stress and anxiety and a decline in visits for other reasons, perhaps as a result of less time spent outside or participating in team sports.[16] More recently, the CDC reported that emergency department visits for suspected suicide attempts began to increase among adolescents in May 2020. Between February 21 and March 20, 2021, emergency department visits for suspected suicide attempts were almost 51 percent higher among girls aged 12-17 than they were for the same period in 2019. Emergency department visits for suspected suicide attempts were almost 4 percent higher for boys aged 12-17.[17]

The pandemic created a perfect storm of stress, anxiety, and trauma.

There is other evidence suggesting that COVID has had a major impact on many children's mental and emotional well-being. In October 2020, a Jed Foundation national study found that almost a third of parents surveyed (31 percent) reported that their child's emotional health was worse than before COVID-19.[18] A national survey conducted by J.C. Mott Children's Hospital in Michigan in January 2021 further found that 46 percent of parents had seen a decline in their teenaged child's mental health since the start of the pandemic.[19]

Demand for services appears to be increasing and child mental health providers report increases in referrals for anxiety and depression. Reporting suggests that at least some hospitals have seen spikes in mental distress among children. UCSF Benioff Children's Hospital Oakland saw a 77 percent increase in children seeking emergency mental health services between May and December in 2020, compared to the same period in 2019—651 children in 2020, up from 368 in 2019.[20]

COVID and the Existing Crisis in Children's Mental Health

Child advocates and children's mental health experts argue that COVID amplified a preexisting crisis in children's mental health. Suicide is now the second leading cause of death among people aged 10-24 and is responsible for more childhood and adolescent deaths than cancer and heart disease combined. In California, mental illness is also the leading reason for hospitalization among children.[21] "We were," Dr. Tom Insel observed, "in a bad way even by 2019, and with COVID we have gotten to an even worse point."[22]

Although data on rates of mental and emotional distress among young people can vary among surveys, studies consistently point to deterioration in child and adolescent mental and emotional health:[23]

- The State Auditor reported in September 2020 that the number of youth suicides in California increased by 15 percent from 2009 through 2018 (from 163 to 188). Incidents of youth self-harm requiring medical attention increased by 50 percent during the same period (from 10,861 to 16,314).[24]
- The federal Substance Abuse and Mental Health Services Administration reports that the average annual percentage of youth aged 12-17 in California who experienced a major depressive episode increased from 8.1 percent in 2004-2007 to 14 percent in 2016-2019.[25]

- The most recent iteration of the California Healthy Kids Survey, conducted between fall 2017 and spring 2019, found that the percentage of 7th graders reporting chronic sadness increased from 25 percent in 2011/13 to 30 percent in 2017/19. The percentage of 11th graders reporting chronic sadness increased from 33 percent to 37 percent.[26]

The sources of increasing rates in depression, self-harm, and suicide, as well as in the incidence of conditions like autism and ADHD, are still unclear.[27] The United States has, however, faced a broad crisis in behavioral health for several decades. "Deaths of despair"—deaths from suicide, drug overdose, and alcoholism—have doubled nationally since the mid-1990s, leading to the first drop in American

Social Media, Children's Mental Health, and the COVID Pandemic

Although studies associate heavy social media use with poor teen mental health, social media has also proved to be a "lifeline" for many teens and adolescents during the pandemic, one that allowed them to remain in contact with friends and combat loneliness and isolation. One national survey found that more than half of young people aged 14 to 22 reported that social media has been very important to them for staying connected with friends and family. This same survey also found that social media has played a supportive role for some with mental health challenges: nearly 30 percent of young people with moderate to severe depression reported that social media was very important for helping them feel less alone, compared to 13 percent of young people without depression.[28]

Studies suggest that social media's relationship to young people's mental health varies with the amount and type of use. Although the relationship between causation and correlation is not certain, researchers find that teenagers who spend more time on social media—three hours a day or more—are more likely to display symptoms of depression.[29] Conversely, moderate and "active" use of social media to connect and interact with friends and peers, as opposed to compulsively scrolling through content, may be protective for mental well-being.[30] More generally, social media can also expose young people to racist, sexist, homophobic, or bullying comments and content.[31]

Several social media companies have taken steps to help users protect their mental health, like offering them the option to hide "like" counts or filter out abusive replies to posts, as well as linking users to mental health resources.[32] Collaboration with social media companies will probably also be essential for facilitating access to the Behavioral Health Services Virtual Platform that will be developed as part of the Children and Youth Behavioral Health Initiative.

Much appears still unknown, however, about social media's impact on children's mental health, what measures can most effectively help to mitigate potentially negative effects, and how social media can best be used to support young people's mental well-being. Studies observe, for example, that it can be hard for some teens to take a break from streams of personalized contact, even when they use apps that prompt them to do so.[33] Education and awareness for young people and parents around healthy social media use and habits will probably continue to be critical.

life expectancy in a century and taking a heavy toll on less well-educated Americans and their communities.[34] Some researchers further point to technology and social media as contributing to decline in mental well-being among children and youth, observing that rise in youth suicide and self-harm appears to coincide with the expansion of social media. Although the relationship between social media and mental health is debated, studies correlate heavy social media use, decreased face-to-face interactions, and cyberbullying with increased risk of depression.[35] Environmental factors, including parental age at conception and exposure to pollutants, can impact children's mental and emotional development and may also contribute to increasing prevalence of certain mental health conditions.[36]

Yet, beyond the economic, social, and technological developments that are driving anxiety and depression, witnesses emphasized that the crisis in mental health is also the result of failure to support mental and emotional well-being and to deliver care to those in need. According to Dr. Insel, "We should think of this as a crisis of care, manifested as high rates of incarceration, homelessness, and mortality."[37] This point holds for children and youth, as well. Increasing rates of suicide, self-harm, and mental distress among children and youth indicate that they are not getting the support they need or the care they require for treatable mental health conditions.

Understanding COVID's Impact

COVID likely exacerbated the preexisting and ongoing challenges around children's mental and emotional well-being. Moreover, it is probable that the pandemic will disproportionately impact the mental and emotional well-being of children from communities of color and low-income communities, which have borne the brunt of the pandemic's economic and physical health effects. It is also probable that the pandemic will have a significant, long-term impact on the well-being of some children and adolescents.

AN UNEQUAL IMPACT

As with its physical health and economic impacts, COVID's effect on children's mental well-being is likely uneven. There is considerable variation in how children experienced the pandemic and additional variation in how they responded to it based on family circumstance and social environment. The presence of trusted caregivers and stable, supportive environments, for example, can buffer the impact of adversity and has probably helped many young people cope with the pandemic's challenges.[38]

It is probable that the pandemic will disproportionately impact the mental and emotional well-being of children from communities of color and low-income communities, which have borne the brunt of the pandemic's economic and physical health effects.

Although the pandemic led to widespread feelings of depression and loss among children, most children will probably ultimately recover. For many children whose mental and emotional health have been impacted by the pandemic, return to school and social reopening likely will bring substantial improvement.

Other children, however, may need more time, support, and investment to bounce back.[39] The pandemic's physical health impact has fallen most heavily on communities of color, with the result

Social Determinants of Mental Health

The impact of unemployment on children's mental well-being illustrates the role of social determinants in children's mental health. Social determinants of mental health refer to the socioeconomic and environmental factors that shape mental well-being. By some estimates, medical care may only account for twenty percent of health outcomes, with behaviors, socioeconomic factors, and environmental circumstances predominately shaping health outcomes.[40] This applies also to individuals' mental health.[41] Poverty, for example, exposes families to a variety of sources of stress, including food and housing insecurity, that can harm children's mental well-being; mental health providers observed that a parent struggling to keep the lights on or avoid eviction is unlikely to be able to support their child's emotional well-being as fully as they would if their basic needs were met.[42] Similarly, the experience of racism and perceived discrimination can impact children's mental health, as can childhood exposure to violence or substance abuse.[43]

that children from those communities were most likely to have had family members sickened by COVID and to have lost family members to the pandemic. Children of color were also most likely to endure anxiety over the loss of employment and income. Job losses fell most heavily on low-income workers, who are disproportionately Black and Latino, and this economic impact will probably affect children's mental health, as well. One study found that a 5 percentage-point increase in the national unemployment rate during the Great Recession increased the probability of "clinically meaningful child mental health problems" by 35 to 50 percent, as a result of household stress, as well as material impacts from income loss.[44]

For many children from low-income families and communities of color, as well as children in rural communities, COVID has exacerbated social, economic, and environmental factors that increase risk of mental health challenges. Currently, only limited data exists on COVID's impact on young people's mental health that is disaggregated by location, race and ethnicity or by family income level. Nevertheless, initial surveys suggest the young people who have had family members sickened by COVID, whose family members lost jobs as a result of COVID, and who worry that their families will not have enough to eat are indeed more likely to have symptoms of depression than those young people whose families were less directly affected by the pandemic.[45] Meanwhile, the pandemic, remote education, and social distancing also intensified isolation for rural and mountain communities.[46]

LONG-TERM CONSEQUENCES

There is reason to believe that initial indications of COVID's toll on young people's mental well-being will ultimately manifest as mental and emotional health challenges. Toby Ewing, Executive Director of the Mental Health Services Oversight and Accountability Commission, observed that the mental health impacts of natural disasters and traumatic events usually play out over a three-to-five year trajectory.[47] Moreover, the pandemic's sustained and often severe impact on children's mental and emotional health may have even longer-term ramifications, which California will be living with for years to come. Prolonged exposure to stress and adversity can have significant consequences for children. "An overwhelming scientific consensus," explains Surgeon General Dr. Burke Harris, "demonstrates that cumulative adversity, particularly during critical and sensitive developmental periods, is a root cause to some of the most harmful, persistent and expensive health challenges facing our nation."[48]

Studies of the impact of adverse childhood experiences (ACEs) show that severe or chronic adversity and stress can have lasting and severe psychological and physical impacts. Research suggests that individuals who experience multiple ACEs are less likely to be employed and are at increased risk of heart disease, stroke, and suicide.[49] Chronic stress can further disrupt child development around executive functioning, affecting children's ability to regulate emotions and behaviors, pay attention, and start and complete tasks. This can contribute to subsequent mental or behavioral health conditions, as well as to challenges in the classroom.[50]

Although COVID is not one of the traditional adverse experiences included in ACEs screenings, it has become a significant stressor for many children and it has further disrupted access to sources of mental and emotional support. Dr. Burke Harris observed that the pandemic, "has been unique in its effect of acting as a major stressor while simultaneously cutting off access to many of the usual sources of buffering care necessary to help children and parents regulate their stress responses, such as grandparents, teachers, coaches, faith leaders and, in some cases, child care providers."[51] Evidence that incidents of domestic abuse have risen during the pandemic and that rates of substance abuse have increased further suggests that the pandemic may also have heightened some children's risk of exposure to other adverse experiences.[52]

Dr. Burke Harris warned of the long-term consequences of the toxic stress and trauma stemming from the COVID pandemic: "Unless we

ACEs and ACEs Aware

Adverse childhood experiences refer to potentially traumatic events that occur during childhood and may include: experiencing physical, sexual or emotional abuse, neglect, parental separation or divorce, substance abuse by a household member, witnessing domestic violence, having an incarcerated household member, or having a household member with mental illness.

ACEs can have lasting psychological and physical impact. Trauma and chronic stress can lead a child's physiological stress response, which includes the release of stress hormones, increase in heart rate and blood pressure, and changes in brain activity, to activate too intensely or for too long. This toxic stress response can impact how genes are read, how the body's immune and metabolic systems function, and lead to changes in brain development, affecting attention, learning, and decision-making.[53] Exposure to four or more categories of adverse childhood experience is associated with a doubling of risk of heart disease, cancer and stroke. Exposure to ACEs is also associated with greater likelihood of experiencing mental health conditions, including depression, anxiety, and eating disorders, and of engaging in risky behaviors.

