School-Based Mental Health Services and Supports

Needs Assessment and Recommendations

Napa County 2007

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for
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Executive Summary

Napa County Office of Education and Napa County Health and Human Services Agency came together to study school-based mental health services and supports in Napa County. The purpose of the study was to provide a picture of the current system of services and supports from multiple perspectives: schools, providers and parents.

A review of literature was completed to give context to the findings and recommendations. A summary of current research begins each section and relevant models from the literature are presented in the conclusions and recommendations (see Section Five).

Key Findings and Recommendations

Mental Health Needs of School-Aged Children

• Research and student surveys suggest that **20% or more of school-aged children experience a need for mental health services and supports in a given year.** This percentage is higher in middle schools, high schools, non-traditional schools and for youth involved with the justice system.

  ✐ Plan services in relationship to identified needs, using the estimate of 20% or more of students experiencing a need for mental health services and supports in a given year. Specifically target services for students who are known to have higher prevalence, including students in non-traditional schools and students involved in the justice system.

• **Stakeholders identified anger management/conflict resolution, family relations, anxiety and trauma as prevalent mental health concerns for school-aged children.** Providers noted anxiety in particular to be increasing. When compared to school and provider responses, families reported similar concerns for their children. It is especially noteworthy that anger management/conflict resolution was high on the list of concerns for parents as this concern was also identified by school administrators and counselors. Anxiety and trauma were less frequently identified by parents, but still noted by families in the interviews and when describing the events in their family that affected their ability to care for and advocate for their child.

  ✐ Work to understand and address the mental health concerns that were most frequently identified by those interviewed: Anger Management/Conflict Resolution, Family Relations, Anxiety and Trauma.
School-Based Mental Health Needs Assessment
Executive Summary

- The context of children’s family, culture, language and environment are important factors to consider when examining mental health needs. The changing demographics and underutilization of mental health services and supports by Latino children, transition-aged youth, and youth in the justice system will continue to affect the mental health needs of children and need to be incorporated into planning efforts to address these needs.

- Stakeholders agreed that mental health services and supports need to be available to families as well as children. Families experience multiple mental health concerns, some chronic and some transitory, and may need resources to support their child’s mental health issue. Families’ need for mental health services and supports are likely to change over time.

- Communicate with families to understand their ability to support the student. Families’ capacity to support their children may be complicated by their own mental health concerns and/or the needs of other family members.

Identifying Mental Health Needs for School-Aged Children

- Schools’ responses to how they identify students at risk were very uniform and providers’ responses were more varied. Less than one-third of the school administrators, counselors and teachers rated their schools’ response to three scripted mental health need scenarios as excellent or good. School administrators and counselors indicated they share the responsibility for the child’s well-being with parents, providers and students.

- Clarify school policies for addressing mental health concerns for students. Providers’ responses to the scripted scenarios varied in comparison to school responses, and this may be of concern to schools. Define provider roles in these scenarios and develop a consistent referral and communication process to be sure students are identified and the supports are consistently available.

- Implement policies to train teachers and school staff to identify mental health concerns for students who are not acting out and may be performing academically. The interviews suggested that personnel who are on campus and have the time to observe students between classes were able to identify and support students in this situation.

- Schools have indicated that they have a shared responsibility with families and providers to address situations where issues are not strictly academic. Use this information to encourage collaboration among families, schools and providers and to keep the focus on the mutual goal of supporting the child’s future success.
School-Based Mental Health Needs Assessment
Executive Summary

- Parents described varying responses to their child’s mental health concern(s). **Parents whose child was identified with a clear academic concern reported receiving academic support and mental health services and support quickly.** Parents whose child was identified as having a behavioral concern reported more frustration and a longer process to enter into the system of services and supports. Parents who contacted the school for support reported a mix of both positive and negative experiences seeking services.

> Develop ways to support parents of children with an identified behavioral concern. Shifting the responsibility completely to parents was a source of frustration for the families interviewed, and did not resolve the behavioral issues. Consider using school-based coordination teams, community agencies, parent support resources, and school-based resources to assist the family as they work to address the concern.

> Ensure that students and parents have a clear pathway to mental health services and supports. Parents noted they did not know what services were available and/or how to access the resources. Many parents reported they noticed the concern at home prior to having the concern identified at school. Clear access to mental health services and supports and a clear way to communicate with the school may result in issues being identified sooner and addressed more effectively.

School-Based Mental Health Services and Supports
Four types of mental health services and supports were presented.

- **Schools reported varying availability of school counselors.** Though the American School Counselor Association recommends a school counselor to student ratio of 1:250, schools interviewed reported ratios from 1:500 to 1:940. **School administrators and counselors described the need to balance academic and mental health needs in light of ongoing pressure to raise students’ test scores.** Providers described school counselors as the link to referrals and trust-building with the students. One parent was able to address her child’s mental health concern with the assistance of a school counselor and did not have to proceed to a school-based coordination team.
Executive Summary

- Improve ratios of school counselors to students to provide all students with equal access to mental health services and supports. Advocate for policy changes to ensure new funding does not restrict the school counselors’ role. Adhere to a multi-faceted role of the school counselor when developing new school counselor job descriptions to support addressing the whole child rather than solely academic and career concerns.

- Review strategies for delivering school-based mental health services and supports without compromising classroom time. Two strategies currently occurring in Napa County include providing services on early-release days and changing the class schedule to hold classes Monday-Thursday and providing all support services (academic, career and/or mental health) on Fridays only.

- **School-based coordination teams are seen as effective by schools**, and providers described them as effective in most cases. Parents noted particular concern about the oversight and accountability once a 504 plan and/or and IEP is established by these teams. Schools, providers and parents described a fragmented system for accessing mental health services and supports. For schools, the fragmentation was noted when they coordinated with outside providers and families, for providers and families the fragmentation was encountered when they worked with the school.

- Improve school-based coordination teams to make them more inclusive of providers and families. Many providers noted they only participated intermittently and some providers did not know about the teams.

- Develop accountability measures and oversight for school-based coordination teams. Families expressed frustration with the variable implementation of the solutions developed by the teams.

- Continue to address the challenge of fragmentation by improving communication between providers and between schools and providers. Differences in information about what is available affect families’ ability to access services for their children.

- **Schools and providers agreed that there are not enough school-based mental health services and supports to address the needs of students.** They also described needing to ration the services to the students who need it the most and the potential for the low-level interventions to be inappropriate for students with a high-level of need. Only half of the school administrators and counselors reported that they are able to address anger
management/conflict resolution at their school, though this was one of the most frequently reported needs. Less than half felt they were able to address family relations with school-based services. Schools and providers noted there are difficulties in coordinating services, and the relationships built by the providers’ presence on the school campus improve service delivery for students.

Barriers to Accessing Mental Health Services and Supports

- Many barriers were noted by schools, providers and parents. Each of the stakeholders noted barriers with other stakeholders. The schools were most concerned about the availability of services and parents’ willingness to approve services. Providers were most concerned about the schools’ culture of providing services and how it clashed with their own culture of service provision. Parents were most concerned with being able to locate, access, and afford appropriate services for their child. Spanish-speaking families described several additional barriers that may help explain why mental health services and supports are underused by Latino children.
School-Based Mental Health Needs Assessment
Executive Summary

- Work with schools to clarify process of consent for mental health and substance abuse services. Many services do not require parental consent, and these laws and/or policies should be consistently observed across school settings.

- Review how consent is obtained by schools. Some providers noted that those schools that have staff to call and discuss the concern and treatment with family have been able to increase parents’ willingness to approve services. Allocate resources to work with families to explain services and obtain consent when needed.

- Consider ways to encourage schools and providers to work together toward common goals. Understanding how each system of service works is vital to improving the availability, quality and effectiveness of mental health services and supports in a school-based setting.

- Develop ways to work with parents and improve knowledge of service systems and available resources. Many parents noted they had observed the behaviors at home prior to the concern being identified by the school. Improved communication with parents could result in earlier identification and intervention for students.

- Improve access to mental health services and supports for Latino families. Review and address the multiple barriers Spanish-speaking families outlined. Increase Spanish-speaking providers and staff to facilitate communication and improve families’ understanding of services and supports.

Impact of Mental Health Services and Supports

- Schools, providers and parents agree that students need effective mental health services and supports. The way effectiveness is evaluated and reported shows a variety of definitions for change and impact. Schools focused on the academic outcomes, providers focused on improved mental health and parents wanted both outcomes for their children. Resiliency measures have been shown to correlate with both positive mental health outcomes and positive academic outcomes and may be a measure to consider as the stakeholders look for common goals and outcomes.
Unmet Mental Health Needs

- **Stakeholders identified a list of unmet mental health needs that centered on improved availability, stability and utilization of mental health services and supports.** Specifically, the following needs were identified. **Increased availability of mental health services and supports** especially services and support available at school and in community, early intervention services, mental health services and supports for families, and system coordination and access. **Long-term funding to improve stability of mental health service and support programs** and **increased use of mental health services and supports** by addressing insurance coverage, culturally and linguistically appropriate services and services for students in non-traditional schools and students involved in the justice system.
Review the accessibility of providers in Napa County. Especially consider ways to increase services for up valley communities.

Add mental health services and supports for preschool and elementary school children. Include families when addressing mental health concerns and involve them in prevention efforts.

Make the system of mental health services and supports accessible for families to reduce the need for each family to navigate the services on their own.

Develop long-term funding for mental health services to provide a consistent and reliable resource for schools, providers and families.

Work with current providers to understand insurance coverage issues. Work with families to understand their insurance and whether or not mental health services and supports are covered.

Work with providers to develop culturally and linguistically appropriate interventions. Accessible services for Spanish-speaking families will continue to be a need over the next 20 years due to changing demographics.

Ensure mental health services and supports are available for students in settings where prevalence is known to be high and utilization low, specifically students in non-traditional schools and those involved in the justice system.

Current Funding for Mental Health Services and Supports

- Schools and providers reported using all known and accessible funding sources. Both indicated frustration with the restrictive and transitory nature of grant-funded programs and preferred long-term flexible funding sources to provide appropriate services effectively.

Current funding is fragmented and restrictive and perpetuates difficulties in treating the whole child. Consider adopting guidelines for funding that reduce the service barriers described by schools and providers. The guidelines presented are intended to be used during the development of new funding sources, and shared with schools and providers who are seeking funds.
Conclusions and Recommendations

- Each of the stakeholder groups was asked what recommendations they had for the current system of mental health services and supports.

  - Focus on the child
  - Increase knowledge and understanding of mental health concerns
  - Increase availability of mental health services and supports at school sites
  - Provide space on campus for mental health services and supports
  - Involve parents in the system of mental health services and supports for school-aged children
  - Consider alternative approaches
  - Coordinate the system of mental health services and supports
  - Focus on prevention
  - Increase community-based supports
  - Stable funding

- Further recommendations are provided using research-based models and guidelines.

  - Twelve tenets of school-based mental health services are presented to begin the conversation with schools, providers and families in order to develop common values and goals.

  - A continuum of school-based mental health services and supports are outlined to provide a guide to implementing a comprehensive and coordinated system of school-based mental health services and supports.
Introduction

In 2004, the Napa County Office of Education received a three year grant to provide mental health services and supports for students at identified school sites throughout Napa County. The Safe Schools Healthy Students Initiative (SSHS) was funded through the US Department of Education and included the following components:

- Safe School Environment
- Alcohol and Other Drugs and Violence Prevention and Early Intervention
- School and Community Mental Health Preventative & Treatment Intervention Services
- Early Childhood Psychosocial & Emotional Development Services
- Supporting & Connecting Schools & Communities
- Safe School Policies
- Sustainability of the most successful elements beyond the three years

The idea for a SSHS initiative was developed through the leadership of a community collaborative of partners looking for long-term solutions to school health and safety issues. In the second year of the initiative it became evident that it would be important to create a sustainability plan that addressed the long-term vision and funding needs for school-based mental health services. A portion of the SSHS grant was allocated for the study and an oversight team was established.

Concurrent with the need for comprehensive planning regarding school-based mental health services, Napa County Health and Human Services Agency (HHSA) began the process for creating the Prevention and Early Intervention Plan under the Mental Health Services Act. The Mental Health Services Act focuses on the behavioral health needs of students at-risk of school failure as a key population. To that end, HHSA and the Napa County Office of Education (NCOE) collaborated to create a comprehensive strategic plan for school-based mental health services in order to provide NCOE with a review of school-based mental health needs. The plan also serves to partially meet the planning requirements under the Mental Health Services Act Prevention and Early Intervention.

Purpose

Current research describes many children in the United States in need of mental health services, and schools are said to be the largest provider of such services.\(^1\) The best practices of providing mental health services in schools, or any environment, include: (1) coordinating a continuum of care that ranges from prevention to treatment of severe and chronic problems; (2) emphasizing cultural competence; (3) incorporating the individual and family voice into services and supports; and, (4) using practices that are supported by research. However, contrary to best practices, services are generally provided based on available funding, rather than need, which typically produces fragmented and overlapping services.

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\(^1\) In 2000, there were approximately 31,000 practicing school psychologists (providing assessment, planning, and treatment services) to children with learning problems in 85,000 schools (Grantmakers in Health, 2003).
Greater collaboration is called for, including a broader approach to mental health that incorporates resilience as a vital part of the system of care.

This study was undertaken to illustrate the current state of the system of school-based mental health services and supports from multiple perspectives and to provide a reference to assist schools, providers and parents in planning for and developing interventions that meet the mental health needs of school-aged children in Napa County.

Organization
Each of the sections in the report begins with a summary of the current literature as it relates to topics discussed in the section. A full review of the literature is included in Appendix A. The sections present the perspectives as they were collected. For more information on methodology, see Appendix D. Each section concludes with recommendations that come directly from the findings in the study. More comprehensive recommendations rooted in the current research and best practices are included in Section Five.

The report begins with a review of the mental health needs of school-aged children in Napa County and how they are identified. This section also discusses prevalence and the most pressing mental health needs according to the stakeholder groups interviewed.

The next section addresses the current mental health services and supports focusing on the services that are provided through the school. Four areas are discussed: school counselors, school-based coordination teams, school-based services and community-based services. In addition, the section reviews the myriad barriers for families to access the current services.

The third section discusses the impact of mental health services and the needs that remain unmet. The section begins with a review of varied definitions of effectiveness from each of the stakeholder viewpoints, and continues to discuss the areas the stakeholders noted as particularly lacking.

The fourth section presents the funding sources currently being used, potential funding sources that may be available for services in Napa County, and research-based recommendations to ensure that future funding promotes coordinated and appropriate services.

The report concludes with recommendations from each of the stakeholder groups in their own words and suggested guidelines for bringing the stakeholder groups together for future planning. The oversight team requested a summary of recommendations from least to most comprehensive in order to be able to apply available dollars to the most pressing needs first and build a system of mental health services and supports that best serves school-aged children given current limitations and constraints. These recommendations conclude the final section.

Several appendices are included to provide background and reference for the oversight team and others as they begin the planning process. Appendix A is the full literature review that was completed for the
School-Based Mental Health Needs Assessment
Introduction

oversight team. Appendix B is a comprehensive look at the parent interview findings to illustrate the user’s perspective of school-based mental health services and supports. Appendix C is a listing of potential funding opportunities. Appendix D reviews the project design and methodology.

Acknowledgements
This report was made possible by the collaborative work and vision of the oversight team: Felix A. Bedolla, Terry Longoria, Jeannie Morris, Halsey Simmons, Jeanne Title and Shirin Vakharia. We thank them for investing in creating a full picture of the current system and their willingness to include so many perspectives.

The richness of the information, findings and recommendations is a result of school administrators, counselors, teachers, providers and parents sharing their time and experiences. Though they were assured of their anonymity for the purposes of this report, we thank each of them profusely for participating and trusting us to tell the story.
# Table of Contents

SECTION ONE: MENTAL HEALTH NEEDS OF SCHOOL-AGED CHILDREN ....................... 19

  Part One: Summary of Current Research ........................................................................................................... 21

  Part Two: Mental Health Needs of School-Aged Children in Napa County .............................................................. 23

  Part Three: Identifying Mental Health Needs in School-Aged Children ............................................................... 39

  Part Four: Recommendations ................................................................................................................................ 49

SECTION TWO: SCHOOL-BASED MENTAL HEALTH SERVICES AND SUPPORTS .......... 51

  Part One: Summary of Current Research ........................................................................................................... 53

  Part Two: School-Based Mental Health Services and Supports ............................................................................. 55

  Part Three: Barriers to Accessing Mental Health Services and Supports .............................................................. 73

  Part Four: Recommendations ................................................................................................................................ 83

SECTION THREE: IMPACT OF MENTAL HEALTH SERVICES AND UNMET NEEDS .......... 85

  Part One: Summary of Current Research ........................................................................................................... 87

  Part Two: Impact of Mental Health Services and Supports ................................................................................... 89

  Part Three: Unmet Mental Health Needs ............................................................................................................. 97

  Part Four: Recommendations ................................................................................................................................ 107

SECTION FOUR: FUNDING SOURCES ....................................................................................... 109

  Part One: Summary of Current Research ........................................................................................................... 111

  Part Two: Current Funding for Mental Health Services and Supports ................................................................. 113

  Part Three: Summary of Potential Funding Sources ........................................................................................... 117

  Part Four: Recommendations ................................................................................................................................ 119
## Table of Contents, *(Continued)*

SECTION FIVE: CONCLUSIONS AND RECOMMENDATIONS .......................................................... 121

- Part One: Summary of Current Research ........................................................................... 123
- Part Two: Suggested Changes to the Current System of School-Based Mental Health Services and Supports 125
- Part Three: Basic Tenets of School-Based Mental Health Services ........................................ 131
- Part Four: A Continuum of School-Based Mental Health Services and Supports .................. 133

APPENDIX A: REVIEW OF LITERATURE REGARDING MENTAL HEALTH SERVICES IN THE SCHOOLS .......................................................................................................................... 137

APPENDIX B: THEMES FROM FIFTEEN PARENT INTERVIEWS ............................................. 161

APPENDIX C: FUNDING OPPORTUNITIES TO PROVIDE SCHOOL-BASED MENTAL HEALTH PREVENTION, EARLY INTERVENTION AND TREATMENT SERVICES FOR CHILDREN AND YOUTH .............................................................................................................................. 179

APPENDIX D: METHODOLOGY ............................................................................................ 227
Section One:
Mental Health Needs
Of School-Aged Children
Part One: Summary of Current Research

A full review of the literature is included in Appendix A. Below are brief summaries of the current literature as it relates to topics in this section.

Prevalence of Mental Health Needs for School-Aged Children

In 2005, 9.6 million children lived in California.\(^2\) Research estimates that 20% of these children and youth will experience a mental health disorder in any given year (Kadandale, 2005) and 16% to 20% of children and youth who need mental health services will actually receive them (Center for Health and Health Care in Schools, 2003).

Complexity of Mental Health Needs

The Policy Leadership Cadre for Mental Health in the Schools points out that in schools and communities that have low incomes, resources for students’ basic needs are scarce. At the same time, these youth face potential barriers to mental health and learning that can include family problems, health issues, violence, gang involvement, substance abuse, and possible language and cultural barriers. Since these same concerns often negatively affect caregivers, the amount of family involvement in the youth’s lives and educational pursuits can be limited. The issues can be exacerbated when systems respond to students’ behaviors with punishment rather than rehabilitation.

Specific Mental Health Needs for School-Aged Children

The following are common mental, emotional and behavioral disorders that affect school-aged children and youth nationally.

<table>
<thead>
<tr>
<th>Common Mental Health Disorders and the Percentage of School-Aged Children and Youth Affected(^3)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Disorder</strong></td>
</tr>
<tr>
<td>Anxiety</td>
</tr>
<tr>
<td>Young people, who experience excessive fear, worry, or uneasiness, may have an anxiety disorder.</td>
</tr>
<tr>
<td>Percentage of Children/Youth Affected</td>
</tr>
<tr>
<td>8-10%</td>
</tr>
<tr>
<td>Conduct</td>
</tr>
<tr>
<td>Young people with conduct disorder usually have little concern for others and repeatedly violate the basic rights of others and the rules of society.</td>
</tr>
<tr>
<td>7%</td>
</tr>
<tr>
<td>Depression</td>
</tr>
<tr>
<td>The disorder is marked by changes in emotions, motivation, physical well-being, and thoughts.</td>
</tr>
<tr>
<td>6%</td>
</tr>
</tbody>
</table>

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\(^2\) Source: www.kidsdata.org

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Percentage of Children/Youth Affected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning</td>
<td></td>
</tr>
<tr>
<td>Difficulties that make it harder for children and adolescents to receive or express information could be a sign of learning disorders. Learning disorders can show up as problems with spoken and written language, coordination, attention, or self-control.</td>
<td>5%</td>
</tr>
<tr>
<td>Attention</td>
<td></td>
</tr>
<tr>
<td>Young people with attention-deficit/hyperactivity disorder are unable to focus their attention and are often impulsive and easily distracted.</td>
<td>5%</td>
</tr>
<tr>
<td>Eating</td>
<td></td>
</tr>
<tr>
<td>Children or adolescents who are intensely afraid of gaining weight and do not believe that they are underweight may have eating disorders. Eating disorders can be life threatening.</td>
<td>0.5%-3%</td>
</tr>
</tbody>
</table>


Part Two: Mental Health Needs for School-Aged Children in Napa County

Overview
To determine the mental health needs of school-aged children in Napa County, prevalence was estimated using student responses to an annual survey, currently available research and current estimates of the school population. In addition, interview and survey data was collected from a variety of stakeholders. Those who provided input included school principals, school counselors, school nurses, service providers (administrators and direct service staff) and parents.

Prevalence was estimated using students’ responses to an annual health survey. The survey responses provide a look at indicators of mental health concerns for Napa County students. Items reviewed include alcohol and drug use, symptoms of depression, bullying and harassment, and school connectedness. Many of these indicators of risk have increased from 2005 to 2006. The prevalence of depression symptoms reported by Napa County students exceeded research-based estimates of the prevalence of mental health needs in California’s school-aged children.

Stakeholders presented mental health concerns as complex issues that require a multi-faceted approach to resolve. Along with larger environmental concerns of poverty and racism, stakeholders consistently noted the need to include the whole family in the discussion of how best to address the students’ needs.

The two issues that were commonly identified were Anger Management/Conflict Resolution and Family Relations. When discussing anger issues, providers and schools noted that children’s behavior reflects what they are learning in their families and community, and several parents noted they needed support at home to address children’s outbursts and meltdowns. Concerns about family relations were defined by stakeholders as situations where families were struggling to support their child due to trauma or other needs.

This section first reviews the prevalence of mental health needs for school-aged children in Napa County and then describes the needs from the perspective of each of the stakeholder groups.

Prevalence of Mental Health Needs
In order to understand how many children are affected by the issues and concerns noted by schools, providers and parents, estimates were developed from existing sources. Together these sources show that one in five school aged children may have a need for mental health services and supports in a given year, and this estimate appears reasonable for service planning.

Research estimates of prevalence were used to estimate the number of high-need school-aged children and the overall number of school-aged children that may have a mental health need in a given year.
For the low end of the prevalence range, it is estimated that 2.66% of the school population are living in families at less than 200% of the federal poverty level and would qualify for Medi-Cal funded mental health services as seriously emotionally disturbed.4,5 These are the students that are considered high-need and using just this figure would provide a very conservative estimate of the number of students in need of mental health support services.

At the other end of the range, research suggests that 20% of children in California experience a need for mental health services in a given year.6

These two research-based estimates were used to calculate the number of school-aged children in Napa County who may be in need of mental health services and supports.

| Estimated Prevalence of Mental Health Concerns for School-Aged Children in Napa County |
|-----------------------------------------------|-----------------------------------------------|-----------------------------------------------|-----------------------------------------------|
| School Type                                  | 2005-2006 CDE Educational Demographics        | Number of Children with Mental Health Concerns (Estimated) |
|                                              | Number of Schools | Enrollment | Children with Serious Emotional Disturbance | All Children Needing Mental Health Services |
| Traditional Schools                          |                   |            |                                             |                                           |
| Elementary                                   | 28                | 8,786      | 234                                         | 1757                                       |
| Middle                                       | 6                 | 4,301      | 114                                         | 860                                        |
| High School                                  | 4                 | 5,596      | 149                                         | 1119                                       |
| Alternative                                  | 5                 | 793        | 21                                          | 159                                        |
| Continuation                                 | 2                 | 224        | 6                                           | 45                                         |
| Community Day                                | 3                 | 39         | 1                                           | 8                                          |
| Juvenile Court                               | 1                 | 42         | 1                                           | 8                                          |
| County Community                             | 1                 | 127        | 3                                           | 25                                         |
| Total                                        | 50                | 19,908     | 530                                         | 3982                                       |

4 The estimate of prevalence was provided by the California Department of Mental Health and is based on projected 2004 Napa County population data (Department of Finance) using Census 2000 as base.

5 Serious emotional disturbance is defined here as "...a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects educational performance: (a) an inability to learn that cannot be explained by intellectual, sensory, or health factors; (b) an inability to build or maintain satisfactory interpersonal relationships with peers and teachers; (c) inappropriate types of behavior or feelings under normal circumstances; (d) general pervasive mood of unhappiness or depression; or (e) a tendency to develop physical symptoms or fears associated with personal or school problems." --- Individuals with Disabilities Education Act (IDEA), Public Law 101-476

The previous table shows a wide range of estimated need; between 530 and 3982 students are in need of mental health services in a given year. Note the percentages are applied equally across all grade levels and school-types, and may underestimate the need in some settings.

Each year the school districts in Napa County have middle and high school students from traditional and non-traditional schools\(^7\) complete a survey to report on their health knowledge, attitudes, behaviors and concerns. Students in 5\(^{th}\) grade complete the survey every other year. All survey data was reviewed for both 2005 and 2006 when available and compared to the statewide aggregated results to provide trend information and context for comparison.

For the purposes of this report, data relating to several risk factors or flags for mental health concerns were reviewed: drug and alcohol use, depression, bullying and harassment, and school connectedness. The students’ responses confirm that these areas are needs.

**Alcohol and Drug Use**

Survey questions asked fifth grade students about their use of alcohol in the past month. Middle and high school students were asked whether they had used drugs or alcohol in the past 30 days. For this indicator, data was reported separately for students in traditional and non-traditional school settings.

Overall 1\% of Napa County 5\(^{th}\) graders indicated they drank a full glass of beer or wine in the past 30 days, and 9\% indicated they had one or two sips. For comparison purposes, the aggregated results for 5\(^{th}\) graders in California showed that 2\% had a full glass and 8\% had one or two sips in the past month\(^8\).

Rates of alcohol or drug use for high school students and students in non-traditional schools have exceeded the state average in at least one of the past two years. Overall, responses showed lowered rates of reported use for students in traditional schools and increased rates of usage for students in non-traditional schools from 2005 to 2006.

\(^7\) Non-traditional schools are defined as “adult education, alternative, county community, juvenile hall, opportunity, special education, and state special schools” for the purposes of the California Healthy Kids Survey. Source: Austin, G. and Duerr, M. “Guidebook for the California Healthy Kids Survey, Part I: Administration, 2007-2008 Edition,” 2007. In Napa County, continuation high schools were surveyed and adult education was not included.

\(^8\) Students were asked, “In the past month, did you drink any beer, wine or other alcohol?” Sources: California Healthy Kids Survey: Technical Report 5\(^{th}\) grade 2004-2005 and 2005-2006 Aggregated California Data and Technical Report 5\(^{th}\) grade Fall 2005 (F2004-s2006 Cycle) Napa County. See Table3.2 in both reports.
**Depression**

To screen for symptoms of depression, students were asked about whether they had stopped their regular activities for more than two weeks as a result of feeling sad. For this indicator, data for students in traditional and non-traditional schools was reported together. This question was not part of the 5th grade survey.

The figure above indicates that in 2006 about 25% of middle school and almost one third of high school students felt sad and hopeless for more than two weeks. It also shows the rates in Napa County have increased slightly from 2005 to 2006 and students in Napa are less likely to report symptoms than students across the state.

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9 Students were asked to answer the question: “During the past 30 days, on how many days did you use...?” with frequency options for alcohol, marijuana, inhalants. 9th and 11th graders and students at non-traditional schools were also asked about cocaine, methamphetamines or any amphetamines, and LSD or other psychedelics.

10 Students were asked to answer the question: “During the past 12 months, did you ever feel so sad and hopeless almost every day for two weeks or more that you stopped doing some usual activities?” The chart shows the percentage of students in each grade who answered “yes.” Source: California Healthy Kids Survey: California School District Secondary School Survey Results, Fall 2006.
Bullying and Harassment

Students were asked to report whether or not they had been harassed or bullied on school property in the previous 12 months. Half of fifth grade students in Napa County reported they had experienced physical and/or verbal harassment at school.\(^{11}\) Over 30% of middle and high school students reported they had been bullied or harassed at least once in the last year.

The results show harassment and bullying increased from 2005 to 2006 and exceeded the state averages for 9th and 11th grade students.

Five of the reasons students indicated for harassment and bullying are considered hate crimes. A breakdown of the reasons reported in 2006 is shown below:

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11 Fifth grade students were asked “Do other kids hit or push you at school when they are not just playing around?” and “Do other kids at school spread mean rumors or lies about you?” Rates for 5th grade students across California were 45%. Sources: California Healthy Kids Survey: Technical Report 5th grade 2004-2005 and 2005-2006 Aggregated California Data and Technical Report 5th grade Fall 2005 (F2004-s2006 Cycle) Napa County. See Table 5.2 in both reports.

12 Students were asked “During the past 12 months, how many times on school property were you harassed or bullied for an of the following reasons?”, with options for “Race, Ethnicity, or National Origin,” “Religion,” “Gender,” “Because you are gay or lesbian or someone thought you were,” “Physical or Mental Disability,” or “Any other reason.” All data is from the California Healthy Kids Survey results, Napa County 2004-2006, Fall 2006 and Statewide 2004-2006, Table A5.7.
Over 20% of students in traditional schools and over 30% of students in non-traditional schools reported they were harassed or bullied for a hate-crime reason in 2006\textsuperscript{13}. The most frequently cited reason was race, ethnicity or national origin. In addition, 4-5% of students in traditional schools and 11% of students in non-traditional school reported being harassed or bullied for a physical or mental disability.

**Key Findings**

Students’ responses reinforce the information from schools, providers and parents.

- Mental health concerns for students are more prevalent for students in non-traditional school settings than in traditional schools settings.
- Students in Grade 11 and students in non-traditional schools exceed the state average in drug and alcohol use.
- Over 20% of students in Grades 7, 9 and 11 reported symptoms of depression.
- Students at all grade levels indicated experiencing bullying and harassment. Rates were highest in elementary schools and in non-traditional schools.

When this data is compared to the research-based prevalence of mental health concerns, the high end of the range (20% of students reporting a mental health concern in a given year) appears reasonable. Recall that over 20% of 7\textsuperscript{th} grade students and approximately 30% of 9\textsuperscript{th} and 11\textsuperscript{th} grade students reported symptoms of depression in the last year.

**Complexity of Mental Health Needs**

Schools, providers and parents all agreed that mental health concerns for children are multi-faceted and are affected by a student's family, school, community and culture.

**School Perspective**

All of the school administrators and school counselors interviewed\textsuperscript{14} agreed that the overall needs of the students they serve exhaust the services and supports that are available to assist students. Schools

\textsuperscript{13} A hate-crime reason is considered any of the following: Race, Ethnicity or National Origin; Religion; Gender; Sexual Orientation; and/or Physical or Mental Disability.