The ACEs Aware Initiative is a first-of-its-kind statewide effort to promote screening for childhood trauma and treat the impacts of adverse childhood experiences. The initiative offers Medi-Cal providers training in screening for ACEs and for providing trauma-informed care. Under ACEs Aware, California offers qualified providers a $29 payment for conducting screenings for ACEs for Medi-Cal patients; providers must have completed ACEs training in order to qualify for payment.[54] The initiative has already trained more than 17,000 providers.

intervene robustly, the consensus of scientific evidence suggests that we are very likely to see an unprecedented increase in toxic stress. Some of this will likely manifest in the short term through behavioral health, mental health, and learning challenges. Some of it may manifest later in terms of higher incidents of cardiovascular disease, incarceration, cancer, stroke, and other health conditions."[55] Early detection and early intervention can prevent and mitigate the impact of toxic stress and promote healing. The social and economic costs of failing to address COVID's impact, on the other hand, will likely be significant. Research suggests that prior to the pandemic, the annual cost of ACEs in California exceeded $100 billion as a result of health care spending and lost years of productive life due to death, disability, and incarceration.[56]

Section II: Barriers to Addressing Children's Mental Health Needs

Even before the pandemic, California's mental health system failed to fully serve children and youth with mental and emotional health needs. Based on its analysis of data from 2018, the Commonwealth Fund found that only 70 percent of California children aged 3-17 received mental healthcare when needed, compared to 82 percent of children nationally. California ranked 48th nationally in terms of children receiving needed treatment or counseling for mental health.[57] Levels of treatment for specific conditions, meanwhile, can be even lower, with Mental Health America reporting that only a quarter of youth in California with severe depression receive consistent treatment.[58] The percentage of eligible children who access mental health services in California also appears to be well below the level expected based on estimates of the number of children with mental health conditions who would benefit from treatment and care.[59]

Too few children receive care, and when they do, too often it occurs too late. In the absence of early intervention and treatment, mental health needs and conditions can intensify and potentially metastasize into mental health crises. Limited availability of mental health providers and thus limited access to timely care probably contributes, for example, to higher rates of child suicide and self-harm in California's rural and northern counties, compared to coastal and more urban counties.[60]

Moreover, children of color and children from low-income families, who, as noted above, have been disproportionately impacted by COVID, tend to access mental health services at lower rates than their peers.[61] Nationally, the Substance Abuse and Mental Health Services Administration reports that about half of White youth aged 12-17 with depression received care in 2019; conversely, only about 36 percent of Black or Latino youth with depression received care.[62] Within California, meanwhile, the Department of Health Care Services reports that Latino and Black beneficiaries under the age of 21 access mental health services from Medi-Cal managed care plans at substantially lower rates than White beneficiaries, with Black beneficiaries accessing services at only half the rate of White beneficiaries and Latinos accessing services at less than 60 percent the rate of their White peers.[63]

A number of factors contribute to young people not receiving needed mental health services. Children of color and children from low-incomes families can confront linguistic, cultural, and social barriers to accessing mental health care.[64] A number of systemic and structural barriers, which are discussed below, can also prevent children in need from accessing mental health services.

In addition, child advocates and health experts identified a key, foundational reason for challenges around children's mental health care: California, like many states, has historically treated mental

health as different from physical health, a product of traditional stigma and misunderstanding around mental health. Ted Lempert, President of Children Now, observed that there is a broad social and political understanding around the importance of children's physical health such that when a child breaks an arm, care is available to set the arm. There is also a general understanding that children should receive vaccines and physical wellness checks, even if application is uneven. Yet, no such common understanding around the significance of mental and emotional health for children's well-being exists.[65]

This situation began to change before COVID as a result of concern about increasing rates of child and adolescent suicide and self-harm; the pandemic further raised awareness around the importance of mental health, especially children's mental health. California is poised to make historic investments in children's and young people's mental well-being. Systemic and structural weaknesses in California's child mental health system may, however, impede efforts to address the pandemic's impact on children's mental health.

California's Child Mental Health "System"

California's mental health system is not really a single system; rather it is a "mosaic" or "patchwork" of systems, plans, agencies, and programs.[66] It is decentralized, fragmented by provider, and bifurcated based on the severity of an individual's condition.

The majority of Californians under the age of 21 who need mental health services are treated through the public mental health system. Although only a third of Californians overall are covered by Medi-Cal, more than half of California's children and adolescents are covered by the program.[67] In addition, the federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) entitlement provides federally-supported mental health screening and treatment for Medicaid-eligible children under 21 years of age.[71]

California splits responsibility for mental health services for Medi-Cal eligible children between 24 managed care plans (MCPs) and 56 largely county-based mental health plans (MHPs) (See Figure 1). Both MCPs and MHPs contract with the Department of Health Care Services (DHCS) to provide services to Medi-Cal beneficiaries. Managed care plans provide a limited set of mental health services for screening and treating "mild to moderate" mental health conditions. Mental health plans, meanwhile, provide specialty mental health services (SMHS), which cover a wider range of mental health services, and are responsible for treating more severe mental health conditions.

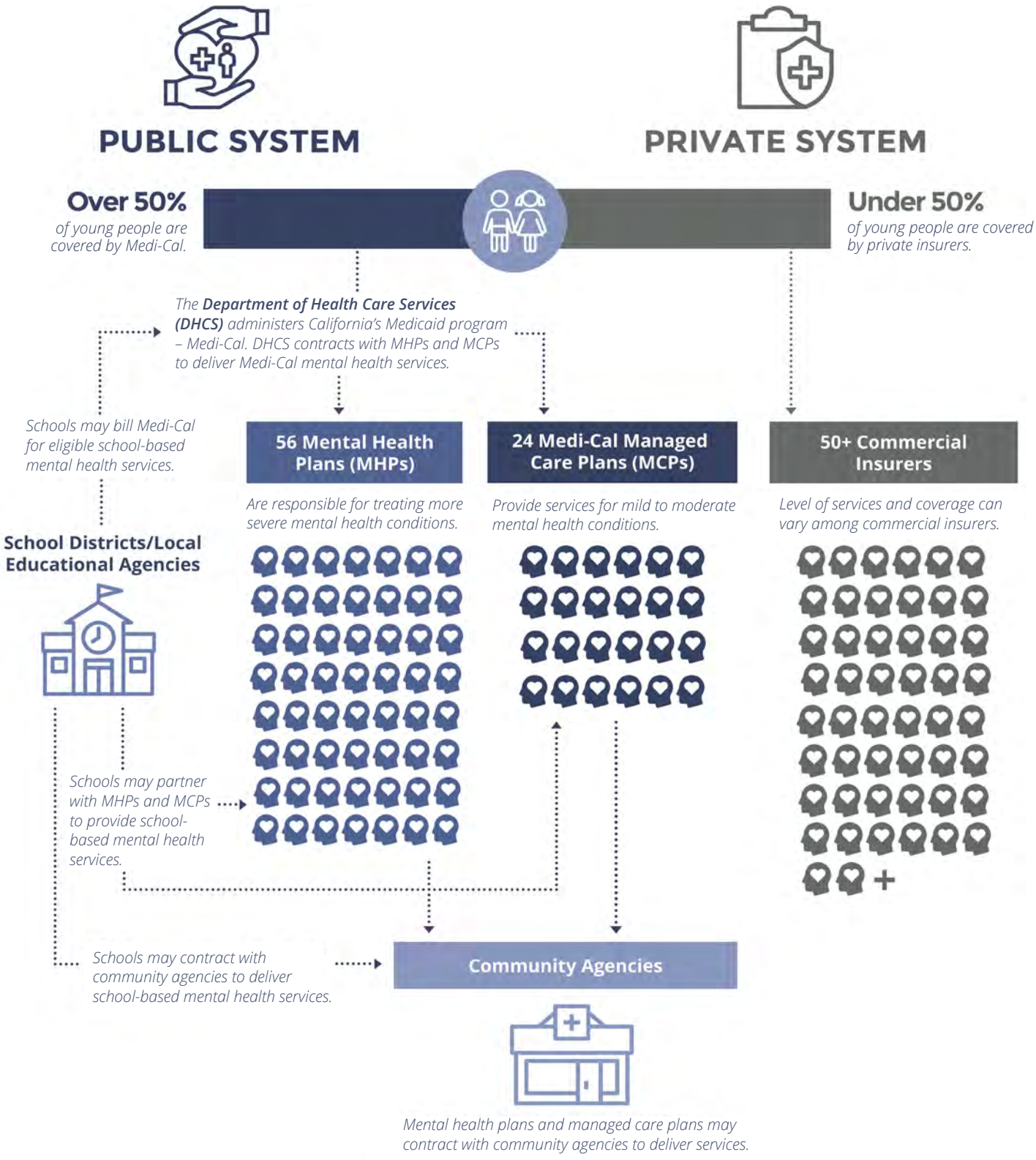
This report focuses on this public system of mental health, which serves the lower income children

Substance Use Disorders and Child Mental Health

Mental health and substance use disorders are often co-occurring. Research suggest as many as 60-to-75 percent of adolescents with substance use disorders also have mental health conditions.[68] Children who have experienced a major depressive episode are twice as likely to begin using alcohol or an illicit drug.[69] For children and adolescents with mental health conditions, substance abuse may be a coping mechanism or may begin as an attempt to self-medicate.

A challenge for meeting child and adolescent mental health needs is that addressing those needs often means also treating issues of substance abuse. Yet fewer than 10 percent of adolescents with substance use disorders receive treatment.[70]

Figure 1: California's Youth Mental Health System is a Mosaic



Note: *This is a simplified illustration of the basic structure of California's child and youth mental health system. It does not include fee-for-service delivery options, which, as of 2018, served about 10 percent of children enrolled in Medi-Cal, including slightly under half of children in foster care or with a probation placement. It also does not reflect that managed care plans may subcontract to other health plans to deliver services.*

who are likely to be disproportionately impacted by COVID.

Children who are not eligible for Medi-Cal are generally covered by one of more than 50 commercial insurers, which provide varying levels of mental health services and coverage.[72] Witnesses noted that mental health is an unusual case in American health care—publicly supported mental health services can be more comprehensive than those provided by commercial insurers, though legislative efforts have sought to expand commercial plans' coverage of conditions and services. Commercial plans also generally do not cover school-based mental health services. The Children and Youth Behavioral Health Initiative includes legislative language that would establish parity across the public and private systems in supporting mental health services in school settings, which child mental health advocates and providers suggest is important for more fully meeting children's mental health needs.

Barriers to Care and Services

Witnesses testifying before the Commission emphasized that addressing COVID's impact will require attending to existing weaknesses in California's system for supporting young people's mental health.

DECENTRALIZATION

Mental health experts and advocates repeatedly observed that a critical weakness in California's child mental health system lies in the highly decentralized character of the system and in the absence of consistent central leadership. "Unlike almost any other state," Dr. Tom Insel observed, "California does not have strong central leadership around behavioral health. There is no person, there is no department, there is no group that is setting outcome goals for the mental health systems in California. There is no one trying to integrate this; we do not have a central data repository to even begin to provide accountability for the state."[73]

There is, witnesses observed, no "common framework" in California for children's mental health that links the various public and commercial systems and providers through shared goals, standards, and approaches.[74] Instead, there is considerable variation in support and care for children's mental health. Lishaun Francis, Associate Director for Health Collaborations at Children Now, observed that California has invested in full-service clinics, community schools, school-county mental health partnerships, and youth-led mental health approaches, in addition to other evidence-based strategies for supporting children's mental health. Yet, while there are highly innovative and notably successful programs for children's mental health around the state, state government has generally failed to commit to particular models: "California's focus constantly shifts in its approach to implementing policy—rather than doubling down on any of the initiatives we create, we move on to the next, spreading out our resources in a way that becomes untenable and ultimately less impactful for California's kids."[75]

Counties vary, moreover, in the resources they have available for supporting mental health systems and in the extent to which they prioritize children's mental health services, with the result that availability of particular services and programs can differ depending on where a child lives. Meanwhile, state government has struggled to develop a consistent mechanism for identifying, scaling, and replicating demonstrated models of care.