\textsuperscript{14} Eleven interviews were conducted with school administrators, school counselors and school nursing staff from schools in St Helena, Napa and American Canyon. The sample included elementary, middle school and high schools as well as non-traditional schools. For more information on Methodology, see Appendix D.
noted, in particular, how outside factors such as poverty and culture affected students and are a necessary context for discussing and describing mental health issues.\(^{15}\)

- “In one or more combinations, the issues are: pre-suicidal behavior, drug and alcohol experimentation, self-identity concerns, stresses of family, gangs, sexual abuse, and adhering to school limits. There are multiple combinations and different levels of severity and issues are on a continuum affected by culture and other factors”

- “We face the same issues as other elementary schools with an overlay of poverty. The themes that cut across the schools include: bullying, non-compliance, disruption of learning environment, and maladjustment. In general, the addition of poverty brings with it lack of information or access to resources for families, stresses of poverty, one parent families (due to jail, rehabilitation, etc.) and limited parenting skills.”

Interviewees mentioned that some families’ permissive attitude toward alcohol and drug use conflicts with the schools’ culture and values:

- “Parent’s permissive and passive attitude toward drinking is especially tricky. We should have a parent education series on NOT hosting a drinking party.”

- “[When a student comes to school high], we call families to come and pick up their child. We have parents who say ‘Why are you calling me? Everyone there gets high.’”

Several of the interviewees noted that “each school year we are seeing more kids with more needs,” and more parents that are “stressed with life” and not always capable of addressing students’ needs as they arise. The following statements illustrate how family issues intertwine with the anger and conflict management concerns at the schools.

- “Parents aren’t able to help with homework…and are not teaching kids healthy patterns. [In elementary school], some of the kids are up until 11-12:00. They are acting out in class due to a lack of sleep. They are frustrated and more likely to get involved in peer conflicts, not able to concentrate and start falling behind.”

- “There are abusive situations at home, especially domestic violence. [One student told me] ‘Sometimes my mom and I hide in the car’. The kids are mimicking what they have seen in terms of acting out anger.”

Provider Perspective

Providers were interviewed after schools noted which agencies served students on their campus.\(^{16}\) As service providers were contacted, they recommended other service providers to highlight a particular

\(^{15}\) All italicized comments are taken directly from interview notes or from written comments in surveys.
innovation or describe a type of services. Interviews were conducted with agencies who served all parts of the county, as well as those who served only certain areas or school populations.

As in the school interviews, the types of mental health concerns that affect students were described as relating to their environment. Providers explained that a mental health need is not only the child’s issue, but a reflection of what the child is experiencing.

- “Kids are the ‘flags’ of our society, they tell you which way the wind is blowing. What’s happening to them and how they behave are reactions to many pressures.”
- “Across the board, poverty is the biggest mental health need for the kids we serve.”

Parent Perspective

Parents were identified and referred by the service providers who were interviewed. Service providers were asked if they had access to parents who may be interested in sharing their experiences using school-based mental health services. Parents were contacted by the service providers and those who agreed to be interviewed were contacted by phone.  

Because parent interviews were limited to parents who agreed to be interviewed about their experiences in the system, the parents interviewed are not a representative sample of all parents whose children receive school-based mental health services. Parents were generally referred by service providers who were providing treatment, so the sample over-represents the experiences of children who have significant mental health needs. Providers who worked with children in a preventative capacity frequently noted they have little or no contact with parents, and thus were not able to refer them for interviews.

Most of the parents interviewed presented their experiences obtaining services for their child in the context of the whole family. Some shared how other events in the family affected their ability to advocate for their child and/or to get the needed services. Others shared stories of serious illness, housing crisis, job changes, divorce, death of a family member, and other events that changed how their family responded to their child’s challenges. They also shared information about issues of child care, economic hardship, transportation and/or their own mental health needs. All of the events and issues affected their child in some way and were important for understanding what a family may need or be able to do at different points in their child’s life. The inclusion of the whole family was especially noted.

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16 Sixteen service provider interviews were conducted with agency administration, therapists, case managers, and direct service staff. Agencies served schools from Calistoga to American Canyon. For more information on methodology, see Appendix D.

17 Fifteen parent interviews were conducted with English and Spanish-speaking parents in American Canyon, Napa, and Calistoga. For a full report of the parent interview findings, see Appendix B. For more information on methodology, see Appendix D.
with the mono-lingual Spanish-speaking parents and was present in the majority of the interviews conducted in English as well.

Families discussed the factors within their family environment that affected their child and their own ability to seek services and advocate. These mental health concerns give more support to the often reported need to incorporate the whole family when addressing mental health concerns in children. Each of these issues not only affects the child, but also affects how the family can respond to the child’s needs.

### Mental Health Concerns within Families as Reported by Parents

<table>
<thead>
<tr>
<th>Mental Health Concern</th>
<th>Number of Families (n=15)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Issue in Family</td>
<td>4</td>
</tr>
<tr>
<td>Divorce</td>
<td>3</td>
</tr>
<tr>
<td>Health Issue in Family</td>
<td>3</td>
</tr>
<tr>
<td>Substance Abuse Issue in Family</td>
<td>2</td>
</tr>
<tr>
<td>Death in Family</td>
<td>2</td>
</tr>
</tbody>
</table>

#### Context of Mental Health Needs

Another way to look at the context of mental health needs, and the potential demand for mental health services and supports in the community is to review demographic projections. Poverty and population changes in Napa County will continue to affect the mental health needs of Napa County children over the next 20 years.

**Poverty**

Median household income in Napa County is estimated to be $65,260.\(^{19}\) About 7% of the county’s population is living below the federal poverty level,\(^ {20}\) almost 30% of families are below the self-sufficiency level,\(^ {21}\) and 40% of school-aged children are eligible for free or reduced lunches.\(^ {22}\) Geographic information system maps provided by the Metropolitan Transportation Commission indicate

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\(^{18}\)Though 15 parents were interviewed, not all families identified a mental health concern for their family. These concerns were coded from interview notes, and were not an interview question or probe. More families may have experienced these events than are noted.

\(^{19}\) U.S. Census American Community Survey (2005).

\(^{20}\) U.S. Census American Community Survey (2005).

\(^{21}\) Computed from data provided by the U.S. Census American Community Survey (2005).

that there are concentrated areas of poverty in both the Calistoga and Napa communities.\textsuperscript{23} There are likely to be concentrations in those two areas of children and youth who are living in impoverished families, have serious emotional disturbance, and are not receiving services.

\textbf{Changing Demographics}

An estimated 131,600 residents live in Napa County. The county is growing at an average rate of about 5.9 percent per year as compared with the statewide average of 6.7 percent per year. American Canyon and St. Helena are the fastest growing communities of the county while the population of Yountville has actually decreased.\textsuperscript{24}

At this time, only about 14 percent of children using mental health services and supports are Latino. African American and White children are overrepresented in mental health service usage, while Asian and Pacific Islander children are underrepresented. Demographic projections indicate that outreach to the growing Asian and Pacific Islander population in the American Canyon area of Napa County must be considered.

A language other than English is spoken in approximately 25\% of all Napa County homes.\textsuperscript{25} By the year 2030, Latinos and Caucasians will each represent about 42 percent of Napa County’s residents. Projections also suggest a steadily growing population of Asian, African-American and American Indian populations. This is shown in the figures on the following page:

\textsuperscript{23} Downloaded from Metropolitan Transportation System Website (2001), Areas of Poverty. \<http://www.mtc.ca.gov/maps_and_data/GIS/maproom.htm>  

\textsuperscript{24} California Department of Finance, 2004, Growth rates based on 2001-2004 data.  

\textsuperscript{25} U.S. Census American Community Survey (2005).
Projected Estimates for Napa County Population by Race 2000-2030

All of these projections have implications for the future diversity of the mental health service workforce and service delivery for children and youth.

Children and Transition Age Youth (TAY)
Based on 2004 data, children represent approximately 21 percent of the total population of Napa County. Sixty-five percent of children are White, and while Latino children currently represent about 27 percent of all children in Napa County, they represent 43 percent of all children 0-5.

About 13 percent of all Napa County residents are currently considered of transition age (ages 16-25). While usage rates for Latino children are far below what might be expected, rates for TAY are even lower.

Mental Health Needs in the Justice System
In 2005, there were about 80 youth placed in juvenile hall, group homes or camps by Napa County Probation. Approximately 70-80 percent of those juvenile offenders have a serious behavioral or substance abuse problem that requires intensive mental health services and supports.

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26 California Department of Finance, 2004
27 Ibid
28 Personal correspondence with Chief of Napa County Probation and Juvenile Hall Superintendent, Excerpted from Napa County Mental Health Services Act, Community Services and Supports, THREE-YEAR PROGRAM AND EXPENDITURE PLAN REQUIREMENTS, Fiscal Years 2005-06, 2006-07, 2007-08
29 Ibid
Key Findings

The context of children’s family, culture, language and environment are important factors to consider when examining mental health needs. The changing demographics and underutilization of mental health services and supports by Latino children, transition-aged youth, and youth in the justice system will continue to affect the mental health needs of children and need to be incorporated into planning efforts to address these needs.

Specific Mental Health Needs for School-Aged Children

School Perspective

After the interviews, an online survey was sent to school administrators and school counselors in the Napa and St. Helena school districts, and teachers in the Napa Valley Unified School District. Respondents were asked to rate whether or not a list of issues were a concern for the students they served. Though Peer Relations, Family Relations and Anger Management were the most commonly noted concerns in the survey, all of the issues were identified as needs by the respondents. The responses from the online survey are in the following figure:

<table>
<thead>
<tr>
<th>Mental Health Concern</th>
<th>Overall</th>
<th>School Administrators and Counselors</th>
<th>Teachers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peer Relations</td>
<td>90</td>
<td>20</td>
<td>70</td>
</tr>
<tr>
<td>Family Relations</td>
<td>96</td>
<td>22</td>
<td>74</td>
</tr>
<tr>
<td>Anger Management/Conflict Resolution</td>
<td>91</td>
<td>20</td>
<td>71</td>
</tr>
<tr>
<td>Bullying</td>
<td>91</td>
<td>20</td>
<td>71</td>
</tr>
</tbody>
</table>

Mental Health Concerns for School-Aged Children as Reported by School Administrators, Counselors and Teachers

30 An online survey was developed to assess school administrators, school counselor and teacher perspectives on mental health needs, services and gaps in care. The survey was distributed to schools in the Napa and St. Helena school districts. See Appendix D for more information on methodology.

31 Categories were taken directly from the Safe Schools, Healthy Students (SSHS) Assessment tool in order to align the information from this needs assessment with the SSHS program reports. See Appendix D for more information on methodology.

32 For more information about the categories of mental health concerns, see Appendix D.
Surveys included the following comments that corroborate and add to information collected through the interviews:

- “If a student can’t learn due to his/her anxiety, worry, etc. you can’t teach them.”
- “The need is growing for more and more support for our students. However, we need to be able to bring in the family into the counseling services. This is a systems issue.”
- “Many high-achieving students suffer from anxiety, depression and compulsive behaviors due to stress.”
- “Negative popular culture influences such as gangs, body image issues, ‘slacker ethic’, etc. can be a problem for many teenagers. These issues may be addressed in a small way at school through some class projects, but I’m not aware of any school-wide or community-wide initiatives to help students with these types of challenges. I think that popular culture encourages a lot of self-destructive attitudes/behaviors and teenagers need to develop skills that will help them resist these negative images and behavior patterns.”
- “The pace of instruction has increased greatly in the class. Children are more stressed. We are not allowed to have parties. Because of the pacing calendar, we often have to rush students when they need to express their personal issues. We need to relax, so the students can relax and enjoy their education too. No Child Left Behind leaves behind the ‘emotional child’.”

To put this data into the context of a larger national sample, when schools across the country were asked to name their top mental health concerns, family and anger issues were the most frequently cited.33

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Provider Perspective
Providers outlined three general categories of mental health needs of children: anxiety, tragedy and family issues.

Anxiety
Though this has many different sources, the most commonly cited triggers were immigration concerns, poverty, language difficulties, cultural pressures, and academic pressures. It was noted that this need seems to be increasing.

- “The number one concern is Anxiety/Depression, especially with the younger kids...due to domestic violence and unstable homes.”
- “Another issue is poor self-image...a by-product of racism. ‘No Child Left Behind’ causes a lot of pressure, not all kids can fit that routine of academic testing and if they don’t do well, they look for somewhere they can fit in and be accepted. Often they have to look to other peers to get support or understanding and others simply have no one to turn to and are alone.”

Tragedy
One provider pointed out that there will always be students in the school system dealing with some type of tragedy such as suicide, death or divorce. Most providers mentioned at least one of these issues. Providers generally described this as an ongoing need/issue for school-aged children and did not particularly note this need was increasing.

- “Grief is a need for the kids we serve. Several lost a parent in the last year due to a car accident, suicide or illness.”

Family Issues
Most providers noted they had either limited or no access to families and limited or no services to assist families. Some providers described families that were not able to support their children due to parental mental illness, substance abuse or other family concerns.

- “...Dysfunctional families don’t have it all together and don’t provide kids with the skills they need. On top of that I see a lot of parental drug use: tobacco, alcohol and pot.”
- “Parents drop back at the junior high level. We need more parents to stay involved and understand their impact on their child.”

Providers’ concern about the lack of mental health services and supports for families is discussed further in Section Three, Part Three: Unmet Mental Health Needs.
Parent Perspective

Parents who were interviewed are likely viewed by the school and service providers as responsive parents, able to care for their child once an issue is identified. Although the parents interviewed faced a variety of challenges and met them in different ways, parents who were unable to care for or consistently advocate for their children were not interviewed for this report.

When asked about their child’s mental health needs, parents who were interviewed discussed their child’s mental health need as an underlying concern that was affecting their child’s behavior and/or academic performance. Many families were working to address more than one concern at the time of the interview. Parents reported the following mental health needs for at least one school-aged child in their household.

<table>
<thead>
<tr>
<th>Mental Health Concerns</th>
<th>Number of Families (n=15)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anger Management/Conflict Resolution</td>
<td>10</td>
</tr>
<tr>
<td>Family Relations</td>
<td>5</td>
</tr>
<tr>
<td>Peer Relations</td>
<td>5</td>
</tr>
<tr>
<td>Anxiety</td>
<td>5</td>
</tr>
<tr>
<td>Bullying</td>
<td>4</td>
</tr>
<tr>
<td>Depression</td>
<td>3</td>
</tr>
<tr>
<td>Trauma</td>
<td>3</td>
</tr>
<tr>
<td>School Connectedness</td>
<td>2</td>
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</tbody>
</table>

The most frequent concern noted by families was Anger Management/Conflict Resolution. Families were less likely to report concern about family relations, and this is not surprising given the reliability of self-report and the selection of families.

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34 Fifteen parent interviews were conducted with English and Spanish Speaking parents in Napa, Calistoga and American Canyon. For a full report of the parent interview findings, see Appendix B. For information about methodology, see Appendix D.

35 Note that eight of the fifteen families had more than one child who had received school-based mental health services.
Summary

Research and student surveys suggest that 20% or more of school-aged children in California experience a need for mental health services and supports in a given year. This percentage is higher in middle schools, high schools, non-traditional schools and for youth involved with the justice system.

Stakeholders agreed that mental health services and supports need to be available to families as well as children. Families experience multiple mental health concerns, some chronic and some transitory, and may need resources to support their child’s mental health issue. Poverty and changing demographics will continue to impact service delivery systems over the next 20 years.

Specifically, stakeholders identified anger management/conflict resolution, family relations, anxiety and trauma as prevalent mental health concerns for school-aged children. Providers noted anxiety in particular to be increasing.

When compared to school and provider responses, families reported similar concerns for their children. It is especially noteworthy that Anger Management/Conflict Resolution was as high on the list of concerns for parents as this concern was also identified by school administrators and counselors. Anxiety and trauma were less frequently identified, but still noted by families in the interviews and when describing the events in their family that impacted their ability to care for and advocate for their child.
Part Three: Identifying Mental Health Needs in School-Aged Children

In all interviews with school personnel and service providers the interviewee was presented with three scenarios. Each scenario was a brief description of a student followed by several questions about how the student would be identified, assisted and referred. All scenarios were developed by the oversight team to address different types of mental health concerns that schools encounter. Each scenario specifically omitted information about student’s academic performance. This section begins by reviewing the responses to these scenarios.

Respondents to the school survey were also presented the three scenarios to understand how well schools thought the mental health concern was addressed at their school site and how responsibility among stakeholders was perceived.

From the parents’ perspective, identifying the need for services was described very differently depending on whether the school identified the child’s need as an academic or behavioral concern. Parents’ responses were grouped into three scenarios and summarized.

Scenarios for Schools and Providers
School interviewees uniformly responded to the scenarios with a three step process: assess, refer, monitor. Though schools varied in the details, all schools included each of these steps. Schools also consistently noted that teachers would bring the concern to their attention.

In contrast, providers gave a wider range of responses to the scripted scenarios. Some of the response variation was due to the professional training of the provider, and some of it was a reflection of providers’ level of familiarity with school procedures and policies. When issues were outside of the purview of the providers’ expertise or intervention, the student was generally referred to the school counselor or the vice principal for further referrals and support. In some cases this was presented as a way to respect the schools’ system for assessing, referring and monitoring student needs and services and in other cases this was described as a way to address a need that the provider could not meet given the parameters of their funding.

All providers delivered services on the school campus, and were asked to respond to the scenario as if it happened during their service delivery to school-aged children and their families.

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36 For more information about the oversight team and methodology, see Appendix D.
Scenario One: Student displays feelings of hopelessness. Student eats alone. Student is a loner, withdrawn and sad.

School Perspective
In the first scenario, school interviewees noted that if the student’s academic work was not declining, he/she may not be identified.

- “[We] hope that someone would notice and make sure someone does something about it.”

One school interviewee stated that the reluctance to identify students who are not integrating into the social environment is common among educators:

- “Teachers, counselors and those who work at schools identify with high-performing students. They have to go out on a limb to get out of their own experiences of really enjoying school to reach out to low-functioning kids.”

Once the student was identified, generally they were referred to school-based services. Peer support, an on-site counselor or an activity that may interest them. A few interviewees noted that if the issue persisted, the student may be referred to psychotherapy or other community-based resources.

The online survey of school administrators, counselors and teachers showed about 30% of respondents rated the schools resources as excellent or good for this student.
Provider Perspective

Providers who had a significant presence on campus (an office, a regular schedule, and/or unscheduled time) noted they would approach the student who was alone. In particular, three providers described working to build trust with the student and to identify how they might help them. Each of the three providers described approaching the student who was alone during the lunch period and starting a conversation. Once the issue was identified, the student was referred to the school counselor for further support (two providers) or the provider would work to connect the student to further services (one provider). In all cases, the providers would continue to check on the student to be sure progress was being made.

- "I would go and sit with them, have a conversation, build trust. Continue to focus on them in a way that’s not obvious. I would try to encourage them to make friends. If they do open up, I would refer them to appropriate providers."

Providers who would receive the referral for this student described a more intensive response of therapy and safety plans. One provider noted that it was most likely that a parent (rather than the school) would bring a student in this situation to their attention.

Scenario Two: Student comes to school high (using prescription drugs or drunk). If asked, “This is the first incident”.

School Perspective

In the second scenario, most schools reported that students would be sent to the vice principal, and then referred to a community-based provider for follow-up and treatment. Five interviewees noted they would also contact law enforcement, and one stated that they have had some instances where the student was taken directly to the hospital. Schools with a school resource officer (SRO) on-site generally referred the student to the SRO first and then to the community-based provider. It was noted that SROs could perform breath and/or saliva tests to determine whether or not the student had been using. Elementary schools noted they did not generally encounter this scenario.
For this scenario, almost 40% of teachers and over 50% of school administrators and counselors reported the schools resources were excellent or good. Some of the elementary school-level personnel indicated they never encounter the situation and therefore declined to rate their schools’ resources for a student in this situation.

Provider Perspective
Several of the providers interviewed were directly involved with these situations when they arose on campus. These providers described being called in by the vice principal to assist in addressing the situation. When asked what they would do if the student came drunk or high to their school-based intervention, providers varied in their responses.

- “I would notify the parent first, and help the parents understand the signs of drug use in kids. Then I would involve the child’s teacher to support the student and refer the family to the [community-based provider].”

- “I would take the student aside and explain that [being high] is not okay at this time or place.”

- “If it is a first time offense, I would bring the parent in and talk to the student about where they got the drugs. Depending on their response, I would refer them to [law enforcement or community-based providers]”

- “[When I look at the data] I see that 11th graders say they have been drunk or high on campus and only a small percentage are caught. For most kids who get high at school, no one catches them. For the ones that are caught, I would refer them to [a community-based provider]”
Providers varied in their responses about how they would address a student who is drunk or high on campus. Some providers would refer the student back to a teacher, some to the family and some to outside providers.

**Scenario Three: Student has a negative disposition and is withdrawn. Written work and artwork contain dark themes and violence.**

**School Perspective**

In the third scenario, the school’s responses were more immediate and all interviewees described their own responsibility to the safety of all the students. In this scenario, students were referred to community-based resources and monitored by using a Student Study Team, a Pupil Study Team or another school-based coordination team.

- “None of our counselors are licensed therapists. We need outside help to prescribe medication or do more intensive services.”

All school personnel noted that they take this very seriously and refer the student right away for further evaluation.

**How Well Schools' Resources Address Students' Concern**

**Scenario Three: Violent Themes in Art or Writing**

<table>
<thead>
<tr>
<th></th>
<th>Teachers (n=82)</th>
<th>School Administrators and Counselors (n=18)</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td></td>
<td></td>
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<tr>
<td>90%</td>
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</table>

Though 30% of teachers and almost 40% of administrators rated the resources as good, very few teachers and none of the school administrators and counselors rated their schools’ resources as excellent for a student in this scenario.
Provider Perspective

Providers were asked how they would respond to a student in this situation if the situation arose during their on-campus interventions. As there were a range of providers interviewed, there were also a range of responses.

Generally, the providers noted that the response “depends.”

- “Is it delinquent behavior, or a quiet kid who has been bullied? It is hard to make a judgment on whether or not it is serious.”
- “Most of the time, it is the expression of a lot of feelings. I would talk to the student and determine if they are a danger to themselves or others, and discuss what it looks like, and why others are reacting.”
- “Kids are great at expressing themselves on paper—sometimes it is scary.”
- “I would explore their feelings about wanting to hurt others.”

Other providers deemed the situation serious and would refer the student back to the school for further resources:

- “I would inform others who are working with or teaching this student to let them know. This is not within our scope –I would refer them back to the school site.”
- “I would refer them to the school to be sure the student is in some type of program.”
- “I would refer the student back to the teacher and have the teacher talk to the family. Teachers hold more credibility.”

A few providers described the services they would recommend for the student:

- “I would assess if it was a treatable mental health issue.”
- “Refer for a psychiatric evaluation.”

Overall, providers noted a variety of responses to a situation the school takes very seriously. If the artwork is identified by the school, the school works to get the student into community-based services and a school-based coordination team. If the student’s work is identified by the providers, the responses varied depending on the provider, the provider’s training, and the provider’s perception of risk.
Perceived Responsibility
When asked who was responsible for meeting the student’s needs, school survey respondents were most likely to indicate the family, followed by schools and service providers. Student responsibility was also noted by the majority of respondents.

<table>
<thead>
<tr>
<th>Responsibility</th>
<th>Scenario One: Withdrawn Student</th>
<th>Scenario Two: High on Campus</th>
<th>Scenario Three: Violent Themes in Art or Writing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents/Guardian/Family</td>
<td>99%</td>
<td>89%</td>
<td>97%</td>
</tr>
<tr>
<td>School</td>
<td>97%</td>
<td>80%</td>
<td>96%</td>
</tr>
<tr>
<td>Service Providers</td>
<td>91%</td>
<td>82%</td>
<td>91%</td>
</tr>
<tr>
<td>Students</td>
<td>84%</td>
<td>79%</td>
<td>86%</td>
</tr>
<tr>
<td>Total Respondents</td>
<td>107</td>
<td>105</td>
<td>104</td>
</tr>
</tbody>
</table>

Scenarios for Parents
Parent interviews provided information about how students’ needs were identified and how the school responded to the need.

Parents described the process of identifying the need as an ongoing journey to understand why a behavior was occurring. Though the scenarios below refer to a parent’s first contacts with the school about their child’s needs, many parents had several experiences with these scenarios as their child’s needs and/or available services changed. Parents were not presented with pre-scripted scenarios, but rather asked to share their own experiences.

Parent Perspective
Parents described three general scenarios that marked their child’s entry into school-based mental health service system.

Parent Scenario One: Academic Issue Identified by School--Parent is notified by teacher that child is falling behind academically and services are provided to support the child’s academic achievement.
Parents in this situation described a fairly smooth process of receiving support services. One parent said, “The school really took my kids in and helped them.” Another reported her son received an Individual Education Plan as soon as he was held back in kindergarten. In all cases, the children were identified and served within a year of the concern arising. Parents also stated that mental health services needed to support their child’s academic performance were provided quickly.

Parent Scenario Two: Behavioral Issue Identified by School--Parent is notified that child’s behavior is unacceptable and parent is brought to the school to discuss situation.
In this scenario, parents reported frustration with their ability to get services for their child. One parent was told their child was “just a bad seed. You’ve just got to make her straighten up,” and the parent
needed to help the child “get with the program.” Several parents described how their child’s learning disability produced anxiety and the anxiety made the child act out. One parent recalled “My son quickly became labeled oppositional and defiant. It was a behavioral issue and there were no services available for a behavioral issue.”

The frustration for this group stemmed from being told there was a problem, but not being offered resources to address the issue. When the problem was clearly academic, the support process was started quickly. When parents were confronted with a behavioral concern, they reported fewer resources and less support from the school to address the concern and identify the reason for the behavior. Parents were held accountable for the behaviors, but generally did not know what to do to address the issue and felt blamed rather than supported by the school.

- “I felt like I did something, or didn’t do something.”
- “No one asked ‘Why? What is the reason, why is he acting out?’”
- “I don’t know what I am supposed to do, what is wrong…he just isn’t acting right.” (regarding her son getting into fights with other kids at school)

Another parent related that her son was diagnosed in kindergarten with several concerns that affected his classroom behavior. The school initially responded with a 504 plan to make classroom accommodations. The parent stated, “My son is high-functioning and intelligent, and because he wasn’t failing, he wasn’t approved for services.” Parent was told that it was “hard to get an IEP under son’s diagnosis” so she delayed initiating the paperwork. When she did request an IEP, she was told that she had requested the IEP too late in the year to attempt it.

Though many parents reported being contacted right away when their child’s behavior was inappropriate, another parent talked about the delay of almost a year before she was contacted and the concern was explained.

- “When my son was in first grade, he had a lot of problems at school. When he complained about the teacher, I called the principal, and they didn’t call me back. He got a lot of timeouts during the day; he was sad and didn’t want to go to school. In second grade, the teacher noticed right away. The teacher told me he was moving around a lot and recommended taking him to the doctor. She thought it was ADD.”

The pediatrician referred the family on to a specialist and her son was diagnosed with ADD. He began medication and does not need an IEP because he is able to keep up with the work and participate in class.

One parent described a partnership between her family and the school. As her son’s behaviors started to increase at home and at school, the on-campus therapist worked with a MD to have her son tested.

Many of the parents who entered the system when their child’s behavior was identified as a concern reported noticing the behavior at home prior to being contacted by the school. Some parents were
working to address and/or understand the issue at home in the context of their family. The parents who contacted the school for services comprise the next scenario.

**Parent Scenario Three: Parent identifies concern and contacts school for support.**

Some parents knew there was a concern and contacted the school to ask for resources or accommodations.

One family reported that while they were experiencing a trauma in their family life, their son started acting out at home by kicking the parent. The parent contacted the principal and asked if he could talk to a counselor at the school. The principal referred the child to the counselor and the parent to a local family resource center for support. The parent related the family resource center was “a godsend.”

Another family reported that when their child started school, the diagnosis was already in place and the child had been receiving community-based services prior to starting kindergarten. The parent was “irritated that I couldn’t pick out the teachers. He needed someone who was stern and wouldn’t back down.” Instead he was put into a class with two teachers who were sharing the class. The parent stated that as a result of this he acted out during the day and was sent home often.

Parents who contacted the school for support had varying degrees of success in obtaining services. For some families, school staff and administrators were responsive and able to connect the family to school and community resources. For other families, the school did not take the parent’s input into account and the child’s school performance was affected.

**Summary**

Overall, the schools’ responses to the scripted scenarios were very uniform and providers’ responses were more varied. Less than half of the school administrators and counselors rated their schools’ response to the scenarios as excellent or good. School administrators and counselors indicted they share the responsibility for the child’s well-being with parents, providers and students.

Parents described varying responses to their child’s mental health concern(s). Parents whose child was identified with a clear academic concern reported receiving academic support and mental health services and support quickly. Parents whose child was identified as having a behavioral concern reported more frustration and a longer process to enter into the system of services and supports. Parents who contacted the school for support reported a mix of both positive and negative experiences seeking services.
Part Four: Recommendations

Mental Health Needs of School-Aged Children in Napa County

- Plan services in relationship to identified needs, using the estimate of 20% or more of students experiencing a need for mental health services and supports in a given year. Specifically target services for students who are known to have higher prevalence, including students in non-traditional schools and students involved in the justice system.

- Communicate with families to understand their ability to support the student. Families’ capacity to support their children may be complicated by their own mental health concerns and/or the needs of other family members. Families need for mental health services and supports are likely to change over time.

- Specifically work to understand and address the mental health concerns that were most frequently identified by those interviewed: Anger Management/Conflict Resolution, Family Relations, Anxiety and Trauma.

Identifying Mental Health Needs in School-Aged Children

- Implement policies to train teachers and school staff to identify mental health concerns for students who are not acting out and may be performing academically. The interviews suggested that personnel who are on campus and have the time to observe students between classes were able to identify and support students in this situation.

- Clarify school policies for addressing mental health concerns for students. Providers’ responses to the scripted scenarios varied in comparison to school responses, and this may be of concern to schools. Define provider roles in these scenarios and develop a consistent referral and communication process to be sure students are identified and the supports are consistently available.

- Develop ways to support parents of children with an identified behavioral concern. Shifting the responsibility completely to parents was a source of frustration for parents and for the families interviewed, did not resolve the behavioral issues. Consider using school-based coordination teams, community agencies, parent support resources, and school-based resources to assist the family as they work to address the concern.

- Ensure that students and parents have a clear pathway to mental health services and supports. Parents noted they did not know what services were available and/or how to access the resources. Many parents reported they noticed the concern at home prior to having the concern identified at school. Clear access to mental health services and supports and a clear
way to communicate with the school may result in issues being identified sooner and addressed more effectively.

• Schools have indicated that they have a shared responsibility with families and providers to address situations where issues are not strictly academic. Use this information to encourage collaboration among families, schools and providers and to keep the focus on the mutual goal of supporting the child’s future success.
Section Two: School-Based Mental Health Services and Supports
Part One: Summary of Current Research
A full review of the literature is included in Appendix A. Below are brief summaries of the current literature as it relates to topics in this section.

School-Based Mental Health Services and Supports
Schools are expected to address any issue that interferes with learning, which often includes mental health issues. Seventy to eighty percent of children receiving mental health assistance obtain the services in a school setting (Center for Health and Health Care in Schools, 2003).