FRAGMENTATION

In addition to the challenges of decentralization, child mental health providers reported that California's fragmented mental health system creates barriers to providing and accessing care. Mental health practitioners observed that counties employ

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program

The federal Early and Periodic Screening, Diagnostic, and Treatment program entitles children and young adults up to 21 years of age covered by Medicaid to a broad range of diagnostic and treatment services as may be necessary to "correct or ameliorate defects and physical and mental illnesses and conditions." The entitlement has its origins as a Great Society program, one which recognized that children from low-income families are more likely to have health conditions and developmental delays and that early identification and intervention can help address those health issues.[76] In addition to services related to identifying and treating mental health issues, the EPSDT mandate covers a range of health services, including well-child visits, oral health, and vision care.

Although the EPSDT mandate constitutes a broad entitlement to medically necessary health services, many eligible young people in California who would benefit from mental health care do not appear to receive services to which they are entitled. Young people in California access EPSDT services at rates that are below the national average—in 2017, 49 percent of eligible children in California accessed at least one preventive service covered by EPSDT, compared to a national average of 58 percent.[77] Several factors, as discussed in this report, contribute to relatively low rates of access for EPSDT mental health services, including: diagnostic requirements for accessing services; capacity and workforce shortages; challenges in coordinating services between managed care plans and mental health plans; as well as, lack of awareness on the part of families of children's entitlement to EPSDT services.

Funding and Medi-Cal financing further complicate the provision of EPSDT services. EPSDT is an uncapped mandate—children are entitled by federal law to services if they are determined to be medically necessary. Yet, while the EPSDT program provides federal reimbursement for preventive and treatment services, a certified public expenditure is necessary to generate that reimbursement. Effective implementation of EPSDT thus requires non-federal dollars, but funding streams may be inadequate to meet rising need, as in the case of some counties' funding for EPSDT services provided under 2011 Realignment, or subject to competing demands, as in the case of MHSA funding.[78] Advocates nevertheless observe that there are opportunities for more fully leveraging expenditures to drawdown federal dollars, including by increasing managed care plans' provision of EPSDT services and by maximizing reimbursement for school-based mental health services.[79]

different screening instruments, require different forms of documentation, and adopt different approaches to contracting with providers, creating significant administrative burdens and barriers to delivering needed services. Christine Stoner-Mertz, CEO of the California Alliance of Child and Family Services, observed that this complexity imposes a substantial burden on providers.[80] The California Children's Hospital Association estimates that between 30 and 50 percent of providers' time is required for administrative purposes, with variation in requirements and documentation contributing significantly to this burden.[81]

The bifurcation of services between managed care plans and mental health plans adds another hurdle

that can act as a barrier to timely care. Dr. Brian Distelberg of Loma Linda University Children's Hospital noted, "even within a county services are disjointed because different levels of mental health care get allocated to different resources. It's very complicated for a patient to understand that; it's very complicated for providers who are professionals to execute this complicated process."[82]

"Unlike almost any other state, California does not have strong central leadership around behavioral health. There is no person, there is no department, there is no group that is setting outcome goals for the mental health systems in California."
– Dr. Tom Insel, Chair of the Steinberg Institute Board of Directors

For example, a managed care plan might recommend a patient for specialty mental health services, but county mental health plans have no obligation to accept that patient for service if their own evaluation does not indicate that the individual's needs meet diagnostic thresholds. Although managed care plans and mental health plans enter into MOUs to define their interactions, the challenges of information sharing and of case management across systems can limit effective collaboration.[83]

FAIL FIRST

Providers and advocates observe that California's approach to children's mental health has historically rested on a "fail first" model: the system of children's mental health is structured to respond when a child's mental health has deteriorated to a particular level of severity, rather than to support good mental and emotional health. Indeed, the State Auditor recently found that nearly half of children served by managed care plans did not access EPSDT preventive health services, including those for mental health.[84]

According to providers and experts, one key manifestation of the fail first quality of mental health care in California is its diagnosis-driven character—a child must be diagnosed with a specific mental illness or condition in order to access specialty mental health services. Advocates argue that this requirement contravenes the EPSDT mandate, which entitles children on Medicaid to treatment that is medically necessary for their health and well-being. As a result of the diagnosis requirement, at-risk children may be unable to access needed services until their condition deteriorates to the point that they can be diagnosed with a specific condition.[85]

CAPACITY

Experts, witnesses, and providers universally agreed that there are not enough mental health counselors or psychiatrists trained to work with children and youth. Dr. Bryan King, Vice President for Child Behavioral Health at University of California, San Francisco Benioff Children's Hospitals, reported that while significant demand for services exists, there is a "breathtaking lack of providers."[86] Shortages in the child mental health workforce are a national—and international[87]—challenge. The number of child psychiatrists in California in proportion to population—10 per 100,000 children, as of 2016—corresponds to the national average, but is half that of Connecticut, Massachusetts, New York, and Rhode Island, states which have lower percentages of children with untreated mental health conditions.[88] More broadly, Christine Stoner-Mertz described the challenges facing California's child mental health workforce: "The children's mental health system in California continues to struggle with low wages, high turnover, and limited racial and ethnic diversity in the workforce."[89]

The mental health workforce is unrepresentative of the populations it serves and unequally distributed by geography. The Healthforce Center at University of California, San Francisco, reports, based on its analysis of American Community Survey data from 2011-2015, that only 8 percent of psychologists, 23 percent of counselors, and 24 percent of social workers in California are Latino. In addition, only 4 percent of psychiatrists are Latino and only 2 percent are Black.[90] Critically, lack of diversity and representation in California's mental health workforce can create challenges around building trust and delivering culturally-competent care. Moreover, many clinicians do not accept Medi-Cal, raising further barriers to access for low-income communities.[91] In addition, per capita ratios for psychiatrists, psychologists, and social workers in the San Joaquin Valley and Inland Empire are half statewide ratios, or lower.

Inadequate physical capacity for care and treatment exacerbates these workforce shortages, especially for children with severe needs. Dr. Brian Distelberg reported that the number of inpatient psychiatric beds in California is approximately a third of the number that SAMHSA recommends.[92] Moreover, there are no inpatient psychiatric beds in 42 counties or in any county north of Napa County, meaning that many children with severe mental health conditions may have to wait to access inpatient services or may not be able to access those services close to home.[93] Dr. Distelberg related that COVID has made this bad situation even worse: residential units have had to close if a patient were diagnosed with COVID, exacerbating the shortage of inpatient facilities. Hospitals resorted to "emergency room boarding," wherein children remained in emergency departments, potentially for more than 10 to 15 days, until an inpatient bed became available, with negative impact on their treatment and recovery.

FUNDING

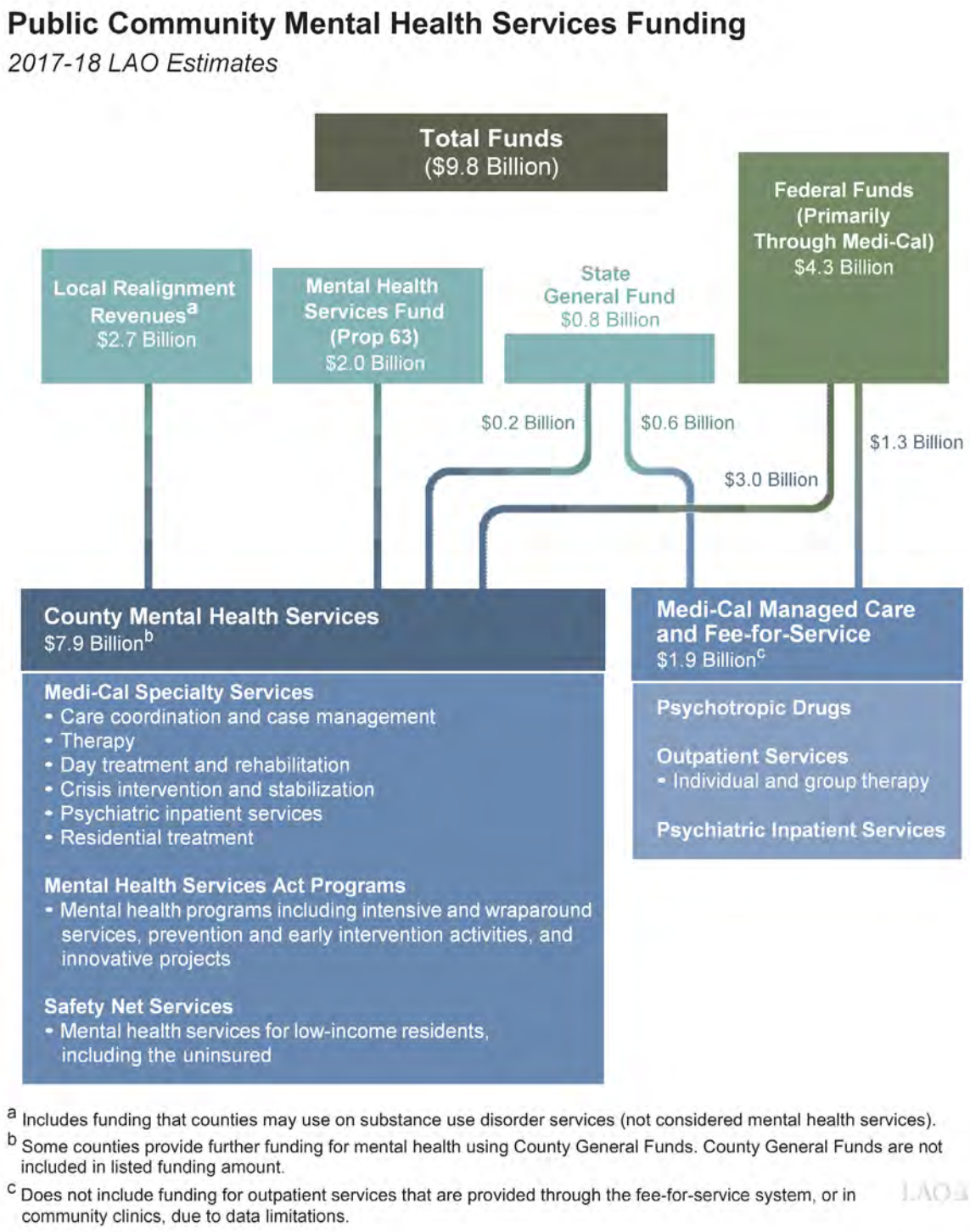
Most child mental health advocates and providers emphasized the need for more substantial investment in children's mental health. Some, however, also argued that while additional investment is needed, the structure and deployment are as important as the amount.

Multiple funding streams support California's system of public mental and behavioral health, including federal Medicaid dollars, funding from the Mental Health Services Act, and funding from 1991 and 2011 Realignment, as well as state and federal grants (See Figure 2). In addition to funding for the public mental health system, many local education agencies (LEAs) may deploy their funding, as well as state and federal grants, to support mental health services for their students. Schools providing mental health care can also bill Medi-Cal for a limited range of services through the Local Education Agency Medi-Cal Billing Option Program (LEA-BOP), though less than half of school districts participate in this program, and can further bill Medi-Cal for costs associated with administering Medi-Cal through the School-Based Medi-Cal Administrative Activities program (SMAA).[94]

Witnesses and child mental health experts identified two key ways in which current structures of mental health funding can act as barriers to meeting children's mental health needs and expanding services:

- First, supporting child mental health and providing mental health services depends on braiding and blending a range of funding sources, especially with the goal of leveraging state and local funding to maximize federal Medicaid draw-downs. The complexity and administrative burdens of maximizing reimbursements can prevent counties from doing so, as well as dissuading school districts from seeking to reimburse eligible mental health expenditures.[95]
- Second, child mental health advocates and providers point to specific challenges arising out of the 2011 Realignment of EPSDT funds. They observe that distribution of Realignment revenues

Figure 2: Funding Streams in the Public System of Mental Health



Source: *Legislative Analyst's Office,* Overview of Funding for Medi-Cal Mental Health Services *(February 26, 2019). Retrived from: https://lao.ca.gov/handouts/health/2019/Funding-Medi-Cal-Mental-Health-Services-022619.pdf.*
Note: *This figure shows total mental health services funding, for both children and adults. It is not possible to determine what percentage of this funding goes to children.*

was determined largely based on historical county spending and thus tends to provide more funding for counties that spent heavily on mental health services at the time of Realignment, and less funding for those that spent less.[96] Providers further observed that Realignment can essentially cap county EPSDT expenditures, putting pressure on the community agencies that contract with county mental health plans to deliver services.[97]

What Is the Role of Schools?

Child mental health advocates and educators emphasized that schools are essential to addressing children's mental health needs. Alex Briscoe, Principal of the California Children's Trust, observed, "Children 8-to-18 go to the doctor the least frequently, but that is when about 60-to-70 percent of mental illness manifests." Yet those same children go to school, so bringing mental health care to schools may significantly expand access to services. Schools play an important role in identifying mental and behavioral health issues, since schools are where there are eyes on children.[98] Students are also much more likely to seek mental health services when those services are offered at a school site and studies further suggest that school-based mental health services can improve student mental health and academic outcomes.[99] Moreover, multi-tiered systems of support (MTSS) frameworks provide a promising model for developing comprehensive school mental health systems.[100] For all these reasons, the Mental Health Services Oversight and Accountability Commission recently recommended that California establish schools as "centers of wellness."[101]

An emphasis on schools as places of healing and wellness is especially important as California addresses COVID's unequal impact. Studies suggest that children who have experienced trauma are more likely to be subject to disciplinary action at schools.[102] In addition, students of color, who often have higher rates of exposure to trauma and ACEs, have also historically been more likely to be suspended from school than White students, though California has recently made important steps to address disparities in school discipline.[104] Looking forward, Pia Escudero, Executive Director of the Division of Student Health and Human Services at Los Angeles Unified School District, suggested that a focus as students return to school in the fall will be to create "healing" school environments that support students' mental health and to catch students who may be at risk before they need higher levels of care.[105]

Multi-Tiered Systems of Supports

MTSS is a framework for deploying evidence-based interventions and supports in school settings. With respect to supporting student mental health through a MTSS framework, a school might provide preventive services and social emotional learning to all students (Tier 1); targeted interventions and supplemental support, like social skills groups, for at-risk students (Tier 2); and intensive services, including therapy or wraparound services, for students with the greatest mental health needs (Tier 3).

California has supported the implementation of MTSS approaches for creating inclusive and positive learning environments that meet the needs of all students through funding for the Scale Up MTSS Statewide (SUMS) Initiative, which is administered by the Orange County Department of Education. This initiative has provided grants to approximately 400 local educational agencies to implement integrated multi-tiered systems that support student academic learning, social emotional learning, and mental health.[103]

School-based mental health resources and approaches take a range of forms. Pupil personnel services (PPS) professionals—school counselors, school psychologists, and school social workers—provide services that support student well-being and development, including, in the case of school psychologists, providing psychological counseling. Many schools and local educational agencies are also working to establish more positive school climates and to develop or introduce curricula that build social emotional learning among students.[106] For example, as of 2019-2020, more than 2,500 schools in California have implemented the Positive Behavioral Interventions and Support (PBIS) approach, a data-based MTSS framework for reducing disciplinary incidents and improving school culture.[107]

Some school districts operate significant, specialized student mental health programs. Los Angeles Unified School District, for example, makes mental health services available through 15 wellness centers, operated by federally qualified health centers, as well as additional school-based health clinics, and employs more than 400 school mental professionals. The district is working to hire an additional 500 psychiatric social workers in order to respond to COVID's impact.[108] In Alameda County, a longstanding partnership exists between the Health Care Services Agency and school districts around student health; Alameda County's School-Based Behavioral Health Initiative reaches more than 40 percent of schools in the county.[109] Other districts have entered into partnerships with county behavioral health departments or community agencies to provide school-based services.

There is, however, considerable variation in the depth of services contained in school mental health programs and in districts' focus on student mental well-being. Ken Berrick and Robin Detterman from Seneca Family of Agencies commented on the importance of providing a continuum of care at schools. They observed that whole school approaches help to equip every student to succeed, while also providing opportunities for prevention and early intervention, as well as more intensive services for students who need them.[110] Yet building out a full, effective MTSS framework and continuum of care can be challenging and administratively burdensome. Schools with programs around social emotional learning and positive school climate may not have linkages to more intensive clinical services.[111] Conversely, community agencies working with schools noted that school-based mental health programs can sometimes focus on the most intensive and expensive interventions, without fully building out more universal supports.

Overall, fewer than half of California's elementary students have access to school-based mental health services, though access improves substantially with grade level. Nearly 90 percent of high schools offer mental health services, at least through school counselors and school psychologists.[112] Yet schools see the same workforce challenges as the mental health system. As of 2018-19, California's K-12 schools employed one school counselor for every 626 students, one school psychologist for every 1,041 students and one school social worker for every 7,308 students.[113] In each case, California does not meet recommended ratios, with the result that the ability of pupil personnel services professionals to meet individual student's needs may be highly limited. In part, this is the result of schools and districts making decisions about how to allocate scarce resources and balancing different priorities; small and rural districts face especially severe capacity constraints around providing mental health services.[114] On the other hand, leadership in some districts and schools may not see supporting students' mental health as part of their school's educational mission.

Partnerships with county behavioral health departments or with community agencies can expand the availability of clinicians and counselors at

schools and expand access to higher levels of mental health care. According to the California Behavioral Health Directors' Association, 85 percent of counties currently provide school-based behavioral health services.[115] Yet developing cross-agency partnerships that work across the educational and health systems is often challenging. Partnerships between schools and county systems raise questions of turf: who should take the lead in responding to children's mental health needs, and how should funding be distributed? School-based mental health partnerships also require cooperation across professional cultures: pupil personnel service professionals and mental health clinicians operate according to different professional standards and under different legal standards regarding privacy and the sharing of information (FERPA vs. HIPAA).[116] From the perspective of schools, a key issue is whether outside mental health clinicians "speak school" and can build trust with students. In addition, schools may not have dedicated facilities or welcoming spaces where clinicians can interact with and treat students.

Section III: Addressing the Crisis

In recent years, the Governor's Office, the Legislature, and state agencies, including the Department of Education, the Department of Health Care Services, and the Mental Health Services Oversight and Accountability Commission, have taken a variety of steps to better support child mental health. This has included funding through the Mental Health Student Services Act for partnerships between county behavioral health departments and schools to support school-based mental health services, efforts to raise awareness around the impact of adverse childhood experiences and childhood trauma on individuals' well-being, and proposed reforms to Medi-Cal to remove barriers to services.

California is now poised to build meaningfully and substantially on this work. The state budget surplus, together with federal recovery and stimulus funding, gives state government the resources to address COVID's impact on children's mental and emotional well-being, address many of the long-standing barriers that prevent children from receiving care and support, and implement preventive programs to alleviate the triggers for mental health conditions.

In the course of this study, witnesses identified a number of steps that California can take to address COVID's impact on children's mental health, including:

Telehealth

There has been a dramatic shift to telehealth as a result of COVID. Practitioners report that they are now providing a majority of services via telehealth and that they find that telehealth can be equally effective as in-person consultations. According to Dr. Brian Distelberg, this shift has increased access and utilization, including increasing the likelihood that patients participate in follow-up appointments and decreasing the number of appointments for which the patient does not show-up.[117] Some providers further observed that telehealth makes it possible to speak with entire families, facilitating whole family care. Studies suggest, moreover, that most young people report being very or somewhat satisfied with their telehealth experiences.[118]

Yet experts also observed that challenges around telehealth remain, including around the digital divide, trust, and privacy.[119] For example, while telehealth can allow clinicians to interact with whole families, children who wish to speak with a clinician privately may have a hard time doing so via telehealth.

- Establishing a larger, more diverse mental health workforce. Witnesses emphasized that training peer support specialists, mental health workers who have lived experience of mental health conditions and who can serve as mentors and models, and community health workers has potential to grow the mental health work force quickly while expanding access to culturally competent care. They also suggested that telehealth approaches can further help to mitigate some challenges of access and capacity.[120]
- Expanding the mental health system's capacity to support those with high levels of need. Witnesses encouraged the development of a genuine continuum of care for children in need of intensive care, featuring crisis response mobile units, expanded inpatient facilities, and crisis residential services.[121]
- Supporting mental wellness. Witnesses observed that while California must expand its capacity to support children with severe mental health conditions, state government should also put greater emphasis on prevention and early intervention by addressing the social determinants of mental health, especially the impact of poverty and social inequality on mental well-being, and by encouraging health promoting interventions, like support for new mothers and children at risk.[122] Witnesses agreed that eliminating the diagnosis requirement for accessing specialty mental health services is a key step toward enabling early intervention.
- Establishing schools as centers of mental wellness. Although other points of access will also be critical to supporting children and families, schools are likely to be "ground zero" for supporting the mental and emotional health of children who have experienced an extended period of stress, anxiety, and trauma.[123] Mental health supports will also be critical to addressing learning loss and helping vulnerable children and those most impacted by COVID re-engage with school.[124] Witnesses noted that partnerships between schools and mental-health oriented community-based organizations, including as part of community school models, can help provide students with access to wraparound and comprehensive services.[125]

Collaborative Health Models/UCSF Benioff Children's Hospitals Child Psychiatry Access Portal

One approach to mitigating the workforce and capacity challenges in children's mental health care lies in psychiatric telehealth consultations for primary care providers, which give pediatricians essential tools to address basic issues of mental and emotional health. These programs help to bridge the gap between physical and mental health care, assist with early identification and treatment of mental health needs, and incorporate pediatricians into the broader continuum of mental health care. Psychiatric consultation programs for pediatricians in Washington State and Massachusetts appear to have facilitated access to mental health care and allowed child psychiatrists to focus on patients with more complex mental and behavioral health issues.[126]

University of California, San Francisco Benioff Children's Hospital has recently launched a new Child Psychiatry Access Portal wherein child psychologists and clinicians work with pediatricians to help address common mental health issues. Through support from philanthropic donations, this program has grown to include more than 70 pediatric practices in the San Francisco Bay Area; it has also entered into agreements with health care providers to expand into the Central Valley.[127]

In addition, the Newsom administration has launched two major initiatives that have potential to fundamentally transform California's system of supporting and treating children's mental health: the California Advancing and Innovating Medi-Cal (CalAIM) proposal and the Children and Youth Behavioral Health Initiative. These initiatives incorporate many of the proposals listed above. Together they can reshape how California approaches child mental health, transforming a system that focuses on treating diagnosed mental and behavioral health conditions into one that more fully supports children's mental and emotional well-being, even prior to conditions developing.