Mental health services can include prevention, screening, assessment, individual and group counseling, crisis intervention and referrals (Olbrich, 2002; Policy Leadership Cadre for Mental Health in Schools, 2001). The majority of schools (80%) report providing case management services for children with behavioral or social difficulties (Center for Health and Health Care in Schools, 2003). Mental health services are provided in the schools by a range of professionals that include school psychologists, social workers, mental health counselors, and psychiatrists (Olbrich, 2002). Some professionals also obtain a pupil personnel services (PPS) certification to provide mental health services in schools.

The federal Mental Health in Schools Program, developed in 1995, was developed to enhance the ability of schools to provide mental health services (Center for Mental Health in Schools and Center for School Mental Health Assistance, 2004). The federal program focuses on using prevention and early intervention strategies to address mental health issues. The services provided may be part of the classroom curriculum for regular or special education or may be separate from classroom activity (Center for Mental Health in Schools and Center for School Mental Health Assistance, 2004). The categories of service delivery provided in the schools as conceptualized by Policy Leadership Cadre for Mental Health in Schools (2001) are:

- School-financed student support services
- School-district mental health unit
- Formal connections with community mental health services
- Classroom-based curriculum and special “pull-out” interventions
- Comprehensive, multifaceted and integrated approaches

Fragmentation can occur when professionals or programs are working separately without appropriate communication. State and federal legislative initiatives intended to reduce service fragmentation have led to struggles in coordinating interagency initiatives. Greater collaboration between professionals and more integration of infrastructure and programs is repeatedly recommended in the literature (Anders, 2001; Center for Mental Health in Schools, 2002; Policy Leadership Cadre for Mental Health in Schools, 2003).
Part Two: School-Based Mental Health Services and Supports in Napa County

This section describes the types and availability of services for students as well as barriers and gaps to accessing these services as reported by each of the stakeholder groups.

Overview
During interviews, school administrators, counselors and nurses were asked whether or not there were services available at the school site to address students’ mental health needs. Overall, school contacts agreed that there are not enough services to meet the demand and they were supportive of having more services available both on-campus and in the community. Respondents to the online survey for school administrators, counselors and teachers agreed that mental health services and supports are important for students.

<table>
<thead>
<tr>
<th>Statements</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Do Not Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall, mental health services are important for the students at my school.</td>
<td>65%</td>
<td>33%</td>
<td>1%</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>I support releasing students from class time to receive mental health services.</td>
<td>41%</td>
<td>46%</td>
<td>5%</td>
<td>3%</td>
<td>5%</td>
</tr>
<tr>
<td>Mental health services located AT THE SCHOOL SITE are a valuable resource for students.</td>
<td>55%</td>
<td>37%</td>
<td>1%</td>
<td>4%</td>
<td>2%</td>
</tr>
<tr>
<td>Mental health services IN THE COMMUNITY (off the school campus) are a valuable resource for students.</td>
<td>48%</td>
<td>45%</td>
<td>3%</td>
<td>0%</td>
<td>5%</td>
</tr>
</tbody>
</table>

Support for mental health services shifts a little when school personnel were asked if they supported releasing students from class time to receive mental health services. While the majority agreed (87%), a few respondents disagreed and several indicated “do not know.”

- “[We]need services during lunch or after-school”
- “Never take students out of core classes for counseling. I’ve seen students try to get into group counseling just to get out of math.”
- “Our block scheduling means that students can miss up to 40% of a class by attending a group regularly”
Four types of mental health services and support are described in this section: school counselors, school-based coordination teams, school-based mental health services provided on the school campus, and community-based mental health services provided off-site.

**School Counselors**

**School Perspective**

At the schools that were interviewed, the ratio of school counselors providing mental health services and supports to students ranged from 1:500 to 1:940. One school counselor shared that the suggested ratio of school counseling staff to students is 1:250 and the average in California is 1:900. The American School Counselor Association reports that the California average for high schools is 1:471 and the state average for elementary students is 1:1,832. California is one of 21 states that does not mandate school counselors at the elementary level.  

The American School Counselor Association notes the role of a school counselor is multi-faceted:

- **“Today’s school counselors are vital members of the education team. They help all students in the areas of academic achievement, personal/social development, and career development, ensuring today’s students become the productive, well-adjusted adults of tomorrow.”**

Because of the multiple components of a school counselor position, it is important to be clear about the specific role of a school counselor. The job descriptions vary among counselors and among schools. Some schools reported dividing the academic support and the mental health support between counselors at the school. Though each had a very different focus, they were both called school counselors. Other schools reported combining the mental health and academic support functions into a single position so that each school counselor was addressing both sets of concerns for the students they served. In some cases this was explicit in the job description and in other settings the counselors were hired for academic counseling, but reported providing mental health support as well.

Several interviewees noted the shift away from mental health supports was a result of increasing pressure to raise test scores. One school counselor noted that the changing demographics of the school put increasing pressure on the staff and administrators to keep test scores up. This focus on test scores meant more resources into academic supports and programs and fewer resources for the programs that served students’ other needs.

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38 Ibid
“... They added support classes for algebra, and made the life skills classes optional. This is a disconnect-- I can’t think of the last time I needed to work through a differential equation, but I use the relationship skills every day.”

“If I could change one thing about the current system, it would be the administrative attitude; I would like to feel they believed in the services.”

Schools are focused on providing academic instruction and resources. Counselors reported that reliable long-term funding from school districts was difficult to secure given the academic standards and the pressure to meet testing goals. Some counselors reported that districts increased counseling staff, but the new counselors were only focused on career counseling, goal setting and academics and did not address the social/emotional issues the students may be experiencing. Thus, additional counselors did little to alleviate students’ “most pressing mental health needs.”

School administrators also noted the tension between academic outcomes and mental health services and supports.

“Attempts to adopt school-wide curriculum regarding prevention, problem solving or social development are almost impossible due to federal and state emphasis on accountability. It all comes down to time and resources.”

Counselors noted the need to balance taking students out of class with the need for academic instruction. Most noted that teachers were willing to refer a student for services, but still wanted the student to be in class as much as possible. Many of the students with mental health needs also have attendance issues that make it even harder to take them out of class when they are at school. Most counselors used words like “balance” and “coordinate” rather than “struggle”, and generally spoke highly of the teachers at the school and the efforts the teachers made to identify mental health issues in their students.

When asked what was going well in the current system of school-based mental health services and supports, several survey respondents (school administrators, counselors and teachers) noted their appreciation of school counselors and their role at the school:

“Any concerns were given to the school counselor, who would speak with the student and then determine whether or not a referral should be made.”

“Having a counselor who is a great listener and very capable of helping students.”

“On-site counselors that teachers know and can discuss concerns with, counselors [who] are bilingual and can make home visits or contacts.”

“Our school counselor is amazing and great with the kids.”
Provider Perspective
Most providers described building and maintaining a relationship with the school counselor in order to receive referrals into their program.

- “Generally, the referrals are good within schools from school counselors; they will vouch for the program.”
- “The counselor on campus is the one contact for referrals. We need to increase awareness among teachers and increase the number of counselors available on campus [to increase awareness of services and number of referrals].”

The Safe Schools Healthy Students evaluation data reflects how school counselors are vital for referring students for services. Of all the referrals to this school-based mental health service program, 53% came from school counselors.

<table>
<thead>
<tr>
<th>Referral Source</th>
<th>Referral to Services with Identified Source (n=372)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
</tr>
<tr>
<td>School Counselor</td>
<td>199</td>
</tr>
<tr>
<td>Teacher</td>
<td>87</td>
</tr>
<tr>
<td>School Administrator</td>
<td>20</td>
</tr>
<tr>
<td>Student Study Teams</td>
<td>5</td>
</tr>
<tr>
<td>School Resource Officer</td>
<td>10</td>
</tr>
<tr>
<td>Probation Officer</td>
<td>2</td>
</tr>
<tr>
<td>Parent</td>
<td>17</td>
</tr>
<tr>
<td>Peer</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>29</td>
</tr>
<tr>
<td><strong>Total Referrals with Identified Source</strong></td>
<td><strong>372</strong></td>
</tr>
</tbody>
</table>

Parent Perspective
For two of the families interviewed, the concern about their child was identified and addressed without a school-based coordination team or a formal plan in place. In both cases the situation was addressed by providers outside the school with support from personnel in the school (in one case, a teacher, in another case a school counselor).

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39 Source: “Napa-Vallejo Safe Schools/Healthy Students Grant, Evaluation Data (July 1, 2005-September 30, 2006)” by Duerr Evaluation Resources, page 3. Note that this program served middle and high school students in American Canyon and Napa.
The parent who worked with a school counselor noted that she had the ability to articulate her child’s needs, and felt that helped her get the services.

- “I am fairly educated, what about [other parents]? You don’t know about all of these resources when you don’t need them. I worry about others that don’t have the ability to get their point across.”

**Key Findings**

Overall, schools reported varying availability of school counselors. Though the American School Counselor Association recommends a school counselor to student ratio of 1:250, schools interviewed reported ratios from 1:500 to 1:940. School administrators and counselors described the need to balance academic and mental health needs and goals in light of ongoing pressure to raise students test scores. Providers described school counselors as the link to referrals and trust-building with the students. One parent was able address their child’s mental health concern with the assistance of a school counselor and did not have to proceed to a school-based coordination team.

**School-Based Coordination Teams**

**School Perspective**

Many interviewees noted that their school participated in a pupil study team, a student support team or a student assistance program. Each of these was described as a way for multiple school-based providers to coordinate with families and community-based providers. These coordination teams were discussed briefly in the school (and provider) interviews and at length in the parent interviews. Schools described these teams as a way for multiple providers to give input to support the student and each other. It was noted that “any child can participate in the pupil study team.”

- “[The pupil study team] is an opportunity for everyone to share their observations and discuss concerns. It is a time to communicate with the parent and work with the teacher to sort things through.”

Students with a 504 plan or an Individualized Education Plan (IEP) were described as “truly in special ed” and as those who have been “assessed and are receiving resources.” Though school staff noted these processes occurred, they did not talk at length about the 504 plans or the IEP process.

- “Kids who have a life dysfunction get a 504 plan. Kids with an IEP or 3632 are receiving true mental health services.”
School interviewees reported that students who weren’t involved in one of the school-based coordination teams encounter a fragmented system of services.

- “Usually the 504 plans are for students with a medical diagnosis that impacts their life. Students with an IEP meet with the school counselor, teacher and parents.”

- “There isn’t a clear overall picture of what’s available at all levels...not all staff are exposed or have been exposed to the services. Information is not readily available to all players, so it becomes ‘Every man for himself!’ and [getting services for a student can depend on] who you know.”

- “The avenue of services needs to be clarified. The information isn’t generally known. You have to be involved with it to know who to talk to—the counselor may not know. We need to know all the resources and what to do.”

A few school administrators and counselors described the system at their school site as either currently integrated or as getting better each year. Generally this was due to changes they had made in their site administration to coordinate services through a single person. Those who did noted difficulty coordinating with outside help.

- “I feel like I am the ‘head of mental health services.’ It is under one eye, and coordinated in that sense.”

- “Our on-site system is integrated. We have a long-standing relationship with [our therapist]. The [on-site support team], the psychologist and the teachers work well together. The piece that seems fragmented is when we need immediate outside help and we can’t get in touch with the parents. We don’t get a consistent response from the [community providers].”

When asked what was going well in the current system of school-based mental health services and supports, some respondents to the online survey noted the school-based coordination teams and/or the school-wide approach to helping students:

- “Having a group of teachers, psych., speech and resource meet and discuss.”

- “Our school gets together and talks about all the students who are ‘needy’ in some way. Then each of the staff members takes a few kids to watch over. We check-in with them and sometimes work with them to solve problems.”

- “We are a small school, so students with problems are less likely to ‘get lost in the crowd’. Staff members get to know our students pretty well and can often spot concerns before they escalate into major issues.”

- “Willingness of all staff to help with these special needs students.”
Provider Perspective
Some of the providers noted that they participated in school-based teams. Their participation was generally at the invitation of the school. Providers described mixed experiences with these teams, but generally described school-based coordination teams as a way to improve service delivery.

- “The counselors are trained to do basic needs assessments. They bring the assessments to the team and the service providers discuss them. We re-refer the student through the school.”
- “There is not enough time for [Student Assistance Program] coordinators. Just a few more hours of their time makes the services more integrated.”
- “We collaborate with the school personnel and get the student re-engaged in school.”

Not all providers knew about the different types of coordination on the school campus. One provider suggested creating teams to improve service coordination.

- “Maybe interdisciplinary teams would work as a way to collaborate more in school settings.”

Parent Perspective
Recall that fifteen parents were interviewed about their experiences seeking school-based mental health services for their child. These parents provide an additional perspective to understand how the services are experienced by those who have used them.

Parents were asked about the process of receiving services; just as providers and schools were asked about the process of providing services. The parent responses outline a continuum of interventions and family experiences at each level of service. Note that many of the families had children with serious mental health needs, and these families experienced more services than families whose children only participate in the prevention and early intervention end of the mental health services and support spectrum. This sample of parents is not representative of all parents with children who access mental health services and supports. It over-represents parents who have participated in a high-level of mental health interventions, and because of their extended experiences provides a view of the entire process of accessing school-based mental health services.

Whereas schools described their services as a school-based coordination team, parents described a process of “working with the school” or “working with the district.” Each of the categories outlined below involve meeting with and working with a school-based coordination team, although parents described the result of the team, not the team itself.

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40 For more information on methodology, see Appendix D.
504 Plan

Parents described the 504 plan as the initial step in getting their child’s needs met in the school setting. The 504 plan was described as a way to let the school and teachers know the child’s needs and for the parents to have a role in how the child was served at school.

Generally, the parents reported the 504 plan was a small response to a larger concern. Some parents reported that despite having a 504 plan, accommodations were not consistently provided. Other parents felt the response was not enough, and didn’t offer enough protection for their child.

- “Their way is the right way—alternatives are expensive. They [the school district] start with the least expensive and easiest option, and ‘see how that works’. In the meantime, continuing behavior problems that were initially addressed with a behavior plan and contract are escalating. The child is in danger of getting expelled. I pushed to get the IEP to protect [him]. Otherwise, he could be expelled before they found the right service.”

- “My son started out on a 504 plan, they [the school staff] weren’t recognizing that it wasn’t working.”

Individual Education Plan (IEP)

Though many families described the struggle to get an Individual Education Plan (IEP) and ensure the services outlined were appropriate and occurred, one family described the school making “IEP-type accommodations” without an IEP.

- “My daughter was a likeable kid and I volunteered at the school quite a bit, so the teachers knew me and liked her. The elementary teachers were able to make accommodations as needed, but without an IEP or 504. The teachers did good work with her. They kept her at the front of the classroom and had her run errands.”

The IEP was something almost all families who were interviewed had in common. As noted previously, parents of children with a clearly identified and familiar academic concern described getting an IEP fairly quickly. Parents of children with behavioral concerns or a diagnosis that did not immediately qualify the child for an IEP described a longer process.

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41 Section 504 of the Rehabilitation Act of 1973 is a federal civil rights law that prohibits discrimination against individuals with disabilities. A 504 Plan is a written document detailing the services or environmental changes that need to occur for a student who is in need of accommodations to the learning environment.

42 The Individual Education Program Plan (IEP) is a written plan/program developed by the school’s special education team with input from the parents and the student. It specifies the student’s academic goals and the method to obtain these goals.
Families described that there was considerable effort on the part of the parent to be sure the IEP was implemented. Parents stated even though their child had an IEP, the services outlined were not provided and the goals for their child were not met.

- “The IEP is seldom read.”
- “IEP and 504 plans are not carried out to the letter, even though they are obligated to provide the services and accommodations.”
- “Teachers lack the knowledge and time to implement plans in IEPs.”
- “I had to put my foot down at the last IEP meeting to get the needs met.”
- “[IEP process was] one parent going up against five or six teachers.”
- “They are setting up rules [at the IEP meetings], but no one follows them...there are no consequences for not doing it.”
- “[IEPs are] not realistic. The teachers try, they say ‘okay, okay’ and bless them, but they have a class with ten kids and each has a different IEP. I have started asking ‘How can they?’ and the answer is ‘They’ve just got to do this; they are trained to do this.’”
- “I am there to make sure they [the school staff] do what they say they are going to do”.
- “There is a law to protect kids. When the district breaks the law, parents have to act.”

3632 Funding

This funding provides for mental health services to support the student’s academic work. Generally parents described receiving this funding after their child was diagnosed with an Emotional Disturbance (ED).

In one case, a parent described receiving 3632 funding without an IEP. “[My daughter’s] behavior brought the concern to the forefront, and she was evaluated.” The evaluation did not qualify her for an IEP. “While the school was trying different services, my daughter was declining.” After being hospitalized for ED, she received a diagnosis and was eventually qualified for 3632 funding.

Other parents who reported that their child received 3632 funding described completing the IEP process first. Parents expressed relief at finally getting to 3632 and getting their child into the services they felt

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36 The California Legislature passed Assembly Bill 3632 in 1984. This law, as subsequently amended, requires the State Department of Mental Health or Community Mental Health services (CMH) to provide psychotherapy and other mental health services to help children with disabilities benefit from their educational programs.

Allen, Shea and Associates
December 2007
were the most appropriate. Parents described access to 3632 as the key to helping their child: “With 3632, more services opened up.”

The 3632 staff was universally described as a guide to the complex system of services and a fellow advocate for the care of their child. The person assigned to assist them with 3632 funding was able to “help get services and facilitate through the schools system” and “jump through hoops when it comes to finding and obtaining services.” Parents also noted that the 3632 staff “understood the complexity of my [child]”, and “never dismissed my input”. Several parents noted the benefit of having the 3632 staff at the IEP meetings where together they “fought with them” to get services.

All comments about the 3632 staff in the interviews were positive. And the only drawbacks noted were that the funding and staff were in such short supply. One family described working with 3632 staff to decrease support when their child was well-served in order to open up a space for another family. The family didn’t want to use up such a valuable resource when they felt they did not need it.

Key Findings

School-based coordination teams are seen as effective by schools, and providers described them as effective in most cases. Parents noted particular concern about the oversight and accountability once a 504 plan and/or and IEP is established by these teams. Schools, providers and parents described a fragmented system for accessing mental health services and supports. For schools, the fragmentation was noted when they coordinated with outside providers and families, for providers and families the fragmentation was encountered when they worked with the school.

School-Based Services to Address Mental Health Needs

School Perspective

In the schools, interviewees were upfront about the lack of services to address students’ mental health needs. Generally, schools described a mixture of student support groups, peer support programs, and counseling services that vary from year to year depending on funding. Three of the schools interviewed had an on-site therapist who was paid out of district funds. In all cases the therapists worked part-time on the campus. In one case the part-time therapist split the hours between two schools. School personnel who were interviewed spoke of the difficulties of getting services for their students.

- “Services for students at risk have been blown out of the water. They don’t exist anymore...It is clear that kids need attention, and parents are asking for help, but kids have got to break the law first.”
• “There is a large step between the initial concern and the 504/IEP mid-level interventions. The gatekeepers are strong to keep kids out of system.”

School administrators, counselors and teachers who responded to the online survey were also asked to rate the availability of the school-based mental health services that were noted in the interviews. Over half of the respondents noted that Grief Counseling, After School Programs, General Mental Health Counseling and Substance Abuse Prevention services were available.

<table>
<thead>
<tr>
<th>School-Based Mental Health Service</th>
<th>Respondents’ Rating of Service Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grief Counseling</td>
<td>n     Agree or Strongly Agree  Disagree or Strongly Disagree  Do Not Know</td>
</tr>
<tr>
<td>Grief Counseling</td>
<td>97    80%                        14%                      5%</td>
</tr>
<tr>
<td>After School Programs</td>
<td>96    69%                        31%                      0%</td>
</tr>
<tr>
<td>General Mental Health Counseling</td>
<td>97    57%                        33%                      10%</td>
</tr>
<tr>
<td>Substance Abuse Prevention</td>
<td>95    53%                        33%                      15%</td>
</tr>
<tr>
<td>General Support Groups</td>
<td>95    47%                        41%                      12%</td>
</tr>
<tr>
<td>Substance Abuse Treatment</td>
<td>94    29%                        42%                      29%</td>
</tr>
</tbody>
</table>

Even for the services that were available, it was noted that they may not fully address the level of need.

• “We do have an after-school program for 140 students, but we have 600 students.”

• “It’s great to have after school programs, but many are fee-based programs. Many of our students are low income/free lunch children and the fee is out of their ballpark.”

In response to this shortage of services, school administrators and counselors also talked about the need to triage students and decide who gets the limited services.

• “[The] biggest request for counseling support is Anger Management classes. We don’t have enough resources; [I] have to screen kids to see which really need it the most.”

In the online survey, school administrators, counselors and teachers were asked whether or not students’ mental health needs were addressed by the services currently available at the school site. The results are outlined in the following figure:

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44 General Mental Health counseling was defined in the survey as “One-on-one support for students’ emotional issues” and General Support Groups was defined as “Group support for students’ emotional issues”.

Allen, Shea and Associates
December 2007
Respondents who indicated they felt the issue was being addressed did not necessarily agree that the current resources met the level of need.

- “When I say "agree" on what is provided at my site, it means we work at it but more help in anger, conflict resolution, bullying, [and] peer relations would always be welcome.”

Overall, the school interviewees agreed that the services that were being offered were effective, and there was a need to expand what was currently working and to secure longer term funding to provide stability of providers and resource for students.

- “We need additional funding for counselors ...We need a qualified counselor to supervise interns so that we can use interns to screen referrals and see students on a one-to-one basis.”

- “[One program] has had the same counselor for three years. The kids really know her.”

- “The funding is not predictable and not stable. I would like more consistent resources for therapists rather than worrying about when grants expire.”

- “We need permanent therapist support at least two days a week. Not from a grant, not with iffy funding”

Counselors spoke about the limited effectiveness of the services they can provide during the school day if a student goes home to a stressful family situation every day. The school interviewees also agreed that the school provides only a limited amount of support and that further support needs to be available to families in the community.

- “Schools can do what they do, but the problem with parents continues.”
We are in the best position to be the first line of defense, but we need more places to refer parents."

When asked what was going well in the current system of school-based mental health services and supports, some respondents to the online survey noted the current school-based mental health services:

- "Community liaison to contact parents; help with understanding insurance forms and filling them out."
- "Good school psychologist."
- "Having an on-site psychologist."
- "I teach [primary grades]. If a student seems to be needy, I speak with parents and discuss the student with our school psychologist."
- "On site psychologist."
- "Peer Support."
- "PIP program."
- "When a crisis happens, they are right there at the school available for any students or teachers who may need them."

Provider Perspective
Providers who were interviewed agreed with school administrators and counselors. Resources are too few, and needs are great. Providers believed that the current efforts were effective; they just need more resources to reach all the students in need.

- "We have about 10% of the kids here that get all the resources. It is working and we are catching them. But what about the others?"
- "Anger management groups are often an example of kids who are really at risk being offered a low-level intervention. The intervention is not matched to their risk level."
- "When kids and families get to 3632, they are a mess, struggling to qualify for services...we need earlier referrals to mental health services and more programs in the schools."

When providers were asked what one thing was working really well in the current system of school-based mental health services, several noted that having a provider presence on the campus helped to build relationships and made the service delivery smoother and more effective. Others noted that they would like more of a presence.
School-Based Mental Health Needs Assessment
Section Two: School-Based Mental Health Services and Supports

- “What’s going well? The relationships we are able to build through our presence on campus.”
- “If [our agency] could be onsite more, we would be more familiar. Some school staff know our services and refer, some don’t.”

Providers who were able to build relationships with the schools and teachers felt the mental health services and supports they provided were respected by teachers.

- “Teachers are under pressure to raise API; I try to work with them. We have a good relationship and teachers support my work.”
- “We talk to principals as well, [we ask] how can we support the family? The connection we make with the family means it is less likely the student will be expelled.”
- “Teachers identify the students and refer them for care. For teachers to trust that the child will be cared for, something HAS to happen.”

Providers on the school campus also described themselves as “the first contact into systems.” Students were sent to several of the providers in crisis, and the provider helped the student through the initial concern and assisted their transition into more formal care.

Parent Perspective
Parents interviewed for this report did not discuss school-based mental health services. They described the services of the school counselor briefly and the school-based coordination teams at length. More information about parents’ experiences can be found in these sections.45

Key Findings

Schools and providers agreed that there are not enough school-based mental health services and supports to address the needs of students. They also described needing to ration the services to the students who need it the most and the potential for the low-level interventions to be inappropriate for students with a high-level of need. Only half of the school administrators and counselors reported that they are able to address anger management/conflict resolution at their school, though this was one of the most frequently reported needs. Less than half felt they were able to address Family Relations with school-based services. Schools and providers noted there are difficulties to coordinating services, and the relationships built by the providers’ presence on the school campus improve service delivery for students.

45 See the two previous sections for more information: School Counselors, Parent Perspective and School-Based Coordination Teams, Parent Perspective.
School-Based Mental Health Needs Assessment
Section Two: School-Based Mental Health Services and Supports

Community-Based Services for School-Aged Children
Many of the providers who are working on the school campus are also serving school-aged children in the community. School administrators, counselors, teachers, providers and parents all commented on the community services. Note that a full review of community-based services was not part of this report and the information presented below is not intended to be comprehensive.

School Perspective
School administrators and school counselors were asked whether or not the services in the community addressed student’s mental health concerns. The results are below:

<table>
<thead>
<tr>
<th>Identified Mental Health Need</th>
<th>n</th>
<th>Agree or Strongly Agree Need is Addressed in Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol/Drug Use</td>
<td>46</td>
<td>61%</td>
</tr>
<tr>
<td>Family Relations</td>
<td>58</td>
<td>41%</td>
</tr>
<tr>
<td>Depression</td>
<td>53</td>
<td>36%</td>
</tr>
<tr>
<td>Adult Relations</td>
<td>30</td>
<td>30%</td>
</tr>
<tr>
<td>Anger Management/Conflict Resolution</td>
<td>71</td>
<td>28%</td>
</tr>
<tr>
<td>Anxiety</td>
<td>55</td>
<td>24%</td>
</tr>
<tr>
<td>Peer Relations</td>
<td>61</td>
<td>20%</td>
</tr>
<tr>
<td>Bullying</td>
<td>58</td>
<td>17%</td>
</tr>
</tbody>
</table>

Surprisingly, 41% of respondents felt that Family Relations were addressed in the community; in contrast to the provider perspective noted earlier stating providers do not have contact, access or services for families.\textsuperscript{46} Anger Management/Conflict Resolution was much lower. All of the respondents reported this was a concern, only 28% felt the need was addressed.

Many of the school respondents indicated “do not know” when it came to rating whether or not a service is available in the community. This supports earlier school comments that not all school personnel are familiar with services, and provider comments that an agency’s presence on campus is vital to building relationships and increasing awareness of available services.

\textsuperscript{46} See Section One, Part Two, under the heading “Specific Mental Health Needs for School-Aged Children” Provider Perspective, Family Issues. This is also discussed in Section Three, Part Three, under the heading “Need for Mental Health Services and Support for Families”, Provider Perspective.
School-Based Mental Health Needs Assessment
Section Two: School-Based Mental Health Services and Supports

### Awareness of Services to Address Mental Health Concerns: School Administrator, Counselor and Teacher Responses

<table>
<thead>
<tr>
<th>Mental Health Concern</th>
<th>Percentage of School Administrators, Counselors and Teachers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>“Do Not Know” if Need is Addressed at SCHOOL SITE</td>
</tr>
<tr>
<td>Family Relations</td>
<td>62</td>
</tr>
<tr>
<td>Adult Relations</td>
<td>28</td>
</tr>
<tr>
<td>Depression</td>
<td>52</td>
</tr>
<tr>
<td>Alcohol/Drug Use</td>
<td>47</td>
</tr>
<tr>
<td>Anxiety</td>
<td>61</td>
</tr>
<tr>
<td>Peer Relations</td>
<td>65</td>
</tr>
<tr>
<td>Anger Management/Conflict Resolution</td>
<td>65</td>
</tr>
<tr>
<td>School Connectedness</td>
<td>51</td>
</tr>
<tr>
<td>Bullying</td>
<td>63</td>
</tr>
</tbody>
</table>

As expected, school personnel were more familiar with services offered on the school site. For most mental health concerns, almost half of the respondents indicated they did not know if the needs were addressed in the community.

**Provider Perspective**

Some providers described their services as a continuum that began on school campuses for prevention and early intervention, and could continue to community services if the student needed more intensive intervention or treatment.

Again, providers noted that schools’ awareness of their services was very important for getting referrals and serving the students from the school in the community.

- “When a service provider is on the school site, coordination to extended services at the agency is easier. But in schools where this doesn’t exist, it’s much more difficult.”

Providers interviewed for this report were specifically asked about their role and experiences providing services at the school site. As community-based services were not a specific area of inquiry for this project, further information about community-based services was not collected from providers.

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47 Note that School Connectedness was not included in this list as this is an issue specific to the school site rather than the community.
Parent Perspective
If community-based services were provided on the school campus, parents generally associated them with the school. Interventions such as support groups, workshops, classes, or counseling may have been provided by an outside provider, but the provider was not noted by the parents. They described the services as available at the school or not available. When parents felt a service that their child needed was not available at the school, they sought out community-based resources.

Mental Health Service Providers
Several parents described seeking out the services of private therapists, psychiatrists and/or psychologists to address their child’s mental health needs. In many cases this was occurring prior to or alongside the process of getting the 504 plan, IEP and/or 3632 funding through the school district. Parents noted that there are few professionals who serve children and are based in Napa County. One practitioner is preparing to retire and is working to transfer his clients to another provider. Other practitioners are hard to access because of demand and difficulties with insurance coverage. This shortage was noted in all interviews, and posed a significant barrier for Spanish-speaking families and families in up valley communities.

Parents described working with up to three professionals before they found one who was appropriate for their child and their family. Though the process of finding a provider and then finding an appropriate provider was difficult, the result was a trusted adult in the child’s life and a new member of the “team” for the child and the parent. Several of these professional relationships have endured over many years.

In several families, parents noted that mental health counseling support was a need for other family members to address issues of postpartum depression, substance abuse, and other concerns that arose in addition to the supports the child needed.

Alternative Treatments and Experts
Three parents described seeking out alternative treatments to assist their children. Though frustrated that the cost of these providers and the cost of treatment fell to the family, parents reported seeing dramatic changes in their child and/or having a fuller understanding of the concern as a result of alternative interventions. In one case, the parent was successful in getting the district to cover the cost of alternative care after she brought the provider and her son’s documented progress to the IEP meeting. Alternative treatments included: private tutoring, biofeedback, homeopathy, art therapy, drama and mentors.

- “Counseling is one response, one tool. It needs to be supplemented."

- “What is there to get? I think I’ve gotten everything [from the school] and he’s still not reading.”
Key Findings

Schools reported that family relations are addressed by mental health services and supports in the community, but anger management/conflict resolution is not. Providers described their on-campus presence as a way to facilitate smoother referrals to community-based treatment services. Parents sought out community-based services in addition to the school-based services and in several cases prior to the concern being identified by the school. Generally, parents were satisfied with the community-based services, but noted they were in short supply and difficult to access.