CAL AIM

The California Advancing and Innovating Medi-Cal (CalAIM) proposal is an ambitious and far-reaching plan to reform and transform Medi-Cal service delivery and financing.[128] According to Dr. Tom Insel, CalAIM is, "the most substantial change to mental or behavioral health in California for the public system in four decades."[129] Although children's mental health is not the focus of CalAIM, the initiative nevertheless includes key features that address the structural and systemic issues discussed above, including:

- Eliminating the requirement for diagnosis to access specialty mental health services. The Department of Health Care Services intends to reform criteria for establishing medical necessity, shifting from requiring a specific diagnosis to instead basing medical necessity on level of impairment. This is designed to lower the bar for establishing that treatments are medically necessary under the EPSDT mandate. DHCS further intends to develop standardized, statewide assessment tools to determine eligibility for services.
- Streamlining reimbursement for county mental health plans and for specialty mental health services with the goal of reducing administrative burden and providing opportunity to reimburse based on the quality of services and not just their cost. This will include expanded opportunities to reimburse for care delivered through value-based care models, which could, for example, support an expanded role for community health workers in the delivery of children's mental health.
- Encouraging closer coordination and cooperation between managed care plans and mental health plans in delivery of mental health services.
- Encouraging administrative and clinical integration of specialty mental health services and substance use disorder treatment services at the county level.[130]

CalAIM is a complex initiative that consists of renewing with amendment the federal Medicaid waivers under which California administers specialty mental health services, updating state contracts with managed care plans, and revising county monitoring and reporting standards. Development and implementation of CalAIM are ongoing, with the Department of Health Care Services submitting its application for waiver renewal to the federal Centers for Medicare & Medicaid Services in June 2021. DHCS aims to make revisions to medical necessity criteria for specialty mental health services effective in early 2022, following approval of the relevant waivers. Some elements of CalAIM, including integration of specialty mental health services and substance use disorder treatment services, will take several years to implement fully.

CHILDREN AND YOUTH BEHAVIORAL HEALTH INITIATIVE

The Children and Youth Behavioral Health Initiative aims to develop a comprehensive system of mental health care for Californians from birth to 25 years of age. The Newsom Administration proposed the Behavioral Health Initiative as part of the May Revision to the 2021-22 state budget; the Legislature subsequently established the initiative through Assembly Bill 133 (Committee on Budget, 2021). The 2021-22 state budget allocates approximately $4.4 billion in funding for the initiative over the next

five years, including about $1.5 billion in both 2021-22 and in 2022-23 and more than $400 million in ongoing funding in 2023-24 and thereafter.

The Children and Youth Behavioral Health Initiative is a capacious program that aims to transform California's child mental health system. In the words of Health and Human Services Secretary, Dr. Mark Ghaly, this ambitious initiative seeks to remake California's child mental health system "into one that is a world-class, innovative, up-stream-focused, early intervention-focused ecosystem where we can promise all of our young people that we will be looking out for their emotional and mental health needs, that we will be able to screen them and assess them in a timely way, and support them with emerging and existing best practices, in a culturally competent and equitable fashion."[131] The Behavioral Health Initiative includes the following components:

- **Behavioral Health Services and Supports Virtual Platform**. The budget allocates $750 million for the development and implementation of a virtual platform that integrates behavioral health services with around the clock access to screening, clinic-based care, and app-based support services. This platform will build on a new Department of Health Care Services project, the CalHOPE Program, to create a responsive platform designed for children, youth, and their families that provides tiered resources and treatment, while also helping to connect users to community-based organizations, wellness programs, and more intensive in-person services. In addition, the platform will support Pediatric Primary Care and Other Healthcare Provider eConsult services, which will facilitate consultation between primary care providers and behavioral health specialists. An outside vendor will develop and manage the platform; a portion of funding is delayed until the project achieves appropriate milestones from the California Department of Technology's Project Approval Lifecycle.
- **School-Linked Behavioral Health Services.** The Children and Youth Behavioral Health Initiative will build partnerships and capacity statewide around school-based and school-linked mental health services through more than $1 billion in incentive and grant funding for schools, counties, health plans, and community-based organizations. Of this funding, $400 million is directed specifically to incentives for Medi-Cal managed care plans to partner with schools and county systems of behavioral health to provide school-linked and school-based mental health services to students and families. This collaboration could ease access to EPSDT mental health services and support greater provision of mental health services in school settings. Partnerships between schools, health plans, and community agencies can also facilitate Medicaid reimbursement for school mental health services.[132] The Behavioral Health Initiative will require that commercial plans support school-based mental health services.
- **Workforce Development.** The budget allocates more than $1 billion in funding to support expansion of the behavioral health workforce. In the Newsom Administration's original proposal for the Behavioral Health Initiative, this funding would support the training of 10,000 culturally and linguistically proficient behavioral health counselors, at varying levels of specialization and certification, as well as psychiatric nurse practitioners, community health workers, and peer support specialists. The initiative will further expand training program capacity and models and also leverage the existing workforce through training for pediatric and primary care providers.
- **Developing and scaling age-appropriate, evidence-based programs.** The budget provides grant funding of $430 million to health plans, county systems of health, and community-based organizations to support evidence-based practices. Priorities will likely include programs that support individuals following a first episode

of psychosis, drop-in wellness centers, and both in-person and telehealth services oriented around prevention and early intervention.

- **Building Continuum of Care Infrastructure.** The budget provides $310 million in grant funding to build continuum of care infrastructure targeted at individuals age 25 and younger, with $205 million of that funding directed toward supporting mobile crisis support teams.
- **Dyadic Service Benefits.** The Behavioral Health Initiative will add dyadic behavioral health visits as a Medi-Cal benefit. Dyadic services refer to care that treats children and their parents/families together. The budget includes $800 million in funding support for these benefits over the next five years.
- **Public Awareness.** Finally, the Behavioral Health Initiative includes funding for a public awareness campaign around mental health, adverse childhood experiences, and toxic stress. The campaign will include measures to support culturally specific engagement and outreach, as well as youth involvement.[133]

The Behavioral Health Initiative aims to simultaneously and comprehensively address the various systemic and structural barriers that can prevent young people from accessing and receiving mental health services. It aims to facilitate access by providing virtual services that both help to make care more available in rural parts of the state and that meet young people where many are—online. It also aims to expand the mental health workforce, center schools as hubs of wellness, develop a fuller continuum of care, and expand awareness around the importance of mental health. In addressing different issues at once, the initiative tackles the interrelated nature of barriers to care. For example, school-based mental health services can facilitate access to care, but making those services genuinely available requires creating a larger mental health workforce that can provide culturally competent care and reducing the stigma that can deter children and adolescents from visiting a school-based clinician.

Yet addressing an array of structural weaknesses and barriers simultaneously also creates an initiative that will be administratively complex. At the state level, the initiative calls for the participation of the Health and Human Services Agency, Department of Health Care Services, Department of Managed Care, Mental Health Services Oversight and Accountability Commission, Office of Statewide Health Planning and Development, Department of Public Health, Office of the Surgeon General, and the Department of Education.

The state budget surplus, together with federal recovery and stimulus funding, gives state government the resources to address COVID's impact on children's mental and emotional well-being, address many of the long-standing barriers that prevent children from receiving care, and implement preventive programs to alleviate the triggers for mental health conditions.

Several initiative components will involve third-party vendors, raising challenges of contract management. Putting the initiative into practice will further depend on collaboration and cooperation among county behavioral health offices, managed care plans, commercial insurers, community agencies, and school districts. Secretary Ghaly was upfront regarding the challenges facing implementation:

"it will not be easy; it will take a lot of innovation, a lot of rolling up sleeves."[134] It will also take strong structures for governing, coordinating, and administering the initiative, together with consistent leadership at the state level.

Section IV: Steps Forward

Given the complexity and urgency of the Behavioral Health Initiative, it is critical that the Governor's Office and leadership of relevant state agencies work with local agencies, health plans, and stakeholders to establish a compact of relevant actors that clearly defines the work to be done, by whom, and when. The first year of the Behavioral Health Initiative focuses on planning, needs assessment, and stakeholder engagement, including creating a Youth Advisory Council and an advisory committee for expanding the mental health workforce. The Commission understands that significant consultation and negotiation will be necessary to build the initiative's component programs and develop concrete plans for implementation, but urges an efficient process so resources are primarily utilized for critical engagement with children. The following are key steps that state government may take that can help to structure and coordinate its response to COVID's impact on children's mental health and ensure that the Behavioral Health Initiative achieves sustainable improvements in California's child mental health system.

ESTABLISHING STATE LEADERSHIP AND OUTCOME GOALS

In its 2015 and 2016 reports on the Mental Health Services Act, the Commission called for stronger, more coherent, and more cohesive state leadership over the mental health system and urged the Governor and Legislature to identify a mental health leader within state government that is able to ensure accountability for outcomes. Witnesses similarly emphasized the need for greater state leadership in addressing children's mental health needs.[135] Dr. Tom Insel recommended creating a new, more robust Department of Behavioral Health that would provide a single point of state leadership over mental health care and could consolidate state mental health programs and funding streams.[136]

Witnesses and advocates generally agreed that the state of California needs to establish outcome goals for children's mental and emotional well-being, especially for vulnerable children and youth. Christine Stoner-Mertz observed, "California's public mental health system does not currently measure the well-being of children (both eligible and those served) and report out on this. . . Setting clear statewide measures so that all delivery systems have increased transparency and accountability to children's well-being is essential."[137] Dr. Insel further suggested mapping managed care plans and county systems onto a common regional template in order to begin centralizing standards.

> **"Setting clear statewide measures so that all delivery systems have increased transparency and accountability to children's well-being is essential." - Christine Stoner-Mertz, CEO, California Alliance of Child and Family Services**

The Children and Youth Behavioral Health Initiative provides a foundation for a truly statewide approach to children's mental and emotional well-being. Strong planning around implementation and governance will be needed to coordinate the initiative's different branches and to ensure that it produces lasting and sustainable results, rather than producing more one-time pilot projects. Establishing a single person or entity with overall leadership—and accountability—

for the initiative, with capacity to oversee initiative elements and ensure that these elements have complementary outcome goals, is also likely to be essential to its success. Clear metrics and goals can further help to guide implementation and focus the initiative's intersystem and interagency partnerships on common objectives both in the short- and long-term.

Moreover, the funding contained in the Behavioral Health Initiative is a potential lever for establishing outcome goals relative to children's mental health and enforcing accountability for outcomes. The Behavioral Health Initiative includes planning around evaluation and data reporting; the portion of the initiative around behavioral health evidence-based programs, for example, would include the requirement that grantees share standardized data in a statewide behavioral health dashboard.

Addressing COVID's impact on children's mental health will require shared accountability, with state government assuming responsibility for ensuring that the various health plans and providers achieve goals.

Yet the Behavioral Health Initiative is also an opportunity to require entities receiving funding to collect and report data relative to more general outcome goals. In order to encourage accountability, the California Health and Human Services Agency and relevant agencies could make access to portions of initiative funding contingent on meeting metrics linked to established outcome goals.

BUILDING CAPACITY FOR STATEWIDE APPROACHES

Several witnesses and experts testified to the importance of metrics and accountability in structuring a more coordinated and strategic approach to children's mental health; witnesses also emphasized, however, that state government must take responsibility for the ability of health plans and providers to meet outcome goals.

Toby Ewing explained, "Part of the reason we do not have a mental health system from a statewide perspective, is the state is not in the business of helping counties build out their systems." Mr. Ewing observed that the Mental Health Services Oversight and Accountability Commission has recently made progress encouraging counties to reduce the amount of unspent MHSA funds, not by seeking to punish counties for failing to expend funds, but by working with them to address the risks that cause counties to accumulate excess reserves and to identify ways to spend the funds more effectively. "We need," Mr. Ewing suggested, "to be equally responsible for success together."[138] Alex Briscoe made the same point, suggesting that the relationship between state government and county systems needs to be reworked around collaboration and support. According to Mr. Briscoe, the state's approach to counties and health plans needs to be predicated on the understanding, "our job is to help you to do your job better."[139]

Addressing COVID's impact on children's mental health will require shared accountability, with state government assuming responsibility for ensuring that the various health plans and providers achieve goals. The Children and Youth Behavioral Health Initiative is potentially a major step in the direction of establishing greater state leadership around children's mental health and toward developing a culture of collaboration between state government and health plans. Secretary Ghaly noted that the proposed virtual platform is a "bold step to say

that we will have something statewide, that we do not expect every county to come up with their own version."[140]

In addition, technical assistance is likely to be instrumental for the success of the Behavioral Health Initiative, especially by enabling health plans, providers, and schools to learn from existing models rather than reinventing the wheel. The Health and Human Services Agency and participating departments may need to build out or identify sources of technical assistance; they can also establish learning collaboratives and communities of practice, as the Oversight and Accountability Commission has done for its early psychosis intervention program. In addition, there is opportunity to leverage the resource and knowledge base of California's university systems. New York State's Department of Education, for example, supports three university-based, regional technical assistance centers for community schools.[141] California could similarly work with universities and relevant non-profit organizations to institutionalize technical assistance around children's mental health, including school-based mental health, evidence-based practices, and approaches around prevention and early intervention.

Separately, witnesses and providers called for the Department of Health Care Services to dedicate resources around capacity building. They suggested that DHCS expand its ability to provide technical assistance around reimbursement and take steps to simplify and streamline state processes around documentation. Although providers were hopeful that CalAIM will ultimately help address and reduce the paperwork burden associated with billing Medi-Cal, they also suggested that more assistance is needed in addressing challenges around documentation and drawing down reimbursements.[142]

BUILDING SCHOOL-LINKED PARTNERSHIPS

School-based and school-linked partnerships will be critical for responding to COVID's impact at scale. It is important, however, to appreciate the complexity and difficulty of what will be involved in creating partnerships around school-based mental health. Centering schools as sites for supporting child mental wellness requires bringing together California's systems of education and mental health. Putting the Behavioral Health Initiative into practice further depends on forging new and deeper partnerships between entities that have little experience working together, like schools and managed care organizations. Moreover, schools will need to develop and expand partnerships with health plans and community agencies while also confronting the significant challenges associated with fully reopening, addressing uncertain risk around COVID, attending to

Seneca Family of Agencies and Coordination of Services

Seneca Family of Agencies is a statewide non-profit that provides school and community-based services addressing children's well-being through an innovative whole child model called Unconditional Education. This model provides a highly developed and integrated example of a MTSS framework that equips school districts with supports to educate all students at local schools. At each school site, an Unconditional Education "coach" guides implementation of the model. This coach works with school leadership to help improve school culture and climate and provides professional development and coaching for school staff and teachers to help them meet students' needs. The coach also supports a coordination of services team that manages referrals and ensures students receive the engagement and supports they may need.[143]

learning loss, and managing the immediate impacts of the pandemic on students' well-being.

Careful planning and coordination at both the district and at the school level is critical. Most importantly, there needs to be clarity around the roles that teachers, pupil services personnel, administrative staff, outside clinicians, and other mental health professionals will play in providing mental health services:

- This does not mean training teachers to be social workers or mental health clinicians.[144] Instead, it means better connecting teachers and educators with resources and helping them understand signs that indicate that a student may be struggling and how to help direct that student to sources of support.[145] It can also mean building awareness around social emotional learning and providing teachers, administrators, and staff with training in trauma-informed approaches, so that they respond to behavioral issues through restorative practices, rather than disciplinary actions.
- Clearly defining the respective roles of pupil services personnel professionals (i.e., school counselors, school social workers, and school psychologists) and outside clinicians and further developing clear understanding regarding care coordination and information sharing, so as to ensure that there is both a "warm hand off" and continued coordination when a student needs more intensive or specialized services. Establishing coordination of services teams can support effective cooperation among the various people and entities involved in providing different levels of care and services. School counselors can also play a key role in managing MTSS frameworks, identifying students who need more intensive services and coordinating with mental health clinicians.[146]
- Developing data-driven approaches to coordinating and delivering care and measuring the effectiveness of interventions. Attendance and academic data can be powerful indicators of student emotional or mental issues. Yet, many schools do not employ this data to identify students who may need support or disaggregate data to identify where there may be issues. With regard to the use of data systems in delivering and tracking school mental health services, Pia Escudero observed, "We're in the infancy stages because of the lack of funding."[147] The Behavioral Health Initiative makes funding available to develop and integrate data systems around student mental health, but connecting and integrating data systems across educational and health agencies will pose administrative and technical challenges.

Technical assistance is likely to play a critical role in supporting the development of viable and effective partnerships around school-based and school-linked mental health services. Existing partnerships between schools and county mental health plans can offer models and lessons that new collaborations can learn from, as can previous state programs that provided technical assistance around school climate and student well-being. For example, the Scale Up MTSS Statewide (SUMS) Initiative administered by Orange County Department of Education also included leadership from Butte County Office of Education and featured technical assistance oriented towards the needs of small and rural districts, as well as creating a community of practice that bridged large and small districts.[148] This initiative could potentially hold lessons for helping small and rural school districts address their unique constraints and challenges in delivering mental health services.

In addition, the 2021-22 State Budget allocates $3 billion in funding to expand implementation of community school models, including $140 million to support regional technical assistance centers for community schools. These centers could potentially also support technical assistance around school-linked mental health.[149]

Recommendations

Governor Newsom and the Health and Human Services Agency are taking critical steps to overhaul and improve California's system for supporting child mental health. Taken together, CalAIM and the Children and Youth Behavioral Health Initiative have potential to transform California's child mental health system and address many of the longstanding structural weaknesses of that system.

Yet these ambitious and expansive proposals may not fully address some of the root causes of these weaknesses. California's child mental health system has long suffered from lack of clear and consistent leadership—leadership that can overcome fragmentation, define the roles of the system's various actors, establish metrics to evaluate success, and hold agencies and providers accountable for outcomes.

California cannot afford to waste the current moment. Meeting children's mental health needs requires clear state leadership and clearly defined goals and expectations.

1. Establish state leadership. The Commission reiterates its recommendation from earlier reports for the state of California to identify a central point of leadership for children's mental health. In the short term, the Governor should establish a clear plan for coordinating the constituent parts of the Children and Youth Behavioral Health Initiative, including developing governance and implementation plans. The Commission suggests that this plan include the creation of a staffed coordinating council for children's mental health that would be charged both with implementing the Behavioral Health Initiative and with overall oversight of the children's mental health system. This council should be chaired by the Secretary of the Health and Human Services Agency. It should also include leadership from relevant agencies, including the Department of Health Care Services, Department of Managed Care, Department of Public Health, Office of the Surgeon General, the Mental Health Services Oversight and Accountability Commission, Office of Statewide Health Planning and Development, and the Department of Education.

In the longer run, the Governor and Legislature should initiate a review process, to be completed no later than October 2022, to examine the creation of a new and robust Department of Behavioral and Mental Health that would be capable of statewide leadership over mental health care and services, with coequal focus on child and adult mental health. This review process would include examination of how other states structure departments of mental health, of the lessons that can be learned from California's previous Department of Mental Health, and of how the department may be best organized to ensure that children's mental health receives equal attention to adult mental health, as well as consideration of whether a distinct Department of Behavioral and Mental Health would impede or support whole person approaches to care that address both mental and physical health.

2. Establish outcome goals. The Commission commends the Newsom Administration for incorporating evaluation as a core component of the Children and Youth Behavioral Health Initiative. However, the Commission also finds that California needs to establish overarching and unifying goals and metrics around child mental health.

In consultation with stakeholders, the Secretary of the Health and Human Services Agency should set statewide goals for child mental health based on a limited number of key metrics related to overall mental well-being, access to care, and quality of care, which could include: increasing attendance and graduation rates for students with behavioral or mental health disorders; increasing recovery after first episode of psychosis; increasing the percentage of children reporting severe depression who receive counseling; decreasing wait time to access care;

increasing the percentage of children being screened for mental wellness and for ACEs, and, if at risk, receiving appropriate interventions; and, increasing the percentage of children with access to school mental health programs. These data should be released publicly each year and, where appropriate, should further be disaggregated by race, gender, and age.

In order to guide local implementation and encourage local accountability, each county, managed care plan, and commercial plan should also be required to establish equivalent goals that would contribute to reaching statewide goals.

3. Support accountability around outcome goals. The Governor and Legislature also need to use the new funding associated with the Children and Youth Behavioral Health Initiative as an opportunity to expand accountability and oversight in the provision of mental health services.

The Commission recommends reserving a portion of Behavioral Health Initiative funding to provide a future tranche of additional funding that would be awarded on a competitive basis to counties and health plans that efficiently and effectively implement successful reforms/programs and that reach identified benchmarks or improvements with respect to outcomes, data collection, data sharing, and care coordination. Within this "race to the top" style competition, entities would compete with like-situated entities.

4. Build shared accountability. In establishing outcomes goals, California needs also to reset the relationship between the state and county systems with regard to accountability and technical support. Currently, accountability around children's mental health centers on audits that focus on how money is spent, rather than on outcomes for children's mental health. CalAIM promises to reduce the burdens associated with Medi-Cal payments, but more is needed to change the culture that exists between state and local government around child mental health services. The Governor and Legislature need to take steps to establish a culture within the relevant state agencies that says to counties and providers, "How can we work together to learn together," and "How do we help you increase capacity?"[150]

The Department of Health Care Services should work with stakeholders to identify ways to increase the technical assistance it provides to counties, managed care plans, and other mental health providers, including local educational agencies. In addition, the review process for the creation of a new Department of Behavioral and Mental Health should include consideration of what changes would potentially be required to expand the capacity of the Department of Health Care Services to provide greater technical assistance to local departments of mental health and to others providers. It should also include consideration of where technical assistance for school-based Medi-Cal payments should reside.

5. Center schools. In addition to funding school-linked mental health partnerships and services, the Governor and Legislature should also use this opportunity to encourage school districts and local education agencies to develop coordinated and comprehensive approaches to student mental and emotional wellness.

The 2021-22 State Budget includes major investments in the development of community schools. Schools can further draw on existing federal and state funding sources to support their counselor and mental health workforces, as well as on significant one-time funding. It is critical that the Governor, Legislature, and associated departments and agencies encourage districts to approach these funding sources in an integrated and strategic fashion so as to position schools as hubs of mental well-being.

School-linked behavioral health services grants within the Children and Youth Behavioral Health Initiative should require the following of recipients:

- Every district and school receiving funding should develop a coordinated plan for how it will deliver multi-tier mental health supports, including clear identification of the roles of teachers, of school support and counseling staff, and of partner organizations. This should be a concise, actionable plan that promotes clear and efficient cooperation, and care should be taken to ensure that developing the plan is not administratively burdensome.
- Every district and its partners should develop a plan detailing how they will use available data to identify students who may need support, how they will share data and information, and how they will coordinate services in an equitable and balanced manner.
- Every district and its partners should specify how they will integrate grant funding with funding from other sources to create sustainable programs around student mental health.
- In order to further highlight the importance of school climate and student mental health, the Superintendent of Public Instruction should also create a program that recognizes schools that are leaders in creating and maintaining positive school climate and in supporting student mental well-being.