Summary

Four types of mental health services and supports were presented. School counselors who address mental health concerns are in short supply in the schools interviewed. Providers described the school counselors as their link to referrals from the school, and one parent described using the school counselor exclusively to seek services for her son. School-based coordination teams were considered effective by the schools, somewhat effective by the providers, and not at all effective by parents due to lack of oversight and accountability during the implementation of the interventions. Each of the stakeholder groups noted that the students who were not involved in a school-based coordination team encountered a fragmented system of services. School-based services and supports were described as effective but in short supply. This leads to schools having to decide which of the students in need are the most in need of the intervention. Providers noted that this selection makes it more likely that high-risk students are receiving inappropriately low levels of intervention. Providers and schools have to negotiate multiple barriers to coordinate services, but generally agreed that the providers' presence on campus enhances service delivery for the students. Community-based services and supports are perceived by schools to be more comprehensive and available than providers and parents reported. There are few providers in Napa County and several barriers to accessing care.
Part Three: Barriers to Accessing Mental Health Services and Supports

Overview
Schools, providers and parents described many barriers to providing or obtaining mental health services and supports. It is important to consider the sample of interviewees when reviewing this section.\(^48\)

- The schools described the barriers for all the students who are at-risk and/or referred.
- The providers described the barriers for students receiving services.
- Parents described barriers encountered while accessing services for their child/ren.

Each of these perspectives offers a slightly different angle on the challenges to accessing services and supports.

School Perspective
School administrators, counselors and teachers were asked to report the barriers that they felt kept students from accessing mental health services and supports. The two most frequently cited barriers were “Availability of Services” and “Parent’s Willingness to Approve Services”.

<table>
<thead>
<tr>
<th>School Administrator, Counselors and Teachers Reported Barriers to Students’ Accessing School-Based Mental Health Services and Supports (n=107)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barrier to Accessing Services</td>
</tr>
<tr>
<td>Availability of Services</td>
</tr>
<tr>
<td>Parents' Willingness to Approve Services</td>
</tr>
<tr>
<td>Students' Attendance</td>
</tr>
<tr>
<td>Cost</td>
</tr>
<tr>
<td>Location of Services</td>
</tr>
<tr>
<td>Cultural Differences between School and Family</td>
</tr>
<tr>
<td>Language</td>
</tr>
<tr>
<td>Cultural Differences between Family and Provider</td>
</tr>
<tr>
<td>Academic Pressures</td>
</tr>
<tr>
<td>Cultural Differences between School and Provider</td>
</tr>
</tbody>
</table>

Respondents to the school survey frequently commented on the lack of services:

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\(^{48}\) See Appendix D for more information about methodology.
“I believe that we make referrals based on perceived availability. If we knew that more services were available, we'd likely make more referrals. I only refer those whose needs are severe.”

“I understand that funding is a huge issue but home visits are a must when trying to understand the problems associated with the mental health of a child. It should not be a school VP/admin [who] makes the visit. It needs to be a mental health professional."

“Our mental health services are spread too thin and generally are a pretty watered down version of what is necessary. Often, school is the only tie-in families have for resources. We are inadequately served with mental health and nursing services.”

“The services are limited due to lack of personnel. We should have a counselor on campus every day.”

“We do not have on-site mental health services beyond the skills of our school counselor and staff. The entire school district is understaffed when it comes to mental health professionals.”

“When we refer students we don't always know if services are given or not. Students sometime leave school when things go wrong...Hard to follow up. Counselors are spread thin at times.”

“I feel that one day a week with a school psychologist cannot service ALL kids [who] SEEM emotionally unstable. Some students have a hard time making friends but don't seem withdrawn or depressed. I think giving them skills through mental health services would be beneficial.”

“We never have enough mental health workers to take care of all the needs of the students who are in NEED.”

“We only have a psychologist once a week. They do observations, but do not seem to have enough time to provide services”

“We don't have school based mental health services.”

“Our school psychologist is as far as I know our only mental health provider. She basically observes the child, informs the parents of parenting classes and gives them literature to read. I think that the school could easily provide one on one and group discussion time with troubled students. I teach Kindergarten and feel that I am dealing with problems on my own. If enough support were given to these kids and families, early on, then much could be avoided.”

“All services are effective; we just need more availability.”

“Our psychologist is open and willing to help families but is over extended. In the past we had trained paraprofessionals (PIP) who did a play therapy (special friend) program. This helped.

“Our school counselors work well with our students but they are 1:600.”
School-Based Mental Health Needs Assessment
Section Two: School-Based Mental Health Services and Supports

When compared to provider and parent responses, schools were much more likely to indicate that parents’ willingness to approve services was a barrier. This was described in the interviews as both a difficulty getting the parents to acknowledge the problem, and difficulty getting the parents to follow-through on the school’s recommendations for services.

- “[One barrier] is family involvement, families who can’t follow-through for one reason or another.”
- “Sometimes it is denial, the students and parents don’t see the issues as a problem”.
- “I wish we could rely on all parents to support their children. We have to teach students to become their own advocate.”

It is surprising that “Cultural Differences between School and Provider” did not receive more responses, as this was described in over half of the school interviews.

In the interviews, schools reported community agencies that provide school-based services often rely on grant funding. Each school year the type of services available and the amount of time the agency has for the school’s students varies considerably. In addition to uncertain services, the staff that provides the services often changes from one school year to the next.

- “The time I spend coordinating the counseling services and programs takes time away from service provision.”
- “Each year I start new with new people, grants, and counselors. I try to encourage the same counselors to come back, but the programs change counselors.”
- “If I could change one thing, it would be to increase the consistency with the agencies. It would help a lot if the counselors who came out were more consistent.”
- “This year we had…counselors staying the whole year, so transitional issues were at a minimum.”

In addition, several survey respondents noted administrative barriers:

- “Teachers are not encouraged to make referrals for mental health issues. We need guidance on how to get help for kids.”
- “Often, I was told by administrators to never refer students, because [the] school site would have to pay for those services. This has kept me from doing more.”
- “We have been told that is not the teacher’s job.”
- “[One barrier to services is the] internal process at school: paperwork takes time, meetings take time.”
Provider Perspective

Providers noted several barriers to accessing school-based mental health services and supports. The difference between the “culture” of schools and “culture” of providers was the most frequently cited concern.

<table>
<thead>
<tr>
<th>Barrier to Accessing Services</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cultural Differences between School and Provider</td>
<td>12</td>
<td>55%</td>
</tr>
<tr>
<td>Availability of Services (Funding)</td>
<td>7</td>
<td>32%</td>
</tr>
<tr>
<td>Location of Services (Transportation)</td>
<td>6</td>
<td>27%</td>
</tr>
<tr>
<td>Cultural Differences between Family and Provider</td>
<td>6</td>
<td>27%</td>
</tr>
<tr>
<td>Academic Pressures</td>
<td>6</td>
<td>27%</td>
</tr>
<tr>
<td>Parents’ Willingness to Approve Services</td>
<td>4</td>
<td>18%</td>
</tr>
<tr>
<td>Cost/Insurance</td>
<td>4</td>
<td>18%</td>
</tr>
<tr>
<td>Cultural Differences between Providers (Quality Control)</td>
<td>4</td>
<td>18%</td>
</tr>
<tr>
<td>Cultural Differences between School and Family</td>
<td>3</td>
<td>14%</td>
</tr>
<tr>
<td>Language</td>
<td>2</td>
<td>9%</td>
</tr>
<tr>
<td>Stigma</td>
<td>2</td>
<td>9%</td>
</tr>
<tr>
<td>Confidentiality</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td>Awareness of services</td>
<td>1</td>
<td>5%</td>
</tr>
</tbody>
</table>

Providers noted difficulties coordinating services with school sites. As was noted by school counselors, providers felt that their time with the student was short and some noted that it “is too little time to be really effective.” Providers understood the pressures of academic testing, and described the difficulty of providing interventions that did not interfere with class time.

- “There is always the push/pull of academics. Teachers are upset if we take kids out of class, but if we meet with them during lunch or after school, it is hard to keep kids. They vote with their feet. They don’t come or they just leave.”

- “Teachers don’t understand why we are there. Their classroom time is valuable, and they don’t see the long-term benefits [of mental health services].”

- “In many instances, we have to be the bigger person and yield much more to build a relationship with a teacher or an administrator. There are so many territorial and authority issues. We strive to explain our role and show understanding for their [role].”

49 Table was created from coded provider interview responses.
School-Based Mental Health Needs Assessment  
Section Two: School-Based Mental Health Services and Supports

Other concerns about providing services on a school campus included insufficient space to provide the intervention (too small, not private, and/or not available) and difficulty coordinating with other providers who are scheduling interventions at the school.

- “Usually we have access to a classroom, but we have used a small storage space, and even held the group outside because the classroom was being used.”
- “Space on campus is huge. The space may be too small, have no windows, or no privacy and sometimes [services] are scheduled in the same space at overlapping times.”
- “Finding confidential space is always a problem. It needs to be inviting and safe. We often find we have to fight for space or contend with interruptions during a counseling session.”
- “Coordination with other providers is more and more difficult, because we aren’t all on campus at one time. Without the coordinating, kids fall through the cracks.”
- “There is no time to coordinate with other providers, and there are different funding sources that impede coordination.”

Though there were many comments about the differing goals and methods used by schools and providers, one provider noted that a provider presence on campus reduced the barriers.

- “The further providers are from schools, the more the issue becomes us vs. them. School becomes the problem rather than the solution.”

Others noted that the focus on academic performance as an indicator of mental health status can be a barrier.

- “Some students have been overlooked/unnoticed because their good academic performance masked some of the mental health issues they were dealing with... Teachers see the academic performance as an indicator that all is well.”

Four providers were very forthcoming about the quality of school-based services. Concerns ranged from consistency to appropriateness to effectiveness of the services. Because providers rely on school administrators and counselors to support their services on the school campus, this poor quality was seen as a barrier to garnering further support for on-site mental health services.

- “[Program] does a good job, but it can vary from school to school.”
- “Services are inconsistent; no one’s services are able to follow-up with students from one week to a year later.”
- “Quality control is an issue, high risk kids are in low-level interventions. The interventions are not matched for the risks.”
School-Based Mental Health Needs Assessment  
Section Two: School-Based Mental Health Services and Supports

- “One of the barriers to services is programs that sound good on paper but show low levels of effectiveness.”

Parent Perspective
Parents noted many barriers while navigating the school and district mental health service systems to meet the needs of their child. As noted previously, the sample of parents is not representative of all parents with children who access mental health services and supports.50

School and District Barriers
Parents whose children were diagnosed with a new or emerging concern were often unable to access services through the school. In three family situations, the diagnosis was made at a time when practitioners, teachers and school administrators were not familiar with it, and services were not provided because no one understood it. Parents spent a lot of their own time researching the issue and bringing information back to the school, but expressed frustration at the amount of work they had to do to be taken seriously and for their child to be assisted.

- “I took the diagnosis to the district, and because the diagnosis wasn’t in the DSM IV, the diagnosis was not accepted.”
- “It offends me that my kids don’t matter”
- “Now the diagnosis of ADHD and ADD are more common, there is a better understanding and more compassion for needs.”
- “No one [at the school site] knows clinically what they are doing.”

In one case, a parent described working with a psychologist to get a diagnosis that would allow her child to get services, even though both the parent and the professional knew that the diagnosis was a symptom of the concern and not the actual concern. Some parents found a different school that was a better fit for their child and postponed or discontinued the process of seeking school-based services, others went on to work toward 504 plans and IEPs.

Those who participated in the 504/IEP process generally described the process as difficult. Although the IEP team may consist of non-school personnel, parents did not separate the IEP team and the school staff/administrators in their comments.

- “It was years of battles to get needs met.”

50 For more information on methodology, see Appendix D.
School-Based Mental Health Needs Assessment  
Section Two: School-Based Mental Health Services and Supports

- “Schools think they know what is best for the kid. They lock them into something and the kid gets stuck there.”
- “We forced a way into the system...my son needed help now and it wasn’t happening.”
- “[The district was] running our family into the ground.”
- “The biggest hurdle to appropriate care was the [school administrator]...who was unfamiliar with special ed. and set my daughter back so far.”
- “When my daughter returned to Napa schools, they didn’t want her. She had been out of school for six weeks and there was too much to do to catch up.”
- “They didn’t know what the diagnosis was, so they took the diagnosis and put it in a garbage can.”
- “I felt ganged up on by the school. Like I had no rights and no voice, even with folks on the [IEP] team.”

One parent described a struggle to get to the IEP and once an IEP was in place, the parent reported that they continued to “request services, and everything had to be in writing...I had to let them know that what was happening to my son was not acceptable.”

- “[The school] didn’t treat her as if she had ED/LD, and they didn’t recognize her strengths.”

There were two instances where the parent found the school supportive and described a cooperative relationship. Both families had children in elementary school and were able to receive services for their children quickly.

In the first situation, the family had changed schools, and did not have the same positive experience with other schools. At the new school they described the process of obtaining school-based services as “easy and smooth.”

In another situation the school had been initially cooperative in providing services, but as the family obtained additional supports, the school wanted to discontinue the school-based service. “They don’t like him to use both counselors. But he really likes [the school counselor] and it is not a conflict for him, he sees her as a friend.” The parent and the school were able to work out a compromise and her son still sees the school counselor.

**Language and Cultural Barriers**

During the interviews, Spanish-speaking families discussed language and cultural barriers that interfere with their ability to get services for their child and family.

**How services are delivered:** Spanish-speaking families generally reported preferring providers who took the circumstances of the whole family into account, and providers who came to their home. Several
families reported that meetings felt punitive or intimidating, especially when it required going out of town, or going to a professional office. Families valued in-home support at all stages of service delivery.

**Availability of Spanish-speaking staff:** When parents are working to obtain services, a Spanish-speaking staff person at the point of entry makes a big difference. An initial contact in Spanish helps in understanding the service and building trust.

**Availability of services in Spanish:** Several parents perceived the lack of services for their child and/or family as due to a lack of Spanish-speaking staff. Others noted their own role in making sure they continued to advocate, despite the language barrier.

- “We have to keep looking for solutions, our kids depend on us. If I can’t explain myself or understand something, I know I need to go find an interpreter, rather than give up.”

**Written communication and forms in Spanish:** Some parents reported relying on family and friends to translate forms and written documents about their child’s progress and services.

- “It’s been years that I have been trusting and signing forms in English without knowing exactly what it says. If my older child can read it to me and understand it, that’s what we have to rely on.”

**Other Barriers**

Though not mentioned as consistently as barriers with the school and language/cultural barriers, the following other barriers were also reported by parents:

**Lack of Providers:** Parents described an overall lack of mental health providers in the community and a lack of after-hour resources. Both shortages were especially acute for elementary-aged children.

- “I begged, groveled, searched and hunted to find a child psychiatrist in Napa.”
- “The county mental health department should have a satellite office in Calistoga or at least a person who is stationed up here in a school or community agency.”
- “When my child is in crisis after 5pm, he has to go to adult mental health, and they don’t know about kids”

**Service Location:** Parents who live in Calistoga noted the significant time it takes to drive to services. Though there are some services in St. Helena, families reported having to drive to Napa or Santa Rosa for care.

- “I saw flyers at the Kaiser office for the local agency and I immediately called. But when my child is supposed to have certain evaluations, I have to drive to Napa, Vallejo or Fairfield, and I can’t do that during my work hours.”

**Service Quality:** Parents described difficulties with the quality of the interventions they received.
School-Based Mental Health Needs Assessment  
Section Two: School-Based Mental Health Services and Supports

- “The behaviorist came for fifteen minutes to observe, and my son acted out at 22 minutes. He knew he was being watched. The providers need to take more time.”

- “My son went into therapy to work through anxiety and fear...but with therapy, he became MORE fearful. Once he stopped therapy, he got better.”

Insurance Coverage: Two families noted that they were having a hard time understanding which mental health services were covered. One family had received a $550 bill for services that they thought were covered and stopped treatment until they could pay the bill. Several families noted difficulties finding therapists that accept Healthy Families.

Summary
Many barriers were noted by schools, providers and parents. Each of the stakeholders noted barriers with other stakeholders. The schools were most concerned about the availability of services and parents willingness to approve services. Providers were most concerned about schools’ culture of providing services and how it clashed with their own culture of service provision. Parents were most concerned with being able to locate, access, and afford appropriate services for their child. Spanish-speaking families described several barriers that may help explain why mental health services and supports are underused by Latino children.
Part Four: Recommendations

School-Based Mental Health Services and Supports

- Review strategies for delivering school-based mental health services and supports without compromising classroom time. Two strategies currently occurring in Napa County include providing services after school on early-release days and changing the class schedule to hold classes Monday-Thursday and to provide all support services (academic, career and/or mental health) on Fridays only.

- Improve ratios of school counselors to students to provide all students with equal access to mental health services and supports. Advocate for policy changes to ensure new funding does not restrict the school counselors’ role. Adhere to multi-faceted role of the school counselor when developing new school counselor job descriptions to support addressing the whole child rather than solely academic and career concerns.

- Improve school-based coordination teams to make them more inclusive of providers and families. Many providers noted they only participated intermittently and some providers did not know about the teams.

- Develop accountability measures and oversight for school-based coordination teams. Families expressed frustration with the variable implementation of the solutions developed on the teams.

- Continue to address the challenge of fragmentation by improving communication between providers and between schools and providers. Differences in information about what is available affect families’ ability to access services for their children.

- Use school-based mental health services and supports for the issues they were designed and developed to address. Placing students with high-levels of needs in low-level interventions as a replacement for the level of service they need is not effective and is not appropriate.

- Develop strategies to address anger management and conflict resolution concerns as schools frequently identified the concern and were not confident the issue was addressed on their school site or in the community.

- Describe and disseminate accurate and current information about the availability of mental health services and supports. Schools, families and providers should all be aware of what types of services exist and how to access them.
Barriers to Accessing Mental Health Services and Supports

- Work with schools to clarify process of consent for mental health and substance abuse services. Many services do not require parental consent, and these laws and/or policies should be consistently observed across school settings.

- Review how consent is obtained by schools. Some providers noted that those schools that have staff to call and discuss the concern and treatment with family have been able to increase parents’ willingness to approve services. Allocate resources to work with families to explain services and obtain consent when needed.

- Consider ways to encourage schools and providers to work together toward common goals. Understanding how each system of service works is vital to improving the availability, quality and effectiveness of mental health services and supports in a school-based setting.

- Develop ways to work with parents and improve knowledge of service systems and available resources. Many parents noted they had observed the behaviors at home prior to the concern being identified by the school. Improved communication with parents could result in earlier identification and intervention for students.

- Improve access to mental health services and supports for Latino families. Review and address the multiple barriers Spanish-speaking families outlined. Increase Spanish-speaking providers and staff to facilitate communication and improve families’ understanding of services and supports.
Section Three: Impact of Mental Health Services and Unmet Needs
Part One: Summary of Current Research

A full review of the literature is included in Appendix A. Below are brief summaries of the current literature as it relates to topics in this section.

Impact of Mental Health Services
The literature notes that comprehensive studies of the impact of school-based mental health services are lacking and that research about the effectiveness of mental health services does not routinely include measures of academic outcomes.

• It is unfortunate that no formal studies have yet been done to determine the impact of truly comprehensive approaches for addressing barriers to learning. There are some natural experiments going on however that suggest the promise of ensuring that all youngsters are provided with a full and comprehensive continuum of such interventions.51

• Despite studies of school context and its effect on both learning and mental health, the numerous reviews of evidence-based or empirically validated school-based mental health practices have largely ignored academic functioning as an outcome of interest. In fact, the evidence-based practice “movement” in mental health as applied to schools has operated in relative isolation from both educational research and from the key policy and practice issues that drive school ecology.52

Resiliency
The American Counseling Association and other organizations found many studies demonstrating the benefits of resilience on school mental health. Expanded school mental health services reduce the need for special education and disciplinary actions and reduce symptomatic behavior for children with severe emotional disturbances. Additionally, school mental health services have a positive effect on the emotional connection to the school, which predicts higher test scores and grades (American Counseling Association, et al., 2006).

Unmet Needs
Some of the potential consequences of untreated mental health issues to children are “school failure, alcohol or other drug use, problems with relationships, violence, and suicide” (Oliva & McCandless, 2006).

51 “A Sampling of Outcome Findings from Interventions Relevant to Addressing Barriers to Learning” Center for Mental Health in Schools. http://smhp.psych.ucla.edu

2001, p. 34). In turn, many of these issues interfere with the child’s ability to learn and to contribute to a positive learning environment. Kanadale (2005) suggests that just 16-20% of students who experience a mental health need in a given year actually receive mental health services and supports.
Part Two: Impact of Mental Health Services and Supports

Impact of Current Services
One of the themes that emerged was how each of the stakeholder groups determines effectiveness. Generally, all parties agreed the services were effective, but in short supply. Agreement diverged when stakeholders described “effective.” Schools evaluated effectiveness by looking to improved academic performance. Providers evaluated effectiveness based on improved mental health outcomes. Parents described working to find mental health services and supports that had both academic and mental health benefits.

Definition of Effectiveness

School Perspective
Schools’ ongoing pressure to raise test scores is reflected in how they assess the effectiveness of a mental health support.

- “While I understand the importance of small group counseling, I do not yet see the relationship between counseling and expected outcomes. In fact, an informal review of grades indicates to me that grades for those students are slipping.”
- “We need some flexibility from community service agencies to develop an alternative approach to scheduling groups that supports academics as well.”

One school administrator noted that “students need proper clinical support to function in the school system.” Schools acknowledge that they need mental health services and support, and diverge from providers when they describe the outcome of an effective intervention.

Provider Perspective
Providers spoke about the effectiveness of their services and interventions, with most noting that they wished they could reach more students. In contrast to schools, providers generally focused on improved mental health outcomes rather than academic outcomes. They saw their role as enabling the student to function at the school. Two providers noted that their interventions improved attendance, none of the providers described improved test scores as a result of their intervention.

- “A recent evaluation indicated that at school sites where there were mental health services and supports, attendance went up.”

Generally each provider spoke of the need for more of their type of service, and noted the underlying cause of students’ concerns were based on the issues that their particular program addressed. This may reflect an underlying competition for diminishing resources, passion about their service area, the difficulty in coordinating with other providers, and/or the provider’s perception that this needs assessment would advocate for one service or another.
Given the above observation, programs discussed the effectiveness of their service or intervention in terms of improved mental health outcomes. Several providers noted their services prevented the escalation of mental health concerns.

- “[Program] means we can address a wider range of issues, depression, abuse, suicidal feelings...issues that will carry into adulthood if not addressed now.”
- “When we are dealing with tantrums, we are teaching the child to deal with their own feelings. We model limit setting and they learn not to hit, yell or leave.”
- “For prevention services, we try to delay the age [they start the behavior], any delay means the student has developed other coping tools and is more protected from [the mental health concern].”
- “[The end of this program] will cut off supports for many students whose problems will likely escalate into more than school-based issues, and instead could pose a community crisis.”

Parent Perspective
Effectiveness from parents’ points of view meant addressing their child’s mental health concern and addressing their child’s academic potential. Many of the interventions that were offered to students addressed either one or the other, and parents noted they changed interventions to find a solution that addressed both needs. This is illustrated further in parents’ description of the effectiveness of the interventions.53

Reported Effectiveness of Mental Health Services

School Perspective
The school administrators, counselors and teachers who responded to the online survey were asked whether their referrals to mental health services and supports resulted in services for the student and how effective and helpful the services were.

- Sixty-nine of the 107 respondents indicated they had referred a student for mental health services in the past year. Of these, 36 (52%) indicated that in general, the students they referred were served. Nine indicated that students were not served and seventeen noted that they did not know if the student received services.
- One-third of respondents reported that students received services within one week; one-third reported students waited more than a week, but were generally served within a month. The

53 See next: “Reported Effectiveness of Mental Health Services” Parent Perspective.
remaining third reported students waited over one month for services. Comments ranged from “sometimes that day” to “many, many months!” to “widely variable.”

- Of the 43 respondents who rated the effectiveness of the services, ten indicated they did not know if the services were effective and helpful and four indicated the services were not effective or helpful.
  - “Can't think of anything that has worked REALLY well.”
  - “Nothing is working well.”

- The other twenty-eight respondents (65%) indicated the services were somewhat or very effective and helpful. When asked specifically what was going well, school respondents noted the following:
  - “Both group and individual counseling.”
  - “For those on Medi-Cal, we have a counselor”
  - “Counseling, having a psychologist on campus and knowing my community resources.”
  - “We have an excellent school psychologist.”
  - “Students who have been diagnosed are meeting with the school psychologist one a week.”
  - “Drug and alcohol prevention, anger management, grief group.”
  - “We have [community provider] come to our campus to help students with drug and alcohol issues.”
  - “Drug counseling.”
  - “Great relationship with county mental health personnel.”
  - “In the past students had art/play therapy. That was wonderful.”
  - “On site grief counseling is fantastic!”
  - “Grief counseling.”
  - “Our students really enjoy the groups we have available. They also enjoy our counselor and the support groups she creates.”
  - “Outside agencies that come in to our school community work well.”
  - “Someone is available to help students [who] need it.”
School-Based Mental Health Needs Assessment
Section Three: Impact of Mental Health Services and Unmet Needs

- "The key providers we have onsite are awesome. We just need more of them and more hours for them to serve our students."
- "The mental health personnel at our school are excellent."
- "The services are located on-campus during the school day."

Despite the variety of experiences school administrators, counselors and teachers reported in making referrals and the effectiveness of the services, sixty-five of the sixty-nine who reported referring a student in the past year indicated they would do it again for students in similar situations.

**Provider Perspective**

One school-based mental health service reported on the effectiveness of their intervention. The evaluation data showed statistically significant improvement in a variety of mental health concerns with an average of five service units.

<table>
<thead>
<tr>
<th>Mental Health Concern</th>
<th>n</th>
<th>Average Intake Rating</th>
<th>Average Exit Rating</th>
<th>Change (all p Value&lt;.1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Relations</td>
<td>167</td>
<td>3.1</td>
<td>2.8</td>
<td>-0.3</td>
</tr>
<tr>
<td>Anger Management</td>
<td>101</td>
<td>2.9</td>
<td>2.5</td>
<td>-0.4</td>
</tr>
<tr>
<td>Anxiety</td>
<td>88</td>
<td>2.7</td>
<td>2.3</td>
<td>-0.4</td>
</tr>
<tr>
<td>Depression</td>
<td>147</td>
<td>2.7</td>
<td>2.4</td>
<td>-0.3</td>
</tr>
<tr>
<td>Peer Relations</td>
<td>181</td>
<td>2.7</td>
<td>2.4</td>
<td>-0.3</td>
</tr>
<tr>
<td>Alcohol and Drugs</td>
<td>67</td>
<td>2.6</td>
<td>2.5</td>
<td>-0.1</td>
</tr>
<tr>
<td>Adult Relations</td>
<td>53</td>
<td>2.5</td>
<td>2.4</td>
<td>-0.1</td>
</tr>
</tbody>
</table>

This data shows that the providers identified the same mental health concerns as the school administrators and counselors: Family Relations and Anger Management. The program was able to impact these areas, showing statistically significant changes in students’ mental health concern from intake to exit.

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55 A service unit was considered any formal or informal contact with program staff that resulted in a conversation that could positively affect the student’s coping skills. This included support groups and individual interventions.

56 The intake and exit ratings are based on a five-point scale where 1=No problem, 2=Mild problems, 3=Moderate problems, and 4=Severe problems. For more information on methodology, see Appendix D.
School-Based Mental Health Needs Assessment
Section Three:  Impact of Mental Health Services and Unmet Needs

Providers also noted that effectiveness is difficult given the limited services they provide on a school-campus. A more comprehensive approach to the whole child and the whole family would improve impact.

- “Kids slip through, services don’t solve situations.”
- “It is hard to engage students who really need to be engaged, how do we reach these kids that are lost in the muck and whose parents are MIA?”
- “Priorities are determined by pressures, and there is no consistent pressure to treat the whole child.”

Parent Perspective

Finding the Right Services

When children began acting out because of their mental health condition, several parents were offered alternative classrooms in the district to address the behavioral concern. Parents described the programs as being for “delinquents” and fought to have their children taken out of the classrooms. Parents were unhappy with the remedial nature of the classroom work and wanted their children to be academically challenged.

- “The environment was inappropriate for her: drugs and weapons and gangs. She was in sixth grade and she was in there with eighth grade boys.”
- “I did not like the remedial courses.”
- “The special ed. class was not helping him succeed. When he was integrated into regular classes, he flourished.”
- “My son was put in a conduct-disorder class for end-of-the-road kids. The mental health issues were mixed in with gang issues and violent behavior. He started to pick up on the negative behaviors.”

Many of the parents talked about the fine line between behavior associated with a learning disability and/or an emotional disturbance and criminal behavior. This concern was especially pronounced in parents whose children were middle school-aged and older.

One parent spoke at length about her efforts to keep her daughter out of the legal system. She described changing schools from one that called the campus police each time her daughter had an outburst to one that called the parent when the behavior started.

- “The nature of my daughter’s disability is that she gets in trouble a lot. She has a lot of meltdowns and acts out. If she is in the legal system, these actions are violations of probation. The legal system is a treadmill, and once you are on it, you don’t get off. Once a child is on
probation, juvenile probation goes up to 21 years old. It isn’t for a set amount of time. This leaves a lot of time for a violation.”

Another parent described:

- “Because of his disorder, he has trouble with impulse control. I am trying to keep him out of Juvenile Hall. Who wants their child in that environment?”

And another parent noted that lack of services can lead to the child’s behavior escalating, and then to legal involvement:

- “He wants to learn and is having a hard time doing it. He is irritated and angry and on the road to criminal behavior.”

Recall that previously, a school interviewee noted that “kids need to break the law” to get services.57 Parents struggled with avoiding that step and still getting appropriate services.

**Student Perspective**

One measure of how supported students feel in school is found in the California Healthy Kids Survey. The survey addresses the students’ total external assets. To understand the importance of external assets, the survey guide states:

- “A growing body of research provides evidence of external and internal factors that protect some adolescents from engagement in a variety of risk behaviors and foster positive developmental outcomes. There is also some evidence that these protective factors, alternately referred to as assets, are significant predictors of change in adolescents’ risk behavior over time. The precise nature of the relationships between risk factors and protective factors, and the conditions under which protective factors moderate risk and foster resilience, are presently the topic of numerous investigations. However, given the strength of the available evidence, many youth development and risk-behavior prevention programs already employ a protective-factors approach, seeking to foster these assets and resilience strengths.”58

The guide continues to state that the measure of total assets “reflects...the positive behaviors and strengths that they, their schools, and their communities demonstrate.”59

The survey results show that approximately 80% of students report moderate or high levels of total assets in the school environment. This is slightly higher for 7th graders and lower for students in non-

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57 See Section Two: Part Two, “School Based Mental Health Services and Supports,” Provider Perspective.


59 Ibid.
School-Based Mental Health Needs Assessment  
Section Three: Impact of Mental Health Services and Unmet Needs

traditional schools. All results are better than or equal to the reported average of students statewide. Except for 11th grade students, slightly fewer students reported moderate or high levels of assets in 2006 than in 2005.

**Students Who Reported a Moderate or High Level of Total Assets in the School Environment**

**Students Reporting Moderate or High Level of Total Assets in School Environment**

<table>
<thead>
<tr>
<th>Grade Level/School Type</th>
<th>Percentage of Students</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non Traditional</td>
<td>Napa County 2006</td>
</tr>
<tr>
<td>Grade 11</td>
<td>Napa County 2005</td>
</tr>
<tr>
<td>Grade 9</td>
<td>California 2004-2005</td>
</tr>
<tr>
<td>Grade 7</td>
<td></td>
</tr>
</tbody>
</table>

**Summary**

Schools, providers and parents agree that students need effective mental health services and supports. The way effectiveness is evaluated and reported shows a variety of definitions of change and impact. Schools focused on the academic outcomes, providers focused on improved mental health and parents wanted both outcomes for their children. Resiliency measures have been shown to correlate with both positive mental health outcomes and positive academic outcomes and may be a measure to consider as the stakeholders look for common goals and outcomes.
Part Three: Unmet Mental Health Needs

Stakeholders reported that the current offering of mental health services and supports was lacking in three areas: availability, stability and use. Not all stakeholders addressed all of the unmet needs that are described below, and perspectives are included as they were given.

Availability: Need for Mental Health Services and Supports

The measure of availability refers specifically to whether or not a child or family can access the service in Napa County.

School Perspective

In interviews and on surveys, school administrators and counselors indicated that the availability of services was a concern.

Respondents were asked to indicate whether or not a mental health concern was a need at their school and whether or not the need was addressed at their school site. For this section on Unmet Needs, the percentages of respondents who indicated a need, but did not feel the need was addressed are presented below.

<table>
<thead>
<tr>
<th>Identified Mental Health Concern</th>
<th>n</th>
<th>Percent of Respondents who Indicated Need is NOT ADDRESSED at the School Site</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>52</td>
<td>70%</td>
</tr>
<tr>
<td>Anxiety</td>
<td>61</td>
<td>68%</td>
</tr>
<tr>
<td>Family Relations</td>
<td>62</td>
<td>62%</td>
</tr>
<tr>
<td>Anger Management/Conflict Resolution</td>
<td>65</td>
<td>51%</td>
</tr>
<tr>
<td>Alcohol/Drug Use</td>
<td>47</td>
<td>38%</td>
</tr>
<tr>
<td>Bullying</td>
<td>63</td>
<td>38%</td>
</tr>
<tr>
<td>School Connectedness</td>
<td>51</td>
<td>30%</td>
</tr>
<tr>
<td>Adult Relations</td>
<td>28</td>
<td>26%</td>
</tr>
<tr>
<td>Peer Relations</td>
<td>65</td>
<td>21%</td>
</tr>
</tbody>
</table>

The most frequently reported unmet mental health need at the school sites was depression, with 70% of respondents indicating the need was not met. Over half of the respondents reported that Anxiety, Family Relations, Anger Management/Conflict Resolution were unmet mental health needs at the school site.

- “[We have] more counselors available at the HS level, but [they are] not sufficiently trained in issues pertinent to students (i.e.: eating disorders, substance abuse, bullying).”
School administrators, counselors and teachers noted a need for more services:

- “I believe the more services we have, the better.”

- “California has a poor track record for dealing with mental health issues in general, so why should the public school system be any exception? Perhaps if schools had a larger support system for teen emotional issues, parents would be less likely to over-medicate teens in an attempt to keep them docile.”

- “Just as we adults, students are all on the continuum of mental health. Sadly, many of our students who move away from mental health toward illness are not recognized until the illness has become entrenched or even deadly. Mental health is just as important as physical health—we would not allow students to walk around campus bleeding profusely yet we often do not recognize and/or intervene when the student is mentally and emotionally ‘bleeding.’ Doing so would honor the whole child and vastly improve learning.”

- “Many students would benefit from a caring adult in their lives, however, only our most needy students getting services.”

- “Need [family planning] representation.”

- “I have had to go to my principal before and say that a student is a danger to himself and others and be told there is no help available. We have some students with serious issues and while [community providers] can help some, there are many other serious needs. Some students need psychiatric help as well.”

- “I would like to see more peer counseling [and] high school to middle school counseling available.”

- “It is something that is not well-funded and should be. In our society we have a growing need for these services and a shrinking budget.”

- “We need more staff!!!!”

- “More access to counselors for general ed. students.”

- Our school is understaffed in many areas due to limited funding for education in general. This problem is not unique to us. Public education in general is seriously underfunded and school-based mental health services are often one of the last types of positions to be staffed.”

- “[Mental Health Services and Supports are] practically non-existent.”
Several teachers noted that additional services could also include support for teachers.

- “I had a girl with severe emotional issues last year and the mom wanted me to do something about it. When I couldn’t, the mother spread rumors about me being an inadequate teacher. I would like to see protections for teachers under these circumstances.”

- “While students are our great concern, I would also like to point out that having services for our teachers and counselors would be great. Sometimes I would love to talk to a professional about everyday things, but because of my busy life through teaching, I don’t have the time to search for a person. Having someone on campus would benefit me tremendously.”

School respondents were also asked to address how well the need was met in the community. Many of the respondents indicated they did not know about the community-based services. Over half indicated that Anger Management/Conflict Resolution needs were not addressed in the community.

### Percentage of School Administrators, Counselors and Teachers who Indicated that Identified Mental Health Concern is Unmet in the Community

<table>
<thead>
<tr>
<th>Identified Mental Health Concern</th>
<th>n</th>
<th>Percent of Respondents who indicated need is NOT ADDRESSED in the community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anger Management/Conflict Resolution</td>
<td>71</td>
<td>52%</td>
</tr>
<tr>
<td>Peer Relations</td>
<td>61</td>
<td>30%</td>
</tr>
<tr>
<td>Bullying</td>
<td>58</td>
<td>26%</td>
</tr>
<tr>
<td>Depression</td>
<td>53</td>
<td>24%</td>
</tr>
<tr>
<td>Anxiety</td>
<td>55</td>
<td>24%</td>
</tr>
<tr>
<td>Alcohol/Drug Use</td>
<td>46</td>
<td>15%</td>
</tr>
<tr>
<td>Family Relations</td>
<td>58</td>
<td>15%</td>
</tr>
<tr>
<td>Adult Relations</td>
<td>30</td>
<td>11%</td>
</tr>
</tbody>
</table>

### Availability: Need for Early Intervention

Mental health concerns for children and families need to be identified and addressed earlier.

### School Perspective

Schools noted their unique ability to access students, and noted they would like the services to be available for younger children.

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60 See Section Two, Part Two, Community-Based Services for School-Aged Children for further discussion of the Awareness of Services
School-Based Mental Health Needs Assessment  
Section Three: Impact of Mental Health Services and Unmet Needs

• “So many kids have so many challenges in their lives. They need more help to overcome these challenges. Sometimes school is the only place [where] they can get help. I think we need to put more money into services for young children.”

Provider Perspective
Though most providers were working in middle and high schools, many talked about the need for school-based counselors and services for elementary-aged children to focus on prevention and early intervention. As a result of fewer programs at the elementary level, programs were increasingly focused on the middle and high school students to provide intervention and treatment.

• “Even when we get a child at age nine, we talk to the family and realize he needed services at age three.”

• “Put the money at the elementary schools and involve the parents.” -- from a provider at a high school campus

• “Early intervention does not happen or is inconsistent. Not all needs have to be seen by a mental health specialist. Intervene at the early stage, before the child deteriorates.”

• “In elementary and middle school, the kids are ripe for prevention. By the time they are in high school, they are avoiding adults and are more likely to need [intensive treatment].”

• “We need to have students vaccinated against mental illness in the same way we vaccinate against other disease. We need curriculums to challenge kids to learn and develop cognitive skills but also need to help them manage negative thoughts, environmental stressors and interpersonal skills.”

Availability: Need for Mental Health Services and Support for Families

School Perspective
Schools had a variety of suggestions for how to address families’ need for services. Some respondents wanted more on-campus services, some wanted more in the community, and some wanted a focus on parenting classes.

• “Families need on-site mental health services.”

• “Services to families outside of school need to be increased.”

• “Parent classes should be offered in the daytime for families that have children in school.”

• “The issues I am seeing now seem to be directly related to a lack of parenting skills, or a lack of parenting. I would like to see mandatory parenting classes for those parents of at-risk students.”
Provider Perspective

Providers also agreed that in order to address the whole child, the child’s family needs to be supported with services beyond the brief school interventions. Providers indicated these services were not currently available. This is in contrast to the 41% of school administrators, counselors and teachers who indicated that Family Relations was being addressed in the community.

- “There is very little in terms of mental health supports for parents, no counseling for parents, nothing for middle income families and there are fewer and fewer community providers.”

- “I think parents can be very effective in [mental health intervention], but we need to support parents to change behaviors. Some families are past the point of interventions, but others could benefit from prevention focused on building and maintaining relationships. The fewer relationships the families have, the worse the mental health issues get.”

- “We need to change parent behavior before we can address the child’s mental health.”

- “We need greater access for all...from the student to the family to be able to have access to a full spectrum of supports.”

- “It isn’t just the whole child, it is the whole family. When we talk to parents, the parents need support and services as well. Only about half of the parents follow up with services. Some think the counseling is bogus, some are using drugs and getting high with their kids.”

- “There should be more parent education about school transitions and support for general parenting skills: how to communicate with your child, discipline support and how to recognize problems.”

- “Sometimes the mental health concern is modeled at home. A large portion of children with mental health concerns have parents who have a BIG mental health need. There are no resources to focus on the parent.”

- “When a mental health concern is identified, parents need support. They are asking, ‘What is it?’, and ‘What does it mean?’ We have to be able to serve the whole family.”

- “Parents need more information about how alcohol abuse and domestic violence impact children.”

- “Counseling in the schools is not a panacea. We have to address issues of parents who aren’t able to deal with the child at home and the question of ‘Whose child is it? Who is responsible?’”

- “If services are provided on the campus during the school day, this will exclude the families who are working. We need a social worker or counselor available in the late afternoon and evenings so families can come to the services.”
“Parents have their heads in the sand for many issues. They think ‘not my kid!’”

“There are no providers in our area to serve children and families. Whether or not families have insurance, they have to drive to meet with a therapist.”

“If we are going to serve families, we will need more Spanish-speaking therapists, especially up valley.”

Availability: Need for System Coordination and Access

School Perspective
Some respondents to the school survey noted that they did not know how to find services for their students.

“As far as I know there is nobody to refer a student to. We do not have an onsite mental health professional, and I think there is only one available district-wide. We are a small school and are always last priority for these types of services.”

“I do not know that any [mental health services] are available.”

“There were no services to refer her to. There was no contact at the district who could tell me where to find help for this student. It was suggested at one point that we call Child Protection Service which was not the right agency to receive help from in this case. The best we could do was to call Mom, who was part of the problem. We need an actual psychologist available for students and teachers to receive support and assistance.”

Parent Perspective
Parents were very candid about the need to find better ways to access the current system and to coordinate the services for their children. Note that this sample of parents is not representative of all parents with children who access mental health services and supports.61

Most parents talked about struggling to understand what their child needed and then struggling to find services to address the needs as they came to light. Parents often did not know the source of the concern, and described not knowing how or when to ask for help.

“Every school is managed separately, and it is unclear who is in charge.”

“No one knows anything about how to serve [my kid].”

61 For more information on methodology, see Appendix D.
School-Based Mental Health Needs Assessment
Section Three: Impact of Mental Health Services and Unmet Needs

- “It took a long time to get where we are now, and I have been very alone working to get this far.”

- “It is like you are going through a forest and you are lost and if someone hasn’t dropped the breadcrumbs, you are REALLY lost.”

- “It is a crisis situation as the family is trying to get services and also having to navigate the politics and issues between the district and county.”

As parents related their struggles, most of their stories had a turning point where they found a guide to the system of mental health services and/or the school system. These guides included attorneys, mental health services case managers, family resource center staff, a parent in a similar situation, a school staff person, a teacher and a principal.

- “When I showed up with an attorney, the professionals changed their behavior. That is a big part of what is wrong.”

- “[The family resource center] did an intake on the phone, and I told them ‘this is overwhelming and I can’t do this!’…They knew where to call and what to do. They helped immensely.”

- “Currently there is a [school-based] specialist who is a stop-gap. She’ll ask other teachers what is expected and communicate the teacher’s responses to me.” --This parent described a long-term effort to get regular communication from the teachers.

Some of the guides assisted for a short time while the family developed the team to surround them and support them. Some guides continued on with the family and became part of the team. All guides helped parents get the needed assessments and/or find the right resources.

Most families described assembling a team of trusted professionals who understand their concerns and their child’s needs. In addition to the parent interviewed, the teams consisted of a myriad of people including grandparents, therapists, psychiatrists, school counselors, teachers, school administrators, community agencies, mentors, case managers, home visitors, and topical experts.

- “I created a team—a support team—to scaffold him to the right place.”

- “Staying in one school (principal, teachers, IEP people)...has been helpful. [The school] is a really good fit, and the services have been consistent and good.”

- “We have a team of support people: lawyer, family resource center, mentor, therapist, and counselor.”

- “After three years of battles, I have a team of professionals, programs and mentors—capable adults to support and connect my son.”
School-Based Mental Health Needs Assessment  
Section Three: Impact of Mental Health Services and Unmet Needs

Parents reported spending considerable time and energy accessing and coordinating services for their children. At the time the need is identified, parents need to be connected with a guide and a team to support them.

**Stability: Need for Long-Term Funding**

Over and over, schools and providers spoke of the need for long-term funding to stabilize the availability of services. Schools were most notably frustrated by the lack of consistency in the interventions available to the school in a given funding cycle. Providers were frustrated by the constant scramble to compete for diminishing dollars and how that detracted from their ability to provide services. Only two parents had a situation where the service they were using had ended abruptly, and both described a smooth transition into another service.

**School Perspective**

In addition to wanting more services available, schools wanted to have stable services from consistent providers. They noted the time they spend coordinating services takes away from other things. They preferred long-term flexible funding (from the district and/or parents) to grant-funding.

- “Each year I start new: new people, new grants, and new counselors. This takes time from service provision.”
- “There is always a change of provider, or a billing issue, or a funding issue. We have a lot more flexibility with the funds from the district.”
- “Our services and our funding are all piecemeal. They aren’t coordinated, they just come to us.”
- “Despite the wealth of our community, there is no funding to bring in mental health services. We have a plan, but no resources to make it happen. We would like to see parents raise money for mental health services the same way that money is raised for sports or other supports.”

**Provider Perspective**

Providers who worked in settings without long-term funding for mental health services and supports spoke of the need to provide a consistent resource.

- “We need an outside full-time person on campus doing quality mental health services. Someone who really knows what they are doing and fits into the context of the school. The ability of that person to access resources depends on relationships. It doesn’t work to use interns. They don’t have the time to invest in building the relationships.”

- “I spend more than half my time building trust with the kids. The [therapist] was available last year, and I heard she’d be available this year, but I don’t know if she is. I don’t know who am I supposed to refer the student to.”
There were mixed outcomes from those who did have more stable funding. Some providers noted they appreciated the support, other noted that it may limit flexibility in service provision.

- “[One thing that is working well] is the school’s commitment to providing for services even when they are financially draining. It allows the [service provider] to be involved at the school.”

Though long-term funding was frequently cited as necessary and lacking, in one instance, a provider described reduced flexibility in the service provision and service availability. The provider stated that services for a particular mental health concern had been consolidated into one agency. The lack of available (and stable) funding meant that other agencies had stopped providing the services. For this agency, consolidating the funding provided more stability for the programs overall and allowed the agency to provide the full range of services. The drawback was that students who didn’t qualify for services with the single agency may not have other options in Napa County.

Use: Need for Equal Access to Mental Health Services and Supports
Schools and providers talked about a number of barriers that impede access to mental health services and supports. The barriers are not equally distributed among all Napa County residents. The services that are available are accessed less frequently by those without access to MediCal, those who do not speak English and those who are involved in the legal system.

Need for Equitable Insurance Coverage
Lack of access to insurance coverage was one of the reasons noted for lower utilization of existing services.

- “For the poorest of the poor... they are eligible for MediCal therapists or psychiatrists. For them, [community-based] services can work well, but it’s the 80-90% in between where it doesn’t work because they are not eligible.” --provider

- “We do a decent effort providing services for the indigent, those on MediCal, but working class/middle class individuals don’t have access to affordable mental health services. This is the wide gap of the underserved.” --provider

Need for Culturally and Linguistically Appropriate services
Schools, providers, and parents all noted a lack of providers who speak Spanish. This barrier to use was especially prevalent in the up valley communities, but still reported in Napa and American Canyon. Parents who spoke Spanish perceived that they waited longer for services because of the lack of providers. 62

62 See Section Two: Part Three: “Barriers to Accessing Mental Health Services and Supports”, Parent Perspective
**Need for Mental Health Services and Supports in Non-Traditional Schools**

Providers who were working with students in non-traditional schools spoke of layers of concerns that need to be addressed, and a very limited capacity to address them. One provider spoke about the need to calm kids who are having a crisis, despite not having a clinical background; the provider was often the one available when the “student lost it in class”. The teacher wants the student out of class, so the provider tries to address the issue.

- “One student is habitually truant. Do we send her to Juvenile Hall? [The last time she was truant,] I went to her house and talked to her. It turns out that she was physically ill in addition to being off her meds. Her parents aren’t around to take her to the doctor or notice. This is not a truancy issue. This is a family issue and a mental health issue.”

Students in non-traditional schools report more risks and both schools and providers reported fewer services. Though students in non-traditional schools have more supervision from probation and law enforcement, this is not a substitute for mental health services and supports. Parents expressed frustration with trying to access services and keep their child out of the legal system.

**Need for Mental Health Services for Students in the Justice System**

Data from 2006 indicates that of the 396 youth booked into juvenile hall, 158 were seen at least once for a mental health service. Thus, 40 percent of youth who required incarceration were provided mental health services, suggesting almost half of this population were not served in 2006. Despite this low level of services for those in need, school administrators reported that students in the legal system have access to more services and supports than those outside the justice system.

**Summary**

Stakeholders identified a list of unmet mental health needs that centered on improved availability, stability and utilization of mental health services and supports. Specifically, the following needs were identified. **Increased Availability of Mental Health Services and Supports** especially services and support available at school and in community, early intervention services, mental health services and supports for families, and system coordination and access. **Long-Term Funding to Improve Stability of Mental Health Service and Support Programs** and **Increased Use of Mental Health Services and Supports** by addressing insurance coverage, culturally and linguistically appropriate services and services for students in non-traditional schools and students involved in the justice system.

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63 Personal correspondence with Chief of Napa County Probation and Juvenile Hall Superintendent, Excerpted from Napa County Mental Health Services Act, Community Services and Supports, THREE-YEAR PROGRAM AND EXPENDITURE PLAN REQUIREMENTS, Fiscal Years 2005-06, 2006-07, 2007-08
Part Four: Recommendations

Impact of Mental Health Services and Supports
- Develop a common definition of success for mental health services and supports that incorporates the goals of the school, the mental health provider and the family.
- Discuss evaluation findings and academic outcomes for programs and students as appropriate to illustrate progress and understand how interventions work over time. This discussion should include schools, providers and families.
- Develop programs and interventions for children with behavioral concerns that continue to challenge students academically. In response to parent concerns, assist parents to keep children out of the justice system and in behaviorally and academically-appropriate services and supports.
- Consider resiliency as a common measure of success.

Unmet Mental Health Needs
- Review the accessibility of providers in Napa County. Especially consider ways to increase services for up valley communities.
- Add mental health services and supports for preschool and elementary school children. Include families when addressing mental health concerns and involve them in prevention efforts.
- Make system of mental health services and supports accessible for families to reduce the need for each family to navigate the services on their own.
- Develop long-term funding for mental health services to provide a consistent and reliable resource for schools, providers and families.
- Work with current providers to understand insurance coverage issues. Work with families to understand their insurance and whether or not mental health services and supports are covered.
- Work with providers to develop culturally and linguistically appropriate interventions. Accessible services for Spanish-speaking families will continue to be a need over the next 20 years due to changing demographics.
School-Based Mental Health Needs Assessment
Section Three: Impact of Mental Health Services and Unmet Needs

- Ensure mental health services and supports are available for students in settings where prevalence is known to be high and utilization low, specifically students in non-traditional schools and those involved in the justice system.
Section Four: Funding Sources
Part One: Summary of Current Research

A full review of the literature is included in Appendix A. Below are brief summaries of the current literature as it relates to topics in this section.

Funding Sources
Resources supporting children’s mental health in schools generates from several sources. “Major categories of financing include private health insurance, federal health insurance programs for low-income children, federal grants, and other sources that include state and foundation funds” (Grantmakers in Health, 2003, p. 6). Federal health insurance such as Medicaid and federal grants are a large source of funding for school mental health, as well as state and local agencies (Grantmakers in Health, 2003). Private insurance also covers some costs of services, although it is used to a lesser extent (Grantmakers in Health, 2003).

The limited nature of funding promotes competition rather than collaboration between various agencies and providers. “The competition is fueled by dependency on varied streams of funding and the lack of coherent connections and coordination among the host of public and private agents involved in addressing child/adolescent mental health, for example, pediatricians, primary care providers, those concerned with education, social welfare, and criminal justice (Policy Leadership Cadres for Mental Health in the Schools, 2001, p. 30).”

One way that schools are able to provide enhanced and/or coordinated services is by “braiding” federal education dollars. “[S]chools can seek waivers in order to braid together various sources of categorical program funding. An example is the Safe Schools/Healthy Students initiative that improved and expanded mental health services by combining three sources of federal funding” (Center for Mental Health in Schools and Center for School Mental Health Assistance, 2004).

Uninsured
Although people with an income level below the poverty line are eligible for Medi-Cal in California, others do not have any health insurance but cannot afford to pay out of pocket. “…[T]he poor (most often women and their children) are eligible for Medi-Cal. The remainder of the population (including lower-wage workers, part-time workers, the self-employed, lower-income men without families and undocumented workers) often have no health insurance. Children in such households tend to lack coverage (Oliva & McCandless, 2001, p. 13).” Some of the children who are eligible for public insurance are not enrolled in Medicaid. Researchers estimate that almost 40% of uninsured children would be eligible for Medi-Cal, and almost 30% would be eligible for the Healthy Families Program (Oliva & McCandless, 2001).
Concerns about Managed Care
Although managed care was implemented with the intention of a more comprehensive and integrated plan, there are several issues, including fragmentation of the system, less accountability, and less availability of services. Under managed care, fragmentation can occur due to the incentive to shift costs onto other public state agencies (juvenile justice, child welfare, or educational system), especially for youth needing long-term care (Brown, 2000). Accountability is an issue in that mental health administration has become much more of a local responsibility for the federal Medicaid program (Policy Leadership Cadre for Mental Health in Schools, 2001). Additionally, due to the emphasis on cost containment and limited benefits through carve-out plans, the availability for children to access mental health services decreased (Olbrich, 2002) as well as the ability for school-based health centers to provide services (Greiner, et al., 2001).

Cost-Effectiveness
Untreated mental illnesses cost the U.S. more than $300 billion dollars a year both directly and indirectly (Grantmakers in Health, 2003). However, the proportion spent on mental health only accounts for 7% of the total amount of money spent by the federal government on health care in the U.S. (Department of Health and Human Services, 1999, as cited by Olbrich, 2002). Research by the Institute of Medicine supports the cost-effectiveness of early childhood interventions, specifically for children from low-income households (American Counseling Association, et al., 2006, p. 2). However, the majority of mental health dollars go toward the most severe and long-term problems rather than prevention (Policy Leadership Cadre for Mental Health in Schools, 2001).

Mental Health Services Act
The Mental Health Services Act (Proposition 63) helped to focus California and the nation’s attention on how to improve the mental, emotional, and behavioral health of citizens. Passed by the citizens of California in November of 2004, the Mental Health Services Act (MHSA) provides funding for expanding and improving existing mental health services in California by levying a 1% tax on individuals with taxable income of over a million dollars. “...[I]t is estimated that by 2006-07, MHSA will raise over $700 million annually, a figure that is estimated to increase by 7 percent each year (Kadandale, 2005, p. 3).”
Part Two: Current Funding for Mental Health Services and Supports

When we spoke to school administrators, there was a general feeling that the non-profits and the county needed to provide more services in the community. When we spoke with the service providers, there was an equal and opposite feeling that the schools needed to provide more funding for the services at the school. Funding was often used interchangeably with “resources” and “responsibility”. The service providers described the schools’ responsibility to the student and the schools described the community’s responsibility to provide appropriate services to the student through the nonprofit and public agencies.

School Perspective
When schools were asked what type of funding they were using, some knew where the money came from; others identified the programs the service came from. Schools identified up to eight funding sources for the services currently available.

- “[We are] using everything we know about.”

Two of the school interviewees noted they were not currently interested in pursuing grant funding:

- “If there is other funding, I am not aware of it, I haven’t looked. It is not a screaming need [to provide more mental health services], the time to pay attention to it will probably be the time it is in flames on my desk.”

- “We use district and site funding. There are certainly grant opportunities out there, but it takes time and resources to go after them. We have used our site funds to increase the hours of our counselor, but it is still not enough.”

Two interviews noted that one community agency began charging for their services. This was not well-received by the schools.

- “This year a [community-based] provider told us they would be charging us for their services. The schools are completely focused on education and think everything else should be community-funded.”

Provider Perspective
Generally providers shared that the services in prevention and early intervention were very fragmented and tended to come and go as grant funding was available. Providers involved in treatment services described more stable but less flexible funding than those who provided prevention/early intervention services.

- “Schools have their own expectations; outside organizations do not always have the funding to meet their expectations.”
School-Based Mental Health Needs Assessment
Section Four: Funding Sources

- “It feels like [this agency] put all their eggs in one basket, nothing else was explored or prepared beyond the term of this grant.”

- “[The current system] is fragmented due to inconsistent, unstable funding and turf issues ... it would be more effective if there was ongoing, stable funding.”

- “Services are more inconsistent at early intervention, but the 3632 funding is limited to only tackling things that benefit the child’s education.”

- “The system of care grant ended eight years ago, and when we had it we used to partner in more discretionary ways... mentors for kids, helping in community...”

All providers spoke about the limited flexibility of their funding. Service providers noted they are accountable for using specific eligibility criteria and outcome measures. This leads to grant-driven programs rather than needs-driven programs.

One provider described a previous experience working as a school counselor. The students’ needs were addressed as they were identified and groups were developed based on an identified need within the student populations. When the need subsided, the group subsided. When a new need arose, a new intervention was developed.

This situation was much different from the current climate of grant-driven interventions. An identified need may or may not be as prevalent once the funding is found, applied for and received. A particular intervention may or may not be appropriate for a student, it might just be what is currently available and a “good enough” fit.

Some service providers spoke at length about the need for further funding for their particular agency and/or intervention and others advocated for funding to create a more coordinated and flexible system of care for school-aged children and their families. Generally, providers who were facing imminent funding cuts were more focused on funding their intervention and providers who had more stable funding wanted to work toward more flexibility.

There was no mention in the interviews about the role of the HMOs or the large health care providers in Napa County in addressing the mental health needs of students.

Parent Perspective
Besides mentioning 3632 funding at length,\(^64\) parents did not generally identify the funding sources for the services they received.

\(^64\) See Section Two: Part Two, “School-Based Coordination Teams”, Parent Perspective.
Summary

Schools and providers reported using all known and accessible funding sources. Both indicated frustration with the restrictive and transitory nature of grant-funded programs and preferred long-term flexible funding sources to provide appropriate services effectively.
Part Three: Summary of Potential Funding Sources

Grant Appendix
The review of literature\(^{65}\) mentions a number of public sector resources for funding mental health services in the schools. Appendix C was developed to highlight possible private sector grant resources for school-based prevention, early intervention, and mental health services for children and youth.

Information was gathered from the subscription-based, online database maintained by the Foundation Center in San Francisco. Key search words included:

- Children
- Youth
- Mental health
- Schools
- Prevention
- Screening
- Early identification
- Early intervention
- Treatment
- Post traumatic
- Youth leadership
- Youth development
- Severe emotional disturbance
- California
- Bay Area
- Napa

After the automated search was completed, each entry was reviewed to determine relevance for this report. Fifty-nine potential funding sources are included in the appendix.

\(^{65}\) See Appendix A
Part Four: Recommendations

Current funding is fragmented and restrictive and perpetuates difficulties in treating the whole child. Consider adopting guidelines for funding that reduce the service barriers described by schools and providers. These guidelines are intended to be used during the development of new funding sources, and shared with schools and providers who are seeking funds.

In developing priorities for funding prevention and early intervention as well as mental health services and supports for children and youth in Napa County, consideration should be given to the following guiding policies\(^6\) (in addition to Mental Health Services Act guidelines):

- **Implement a Comprehensive Approach:** The approach should focus on both strengthening services and supports for children with serious emotional disorders and their families and on prevention and early intervention strategies for all children.

- **Finance a Broad Array of Services and Support:** Funding for home and community-based services and supports that are individualized, family-focused, coordinated, and culturally-competent. Included are funds to develop and maintain an interagency, coordination infrastructure (e.g., co-location, cross-training, team support).

- **Strengthen Family and Youth Partnerships and Family Support:** Ensure that families, substitute families, and other caregivers, as well as youth, are full partners and have substantial involvement in all aspects of service planning and decision making for their children.

- **Individualize Care: A Single Plan of Care for a Child and Family:** Children and youth with a serious emotional disorder have an individualized, single plan of care (Individualized Service and Support Plan – ISSP) that addresses the child or youth and family’s needs across life domains and incorporates services and supports from all needed agencies and systems.

- **Broaden the Range of Services and Support:** Promote a broader concept of “mental health” services for children and youth with emotional disorders and their families. Include a comprehensive array of treatment services and supports needed to enable individuals to reach and maintain their optimal level of functioning within their homes, schools, and communities.

- **Strengthen Mental Health Services to Children Within Schools:** Recognize and address the mental health needs of children and youth in the education system. Work collaboratively with families and develop, evaluate, and disseminate effective approaches for providing mental health services and supports to children and youth in schools.

• **Screen High-Risk Populations and Link Them with Services:** Systematic screening procedures to identify mental health and substance abuse problems and treatment needs should be implemented in specific settings in which youngsters are at high risk for emotional disorders or where there is known to be a high prevalence of these or co-occurring mental health and substance abuse disorders. Screening should be implemented upon entry into, and periodically thereafter in, the juvenile justice and child welfare systems, as well as in other settings and populations with known high-risk, such as the Medicaid population. When mental health problems are identified, youth should be linked with appropriate services and supports.

• **Strengthen Early Childhood Mental Health Interventions:** A national effort focusing on the mental health needs of young children and their families should be implemented. Grounded in emerging neuroscience research highlighting the ability of environmental factors to shape brain development and subsequent behavior, this effort should include educating parents, the public, and professionals about the importance of the first years of a child’s life for developing a foundation for healthy social and emotional development.

• **Prevent Mental Health Disorders:** Develop and implement a comprehensive approach for enhancing the well-being of children and youth, based on a bio-psychosocial model, through preventive interventions prior to the onset of mental and behavioral disorders.

• **Build an Adequate Workforce:** Work in partnership with state governments, national accrediting organizations, professional disciplines and organizations, licensure entities, family organizations, and universities to ensure an adequate workforce for the delivery of children’s mental health services.
Conclusions and Recommendations
Part One: Summary of Current Research

A full review of the literature is included in Appendix A. Below are brief summaries of the current literature as it relates to topics in this section.

Continuum of Intervention

Instead of focusing on implementing particular programs that can lead to fragmentation, the Policy Leadership Cadre for Mental Health in Schools (2001) recommends integrating the systems that provide services. Such integration would combine school and community resources to create the systems of prevention, systems of early intervention, and systems of care for more serious or chronic problems.