6. Strengthen the behavioral health services virtual platform. The Commission commends the Newsom Administration for building on the momentum and innovation surrounding telehealth services for mental health. The proposed virtual platform has potential to expand availability of telehealth options while "meeting children where they are." Yet the ongoing challenges surrounding IT systems at the Employment Development Department and FI$Cal, as well as with the MyTurn and MyTurn Volunteer websites, should also urge caution as the state proceeds to support the development of a complicated technology system, and one that must be accessible and inviting to children and youth of different ages and backgrounds.

In order to mitigate risks associated with platform development, the Governor should provide specifications on the bidding and contracting process for the virtual platform. The Governor should also establish a clear timeline for the development, testing, and piloting of the platform, with vigorous oversight at every stage of development.

In addition, in developing and rolling out the virtual platform, the Governor and relevant agencies should address how they will ensure that the virtual platform does not exacerbate the digital divide. The design and development of the platform should include consideration of how this platform can be made available to children and youth who do not have broadband and may also have limited internet access. Development should also include identification of strategies to provide equivalent in-person services for those children who are unable to access the platform.

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Little Hoover Commission Members

CHAIRMAN PEDRO NAVA | Santa Barbara
Appointed to the Commission by Speaker of the Assembly John Pérez in April 2013 and reappointed by Speaker of the Assembly Anthony Rendon in 2017 and again in 2021. Government relations advisor. Former State Assemblymember from 2004 to 2010, civil litigator, deputy district attorney and member of the state Coastal Commission. Elected chair of the Commission in March 2014.

VICE CHAIRMAN SEAN VARNER | Riverside
Appointed to the Commission by Governor Edmund G. Brown Jr. in April 2016 and reappointed in January 2018. Managing partner at Varner & Brandt LLP where he practices as a transactional attorney focusing on mergers and acquisitions, finance, real estate, and general counsel work. Elected vice chair of the Commission in March 2017.

DION ARONER | Berkeley
Appointed to the Commission by the Senate Rules Committee in April 2019. Partner for Aroner, Jewel, and Ellis. Former State Assemblymember from 1996 to 2002, chief of staff for Assemblymember Tom Bates, social worker for Alameda County, and the first female president of Service Employees International Union 535.

DAVID BEIER | San Francisco
Appointed to the Commission by Governor Edmund G. Brown Jr. in June 2014 and reappointed in January 2018. Managing director of Bay City Capital. Former senior officer of Genentech and Amgen, and counsel to the U.S. House of Representatives Committee on the Judiciary.

CYNTHIA BUIZA | Los Angeles
Appointed to the Commission by Speaker of the Assembly Anthony Rendon in October 2018. Executive director of the California Immigrant Policy Center. Former policy director for the American Civil Liberties Union, San Diego, and policy and advocacy director at the Coalition for Humane Immigrant Rights of Los Angeles.

BILL EMMERSON | Redlands
Appointed to the Commission by Governor Edmund G. Brown Jr. in December 2018. Former senior vice president of state relations and advocacy at the California Hospital Association, State Senator from 2010 to 2013, State Assemblymember from 2004 to 2010, and orthodonist.

ASM. CHAD MAYES | Yucca Valley
Appointed to the Commission by Speaker of the Assembly Toni Atkins in September 2015. Elected in November 2014 to represent the 42nd Assembly District. Represents Beaumont, Hemet, La Quinta, Palm Desert, Palm Springs, San Jacinto, Twentynine Palms, Yucaipa, Yucca Valley, and surrounding areas.

SEN. JIM NIELSEN | Gerber
Appointed to the Commission by the Senate Rules Committee in March 2019. Elected in January 2013 to represent the 4th Senate District. Represents Chico, Oroville, Paradise, Red Bluff, Yuba City, and surrounding areas.

ASM. BILL QUIRK | Hayward
Appointed to the Commission by Speaker of the Assembly Anthony Rendon in 2017. Elected in November 2012 to represent the 20th Assembly District. Represents Hayward, Union City, Castro Valley, San Lorenzo, Ashland, Cherryland, Fairview, Sunol, and North Fremont.

SEN. RICHARD ROTH | Riverside
Appointed to the Commission by the Senate Rules Committee in February 2013. Elected in November 2012 to represent the 31st Senate District. Represents Corona, Coronita, Eastvale, El Cerrito, Highgrove, Home Gardens, Jurupa Valley, March Air Reserve Base, Mead Valley, Moreno Valley, Norco, Perris, and Riverside.

CATHY SCHWAMBERGER | Calistoga
Appointed to the Commission by the Senate Rules Committee in April 2018 and reappointed in January 2019. Retired associate general counsel for State Farm Mutual Automobile Insurance Company. Former board member of the Civil Justice Association of California and the Capital Political Action Committee.

JANNA SIDLEY | Los Angeles
Appointed to the Commission by Governor Edmund G. Brown Jr. in April 2016 and reappointed in February 2020. General counsel at the Port of Los Angeles since 2013. Former deputy city attorney at the Los Angeles City Attorney's Office from 2003 to 2013.

Full biographies are available on the Commission's website at www.lhc.ca.gov.

“DEMOCRACY ITSELF IS A PROCESS OF CHANGE, AND SATISFACTION AND COMPLACENCY ARE ENEMIES OF GOOD GOVERNMENT.”

By Governor Edmund G. “Pat” Brown,
addressing the inaugural meeting of the Little Hoover Commission,
April 24,1962, Sacramento, California

Milton Marks Commission on California State Government Organization and Economy

www.lhc.ca.gov

Opinion: What California can do to improve children's mental health

Even before the pandemic, rates of adolescent suicide and self-harm were on the rise. COVID exacerbated the problem

By **PEDRO NAVA**, **SEAN VARNER** and **DAVID BEIER** |
PUBLISHED: January 14, 2022 at 5:00 a.m. | UPDATED: January 14, 2022 at 5:03 a.m.

California's children are struggling. Unprecedented levels of toxic stress and trauma stemming from the pandemic have exacerbated a pre-existing crisis in children's mental health.

Even before the pandemic began, rates of adolescent suicide and self-harm were on the rise. Now, nearly two years into the pandemic, social isolation, emotional disconnection, economic stress and COVID's physical impact have taken a toll on our youth and exacerbated an already critical problem.

The Little Hoover Commission, California's independent government watchdog, calls on the state to strengthen its system for supporting children's mental and emotional well-being. The state must name an accountable leader, set clear goals, encourage coordination and employ schools as key sites to help kids. This will ensure the state uses funds dedicated to children's mental and emotional well-being efficiently and in a way that has the most impact, both short- and long-term.

Chronic stress is affecting many children's ability to regulate emotions and behaviors, pay attention, and start and complete tasks. Educators are seeing this first-hand.

As many children returned to in-person learning this fall, school districts reported soaring rates of absenteeism and surges in student misbehavior. Even worse, in early 2021 emergency department visits for suspected suicide attempts were almost 51% higher among adolescent girls and 4% higher among adolescent boys compared to the same time period in 2019.

Major national organizations declared a state of emergency in children's mental health this fall. The U.S. surgeon general released an advisory last month with recommendations for supporting children amid the mental health crisis.

But California has long struggled to adequately support children's mental and emotional well-being.

Its system for supporting children's mental health contends with a slew of systemic barriers – including decentralization and workforce shortages – that prevent children from accessing much-needed mental health services. In 2018, California ranked 48th nationally for providing mental health services to children.

Moreover, accessing care is often most challenging for youth from minority and low-income communities, who have also borne the brunt of the pandemic's impacts.

The good news is that Gov. Gavin Newsom and the Legislature have taken critical steps to improve California's system for supporting child mental health. Last year, they established the Children and Youth Behavioral Health Initiative – a $4.4 billion investment in developing a comprehensive system of mental health care for Californians from birth to 25 years of age.

In our report, COVID-19 and Children's Mental Health, the commission calls for additional reforms to ensure that the behavioral health initiative achieves its potential:

First, establish a single point of overall leadership for children's mental health. This statewide leader should be tasked with creating clear plans for coordinating and implementing the Children and Youth Behavioral Health

Second, set clear outcome goals. The state should establish goals for children's mental health based on key metrics related to overall mental well-being, access to care and quality of care.

Third, promote coordination around children's mental health care and services. The state should increase the support and technical assistance it provides to counties, health plans and other mental health providers. By cultivating a culture around collaboration and support, state and local governments can work better together to advance statewide goals.

Finally, center schools as sites for supporting child mental wellness. The state should encourage schools to develop comprehensive plans for coordinating student mental health services, using and sharing data, and integrating new and existing funding to create sustainable mental wellness programs.

Under California's current system for supporting child mental health, too many children are slipping through the cracks. To fully address the mental health needs of our children, we must first tackle the system's deficiencies – before it is too late.

Pedro Nava is chairman of the Little Hoover Commission. Sean Varner and David Beier are members of the commission's subcommittee studying economic recovery from the pandemic. They wrote this commentary for CalMatters.

Tags: **california-legislature**, **Gavin Newsom**, **K 12 Education**, **Mental Health**

Pedro Nava

David Beier

Contra Costa County Mental Health Commission's
Quality of Care Committee

The Mission Statement of the Quality of Care Committee is: To assist Contra Costa County mental health consumers, family members and the general public in advocating for the highest quality mental health services and supports delivered with dignity and respect.

2015 ACTION PLAN

For the Period January-December 2015

Goals *(List of Committee Goals)*	**Tasks** *(What the Committee needs to do to achieve the Goals)*	**Success Criteria** *(How the Committee can identify their success)*	**Time Frame** *(By when the Committee needs to achieve the Goals)*	**Resources** *(What resources are needed for each task)*
1) Advocate to establish a crisis residential facility as well as expand Psychiatric Emergency Services for children and adolescents.				Vern Wallace, LMFT, MHA Children/ Adolescent Program Chief
2) Advocate for specialty mental health services for consumers who have chronic health difficulties, dual diagnosis of developmental disabilities & mental illness, and/or seniors with mental illness.				Victor Montoya, MHA TAY/Adult/Older Adult Program Chief

2015 ACTION PLAN (Cont'd)

Goals *(List of Committee Goals)*	**Tasks** *(What the Committee needs to do to achieve the Goals)*	**Success Criteria** *(How the Committee can identify their success)*	**Time Frame** *(By when the Committee needs to achieve the Goals)*	**Resources** *(What resources are needed for each task)*
3) Address gaps in medical, psychiatric, social and cultural services: a) explore and address concerns re time allotted for initial psychiatric exam b) continue to monitor repairs at Crestwood to meet standard of care.				Psychiatric Services: Kristine Girard, M.D. Chief Psychiatrist, CCRMC Quality Improvement Plan: Ziba Rahimzadeh, Ph.D.. BHS Provider Services Manager Erin McCarty, MPH, MH Project Manager Travis Curran, Executive Director, Crestwood Pleasant Hill

50 Example Nonprofit Mission Statements

50 EXAMPLE MISSION STATEMENTS

An organization's mission statement should clearly communicate what it is that they do. Many mission statements succumb to an overuse of words in general, but especially jargon. Good mission statements should be ***clear, concise, and useful***. Some might also add "inspiring" to the list of descriptors. We don't altogether disagree, but we find that including this as upfront criteria often ends up with a Frankenstein that is a part mission, part vision statement (desired end-state), and almost always too long.

What is a Mission Statement?

A mission statement is a one-sentence statement describing the reason your organization or program exists. (What you do + who/what you do this for).

What is the Purpose of a Mission Statement?