- **Prevention** is designed to avoid the onset of mental health issues by offering information and coping strategies before problems begin.

- **Screening** is a process that identifies particular individuals out of the larger group that are at risk of developing mental health issues or are demonstrating early warning signs.

- “*Early intervention programs are generally targeted toward children and adolescents and aim to detect and address mental, emotional, behavioral, or learning problems before they become established and more difficult to treat or reverse* (Grantmakers in Health, 2003, p. 15).”

- **Crisis response** is the ability for professionals and the school system to identify and appropriately respond to a mental health crisis.

- **A system of care** is the assortment of treatments necessary when mental health problems are severe and chronic.

The earlier interventions (prevention, screening and early intervention) are less costly per student and reflect a lower level of need. The interventions that follow a mental health crisis, such as a system of care, are more costly per student and are only offered to particular students (Center for Mental Health in Schools, 2002).

The Importance of Collaboration and Coordination

The literature highlights the tendency to try to compensate for unmet needs with services that disregard the existing services in the school and community. As a result, some services are duplicated while other needs remain unaddressed. The literature concludes that there is a need for greater collaboration and coordination reflected in a more comprehensive approach to providing services at all levels, from prevention to a system of care (Center for Mental Health in Schools and Center for School Mental Health Assistance, 2004).
Integration of Mental Health Services in Schools
The Center for Mental Health in Schools (2002) and the Policy Leadership Cadre for Mental Health in Schools (2001) argue that in order for mental health services to be successful, schools must change the infrastructure of the school system to integrate mental health as a more central component. The Center for Mental Health in Schools emphasizes the importance of an "enabling component" that, in addition to school management and instruction, provides a more preventative and responsive environment. The Policy Leadership Cadre for Mental Health in Schools highlights the need for a more integrated set of services rather than adding programs with a narrow focus simply because they have an evidence base in a limited application.

Research-Based Practices
A program is considered evidence-based if research has shown efficacy in gaining results. There are different levels of evidence-based research depending on the amount of research conducted and the credibility of the study. "The evidence base for treatment of child and adolescent mental health disorders is limited, but growing. Specific school-based and family interventions have shown success, as have specific forms of psychotherapy, although most evidence is from experimental rather than actual practice settings" (Van Landeghem, et al., 2005, p. 16). In evidence-based practices as in all practices, there is always a need to tailor and customize services and supports to meet local cultural conditions. Funding usually supports evidence-based practices.

Cultural Competence & Underserved Groups
White students are much more likely to receive mental health assistance, whereas Latino, African American and Native American students experience the same or greater need and yet do not receive services (Hernandez, et al., 2006). There are several important avenues for increasing access, including outreach, intake procedures, and attention to ethnic matching and culturally-competent practice. Hernandez, Nesman, Issacs, Callejas, & Mowery (2006) suggest that the school system, as well as the neighborhood center, can be a way to increase utilization of needed services as children and adolescents can access mental health services while minimizing the stigma associated with therapy.

Student and Family Involvement
The input from service users needs to be included in the quality improvement process. "As the persons most affected by service provision, service users and their families are in the best position to identify improvement opportunities and to have an active role in improvement plans. Therefore, quality improvement activities should involve service users and their families at every level of development (Allegheny County Coalition for Recovery Child and Family Committee, 2006, p. 7)."
Part Two: Suggested Changes to the Current System of School-Based Mental Health Services and Supports

School administrators, counselors, nurses, teachers, service providers and parents were asked, “If you had a magic wand, what one thing would you change about school-based mental health services and supports?” Comments are identified by the stakeholder group: school, provider or parent.

Focus on the child

• “Be realistic in our expectations for students. Not every student will go to Yale. What are the other goals we can set for them and help them achieve? Right now, it seems we are expecting every child to come out academically perfect. This is so hard for some of the kids.” —school
• “Make kids and their needs visible and a priority” —provider
• “I would use my magic wand to sprinkle everyone’s head with the reminder to focus on the child, and to look directly at how best to serve kids.” —parent
• “Take the focus off of ‘who’s to blame?’ and put it on the well-being of the child.” —parent
• “Don’t label [kids], figure out WHY” —parent

Increase knowledge and understanding of mental health concerns

• “Professional development for all staff, the opportunity to learn more about mental health challenges kids are likely to face and the organic reasons for behaviors. They are all working with these kids every day.” —school
• “Offer units to attend workshops regarding mental health challenges. We are not special education experts.” —school
• “Case managers who are educated and intelligent and can work with families. When parents don’t respond, kids will.” —school
• “More training available to teachers to help them identify mental health concerns in their students.” —school
• “I don’t care for [the mental health] personnel providing services - I thought all the blame was placed on teachers” —school
• “Improved administrative attitude and belief in the services.” —school
• “Increase not only the number of counselors available K-12, but assure their expertise in youth issues and ability to effectively help students deal with these issues” —school
• “Educate people more about how services are beneficial. Some students and families hide their needs and struggle without supports. Others are not used to asking [for] and receiving services. If we can’t uncover the needs, we can’t address them. Help them recognize when they need help” —school
• “Not enough providers were educated to identify my son’s issues. No one was willing to look past the anxiety diagnosis.” —parent
• “There should be a clinical advisor in the schools” —parent
School-Based Mental Health Needs Assessment
Conclusions and Recommendations

• “Someone has to have expertise...who is responsible for becoming the expert?” —parent
• “I am concerned about the professional qualifications of the district staff making decisions about children’s mental health needs.” --parent
• “Sensitivity training for the principal...regarding mental health issues” --parent

Increase availability of mental health services and supports at school sites

• “More resources!” —school
• “More funding for services” —school
• “MORE HELP! I would like four of me to be available. One counselor per grade level.” —school
• “Parents raising money for mental health services and supports.” —school
• “I want the mental health services to EXIST. Consistently every year with good stable people.”--school
• “Get mental health workers on campus.” —school
• “It would be great if Napa as a community could find a way to recruit and train more people into the field of mental health.” —school
• “A gang-prevention group for at-risk students, with ex-gang members facilitating” —school
• “All students who need help would have services available”—school
• “Be easier for the child to get help quicker.”—school
• “Even though we have a small school, the more people helping students with mental health needs, the better”—school
• “Have a nurse available full-time at elementary campuses...for initial contact in an emergency situation”—school
• “Have an on-site psychologist”—school
• “Have more types of services to give students coping skills.”--school
• “Have the school psychologist on site more than one day per week.”--school
• “Having the psychologist at the school more.”--school
• “Home visits by psychologists.”--school
• “I’d like to see an evaluation be available to those we think may be having extreme issues. A referral to services in the area should be made available based on the results.”--school
• “I think that every school needs a mental health professional on campus for at least two days out of every week. The school guidance counselor cannot be expected to deal with these issues in addition to all of the scheduling and testing responsibilities she has.”—school
• “I would like to see every student who needs help, get help. Even if it is on a drop-in basis to talk over a small problem, so they can feel heard and learn some coping skills. Classroom teachers just don’t have time for it anymore.”—school
• “Increased funding so that the school district could afford to employ more mental health professionals on a full-time basis, especially Ph.D. level psychologists.”—school
• “Make more services available and include services to the whole family.”—school
• “More counselors.”—school
• “More time for counselors to work with students.”—school
School-Based Mental Health Needs Assessment
Conclusions and Recommendations

- "Need more adults. Need home visits."—school
- "Need more full time counselors on each campus."—school
- "Need more professionals."—school
- "Not enough staff/specialists to meet the student need at our school."—school
- "On site mental health services."—school
- "Our school counselor needs more time on campus, as much of her time is taken up with responsibilities other than working directly with kids."—school
- "Provide a time students that need help can be pulled for individualized help."—school
- "We have very few services for kids in need. Our psychologist is literally only here for a couple of hours a week."—school
- "We need more qualified people and more hours of service."—school
- "We need on-site or at least phone call available expert help for our students."—school
- "We should have a counselor on-site that can deal specifically with emotional issues not just scheduling and career issues."—school
- "Students from the regular education (not special ed) should be able to access school therapists during school hours."—school
- "Students should be able to receive more help from school psychologist."—school
- "The availability of providers; the time it takes for the referral to process; the ‘activities’ done by providers are lacking."—school
- "The one or two people hired to fill this role on campus are not on campus each and every day. They split their time between schools."—school
- "There aren’t enough spots for all students needing services."—school
- "More on-site counseling and the ability to refer students out to community resources. More groups and more partnering with community agencies."—school
- "I would like the ratio of mental health professionals to students to go down."—school
- "Permanent therapist support"—school
- "To actually have a system of school-based mental health services"—provider
- "School counselors at every elementary school"—provider
- "A mental health professional on site all the time or available by phone for backup"—provider
- "Increase the hours of the counselors on campus"—provider
- "One full-time quality person doing mental health services on the campus."—provider
- "Put the money in the elementary schools and provide parenting classes. Especially around discipline"—provider
- "School counselors on every campus."—provider
- "I want the district to provide before the fight"—parent
- "Parents aren’t always able to help. School needs to step up and do it."—parent
- "Remove barriers to 3632, response to intervention takes time."—parent
Provide space on campus for mental health services and supports
- “More confidential spaces on campus that are appropriate for mental health services” — school
- “More permanent, cozy, dedicated space for interventions” — school
- “I would make space on campus not an issue” — provider

Involve parents in the system of mental health services and supports for school-aged children.
- “The ability to connect with families better around specific behavior plans” — school
- “Connect with social services. With a PERSON, not a list. Someone who can meet with parents and talk about what’s available and help families who are too proud to ask for help.” — school
- “Change parent behavior. Positive family relationships are very powerful mental health supports.” — school
- “There isn’t enough counseling for parents to support them with economic issues as well as drug and alcohol use.” — school
- “We need more places to refer parents—especially for low or no cost counseling and therapy for families that are Spanish-speaking and have no insurance.” — school
- “Having the services that are in the community visit the schools and inform parents about their services.” — school
- “Work with parents to help them support their child’s academic success” — provider
- “Address parents’ responses to child’s behavior. 60-70% of parents are triggered by their child’s behaviors. If a parent comes from an abusive background, their response to their child’s tantrums may be to shut down, rather than help the child manage the behaviors.” — provider
- “All schools [should] have a link to family resource centers and a person on the school campus to link families to the FRC. The community services exist, the missing link is the human to connect them.” — provider
- “Embrace parents’ perspective. DO NOT alienate parents. Allow advocacy.” — parent
- “Parents need different forums; the ways we invite people to participate currently DOES NOT WORK.” — parent
- “Parent’s requests are seen way too easily as asking for the moon.” — parent
- While parents understand how professionals are helping their child in the school setting, or in therapeutic services, several parents reported feeling unequipped to deal with challenging situations at home.

Consider alternative approaches
- “Do it differently, don’t just do MORE” — parent
- “Consider alternatives instead of pushing past resistance to treatment barriers.” — parent
- While privacy was highly valued, several families shared that they wanted to be treated as a whole family. Having a home visitor come to their home and pay attention to the context of their family and the needs of all the members was more valued for these families than having a
Coordinate the system of mental health services and supports

- “Coordinate all counseling and small groups on early release day”—school
- “Make services more accessible to students. Not just somewhere on campus, but also someone else available on call for students in crisis.”—school
- “Develop avenues to foster communication and share information about programs”—school
- “Have a way for school counselors to gather and discuss common themes in their work. Resources? Concerns? Solutions?”—school
- “Provide greater access for teachers to know who is receiving services and when, by whom”—school
- “I need more information about what is available and a more ready system of intervention when needed. As a classroom teacher, it is nearly impossible to attend to the mental health issues of our students. We need a ready method of intervention and response when we see students in need.”—school
- “Overall speed of referral process”—school
- “Process is very lengthy”—school
- “Speed up the process for counseling”—school
- “The support system for students in special education is not as clear as those students in the general population. In addition, we could have more groups, adapted to ability level, and more diverse needs. For example, we have one group for preventing drugs and alcohol, and one bullying group. I would like to see the bullying group divided into segments (most severe and least severe) as well as adding a group for kids who lack social skills.”—school
- “Clear process about how to get services for students you have concerns about.”—school
- “Be less rigid about what therapists and counselors can do within school setting”—provider
- “Develop a clear understanding of what each agency or school can do….we need a cohesive plan, one with flexibility, not so rigid but with some ability to meet needs of people in a coordinated way, and especially those children/families who are not eligible for some services but can’t afford to pay on their own.”—provider
- “Make a systematic change to a more coordinated system. There are plenty of services available; we need to address the issues of access and barriers.”—provider
- “Get all providers working on the campus to attend the CORE team meetings.”—provider
- “I want the principal to be more responsive.” (Parent left messages for principal about concerns and did not hear back for over two weeks.)—parent
Focus on prevention

- “Refocus on prevention rather than crisis management”—provider
- “Feeling-based curriculums about how to identify and deal with feelings. Devote 1-2 hours a week to students’ emotional education”—provider

More community-based supports

- “A divorce group is really needed in the community for students coping with changes in their families.”—school
- “More child psychiatrists in Napa County.”—provider
- “Greater access for all... from the student to the family to be able to have access to a full spectrum of supports.”—provider
- “Lower the criteria to get services.”—provider
- “Guarantee consistent funding for full spectrum of mental health services”—provider
- “Improved geographic and economic access to mental health services”—provider
- “More therapists up valley including Spanish-speaking and low cost services.”—provider
- “Make services available to every child.”—provider
- “More skilled therapists trained specifically to work with kids”—provider

Stable funding

- “Make money not an issue.”—provider
- “I wish it weren’t so hard to fight for funding. The time we put into accountability—why do providers have to fight so hard to provide needed services?”—provider

Advocacy

- “Increase awareness among those who make decisions about funding and programs. They need to understand how the shifts in policies and dollars actually impact schools, students and families.”—school
Part Three: Basic Tenets of School-Based Mental Health Services

Underlying the development or expansion of school-based mental health services and supports, there should be an agreed upon set of values, beliefs and practices. The following twelve tenets support the development of common values and goals with schools, providers and families67 and reflect the recommendations from schools, providers and parents.

- **Services coordinated with educational programs**: The mental health program (preventive strategies and mental health services) should be coordinated with educational programs and other school-based health services. School social workers, guidance counselors, school psychologists, school nurses, and all mental health therapists should plan preventive and intervention strategies together with school administrators and teachers as well as with families and community members.

- **Comprehensive prevention services**: Preventive mental health programs should be developed that include a healthy social environment, clear rules, and expectations that are well publicized. Staff members should be trained to recognize stresses that may lead to mental health problems as well as early signs of mental illness and refer these students to trained professionals within the school setting.

- **Referral protocols**: Mental health referrals (within the school system as well as to community-based professionals and agencies) should be coordinated by using written protocols, should be monitored for adherence, and should be evaluated for effectiveness.

- **Peer-reviewed practices**: School-based specific diagnostic screenings, such as for depression, should be implemented at school only if they have been supported by peer-reviewed evidence of their effectiveness in that setting.

- **Defined roles**: Roles of all the various mental health professionals who work on campus with students should be defined so they are understood by students, families, all school staff members, and the mental health professionals themselves.

- **Varied types of therapy**: Group, individual, and family therapies should be included as schools arrange for direct services to be provided at school sites. Alternatively, referral systems should

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<http://aappolicy.aappublications.org/cgi/content/full/pediatrics;113/6/1839>
be available for each of these modes of therapy so that students and families receive the mode of therapy most appropriate to their needs.

- **Staff training**: It should be documented that mental health professionals providing services on site in school (whether hired, contracted, or invited to school sites to provide services) have training specifically in child and adolescent mental health (appropriate for students’ ages) and are competent to provide mental health services in the school setting.

- **Location**: Private, confidential, and comfortable physical space should be provided at the school site. Often, this is not difficult for schools if mental health services are provided after school hours. Having school-based services should not preclude the opportunity for mental health services to be provided at non-school sites for situations in which therapy at school for a student may be ill advised. During extended school breaks, schools must provide continued access to mental health services.

- **Clinical supervision**: Staff members should be provided with opportunities to consult with a child psychiatrist or clinical psychologist (on or off the school site) so that they may explore specific difficult situations or student behaviors and review school policies, programs, and protocols related to mental health.

- **Quality-assurance**: Strategies should be developed for mental health services provided at school, and all aspects of the school health program should be evaluated, including satisfaction of the parent, student, third-party payers, and mental health professionals.

- **Confidentiality**: Health information should be confidentially maintained, as mandated by law.

- **Support from school board**: Policies should be in place at each district which support the development and importance of school-based mental health services.
Part Four: A Continuum of School-Based Mental Health Services and Supports

Below are seven commonly used strategies of providing partial or comprehensive mental health services and supports in a school environment\(^{68}\) from the least to the most comprehensive. The most comprehensive approach would be a combination of all seven strategies.

**Step 1: School Policies**
Development and enforcement of school district policies that support a safe, disciplined, and drug-free learning community.

**Step 2: School-Financed Student Support Services**
Use of pupil services professionals (such as school psychologists, counselors, and social workers) to perform services related to mental health and psychosocial problems. Services can include:

- Crisis intervention and emergency assistance (e.g., suicide prevention, post-trauma, food, clothing, transportation);
- Needs assessment, gate-keeping, referral, triage, and case monitoring/management (e.g., participating on student study/assistance teams; facilitating communication among all concerned parties);
- Development and support of accommodations to allow for differences and disabilities;
- Positive development, and wellness (e.g., guidance counseling, contributing to development and implementation of health and violence reduction curricula);
- Placement assistance; advocacy; liaisons between school and home; gang, delinquency, and safe-school programs; and,
- Multidisciplinary teamwork, consultation, training, coordination of activities (across disciplines and components), and supervision to increase the impact of direct services.

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\(^{68}\) Excerpted and adapted from Mental Health in Schools: Guidelines, Models, Resources, & Policy Considerations (May, 2001). Policy Leadership Cadre for MH in Schools, Center for Mental Health in Schools, School Mental Health Project, Department of Psychology, UCLA) http://smhp.psych.ucla.edu and U.S. Dept. of Health and Human Services, Substance Abuse and Mental Health Services Administration’s Center for Mental Health Services.
Step 3: Classroom-Based Curriculum and Special “Pull Out” Interventions
Specific instructional activities designed to promote healthy social and emotional development and/or prevent psychosocial problems such as behavior and emotional problems, school violence, and drug abuse. For example:

- Integrated instruction as part of the regular classroom content and processes;
- Specific curriculum or special intervention implemented by personnel specially trained to carry out the processes; and,
- A curriculum approach as a part of a multifaceted set of interventions designed to enhance positive development and prevent problems, such as after-school programs.

Step 4: School-District Mental Health Unit
Develop specific mental health units that include clinic facilities, as well as providing services and consultation to schools. Some districts develop school-based health centers with a mental health service component. Typically, units are off-site and provide outreach to schools.

Step 5: Formal Connections with Community Mental Health Services
The development of formal connections with community agencies, such as:

- Co-location of community agency personnel and services at schools (partly financed by community health or mental health organizations);
- Formal linkages with agencies to enhance access and service coordination for students and families at the agency, at a nearby satellite clinic, or in a school-based or linked family resource center;
- Formal partnerships between a school district and community agencies to establish or expand school-based or linked facilities that include provision of mental health services; or
- Contracting with community providers to provide needed student mental health or health services at school and/or off campus.

Step 6: Comprehensive Prevention and Early-Intervention Strategies
While not typical, the development of a comprehensive prevention and early intervention strategy is critical to strengthening school-based mental health services and supports for children. Strategies should include:

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69 U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. School Mental Health Services in the United States (2002-2003).
School-wide approaches to promote safe, drug-free schools;
• School-wide programs to prevent alcohol, tobacco, or drug use;
• Prevention and pre-referral interventions for mild behavioral or mental health problems;
• Curriculum-based programs designed to enhance social and emotional functioning;
• Peer counseling/medication, support groups;
• Outreach to parents regarding mental health (e.g., signs, symptoms, stigma); and
• School-wide screening and referral resources for behavioral or emotional problems.

Step 7: Comprehensive, Multifaceted, and Integrated Approaches
Restructure student support services that integrate community resources and all instructional efforts that affect healthy development. The intent is to develop a full continuum of programs and services encompassing efforts to promote positive development, prevent problems, respond as early-after-onset as is feasible, and offer treatment regimens.

Mental health and psychosocial concerns are a major focus of the continuum of interventions. Efforts to move toward comprehensive, multifaceted approaches are likely to be enhanced by initiatives to integrate schools more fully into systems of care and the growing movement to create community schools.

A comprehensive approach would include all services previously described, plus the following:

• Assessment for emotional or behavioral problems or disorders (including behavioral observation, psychosocial assessment, and psychological testing);
• Behavior management consultation (with teachers, students, family);
• Case management (monitoring and coordination of services);
• Referral to specialized programs or services for emotional or behavioral problems or disorders;
• Crisis intervention;
• Individual counseling/therapy;
• Group counseling/therapy;
• Substance abuse counseling;
• Referral for medication assessment and/or management; and,
• Family support services (e.g., child/family advocacy, counseling).
Appendix A
Summary of Current Literature
Review of Literature Regarding School-Based Mental Health Services

Introduction
Many children in the United States are in need of mental health services, and schools are said to be the largest provider of such services. The best practices of providing mental health services in schools, or any environment, include:

- Coordinating a continuum of care that ranges from prevention to treatment of severe and chronic problems;
- Emphasizing cultural competence;
- Incorporating the individual and family voice into services and supports; and
- Using practices supported by research.

However, services are generally provided based on available funding, rather than need, which typically produces fragmented and overlapping services. Greater collaboration is called for, and a broader approach to mental health that incorporates resilience as a vital part of the system of care.

National Trends

Mental Health as an Issue for Children and Adolescents
A quarter of the U.S. population is comprised of children (Federal Interagency Forum on Child and Family Statistics, 2006). In fact, 73 million children below the age of 18 lived in the U.S. as of 2004 and the population of children is expected to increase to 80 million by 2020 (Federal Interagency Forum on Child and Family Statistics, 2006). In California, there were an estimated 9.6 million children in 2005 (www.kidsdata.org). Kadandale (2005) estimates that in California 20% of all children and youth will experience a mental health disorder in any given year. However, it is also estimated that only 16% to 20% of children and youth who need mental health services will actually receive them. (Center for Health and Health Care in Schools, 2003).

Children receive fewer services than adults and have more difficulty gaining access to services (Brown, 2000; Grantmakers in Health, 2003). Usually services are created for adults and later revised to include children rather than designing the services to meet the children’s needs (Brown, 2000). Some of the potential consequences of untreated mental health issues to children are “school failure, alcohol or other drug use, problems with relationships, violence, and suicide” (Oliva & McCandless, 2001, p. 34). Many of these issues interfere with the child’s ability to learn and to contribute to a positive learning environment.

70 In 2000, there were approximately 31,000 practicing school psychologists (providing assessment, planning, and treatment services) to children with learning problems in 85,000 schools (Grantmakers in Health, 2003).
Overview of Mental Health Services in the Schools

Schools are the largest provider of mental health services to children and adolescents, (Health Human Services, 1999, as cited by Grantmakers in Health, 2003). There are about 90,000 schools in the United States located in approximately 15,000 districts that serve our nation’s children and youth (Center for Mental Health in Schools and Center for School Mental Health Assistance, 2004). Public schools are the one resource to which all children have access and are expected to attend on a regular basis regardless of socioeconomic status and background. The vast majority (70% to 80%) of children receiving mental health assistance obtain the services in a school setting (Center for Health and Health Care in Schools, 2003).

Schools are expected to address any issue that interferes with learning, which can include mental health issues. “Schools often function as the de facto mental health system for children. School-based mental health services have been defined as any program, or intervention that has been applied in a school setting that was designed to influence the students’ emotional, behavioral or social functioning” (Olbrich, 2002, p. 11). The Carnegie Council Task Force on Education of Young Adolescents stated in 1989 that although not all services must be provided in the school, the educational system is responsible for those addressing those needs that impede the ability to learn (American Counseling Association, American School Counselor Association, National Association of School Psychologists, School Social Work Association of America, 2006). Some of the public, policymakers, and educators are hesitant about describing mental health services as an imperative in schools (Policy Leadership Cadre for Mental Health in Schools, 2001), however, appropriate treatment of mental health disorders is considered in the literature an important part of addressing barriers to learning.

Mental health issues can affect the ability of the student to succeed in a learning environment. For example, students with mental health needs drop out of school at almost twice the rate of other students (Lehr, et al., 2004, as cited by American Counseling Association, et al., 2006). According to the Center for Mental Health in Schools and Center for School Mental Health Assistance (2004), addressing mental health issues is imperative to learning and schools are an effective way of accessing needed mental health services.

Mental health services in schools are provided in many different ways, both formal and informal, within the school and contracted out to the community.

- “The literature reflects a variety of types of services, the location and source of services and the professionals that provide the service. Mental health services in schools are provided through different arrangements, which vary, by school environment....Services in schools can be provided through various arrangements: through the school as stand-alone services, through the community at the school as stand-alone services, through programs for specific mental health issues, and through school based health centers” (Olbrich, 2002, p. 11).

There is currently no national database that catalogues how schools are providing mental health services (Policy Leadership Cadre for Mental Health in Schools, 2001). However, in 2001, the federal
government funded a survey to gather basic information regarding mental health services in schools (Policy Leadership Cadre for Mental Health in Schools).

Services provided can include evaluation, assessment, individual and group counseling, crisis intervention and referrals (Olbrich, 2002). Prevention and screening services are also often provided in the schools (Policy Leadership Cadre for Mental Health in Schools, 2001). Case management is a service that over 80% of schools report providing for children with behavioral or social difficulties (Center for Health and Health Care in Schools, 2003). The Center for Mental Health in Schools and Center for School Mental Health Assistance (2004) states:

- “...most schools have some programs to address a range of mental health and psychosocial concerns, such as school adjustment and attendance problems, substance abuse, emotional problems, relationship difficulties, violence, physical and sexual abuse, delinquency, and dropouts. And, there is a large body of research supporting the promise of much of this activity” (p. 18).

These services and the research will be further discussed in the subsequent section on best practices.

Mental health services are provided in the schools by a range of professionals that include school psychologists, social workers, mental health counselors, and psychiatrists (Olbrich, 2002). Pupil personnel services (PPS) are professionals especially certified to provide mental health services in schools. The number of PPS staff hours in a district is determined by federal and state mandates and the school district has some flexibility in their distribution of the Full Time Equivalency hours (FTE) (Center for Mental Health in Schools, 2002). In larger districts, the roles and responsibilities of professionals sometimes overlap and the programs can be fragmented (Center for Mental Health in Schools, 2002). The problems of overlapping and fragmentation are exacerbated by the shortage of trained professionals working in the schools. The ratio between students and school counselors is reportedly more than double what it should be (513 students to 1 counselor instead of the recommended ratio of 250:1) according to the National Center for Educational Statistics (Grantmakers in Health, 2003). In addition, options for referral of children to community resources for needed mental health services are limited (American Counseling Association, et al., 2006).

**Best Practices**

The literature has a variety of suggestions for the best practices of mental health services in the schools. The need for a continuum of care and the need for collaboration and coordination of services to avoid fragmentation are two prevalent themes in the literature.

- *Awareness is growing that there can never be enough school-based and linked ‘support services’ to meet the demand in many public schools. Moreover, it is becoming more and more evident that efforts to address barriers to student learning will continue to be marginalized in policy and practice as long as the focus is narrowly on providing ‘services’* (Center for Mental Health in Schools, 2002, p. 13).
Another major theme is the application and implementation of research-based programs. (Note: Some argue that a narrow focus on adding programs may add to fragmentation.) Each of these areas of best practices will be further explored.

Continuum of Intervention
The literature reflects the established practice of providing a continuum of services that include prevention, screening, early intervention, crisis response and a system of care for children or youth with severe or chronic mental health challenges. Each of the services on the continuum of services is defined by their place on the timeline of a mental health issue and by the individuals to whom they are offered:

- **Prevention** is designed to avoid the onset of mental health issues by offering information and coping strategies before problems begin. Prevention services are usually provided school-wide or to large groups of potentially at-risk students and/or families, such as general drug and alcohol education. Prevention efforts can be described as:
  - **Universal** -- Intended to reach all members of the community;
  - **Selective** -- Directed toward people with some risk, often based on their membership in a vulnerable subgroup; and
  - **Indicated** -- For people identified as having the greatest risk based on specific symptoms or signs but who lack the criteria for a mental health diagnosis (*California Mental Health Services Oversight and Accountability Commission’s Prevention and Early Intervention Funding Criteria, 2006)*.

- **Screening** is a process that identifies particular individuals out of the larger group that are at risk of developing mental health issues or are demonstrating early warning signs. The screening process should also determine if, and what type of services, are needed for those individuals. After a screening, an early intervention would ideally take place.

- **“Early intervention programs are generally targeted toward children and adolescents and aim to detect and address mental, emotional, behavioral, or learning problems before they become established and more difficult to treat or reverse (Grantmakers in Health, 2003, p. 15).”** An example of an early intervention program would be learning or behavior accommodations for a child experiencing mild to moderate problems (Center for Mental Health in the Schools, 2002).

- **Crisis response** is the ability for professionals and the school system to identify and appropriately respond to a mental health crisis.

- **A system of care** is the assortment of treatments necessary when mental health problems are severe and chronic. Once mental health concerns are at this point, the child necessitates a higher level of care, which usually incorporates resources both within and external to the school system (Center for Mental Health in Schools, 2002). The goal is to tailor the system of care to the individualized needs of the child and family. An example of a system of care approach might be a wraparound program that includes the judicial system, the child welfare system and the school system in providing long-term treatment to a child as needed.
The earlier interventions (prevention, screening and early intervention) are less costly per student and reflect a lower level of need. The interventions that follow a mental health crisis, such as a system of care, are more costly per student and are only offered to particular students (Center for Mental Health in Schools, 2002). Preventative efforts have yielded promising results in reducing future need for costly services such as juvenile detention and welfare dependency, as well as improving school readiness, academic achievement, and health status and reduce the need for grade retention (Van Landeghem, Hess, Finan, & Shartzer, 2005).

A focus on prevention as a cost-saving measure over time is reflected in the inclusion of health centers within the schools. Physical health as well as mental health is often considered part of the continuum of services that in best practice is offered to children through the schools. Such a belief is reflected in the concept of the School Based Health Center, which provides both physical and mental health services within the schools. Some organizations such as the Center for Health Care in the Schools also advocate for dental services within the schools (Greiner, Nickerson, & Rosenberg, 2001).

Instead of focusing on implementing particular programs that can lead to fragmentation, the Policy Leadership Cadre for Mental Health in Schools (2001) recommends integrating the systems that provide services. Such integration would combine school and community resources to create the systems of prevention, systems of early intervention, and systems of care for more serious or chronic problems. “The intent is to develop a full continuum of programs and services encompassing efforts to promote positive development, prevent problems, respond as early-after-onset as is feasible, and offer treatment regimens” (Policy Leadership Cadre for Mental Health in Schools, 2001, p. 23). Some recommended routes to implementing service integration include forming a subcommittee in the Board of Education on mental health, and including school-based mental health clinicians as part of the district administrative decision-process and policy implementation (Policy Leadership Cadre for Mental Health in Schools, 2001).

**Student Assistance Programs (SAP)**

Another model of service delivery in the school environment is the Student Assistance Program (SAP). The SAP provides a comprehensive model for the delivery of K-12 prevention, intervention and support services. Student assistance services are designed to reduce student risk factors, promote protective factors and increase asset development. The nine SAP components described below are recommended, as the minimum requirements needed to reduce barriers to learning and ensure student success in safe, disciplined and drug-free schools and communities.

- **School Board Policy**: To define the school's role in creating a safe, disciplined and drug-free learning community and to clarify the relationship between student academic performance and the use of alcohol, other drugs, violence and high-risk behavior.

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71 Excerpted from Student Assistance Program Components, National Student Assistance Association (http://www.nasap.org/sapcomponents.html).
School-Based Mental Health Needs Assessment  
Appendix A: Summary of Current Literature

- **Staff Development**: To provide all school employees with the necessary foundation of attitudes and skills to reduce risks, increase protective factors and foster resilience through SAP services.

- **Program Awareness**: To educate parents, students, agencies and the community about the school policy on alcohol, tobacco, other drugs, disruptive behavior and violence and provide information about Student Assistance services that promote resilience and student success.

- **Internal Referral Process**: To identify and refer students with academic and social concerns to a multi-disciplinary problem-solving and case management team.

- **Problem Solving Team and Case Management**: To evaluate how the school can best serve students with academic or social problems through solution-focused strategies.

- **Student Assistance Program Evaluation**: To ensure continuous quality improvement of student assistance services and outcomes.

- **Educational Student Support Groups**: To provide information, support and problem-solving skills to students who are experiencing academic or social problems.

- **Cooperation and Collaboration with Community Agencies and Resources**: To build bridges between schools, parents and community resources through referral and shared case management.

- **Integration with Other School-Based Programs**: To integrate student assistance services with other school-based programs designed to increase resilience, improve academic performance and reduce student risk for alcohol, tobacco, other drugs and violence.

**The Importance of Collaboration and Coordination**

The literature highlights the tendency to try to compensate for unmet needs with services that disregard the existing services in the school and community. As a result, some services are duplicated while other needs remain unaddressed. The push for evidence-based practices with a narrow intervention focus, specific funding for limited-scope initiatives, and competition for funding between school and community systems perpetuate this phenomenon (Policy Leadership Cadre for Mental Health in Schools, 2001). The literature concludes that there is a need for greater collaboration and coordination reflected in a more comprehensive approach to providing services at all levels, from prevention to a system of care (Center for Mental Health in Schools and Center for School Mental Health Assistance, 2004). Policy Leadership Cadre for Mental Health in Schools (2001) describes collaboration in this way:

- “Collaboration is not simply about integrated services. Nor is it about establishing school-community councils or better school-home communication. It is about developing a school-community-home infrastructure that maps, analyzes, and uses the resources of all in better ways. Such an infrastructure is essential to developing mental health in schools in the context of the type of comprehensive, multifaceted, and integrated approach essential for addressing complex problems in the most cost-effective manner” (p. 29).
School-Based Mental Health Needs Assessment
Appendix A: Summary of Current Literature

Rather than focusing on creating a new program to meet the need, a more comprehensive view of the services available to children is needed.

Schools are included as part of the continuum of community mental health services not only by the services provided at the school site, but also by utilizing the school as a setting for outpatient counseling, crisis intervention, and partial hospitalization (Grantmakers in Health, 2003). The school’s resources, which can include “compensatory and special education, support services, initiatives for safe and drug free schools, family-oriented programs, recreation and enrichment programs, facility use” and community resources such as “public and private agencies, family services, programs, facilities, volunteers, professionals-in-training” can all be focused toward collaborating to provide a comprehensive set of services (Policy Leadership Cadre for Mental Health in Schools, 2001, p. 38).

Cultural Competence and Underserved Groups
In order to ensure services to all students in need, it is important to provide culturally competent and accessible services. White students are much more likely to receive mental health assistance, whereas Latino, African American and Native American students experience the same or greater need and yet do not receive services (Hernandez, et al., 2006). Important differences based on racial identification were found in variations of misdiagnoses, the length of treatment offered and the rates of remaining in treatment for the recommended amount of time, which affects access to appropriate treatment (Hernandez, et al., 2006). “… [T]o increase utilization of mental health services by culturally and linguistically diverse children and their families, culturally competent access practices must be present along with a culturally and linguistically adapted and appropriate array of services and supports” (Hernandez, et al., 2006, p. 2).

There are several important avenues for increasing access, including outreach, intake procedures, and attention to ethnic matching and culturally competent practice. Hernandez, Nesman, Issacs, Callejas, & Mowery (2006) suggest that the school system, as well as the neighborhood center, can be a way to increase utilization of needed services as children and adolescents can access mental health services while minimizing the stigma associated with therapy. Involving the children first can be an important step to reaching out to the family.

The intake process for traditionally underserved or limited access groups can be a key link to engaging the family and providing culturally competent services. “A recommended strategy is for providers to develop and train staff on ways to positively influence a patient’s perception of the intake process, and adopt organizational policies and procedures that support the additional time this may require” (Hernandez, et al., 2006, p. 35). The intake process develops the family’s trust that they will receive appropriate and culturally sensitive services. The use of linguistically competent staff throughout the process, support the ongoing relationship with the family.

Hernandez and colleagues (2006) also recommend paying attention to rates of utilization with ethnic matching for children and adolescents from different backgrounds. For example, African American adolescents show lower rates of attrition from treatment when matched with an African American
clinician, although this trend is not true for younger children (Hernandez, et al., 2006). Younger African American children do have greater rates of mental health service use and reduced need for services when involved in a race specific group program (Hernandez, et al., 2006). Research such as this indicates the best practice for particular racial and ethnic groups at different ages and stages in identity development.

Outreach and parent education are recommended by researchers as a way to increase utilization of needed services, particularly to members of groups that historically under utilize services (Hernandez, et al., 2006). Providing information about the variety of services available to families can be conducted through formal outreach or through informal supports. Another way to expand access to families is to “...create linkages between parents, schools, informal, and formal mental health services” (Hernandez, et al., 2006, p. 47). The disparities between services accessible and used by different ethnic minority groups should be addressed on an individual level by increasing clinician’s cultural competence, broadening outreach strategies to parents, and addressing the issue on the procedural and policy levels.

Cultural competency affects the access to and appropriateness of services delivered to minority groups. “Differences in assessment based on the ethnicity of the clinician point to the need for adaptations such as training, consulting with cultural experts, or tailoring instruments to the populations served (Hernandez, et al., 2006, p. 74).” Hernandez and colleagues (2006) in their meta-analysis of the current research enumerate specific strategies for delivering culturally competent services and increasing utilization for particular ethnic minority groups.

**Consumer Involvement**

The input from service users needs to be included in the quality improvement process. “As the persons most affected by service provision, service users and their families are in the best position to identify improvement opportunities and to have an active role in improvement plans. Therefore, quality improvement activities should involve service users and their families at every level of development (Allegheny County Coalition for Recovery Child and Family Committee, 2006, p. 7).”

**Research-Based Practices**

A program is considered *evidence-based* if research has shown efficacy in gaining results. There are different levels of evidence-based research depending on the amount of research conducted and the credibility of the study. “The evidence base for treatment of child and adolescent mental health disorders is limited, but growing. Specific school-based and family interventions have shown success, as have specific forms of psychotherapy, although most evidence is from experimental rather than actual practice settings (Van Landeghem, et al., 2005, p. 16).” In evidence-based practices as in all practices, there is always a need to tailor and customize services and supports to meet local cultural conditions. Funding usually supports evidence-based practices. For a thorough listing of such practices in children’s mental health, see the Substance Abuse and Mental Health Services Administration’s (SAMHSA) Resource Guide for Promoting an Evidence-Based Culture in Children’s Mental Health (http://systemsofcare.samhsa.gov/ResourceGuide/ebp.html).
Evidence-based programs can be divided into “proven” practices that have shown results in several studies, “promising” practices that have shown some results but not been as rigorously tested and “emerging” practices that either have potential or focus on underserved groups (Kadandale, 2005). Examples of each of these potentially best practices follow.

**A proven practice** targeting aggressive behavior and reducing conduct disordered behavior in individual children between the ages of 2 and 8 years can be found in The Incredible Years (IYS). This program includes components for the child, the parent and the teacher to reduce the targeted behavior and prevent future conduct problems.

Two examples of **promising practices** relevant to the school setting are Cognitive-Behavioral Therapy (CBT) and Aggression Replacement Therapy (ART). CBT targets cognitive errors and focuses on training behaviors. A specific type of CBT has been developed for use in the schools, called Cognitive Behavioral Intervention for Trauma in Schools (CBITS) of which the main focus is to “help children cope with violence, reduce anxiety and solve real-life problems (Kandandale, 2005, p. 11).” Results for CBITS found improvement in both PTSD symptoms and depression for a majority of children in a three-month follow up study. ART is a more widespread and preventative intervention for use in the curriculum by teacher and school counselors. “ART is designed to help participants with their interpersonal skills, anger control, and moral reasoning and social problem-solving skills. The program uses various elements of cognitive behavioral training and aims to arm the youth with nonviolent, constructive skills to use in school, at home and in their community (Kadandale, 2005, p. 13).”

Two **emerging practice** programs were identified by Kadandale (2005), the Primary Intervention Program (PIP) and Students Targeted with Opportunities for Prevention (STOP). PIP identifies children who may be at risk of mild or moderate scholastic adjustment or at risk of out of home placement in kindergarten through 3rd grade. “Primary Intervention Program (PIP) is a school-based prevention and early intervention program aimed at enhancing the social and emotional development of young children and preventing the development of serious mental health problems, substance abuse, academic failure, and delinquent behavior (Kadandale, 2005, p. 68).” The child spends 30 to 45 minutes per week for 12 weeks with an aide in a specially equipped activity room on the campus and the program costs an average of $500 per child.

The other emerging practice program, STOP, targets youth ages 10 to 14 years who are at risk of juvenile delinquency but who are not on probation. The services provided are in a Wraparound style of family based interventions to the youth. “STOP includes services like tutoring, family and individual counseling, gang education and intervention, substance abuse/alcohol education and counseling, parenting classes, and evening and weekend activities and recreation. The average cost per participant is $4,400 for the entire year” (Kadandale, 2005, p. 16).

**Wraparound services** are commonly considered another best practice and can be included in the schools as part of the interventions. Wraparound services are individualized to the child and family’s needs and based on a collaborative team approach that is delivered in several different settings.
“Wraparound programs target children in foster care, probation, and special education programs, as well as other children with Severe Emotional Disturbance [who] are either at risk of out-of-home placement or are returning from out-of-home placement” (Kadandale, 2005, p. 17).

Some argue that School-Based Health Centers (SBHC), which typically offer both physical and mental health services, are an example of best practices. Although there does not seem to be any research cited on effective results, the SBHC provide services that address the overall health of children and decrease the stigma associated with mental health counseling (Olbrich, 2002).

- “School-based health centers can successfully expand access to mental health services to all students when programming includes community assessment, school endorsement, integration with existing health services, and reimbursement from 3rd party payers. A well-designed, integrated school based health center program, when coupled with comprehensive school health education, will advance the state of health of the nation’s children, youth, and families” (Olbrich, 2002, p. 30).

School-Based Health Centers combine funding in a variety of ways to be able to meet the needs of their students. Several school districts have centralized mental health services into a district-wide service. The Los Angeles School District and Baltimore Mental Health Systems are examples of programs that integrate school mental health services through clinics that serve several schools at once (Policy Leadership Cadre for Mental Health in Schools, 2001).

Service Integration
The Center for Mental Health in Schools (2002) and the Policy Leadership Cadre for Mental Health in Schools (2001) argue that in order for mental health services to be successful, schools must change the infrastructure of the school system to integrate mental health as a more central component. The Center for Mental Health in Schools emphasizes the importance of an “enabling component” that, in addition to school management and instruction, provides a more preventative and responsive environment. The Policy Leadership Cadre for Mental Health in Schools highlights the need for a more integrated set of services rather than adding programs with a narrow focus simply because they have an evidence base in a limited application. This is further discussed in the subsequent section.
Typical Practices

Fragmentation

- "More is not necessarily better in terms of mental health services if there is a lack of collaboration and integration between the programs. At the school level, analyses of the current state of affairs find a tendency for student support staff to function in relative isolation of each other and other stakeholders, with a great deal of the work oriented to discrete problems and with an over-reliance on specialized services for individuals and small groups... Such fragmentation not only is costly in terms of redundancy and counterproductive competition, it works against developing cohesive approaches and maximizing results" (Center for Mental Health in Schools, 2002, p. 3).

Fragmentation can occur on the level of professionals working separately without appropriate communication, as well as on a programmatic level. State and federal legislative initiatives intended to reduce service fragmentation have led to struggles in coordinating interagency initiatives. When an initiative targets only a specific population or problem, they can overlap (Anders, 2001) or leave gaps of unmet need (Policy Leadership Cadre for Mental Health in Schools, 2003). “Rather than address the problems surrounding school-owned support programs and services, policy makers seem to have become enamored with the concept of school-linked services, as if adding a few community health and social services to a few schools is a sufficient solution” (Center for Mental Health in Schools, 2002, p. 13). Greater collaboration between professionals and more integration of infrastructure and programs is recommended by the literature (Anders, 2001; Center for Mental Health in Schools, 2002; Policy Leadership Cadre for Mental Health in Schools, 2003).

Mental Health Services That Address Barriers to Learning

The Policy Leadership Cadre for Mental Health in the Schools (2001) points out that in schools and communities that have low incomes, resources for students’ basic needs are scarce. At the same time, these youth face potential barriers to mental health and learning that can include family problems, health issues, violence, gang involvement, substance abuse, and possible language and cultural barriers. Since these same concerns often negatively affect caregivers, the amount of family involvement in the youth’s lives and educational pursuits can be limited. The educational system can exacerbate these issues with punishment rather than rehabilitation.

- “It has long been acknowledged that a variety of such problems affect learning in profound ways. Moreover, these problems are exacerbated as youngsters internalize the debilitating effects of performing poorly at school and are punished for the misbehavior that is a common correlate of school failure. Because of this, school policy makers, have a lengthy, albeit somewhat reluctant, history of trying to assist teachers in dealing with problems that interfere with schooling.” (Center for Mental Health in Schools and Center for School Mental Health Assistance, 2004, p. 18).
Two, macro-level interventions are suggested by the Policy Leadership Cadre for Mental Health in Schools (2001).

• “Parents and teachers stress that, in many schools, major academic improvements are unlikely until comprehensive and multifaceted programs/services to address these barriers are developed and pursued effectively. At the same time, it is evident to anyone familiar with the situation that there is no direct accountability for whether these barriers are addressed. To the contrary, when achievement test scores do not reflect an immediate impact for the investment, efforts essential for addressing barriers to development and learning often are devalued and cut” (Policy Leadership Cadre for Mental Health in Schools, 2001, p. 8-14).

Improving the infrastructure of the programs available to fully address barriers to learning and determining the accountability for who is in charge of improving access to learning are two ways that schools can effectively raise the level of academic achievement.

Types of Programs Offered in the Schools
The federal Mental Health in Schools Program, developed in 1995, was developed to enhance the ability of schools to provide mental health services through the professionals and stakeholders involved in the decisions. (Center for Mental Health in Schools and Center for School Mental Health Assistance, 2004). One of the major foci of the federal program is to use prevention and early intervention strategies to address mental health issues.

• “Although the Mental Health in Schools Program is implemented at the federal level, the types of programs offered in schools differ by district and by individual school. Some [support programs and services] are provided throughout a school district, others are carried out at or linked to targeted schools. Some are owned and operated by schools; some are from community agencies. The interventions may be for all students in a school, for those in specified grades, for those identified as “at risk,” and/or for those in need of compensatory education” (Center for Mental Health in Schools, 2002, p. 2).

The services provided may be part of the classroom curriculum for regular or special education or programs separate from classroom activity (Center for Mental Health in Schools and Center for School Mental Health Assistance, 2004).

The categories of service delivery provided in the schools as conceptualized by Policy Leadership Cadre for Mental Health in Schools (2001) are: school-financed student support services, school-district mental health unit, formal connections with community mental health services, classroom-based curriculum and special “pull-out” interventions, comprehensive, multifaceted and integrated approaches. Each are described below:

School-financed student support services are usually delivered by pupil service professionals, which may be school-based or centralized in the district. Special education is included in this category.
School-based mental health units are usually centralized clinics that provide outreach to schools. An example is School-Based Health Centers that provides health and mental health services to several schools. Formal connections with community mental health services are also part of the school-based health center movement.

Connections to community agencies sometimes include the wraparound model of a system of care. These connections usually occur as: community agencies that occupy space within the schools (sometimes as a school-based health center); formal links with an agency for referrals; partnerships between agencies and the school district to increase access; and/or, contracts with community agencies for services.

Classroom-based and out-of-classroom interventions typically occur in three different formats. The information can be presented to the students as an integrated part of the curriculum and process of the classroom, a specific curriculum presented by a specifically trained professional, or a multi-faceted curriculum approach.

The “comprehensive, multifaceted and integrated approaches” combine school and community services into interventions along a continuum that manifests in three different formats. The approach can take the form of community schools, initiatives that reforms school agenda through programs and services, or the mechanisms that integrate available community and school services.

**Screening & Early Intervention**

Schools are often the places where mental health problems in children are detected. The continuum of care that is considered best practice can start in the school system with the detection of potential problems or interventions soon after the onset of a mental health issue. “Targeted interventions to prevent progression of these conditions to diagnosable mental disorders could help reduce the prevalence of mental disorders among both children and adults” (Grantmakers in Health, 2003, p. 7). Screening and early intervention services are both available and generally recognized as a best practice in mental health services.

However, there are issues around utilization and access to preventative measures, as well as misdiagnosis. Cost-efficient systems for screening and training teachers to recognize mental health disorders in the early stages are not widely used strategies (Van Landeghem, et al., 2005). Even when screening or early intervention techniques are used, the first screen will often identify more children as in need of assistance for early intervention than there are resources or may not accurately diagnose the problem.

- “Currently, few youngsters can readily access help for an emotional, behavioral, or learning problem unless the problem is severe or pervasive enough to warrant diagnosis as a disorder/disability. As long as this is the case, large numbers of misdiagnoses are inevitable and

- “Additionally, the preventative or early intervention methods for youth at risk may not be funded to the extent necessary in order to reach maximum effectiveness”.

- “For the large numbers of youngsters seen as ‘at risk,’ current financing does expose a significant number to a range of interventions, however, such exposure typically is rather superficial. Schools are in a unique position to improve this state of affairs. To do so, the prevailing trends to marginalize and fragment mental health in schools must be reversed.” (Policy Leadership Cadre for Mental Health in Schools, 2001, p. 29).

Program funding is a major issue for providing effective and comprehensive services, in screening and ongoing treatment.

**Funding**

As earlier stated, available funding often determines the children’s mental health services that are offered in schools rather than needed services creating the impetus for funding. Part of the problem, according to the Policy Leadership Cadre for Mental Health in Schools (2001), is that there is a lack of information about the funding for school mental health and the services provided. “Without such a big picture analysis, policymakers and practitioners are deprived of information that is essential to determining equity and enhancing system effectiveness (Policy Leadership Cadre for Mental Health in Schools, 2001, p. 29).” Sometimes schools or school districts engage in creative use of funds by combining resources with community agencies or across districts. However, even combined funding is not adequate to meet the needs of the students (Policy Leadership Cadre for Mental Health in Schools, 2001).

**Funding Sources**

Resources supporting children’s mental health in schools generates from several sources. “Major categories of financing include private health insurance, federal health insurance programs for low-income children, federal grants, and other sources that include state and foundation funds” (Grantmakers in Health, 2003, p. 6). Federal health insurance such as Medicaid and federal grants are a large source of funding for school mental health, as well as state and local agencies (Grantmakers in Health, 2003). Private insurance also covers some costs of services, although it is used to a lesser extent (Grantmakers in Health, 2003).
Medicaid and Medi-Cal
The federal public insurance program Medicaid, and the California state benefit known as MediCal, are important sources of reimbursement for mental health services and have grown substantially in recent years. “In 1994, the percentage of the total Medicaid enrollment in managed care plans was 23.17%; by 2000, it had grown to 55.76%, including primary care case management arrangements (Greiner, et al., 2001, p. 6).” Children can qualify for Medicaid in several ways (Brown, 2000). Children are generally eligible for Medicaid benefits if they are under age 21 and their families’ income is low. Additionally, most states extend eligibility to children who have qualified for the Supplemental Security Income Children’s Program and children that qualify under special home and community-based waivers. Thirty-six states have converted from fee-for-service to managed care models of funding for adults and children (Substance Abuse and Mental Health Services Administration, 1998, as cited by Brown, 2000). Almost all other states are currently converting to a managed care system.

Medicaid has exceeded the expenditures of state mental health agencies to become the second largest source of funding for mental health after Social Security Administration payments to individuals with mental illness (Oliva & McCandless, 2001). As of 2002, 20 percent of children were covered under Medicaid in the U.S. (Grantmakers in Health, 2003). However, according to report by the U.S. Government Accounting Office many of the children that are covered under public insurance may not be receiving services for which they are eligible, although the extent of the service gap is unknown (Grantmakers in Health, 2003).

Medicaid offers services through Early Periodic Screening, Diagnosis and Treatment (EPSDT) that reimburses for assessment as well as treatment for any condition (Olbrich, 2002). In fact, children under age 22 with Medicaid are mandated to be regularly screened and treated for physical and mental health problems regardless of whether the service is covered under the Medicaid plan (Grantmakers, 2003). The majority of mental health services are funded through public mental health, since in practice private insurance companies do not have equal parity for physical and mental health (Policy Leadership Cadre for Mental Health in Schools, 2001).

Federal Grants
Federal mental health grants support programs such as Head Start and Early Intervention under the Individuals with Disabilities Education Act (Grantmakers in Health, 2003). Federal grants can also originate from the child welfare and juvenile justice systems, and can support implementation and system coordination (Grantmakers in Health, 2003).

SCHIP
Another funding source for some mental health services is the State Children’s Health Insurance Program.

- “The State Children’s Health Insurance Program (SCHIP) is a federal program enacted in 1997 that provides funding to states for health coverage of low- and moderate-income children. In federal fiscal year 2001, 4.6 million children were enrolled in SCHIP (Centers for Medicare and Medicaid Services 2002)... It is estimated that around 15 percent of SCHIP-eligible children need...
School-Based Mental Health Needs Assessment
Appendix A: Summary of Current Literature

mental health or substance abuse services (Howell, Roschwalb, and Satake 2000. (Grantmakers in Health, 2003, p. 21)."

However, state SCHIP programs are more restrictive than Medicaid. Similar to many types of private insurance, SCHIP does not usually provide reimbursement for school-based health services (Grantmakers in Health, 2003).

Services provided in the schools such as the School-Based Health Centers (SBHCs) are more likely to receive funding for expansion and maintenance of their programs through managed care. “[School-Based Health] Centers may find themselves negotiating not with the state but with managed care plans that have enrolled Medicaid and SCHIP beneficiaries” (Greiner, et al., 2001, p. 1). School-Based Health Services can be funded through Medicaid and private insurance, although such sources are typically underutilized (Greiner, Nickerson, & Rosenberg, 2001).

State Funding
States also fund children’s mental health treatment, particularly through matching federal Medicaid funds with state funds (Grantmakers in Health, 2003). “Over 20% of children’s mental health costs are paid by state and local agencies from sources other than public or private insurance (Grantmakers in Health, 2003, p. 7).” States are moving toward transforming into or contracting with managed care in an effort to provide more preventative and inclusive services (Greiner, et al., 2001). States have an important role in determining the extent to which managed care is required to reimburse mental health services (Olbrich, 2002). Reimbursement policies currently vary by state.

• “For mental health services, many states are using a capitated model of payment, in which a mental health managed care organization receives a fixed amount per beneficiary per month from the state, and then pays providers on either a capitated or fee-for-service basis. Other states may still be using a fee-for-service model to pay for covered mental health services, with or without a case management component” (Greiner, Nickerson, & Rosenberg, 2001, p. 7).

State and managed care policies can affect the services available to children in the schools and community.

Private Insurance
Funding also stems from private insurance, but limitations on managed care regulate the utility of private insurance (Olbrich, 2002). “Although over two-thirds of children have private insurance coverage, less than half of children’s mental health treatment is paid by this source (Grantmakers in Health, 2003, p. 1).” Mental health services are often excluded or restricted from benefits or through carve out plans that can charge a higher amount for services that often leads to the necessity of paying out of pocket (Olbrich, 2002).

Uninsured
Although people with an income level below the poverty line are eligible for Medi-Cal in California, others do not have any health insurance but cannot afford to pay out of pocket. “…[T]he poor (most
often women and their children) are eligible for Medi-Cal. The remainder of the population, including lower-wage workers, part-time workers, the self-employed, lower income men without families, and undocumented workers, often have no health insurance. Children in such households tend to lack coverage (Oliva & McCandless, 2001, p. 13).” Some of the children who are eligible for public insurance are not enrolled in Medicaid. Researchers estimate that almost 40% of uninsured children would be eligible for Medi-Cal, and almost 30% would be eligible for the Healthy Families Program (Oliva & McCandless, 2001).

In California, almost one-fifth of children under age 18 were uninsured in 1999 (Brown, Ponce, & Rice, 2001, as cited by Oliva & McCandless, 2001). Children who are uninsured are less likely to receive mental health services (Hernandez, et al., 2006). The uninsured children who do receive mental health services are most likely to access services through the school system (Hernandez, et al., 2006). “Schools are a particularly good place to deliver health care to children and adolescents... Simply citing the potentials for positive health outcomes, however, is not sufficient to resolve funding challenges, especially in negotiations with managed care organizations (Greiner, Nickerson, & Rosenberg, 2001, p. 8).”

**Concerns about Managed Care**

Although managed care was implemented with the intention of a more comprehensive and integrated plan, there are several issues, including fragmentation of the system, less accountability, and less availability of services. Under managed care, fragmentation can occur due to the incentive to shift costs onto other public state agencies (juvenile justice, child welfare, or educational system), especially for youth needing long-term care (Brown, 2000). Accountability is an issue in that mental health administration has become much more of a local responsibility for the federal Medicaid program (Policy Leadership Cadre for Mental Health in Schools, 2001). Additionally, due to the emphasis on cost containment and limited benefits through carve-out plans, the availability for children to obtain mental health services decreased (Olbrich, 2002) as well as the ability for school-based health centers to provide services (Greiner, et al., 2001).

**Effect on Provision of Services**

Schools do not always address barriers to learning by responding to the mental health needs of their students. For example, according to Foster (2005), in 2005 the funding for one-third of the schools had decreased from the previous year even though the majority (two-thirds) of school districts reported an increase in the demand for mental health services (as cited by American Counseling Association, et al., 2006).

One way that schools are able to provide enhanced and/or coordinated services is by “braiding” federal education dollars. “[S]chools can seek waivers in order to braid together various sources of categorical program funding. As such opportunities also increase for community agencies, school and community resources can be braided. With the enhanced emphasis on coordinating and integrating resources, availability, access, and accountability will increase” (Center for Mental Health in Schools and Center for School Mental Health Assistance, 2004, p. 6). An example is the Safe Schools/Healthy Students initiative
that improved and expanded mental health services by combining three sources of federal funding (Center for Mental Health in Schools and Center for School Mental Health Assistance, 2004). A further recommendation by the Center for Mental Health in Schools and Center for School Mental Health Assistance is to “address the problems of so-called ‘silo’ funding to schools within and across federal agencies (Center for Mental Health in Schools and Center for School Mental Health Assistance, 2004, p. 8).”

Managed care can decrease the efficacy of funding dollars on services. In a study conducted by Cooper & Wagenfeld, clinicians expressed concern about how changes in funding affect clients. “… [T]here was a great deal of discussion about alleged cost savings [among the study’s frontier area focus groups]. When the state was directly funding services, the center could expect to spend about 80% on clients. With the introduction of an additional echelon, the amount available has declined to 50 or 60% (Cooper & Wagenfeld, 2000, p. 5).”

Cost-Effectiveness

Untreated mental illnesses cost the U.S. more than $300 billion dollars a year both directly and indirectly (Grantmakers in Health, 2003). However, the proportion spent on mental health only accounts for 7% of the total amount of money spent by the federal government on health care in the U.S. (Department of Health and Human Services, 1999, as cited by Olbrich, 2002).

Research by the Institute of Medicine supports the cost-effectiveness of early childhood interventions, specifically for children from low-income households (American Counseling Association, et al., 2006, p. 2). However, the majority of mental health dollars go toward the most severe and long-term problems rather than prevention (Policy Leadership Cadre for Mental Health in Schools, 2001).

- “Overall, of the $137 million dollars in federal funds devoted to children’s mental health in 1998, only 3 percent went to early identification and intervention efforts. Of the remaining money, the majority is spent on services for youth with serious mental health disorders, the group that represents the smallest proportion of children receiving mental health services.” (Olbrich, 2002, p. 10).

One major source of expenditure is psychotropic medication, with has rapidly increased, exceeding $1 billion dollars spent in 1998 (The Center for Health and Health Care in Schools, 2003).

Pupil Service Personnel

The limited nature of funding promotes competition rather than collaboration between various agencies and providers. “The competition is fueled by dependency on varied streams of funding and the lack of coherent connections and coordination among the host of public and private agents involved in addressing child/adolescent mental health, for example, pediatricians, primary care providers, those concerned with education, social welfare, and criminal justice (Policy Leadership Cadres for Mental Health in the Schools, 2001, p. 30).” In addition, certain professional categories are not reimbursable for specific services based on state licensure requirements (Greiner et al., 2001). The specialization and
competition leads to further fragmentation of school mental health services (Policy Leadership Cadre for Mental Health in the Schools, 2001).

**Mental Health Services Act**
The Mental Health Services Act (Proposition 63) helped to focus California and the nation’s attention on how to improve the mental, emotional, and behavioral health of citizens. Passed by the citizens of California in November of 2004, the Mental Health Services Act (MHSA) provides funding for expanding and improving existing mental health services in California by levying a 1% tax on individuals with taxable income of over a million dollars. “…[I]t is estimated that by 2006-07, MHSA will raise over $700 million annually, a figure that is estimated to increase by 7 percent each year (Kadandale, 2005, p. 3).” This funding is granted to bidding agencies that use the money to expand or enhance existing services.

**Resiliency**
Mental health is often limited in the public dialogue to only encompass mental disorders, to the detriment of acknowledging that mental health also includes health and development. “…[M]ental health is de facto defined as the absence of these problems, and there is a lack of emphasis on the enterprise of promoting positive social and emotional development (Policy Leadership Cadre for Mental Health in the Schools, 2001, p. 5).” Instead, mental health can be examined from a strengths-based perspective that, in spite of facing adversity, a child or youth maintains healthy functioning. Resilience is commonly defined as the “process of, capacity for, or outcome of successful adaptation despite challenging or threatening circumstances” (Masten, Best, & Garmezy, 1990, p. 426). Resilience, therefore, examines three stages of facing adversity: the process of coping, how a person can have positive outcomes by adapting, and the ability to heal.

Resilience is a characteristic that can be part of the recovery process. The characteristic of resilience is considered both hereditary and developed through experience (Allegheny County Coalition for Recovery Child and Family Committee, 2006). The services of risk identification and early intervention to children and families facing adversity foster resilience. “Identification of children and families at risk for emotional disturbance, mental illness and substance use will allow opportunities to provide assistance early and avoid disruptions and stress associated with these difficulties (Allegheny County Coalition for Recovery Child and Family Committee, 2006, p. 15).” Schools can be an important part of this process to foster resilience, as most screening services are through schools.