Mission statements serve 3 primary functions, each geared to different audiences.

Inform External Audiences of What You Do – Your mission statement is a great way to summarize what your org is about, providing context for follow-up information on programs and services.

Focus & Motivate Your Team – Staff and volunteers want to believe in the work they do. Your mission statement should be easy for staff & volunteers to understand, remember, and own.

Guide Strategic Planning & Decisions – By definition, you cannot prioritize everything. Your mission statement should serve as the leadership team's guiding star when considering priorities and new initiatives.

3 Guidelines for Creating a Great Mission Statement

We have been studying mission statements for years and are passionate about helping nonprofits and businesses alike create truly effective mission statements. We have distilled our experience into the following 3 guidelines for creating a Great Mission Statement.

Clear (Easy to Understand) This is not a time to show off your vocabulary. Use concrete language and keep things simple. Try to keep to an 8th-grade reading level (avoid anything over 10th grade).

- Avg length for the full 50 organizations listed here is only 15.3 words (excluding brand references)
- Avg length for the first 20 organizations below is only 9.5 words (excluding brand references).
- The shortest contains only two words (TED)
- The longest contained 235 words (UNHCR)

Concise (Short & To-the-Point) Don't fall prey to buzzwords, adjective strings and fluff. Aim for 5-14 words, 20 max. This is often the hardest part, but anything longer and you undermine its utility.

Useful (Inform. Focus. Guide.) It doesn't matter how short, clear, or cute your phrase is if it fails to inform others about what you do and focus and guide internal team members and decisions.

50 Mission Statements from Top Nonprofits

TED: Spread Ideas. (2 words)
*Too short for readability grading, but clearly easy to understand.

Smithsonian: The increase and diffusion of knowledge. (6 words)
Readability grade; A. 100% Reach. 8th-grade reading level.

Monterey Bay Aquarium: To inspire conservation of the oceans. (6)

USO lifts the spirits of America's troops and their families. (9)
Grade A. 100% Reach. 8th-grade reading level.

Kiva: To expand financial access to help underserved communities thrive (9)
Grade C. 84% reach. 11th-grade reading level.

Human Rights Campaign Working to achieve lesbian, gay, bisexual and transgender equality. (9)
Grade E. 44% reach. 14th-grade (college sophomore) reading level.

AARP: To enhance quality of life for all as we age. (10)
Grade A. 100% reach. 5th-grade reading level.

MoMA: To share great modern and contemporary art with the public (10)
Grage A. 100% reach. 7th-grade reading level.

Oxfam: To create lasting solutions to poverty, hunger, and social injustice. (10)
Grade C. 80% reach. 11th-grade reading level.

charity: water: Bringing clean, safe drinking water to people in developing countries. (10)
Grade B. 88% reach. 10th-grade reading level.

The Alzheimer's Association leads the way to end Alzheimer's and all other dementia (10)
Grade A. 100% reach. 6th-grade reading level.

Environmental Defense Fund: To preserve the natural systems on which all life depends. (10)
Grade A. 100% reach. 7th-grade reading level.

Candid (Guidestar + Foundation Center) Candid gets you the information you need to do good. (10)
Grade A: 100% reach. 5th-grade reading level.

New York Public Library: To inspire lifelong learning, advance knowledge, and strengthen our communities. (10)
Grade C. 71% reach. 13th-grade (college freshman) reading level.

Doctors without Borders (Médecins Sans Frontières) to provide lifesaving medical care to those most in need. (10)
Grade A. 100% reach. 8th-grade reading level.

March of Dimes leads the fight for the health of all moms and babies. (11)
Grade A. 100% reach. 3rd-grade reading level.

The Humane Society: We fight the big fights to end suffering for all animals. (11)
Grade A. 100% Reach. 6th-grade reading level.

The Nature Conservancy: To conserve the lands and waters on which all life depends. (11)
Grade A. 100% reach. 5th-grade reading level.

San Diego Zoo is a conservation organization committed to saving species around the world. (11)
Grade D. 60% reach. 12th-grade reading level.

CARE: To serve individuals and families in the poorest communities in the world. (12)
Grade C. 80% reach. 10th-grade reading level.

American Heart Association: To be a relentless force for a world of longer, healthier lives.(12)
Grade A. 100% reach. 7th-grade reading level.

Best Friends Animal Society: to bring about a time when there are no more homeless pets. (12)
Grade A. 100% Reach. 3rd-grade reading level.

National Wildlife Federation: Uniting all Americans to ensure wildlife thrive in a rapidly changing world (12)
Grade C. 80% reach. 8th-grade reading level.

National Parks Conservation Association: To protect and enhance America's National Park System for present and future generations. (13)
Grade D. 62% reach. 11th-grade reading level.

JDRF: To find a cure for diabetes and its complications through the support of research. (14)
Grade A. 100% reach. 9th-grade reading level.

Heifer International: To work with communities to end hunger and poverty and care for the Earth. (14)
Grade A. 100% reach. 7th-grade reading level.

Invisible Children: to end the violence and exploitation facing our world's most isolated and vulnerable communities (14)
Grade E. 53% Reach. 13th-grade (college freshman) reading level.

ASPCA: To provide effective means for the prevention of cruelty to animals throughout the United States. (15)
Grade C. 80% reach. 11th-grade reading level.

Defenders of Wildlife is dedicated to the protection of all native animals and plants in their natural communities. (15)
Grade D. 68% reach. 11th-grade reading level

Amnesty International: To undertake research and action focused on preventing and ending grave abuses of these rights. (15)
Grade C. 80% reach. 11th-grade reading level.

St. Jude Research Hospital: To advance cures, and means of prevention, for pediatric catastrophic diseases through research and treatment (15)
Grade D. 68% reach. 13th-grade (college junior)

Girls Scouts: Girl Scouting builds girls of courage, confidence, and character, who make the world a better place. (16)
Grade B. 100% reach. 9th-grade reading level.

American Diabetes Association: To prevent and cure diabetes and to improve the lives of all people affected by diabetes. (16)
Grade B. 92% reach. 10th-grade reading level.

World Wildlife Fund: to conserve nature and reduce the most pressing threats to the diversity of life on Earth (16)
Grade B. 100% reach. 8th-grade reading level.

Grade B. 87% reach. 9th-grade reading level.

Creative Commons helps overcome legal obstacles to the sharing of knowledge and creativity to address the world's pressing challenges. (17)
Grade D. 66% reach. 12th-grade reading level.

Cleveland Clinic: To provide better care of the sick, investigation into their problems, and further education of those who serve. (18)
Grade C. 77% reach. 10th-grade reading level.

The U.S. Fund for UNICEF fights for the survival and development of the world's most vulnerable children and protects their basic human rights. (18)
Grade C. 77% reach. 11th-grade reading level.

Leukemia & Lymphoma Society: Cure leukemia, lymphoma, Hodgkin's disease and myeloma, and improve the quality of life of patients and their families. (18)
Grade D. 57% reach. 13th-grade (college freshman) reading level.

NRDC: to safeguard the earth—its people, its plants and animals, and the natural systems on which all life depends. (19)
Grade B. 91% reach. 10th-grade reading level

Teach for America: Growing the movement of leaders who work to ensure that kids growing up in poverty get an excellent education. (20)
Grade C. 77% reach. 11th-grade reading level.

Save the Children: To inspire breakthroughs in the way the world treats children and to achieve immediate and lasting change in their lives. (20)
Grade B. 95% reach. 9th-grade reading level.

Ducks Unlimited conserves, restores, and manages wetlands and associated habitats for North America's waterfowl. These habitats also benefit other wildlife and people. (20)
Grade E. 53% reach. 13th-grade (college freshman) reading level.

American Museum of Natural History: To discover, interpret, and disseminate—through scientific research and education—knowledge about human cultures, the natural world, and the universe. (20)
Grade E. 37% reach. 13th-grade (college junior) reading level.

Make-A-Wish: We grant the wishes of children with life-threatening medical conditions to enrich the human experience with hope, strength and joy. (21)
Grade C. 72% reach. 12th-grade reading level.

American Red Cross prevents and alleviates human suffering in the face of emergencies by mobilizing the power of volunteers and the generosity of donors. (21)
Grade E. 34% reach. 14th-grade (college sophomore) reading level.

Feeding America: To feed America's hungry through a nationwide network of member food banks and engage our country in the fight to end hunger. (22)
Grade C. 80% reach. 10th-grade reading level.

Susan G Komen for the Cure save lives by meeting the most critical needs in our communities and investing in breakthrough research to prevent and cure breast cancer. (22)
Grade C. 76% reach. 11th-grade reading level.

Audubon: To conserve and restore natural ecosystems, focusing on birds, other wildlife, and their habitats for the benefit of humanity and the earth's biological diversity. (24)
Grade E. 26% reach. 15th-grade (college junior) reading level.

Mayo Clinic: Inspiring hope and promoting health through integrated clinical practice, education and research. (12)
Grade E. 50% reach. 15th-grade (college sophomore) reading level.

Metropolitan Museum of Art collects, studies, conserves, and presents significant works of art across all times and cultures in order to connect people to creativity, knowledge, and ideas. (24)

The Rotary Foundation: To enable Rotarians to advance world understanding, goodwill, and peace through the improvement of health, the support of education, and the alleviation of poverty. (24)
Grade E. 37% reach. 15th-grade (college junior) reading level.

Boy Scouts of America: To prepare young people to make ethical and moral choices over their lifetimes by instilling in them the values of the Scout Oath and Law. (25)
Grade C. 73% reach. 11th-grade reading level.

NPR: To work in partnership with member stations to create a more informed public – one challenged and invigorated by a deeper understanding and appreciation of events, ideas and cultures. (28)
Grade E. 40% reach. 14th-grade (college sophmore) reading level.

What does this mean for you?

Is your mission statement longer than 20 words? Can you get it below 15? Below 10? Design it to clearly communicate what you do in such a way that people can remember it and communicate this to others. If you can't get a mission statement below 15 words, consider also creating a mission tagline (2-6 words) which people can more easily remember.

Definitions

Readability grade is Readable.com's bespoke rating system grade text from A to E for readability. According to their recommendations, text aimed at the general public should be grade B or better.

Reach also comes from readable.com and measures the proportion of the literate general public, so a reach of 100% means your content is readable by about 85% of the public (that being the percentage that are literate)

Reading grade level is equivalent to the number of years of education a person has had. A score of around 10-12 is roughly the reading level on completion of high school. Text to be read by the general public should aim for a grade level of around 8 (source Readable).

How the list was compiled

- Mission statements were gathered for each of the top 100 nonprofits (based on a series of web, social, and transparency metrics) and then evaluated for content and length.
- The top 50 were then selected for this list based on length and organized roughly from shortest to longest

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Mental Health Commission and Quality of Care Committee
Mission Statements, February, 2022

Mental Health Commission

The Contra Costa County Mental Health Commission has a dual mission:

1. To influence the County's Mental Health System to ensure the delivery of quality services which are effective, efficient, culturally relevant and responsive to the needs and desires of the clients it serves with dignity and respect; and
2. To be the advocate with the Board of Supervisors, the Mental Health Division, and the community on behalf of all Contra Costa County residents who are in need of mental health services.

Quality of Care

"The Mission Statement of the Quality of Care Committee is: To assist Contra Costa County mental health consumers, family members and the general public in advocating for the highest quality mental health services and supports delivered with dignity and respect."

Ideas for simpler version based on "50 Top Mission Statements" from TOPNONPROFITS:

> "To advocate for the highest quality mental health care for all people living in Contra Costa County."
>
> "To *fiercely* advocate for the highest quality mental health care *possible* for all people living in Contra Costa County."