Research has found that scholastic achievement is associated with the receipt of preventative and supportive services. The American Counseling Association and other organizations found many studies demonstrating the benefits of resilience on school mental health. For example, expanded school mental health services reduce the need for special education and disciplinary actions and reduce symptomatic behavior for children with severe emotional disturbances. Additionally, research found that school mental health services have a positive effect on the emotional connection to the school, which predicts higher test scores and grades (American Counseling Association, et al., 2006).
Programmatic elements influence how much resilience is emphasized in a school or agency. The Allegheny County Coalition for Recovery Child and Family Committee outlines many macro-level interventions to develop resilience. In addition to providing culturally competent services that respect various views of recovery, resilience can be the focus in the areas of: administration, treatment, support services and prevention (Allegheny County Coalition for Recovery Child and Family Committee, 2006).

**Conclusion**

Schools provide an opportunity to facilitate access to comprehensive mental health services for a population with a high level of need that is underserved. Research indicates that school-based mental health programs yield positive outcomes in many areas, including prevention and early intervention programs. Although there is not a clear consensus on the best practices in terms of evidence-based programs only or more broad-based collaborative approach, a continuum of care and culturally competent services are widely recognized as best practices. Greater flexibility in funding than the limitations of managed care or specific initiatives will be necessary to address the current typical practices of fragmentation and competition. Finally, schools are instrumental in enhancing children’s resilience, reducing the future costs of mental illness, and working toward a future characterized by greater mental health.
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Appendix B
Parent Interview Findings
Themes from fifteen parent interviews

Introduction
In an effort to incorporate the experience of parents, a series of parent interviews were conducted. Service providers, who were interviewed for this project, were asked to identify parents whose children have used school-based mental health services. Service providers contacted parents and obtained their consent to be interviewed. Fifteen parents were interviewed with the understanding that all information would be aggregated and anonymous.

The term, “parent,” in this narrative refers to a variety of caregivers. Interviews were conducted with grandparents, foster parents, step parents and biological parents. For the purposes of this summary, all caregivers are intentionally referred to as parents to protect the identity of the families who shared their experiences. When reviewing these findings, it is important to note that all parents have participated in the system of school-based mental health services, eight of the fifteen families had more than one child who has received services. It’s also important to note that while fifteen families represents a very small percentage of the total number of families who receive services, their perspective offers a greater richness to the information collected from school administrators, counselors, and service providers.

Five of the parents interviewed were mono-lingual Spanish-speaking and were interviewed in Spanish. Interviews took place in American Canyon, Napa and Calistoga, and parents were given the choice of where and how they would like to be interviewed. Some parents chose office settings, service provider settings, or phone interviews and others invited the interviewer to come to their home.

A partial listing of concerns that were identified in the children of the parents interviewed included: anxiety, depression, trauma, autism, ADD, ADHD, emotional disturbances and learning disabilities. Many families were working to address more than one concern at the time of the interview.

The interviews began with a protocol that followed the progress of the child from the point of initial concern, through diagnosis and treatment to the specific circumstances of the child and family today. Once the interviews began, it became apparent that each family had a story. The interviewers encouraged families to tell the story of “what happened for your family” and used the protocol to prompt further information from areas that were not covered. Interviews were scheduled for 45-60 minutes, and several spanned two hours as parents described their experiences.

Identification of the Concern
Interview questions about how a child’s mental health concern was identified were asked to understand more about the beginning of the process of seeking services. However, parents described it as an ongoing process of seeking more information about the reason for the concern and getting an appropriate diagnosis.
Entering the System
Parents reported three general scenarios to enter the system of school-based mental health services.

Scenario One: Academic Issue Identified by School--Parent is notified by teacher that child is falling behind academically and services are provided to support the child’s academic achievement.
Parents in this situation described a fairly smooth process of receiving support services. One parent said, "The school really took my kids in and helped them." Another reported her son received an IEP as soon as he was held back in kindergarten. In all cases, the children were identified and served within a year of the concern arising. Parents also stated that mental health services needed to support their child’s academic performance were provided quickly.

Scenario Two: Behavioral Issue Identified by School--Parent is notified that child’s behavior is unacceptable and parent is brought to the school to discuss situation.
In this scenario, parents reported frustration with their ability to get services for their child. One parent was told their child was “just a bad seed. You’ve just got to make her straighten up," and the parent needed to help the child “get with the program.” Several parents described how their child’s learning disability produced anxiety and the anxiety made the child act out. One parent recalled “My son quickly became labeled oppositional and defiant. It was a behavioral issue and there were no services available for a behavioral issue.”

The frustration for this group stemmed from being told there was a problem, but not being offered resources to address the issue. When the problem was clearly academic, the support process was started quickly. When parents were confronted with a behavioral concern, they reported fewer resources and less support from the school to address the concern and identify the reason for the behavior. Parents were held accountable for the behaviors, but generally did not know what to do to address the issue and felt blamed rather than supported by the school.

- “I felt like I did something, or didn’t do something.”
- “No one asked ‘Why? What is the reason, why is he acting out?’”
- “I don’t know what I am supposed to do, what is wrong...he just isn’t acting right.” [regarding her son getting into fights with other kids at school]

Another parent related that her son was diagnosed in kindergarten with several concerns that affected his classroom behavior. The school initially responded with a 504 plan to make classroom accommodations. The parent stated, “My son is high-functioning and intelligent, and because he wasn’t failing, he wasn’t approved for services.” Parent was told that it was “hard to get an IEP under son’s diagnosis” so she delayed initiating the paperwork. When she did request an IEP, she was told that she had requested the IEP too late in the year to attempt it.
School-Based Mental Health Needs Assessment
Appendix B: Parent Interview Findings

Though many parents reported being contacted right away when their child’s behavior was inappropriate, another parent talked about the delay of almost a year before she was contacted and the concern was explained.

- “When my son was in first grade, he had a lot of problems at school. When he complained about the teacher, I called the principal, and they didn’t call me back. He got a lot of timeouts during the day; he was sad and didn’t want to go to school. In second grade, the teacher noticed right away. The teacher told me he was moving around a lot and recommended taking him to the doctor. She thought it was ADD.”

The pediatrician referred the family on to a specialist and her son was diagnosed with ADD. He began medication and does not need an IEP because he is able to keep up with the work and participate in class.

One parent described a partnership between her family and the school. As her son’s behaviors started to increase at home and at school, the on-campus therapist worked with a MD to have her son tested.

Many of the parents who entered the system when their child’s behavior was identified as a concern reported noticing the behavior at home prior to being contacted by the school. Some parents were working to address and/or understand the issue at home in the context of their family. The parents who contacted the school for services comprise Scenario Three.

Scenario Three: Parent identifies concern and contacts school for support.
Some parents knew there was a concern and contacted the school to ask for resources or accommodations.

One family reported that while they were experiencing a trauma in their family life, their son started acting out at home by kicking the parent. The parent contacted the principal and asked if he could talk to a counselor at the school. The principal referred the child to the counselor and the parent to a local family resource center for support. The parent related the family resource center was “a godsend.”

Another family reported that when their child started school, the diagnosis was already in place and the child had been receiving community-based services prior to starting kindergarten. The parent was “irritated that I couldn’t pick out the teachers. He needed someone who was stern and wouldn’t back down.” Instead he was put into a class with two teachers who were sharing the class. The parent stated that as a result of this he acted out during the day and was sent home often.

Parents who contacted the school for support had varying degrees of success in obtaining services. For some families, school staff and administrators were responsive and able to connect the family to school and community resources. For other families, the school did not take the parent’s input into account and the child’s school performance was affected.
Addressing the Concern
As previously stated, parents of children who entered the system of services with a clear academic concern reported that their children received their IEP quickly; and those who entered the system on the basis of a behavioral concern reported spending considerably more time working through assessments and diagnosis to understand the reason for the behaviors. For some parents the diagnosis meant access to services, for others the diagnosis was just the first of many attempts to get services for their child.

Parent’s Role
Upon the identification of the concern, all parents interviewed became advocates for their child. Though parents varied in their response to the schools’ suggestions for addressing the concern, parents consistently felt they were the expert on their child and they continued to advocate to be sure the child’s needs and potential were met.

- “He can learn in a proper environment and one that knows how to teach for him.”
- “I saw a bright light in him and I needed someone to help it come out.”

Generally parents fell into two groups after the concern was identified. One group described questioning the school’s choices of assessments, accommodations and/or interventions. The other group reported trusting that the school had the best interests of their child in mind. A few parents described changing their level of concern and/or trust over time. Either they initially trusted the response and then questioned it, or they initially questioned the response and then trusted it.

Parents shared more than just the story and situation of the one child in their family who was receiving services. Many parents presented their experiences getting services for their child in the context of their whole family. Some shared how other events in the family impacted their ability to advocate for their child and/or to get the needed services. Families shared stories of serious illness, moving, financial difficulties, job changes, divorce, death of a family member, and other events that changed how their family responded to their child’s challenges. They also shared information about issues of child care, economic hardship, transportation and/or their own mental health needs. All of the events and issues impacted their child in some way and were important context for understanding what a family may need or be able to do at different points in their child’s life. This was especially noted for the mono-lingual Spanish-speaking parents, and was present in several of the interviews conducted in English as well.

Questioning the School, Services and System
Several of the parents who questioned the school’s response discussed the amount of time they devoted to being an advocate for their child. When parents realized that their time and research were the way to get needed services, those who were able, devoted their attention to the task. Some of the parents left their jobs to be their child’s advocate, and some were out of the paid workforce and talked about how important the flexibility was in advocating for their child.
School-Based Mental Health Needs Assessment
Appendix B: Parent Interview Findings

- “I sold my business and became a full-time advocate for my son.”
- “I’m a homemaker now, and I am able to really focus on him. I research what can work for him and bring it to the school. When I was a working parent, I didn’t have time.”
- “Getting services for my son is a full-time job.”

Some parents feared their child being expelled from school. Even though their child had a diagnosis and was on medication, the continued difficulties in class prompted parents’ concern about further consequences.

In several cases, parents who questioned the system described creating a team of people to assist their child. Once this team was in place, the parent described trusting the services and the practitioners who were serving the child.

**Trusting the School, Services and System**

Some described trusting the school and the services offered. These parents reported being happy with the services that were provided and relieved that someone else was helping them through a confusing and difficult situation. Parents in this group respected and trusted professionals to raise the alarm when there was a concern and had confidence in the current systems.

- “The schools have done as well as possible; my kid is doing a lot better.”
- “I try to give the school the benefit of the doubt.”
- “I know angels are in heaven, but I’ve got mine here on the ground working with me and my family.”
- “As a single parent raising three kids, my time is spread so thin. It made all the difference to have [the] records and staff resources so handy.”

Appreciation and trust in the current support systems was especially noted for parents who were monolingual Spanish-speaking and were interviewed in Spanish.

Some parents also noted an appreciation of the ancillary services such as ESL classes, parent networks, videos and workshops. They viewed the resources as support to becoming a better parent, and as a way to strengthen the whole family.

- “At first, it was just me alone, my husband wouldn’t get involved. But with the knowledge we’ve gained about our child’s problems, and the support of the agency, now my husband has changed. He is helping.”
Parents who trust the school to do the best for their child still reported being vigilant about their child’s needs. When asked what advice she had for other families, one parent who described trusting the school’s response stated: “Stand firm, be demanding, take advice and give opinions. Don’t be afraid.”

Schools’ Role
With two of the families interviewed, the concern about the student was identified and addressed without a 504 plan, IEP or 3632 funding. In both cases the situation was addressed by providers outside the school with support from personnel in the school (in one case, a teacher, in another case a school counselor). Other parents sought out a 504 plan, an Individual Education Plan (IEP) and/or 3632 funding.

504 Plan
Most parents described the 504 plan as the initial step in getting their child’s needs met in the school setting. The 504 plan was described as a way to let the school and teachers know the child’s needs and for the parents to have a role in how the child was served at school.

Generally, the parents reported the 504 plan was a small response to a larger concern. Some parents reported that despite having a 504 plan, accommodations were not consistently provided. Other parents felt the response was not enough, and didn’t offer enough protection for their child.

- “Their way is the right way—alternatives are expensive. They [the school district] start with the least expensive and easiest option, and ‘see how that works’. In the meantime, continuing behavior problems that were initially addressed with a behavior plan and contract are escalating. The child is in danger of getting expelled. I pushed to get the IEP to protect [him]. Otherwise, he could be expelled before they found the right service.”

- “My son started out on a 504 plan, they [the school staff] weren’t recognizing that it wasn’t working.”

IEP
Though many families described the struggle to get an Individual Education Plan (IEP) and ensure that the services outlined were appropriate and occurred, one family described the school making “IEP-type accommodations” without an IEP.

- “My daughter was a likeable kid and I volunteered at the school quite a bit, so the teachers knew me and liked her. The elementary teachers were able to make accommodations as needed, but without an IEP or 504. The teachers did good work with her. They kept her at the front of the classroom and had her run errands.”

The IEP was something almost all families had in common. As noted previously, parents of children with a clearly identified and familiar academic concern described getting an IEP fairly quickly. Parents of children with behavioral concerns or a diagnosis that did not immediately qualify the child for an IEP described a longer process.
School-Based Mental Health Needs Assessment
Appendix B: Parent Interview Findings

Families noted that there was considerable effort on the part of the parent to be sure the IEP was implemented. Parents stated even though their child had an IEP, the services outlined were not provided and the goals for their child were not met.

• “The IEP is seldom read”
• “IEP and 504 plans are not carried out to the letter, even though they are obligated to provide the services and accommodations.”
• “Teachers lack the knowledge and time to implement plans in IEPs”
• “I had to put my foot down at the last IEP meeting to get the needs met.”
• “[IEP process was] one parent going up against 5 or 6 teachers”.
• “They are setting up rules [at the IEP meetings], but no one follows them...there are no consequences for not doing it.”
• “[IEPs are] not realistic. The teachers try, they say ‘okay, okay’ and bless them, but they have a class with 10 kids and each has a different IEP. I have started asking ‘How can they?’ and the answer is ‘They’ve just got to do this; they are trained to do this.’”
• “I am there to make sure they [the school staff] do what they say they are going to do”.
• “There is a law to protect kids. When the district breaks the law, parents have to act”

3632 Funding
This funding provides for mental health services to support the student’s academic work. Generally parents described receiving this funding after their child was diagnosed with an Emotional Disturbance (ED).

In one case, a parent described receiving 3632 funding without an IEP. “[My daughter’s] behavior brought the concern to the forefront, and she was evaluated.” The evaluation did not qualify her for an IEP. “While the school was trying different services, my daughter was declining”. After being hospitalized for ED, she received a diagnosis and was eventually qualified for 3632 funding.

Other parents, who reported that their child received 3632 funding, described completing the IEP process first. Parents expressed relief at finally getting to 3632 and getting their child into the services they felt were the most appropriate. Parents described access to 3632 as the key to helping their child: “With 3632, more services opened up.”

The 3632 staff was universally described as a guide to the complex system of services and a fellow advocate for the care of their child. The person assigned to assist them with 3632 funding was able to “help get services and facilitate through the schools system” and “jump through hoops when it comes to finding and obtaining services.” Parents also noted that the 3632 staff “understood the complexity of my
“[child],” and “never dismissed my input”. Several parents noted the benefit of having the 3632 staff at the IEP meetings where together they “fought with them” to get services.

All comments about the 3632 staff in the interviews were positive. The only drawbacks noted were that the funding and staff were in such short supply. One family described working with 3632 staff to decrease support when their child was well-served in order to open up a space for another family. The family didn’t want to use up such a valuable resource when they felt they did not need it.

Community-Based Services Role
If community-based services were provided on the school campus, parents generally associated them with the school. Interventions such as support groups, workshops, classes, or counseling may have been provided by an outside provider, but the provider was not noted by the parents. They described the services as available at the school or not available. When parents felt a service that their child needed was not available at the school, they sought out community-based resources.

Mental Health Service Providers
Several parents described seeking out the services of private therapists, psychiatrists and/or psychologists to address their child’s mental health needs. In many cases this was occurring prior to or alongside the process of getting the 504 plan, IEP and/or 3632 funding through the school district. Parents noted that there are few professionals who serve children and are based in Napa County. One practitioner is preparing to retire and is working to transfer his clients to another provider. Other practitioners are hard to access because of demand. This shortage was noted in all interviews, and posed a significant barrier for families in up valley communities.

Parents described working with up to three professionals before they found one who was appropriate for their child and their family. Though the process of finding a provider and then finding an appropriate provider was difficult, the result was a trusted adult in the child’s life and a new member of the “team” for the child and the parent. Several of these professional relationships have endured for many years.

In several families, parents noted that mental health counseling support was a need for other family members to work on issues of postpartum depression, substance abuse, and other concerns that arose in addition to the supports the child needed.

Alternative Treatments and Experts
Three parents described seeking out alternative treatments to assist their children. Though frustrated that the cost of these providers and the cost of treatment fell to the family, parents reported seeing dramatic changes in their child and/or having a fuller understanding of the concern as a result of alternative interventions. In one case, the parent was successful in getting the district to cover the cost of alternative care after she brought the provider and her son’s documented progress to the IEP meeting. Alternative treatments included: private tutoring, biofeedback, homeopathy, art therapy, drama and mentors.

- “Counseling is one response, one tool. It needs to be supplemented.”
School-Based Mental Health Needs Assessment
Appendix B: Parent Interview Findings

- “What is there to get? I think I’ve gotten everything [from the school] and he’s still not reading.”

Unmet Needs: Parent’s Experiences with Barriers and Gaps in Services
Parents noted many barriers and gaps and also outlined very similar strategies for navigating the school and mental health service systems to meet the needs of their child.

School and District Barriers
Parents whose children were diagnosed with a new or emerging concern were often unable to access services through the school. In three family situations, the diagnosis was made at a time when practitioners, teachers and school administrators were not familiar with it, and services were not provided because no one understood it. Parents spent a lot of their own time researching the issue and bringing information back to the school, but expressed frustration at the amount of work they had to do to be taken seriously and for their child to be assisted.

- “I took the diagnosis to the district, and because the diagnosis wasn’t in the DSM IV, the diagnosis was not accepted.”
- “It offends me that my kids don’t matter”
- “Now the diagnosis of ADHD and ADD are more common, there is a better understanding and more compassion for needs.”
- “No one [at the school site] knows clinically what they are doing.”

In one case, a parent described working with a psychologist to get a diagnosis that would allow her child to get services, even though both the parent and the professional knew that the diagnosis was a symptom of the concern and not the actual concern. Some parents found a different school that was a better fit for their child and postponed or discontinued the process of seeking school-based services, others went on to work toward 504 plans and IEPs.

Those who participated in the 504/IEP process generally described the process as difficult. Although the IEP team may consist of non-school personnel, parents did not separate the IEP team and the school staff/administrators in their comments.

- “It was years of bottles to get needs met.”
- “Schools think they know what is best for the kid. They lock them into something and the kid gets stuck there.”
- “We forced a way into the system…my son needed help now and it wasn’t happening.”
- “[The district was] running our family into the ground.”
School-Based Mental Health Needs Assessment
Appendix B: Parent Interview Findings

- “The biggest hurdle to appropriate care was the [school administrator]...who was unfamiliar with special ed. and set my daughter back so far.”
- “When my daughter returned to Napa schools, they didn’t want her. She had been out of school for six weeks and there was too much to do to catch up.”
- “They didn’t know what the diagnosis was, so they took the diagnosis and put it in a garbage can.”
- “I felt ganged up on by the school. Like I had no rights and no voice, even with folks on the [IEP] team.”
- One parent described a struggle to get to the IEP and once an IEP was in place, the parent reported that they continued to “request services, and everything had to be in writing...I had to let them know that what was happening to my son was not acceptable.”
- “[The school] didn’t treat her as if she had ED/LD, and they didn’t recognize her strengths.”

There were two instances where the parent found the school supportive and described a cooperative relationship. Both families had children in elementary school and were able to receive services for their children quickly.

In the first situation, the family had changed schools, and did not have the same positive experience with other schools. At the new school they described the process of obtaining school-based services as “easy and smooth.”

In another situation the school had been initially cooperative in providing services, but as the family obtained additional supports, the school wanted to discontinue the school-based service. “They don’t like him to use both counselors. But he really likes [the school counselor] and it is not a conflict for him, he sees her as a friend.” The parent and the school were able to work out a compromise and her son still sees the school counselor.

**Finding the right resources**
Many of the parents talked about the fine line between behavior associated with a learning disability and/or an emotional disturbance and criminal behavior. This concern was especially pronounced in parents whose children were middle school aged and older.

When children began acting out, several were offered alternative classrooms in the district to address the behavioral concern. Parents described the programs as being for “delinquents” and fought to have their children taken out of the classrooms. Parents were also unhappy with the remedial nature of the classroom work and wanted their children to be academically challenged.

- “The environment was inappropriate for her: drugs and weapons and gangs. She was in sixth grade and she was in there with eighth grade boys.”
School-Based Mental Health Needs Assessment  
Appendix B: Parent Interview Findings

- “I did not like the remedial courses.”
- “The special ed. class was not helping him succeed. When he was integrated into regular classes, he flourished.”
- “My son was put in a conduct-disorder class for end-of-the-road kids. The mental health issues were mixed in with gang issues and violent behavior. He started to pick up on the negative behaviors.”

One parent spoke at length about her efforts to keep her daughter out of the legal system. She described changing schools from one that called the campus police each time her daughter had an outburst to one that called the parent when the behavior started.

- “The nature of my daughter’s disability is that she gets in trouble a lot. She has a lot of meltdowns and acts out. If she is in the legal system, these actions are violations of probation. The legal system is a treadmill, and once you are on it, you don’t get off. Once a child is on probation, juvenile probation goes up to 21 years old. It isn’t for a set amount of time. This leaves a lot of time for a violation.”

Another parent described:

- “Because of his disorder, he has trouble with impulse control. I am trying to keep him out of Juvenile Hall. Who wants their child in that environment?”

And another parent noted that lack of services can lead to the child’s behavior escalating, and then to legal involvement:

- “He wants to learn and is having a hard time doing it. He is irritated and angry and on the road to criminal behavior.”

**Getting a guide and creating a team**

Most parents talked about struggling to understand what their child needed and then struggling to find services to address the needs as they came to light. Parents often don’t know the source of the concern, and described not knowing how or when to ask for help.

- “Every school is managed separately, and it is unclear who is in charge.”
- “No one knows anything about how to serve [my kid].”
- “It took a long time to get where we are now, and I have been very alone working to get this far.”
- “It is like you are going through a forest and you are lost and if someone hasn’t dropped the breadcrumbs, you are REALLY lost.”
School-Based Mental Health Needs Assessment
Appendix B: Parent Interview Findings

• “It is a crisis situation as the family is trying to get services and also having to navigate the politics and issues between the district and county.”

As parents related their struggles, most of their stories had a turning point where they found a guide to the system of mental health services and/or the school system. These guides included: attorneys, mental health services case managers, family resource center staff, a parent in a similar situation, a school staff person, a teacher and a principal.

• “When I showed up with an attorney, the professionals changed their behavior. That is a big part of what is wrong.”

• “[The family resource center] did an intake on the phone, and I told them ‘this is overwhelming and I can’t do this!’...They knew where to call and what to do. They helped immensely.”

• “Currently there is a [school-based] specialist who is a stop-gap. She’ll ask other teachers what is expected and communicate the teacher’s responses to me.” (This parent described a long-term effort to get regular communication from the teachers.)

Some of the guides assisted for a short time while the family developed the team to surround them and support them. Some guides continued on with the family and became part of the team.

Most families described assembling a team of trusted professionals who understand their concerns and their child’s needs. In addition to the parent interviewed, the teams consisted of a myriad of people, including grandparents, therapists, psychiatrists, school counselors, teachers, school administrators, community agencies, mentors, case managers, home visitors, and topical experts.

• “I created a team—a support team—to scaffold him to the right place.”

• “Staying in one school (principal, teachers, IEP people)...has been helpful. [The school] is a really good fit, and the services have been consistent and good.”

• “We have a team of support people: lawyer, family resource center, mentor, therapist, and counselor.”

• “After three years of battles, I have a team of professionals, programs and mentors—capable adults to support and connect my son.”

Language and Cultural Barriers
During the interviews, families discussed language and cultural barriers that interfere with their ability to get services for their child and family.

How services are delivered: Spanish-speaking families generally reported preferring providers who took the circumstances of the whole family into account, and providers who came to their home. Several
families reported that meetings felt punitive or intimidating, especially when it required going out of town, or going to a professional office. Families valued in-home support at all stages of service delivery.

**Availability of Spanish-Speaking staff:** When parents are working to obtain services, a Spanish-speaking staff person at the point of entry makes a big difference. An initial contact in Spanish helps in understanding the service and building trust.

**Availability of Services in Spanish:** Several parents perceived the lack of services for their child and/or family as due to a lack of Spanish-speaking staff. Others noted their own role in making sure they continued to advocate, despite the language barrier.

- “We have to keep looking for solutions, our kids depend on us. If I can’t explain myself or understand something, I know I need to go find an interpreter, rather than give up.”

**Written communication and forms in Spanish:** Some parents reported relying on family and friends to translate forms and written documents about their child’s progress and services.

- “It’s been years that I have been trusting and signing forms in English without knowing exactly what it says. If my older child can read it to me and understand it, that’s what we have to rely on.”

**Other Barriers**
Though not mentioned as consistently as barriers with the school and language/cultural barriers, the following other barriers were also noted:

**Lack of Providers:** Parents described an overall lack of mental health providers in the community and a lack of after hour resources. Both shortages were especially noted for elementary-aged children.

- “I begged, groveled, searched and hunted to find a child psychiatrist in Napa.”
- “The county mental health department should have a satellite office in Calistoga or at least a person who is stationed up here in a school or community agency.”
- “When my child is in crisis after 5pm, he has to go to Adult Mental Health, and they don’t know about kids”

**Service Location:** Parents who live in Calistoga noted the significant time it takes to drive to services. Though there are some services in St Helena, families reported having to drive to Napa or Santa Rosa for care.

- “I saw flyers at the Kaiser office for the local agency and I immediately called. But when my child is supposed to have certain evaluations, I have to drive to Napa, Vallejo or Fairfield, and I can’t do that during my work hours.”

**Service Quality:** Parents described difficulties with the quality of the interventions they received.
“The behaviorist came for 15 minutes to observe, and my son acted out at 22 minutes. He knew he was being watched. The providers need to take more time.”

“My son went into therapy to work through anxiety and fear...but with therapy, he became MORE fearful. Once he stopped therapy, he got better.”

**Insurance Coverage:** Two families noted that they were having a hard time understanding which mental health services were covered. One family had received a $550 bill for services that they thought were covered and stopped treatment until they could pay for the service. Several families noted difficulties finding therapists that accept Healthy Families.

**Parents’ Recommendations**
Parents were asked what advice they would give other parents in a similar situation and what they would change about the system of school-based mental health services.

**Advice to Parents**
Parents gave very consistent advice to other parents about how to access services and get their child’s needs met.

**Know your rights**
Parents should understand what their legal rights are and what schools are legally obligated to provide for their child.

- “Have your child assessed. Parents have the right to call a SST [Student Study Team] meeting.”
- “The school doesn’t get to say ‘we don’t have resources for your child.’”
- “The school district is doing what they can by law. Parent’s role is to understand and know what their rights are. Most don’t know their rights.”

**Do research**
Parents should do their own research to supplement what professionals are telling them and to help them understand the concern and how to best meet the needs of their child.

- “Continue to educate yourself. The time and energy you put into the research will educate and empower you.”
- “Do your own research and you’ll get further. Doctors are not on a pedestal.”

**Advocate**
Parents are their child’s most dedicated advocate. Parents need to continually advocate as children’s needs and providers change over time.
School-Based Mental Health Needs Assessment
Appendix B: Parent Interview Findings

- “Schools try to fit your kid into a program that already exists, whereas an IEP is INDIVIDUAL.”
- “Know the therapists”
- “I have every faith that my son will make it, and it is not because of the district.”
- “A lot can be accomplished with honey instead of vinegar. Parents need to get service providers to help them and not turn their backs.”

Suggested Changes to the Service System
Parents were asked, “If you had a magic wand, what one thing would you change about school-based mental health services and supports?”

Focus on the child
- “I would use my magic wand to sprinkle everyone’s head with the reminder to focus on the child, and to look directly at how best to serve kids.”
- “Take the focus off of ‘who’s to blame?’ and put it on the well-being of the child.”

Increase knowledge, understanding and resources for school sites
- “Not enough providers were educated to identify my son’s issues. No one was willing to look past the anxiety diagnosis.”
- “There should be a clinical advisor in the schools”
- “Someone has to have expertise...Who is responsible for becoming the expert?”
- “I am concerned about the professional qualifications of the district staff making decisions about children’s mental health needs.”
- “Sensitivity training for the principal...regarding mental health issues”

Create a way for parents to enter system.
- “Embrace parent’s perspective. DO NOT alienate parents. Allow advocacy.”
- “Parents need different forums; the ways we invite people to participate currently DOES NOT WORK.”
- “Parent’s requests are seen way too easily as asking for the moon.”

While parents understand how professionals are helping their child in the school setting, or in therapeutic services, several reported feeling unequipped to deal with challenging situations at home.

Change responses
- “I want the district to provide before the fight”
“Do it differently, don’t just do MORE”

“Parents aren’t always able to help. School needs to step up and do it.”

“Consider alternatives instead of pushing past resistance to treatment barriers.”

“Don’t label [kids], figure out WHY”

“I want the principal to be more responsive.” (Parent left messages for principal about concerns and did not hear back for over two weeks.)

“Remove barriers to 3632, response to intervention takes time.”

While privacy was highly valued, several families shared that they wanted to be treated as a whole family. Having a home visitor come to their home and pay attention to the context of their family and the needs of all the members was more valued for these families than having a parent got to an office and report on one child’s issues. This was especially noted by the Spanish-speaking families.
Appendix C
Potential Grant Opportunities
Funding Opportunities to Provide School-Based Mental Health Prevention, Early Intervention and Treatment Services For Children and Youth

Introduction
This appendix was developed to highlight possible grant sources for school-based prevention, early intervention, and mental health services for children and youth. Information was gathered from the subscription-based, online database maintained by the Foundation Center in San Francisco. Key search words included: children, youth, mental health, severe emotional disturbance, youth development, prevention, schools, treatment, early intervention, California, Bay Area, and Napa. The following is an index of the search summary along with page numbers. The summary follows the index.

Index of Potential Funders

<table>
<thead>
<tr>
<th>Name</th>
<th>Field of Interest (abridged for purposes of index)</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Foundation of the Napa Valley</td>
<td>Education; Family services; Health care; Housing/shelter; Human services; Youth; Youth development.</td>
<td>185</td>
</tr>
<tr>
<td>Five Bridges Foundation</td>
<td>AIDS; Children, services; Children/youth, services; Crime/violence prevention, domestic violence; Crime/violence prevention, youth; Disabilities, people with; Education; Family services; Substance abusers; Women, centers/services.</td>
<td>185</td>
</tr>
<tr>
<td>E. Richard Jones Family Foundation</td>
<td>Education; Family services; Health care; Higher education; Human services.</td>
<td>186</td>
</tr>
<tr>
<td>The Gamble Foundation</td>
<td>Crime/violence prevention, abuse prevention; Crime/violence prevention, youth; Environmental education; Homeless, human services; Human services; Public health; Recreation; Youth development, services.</td>
<td>186</td>
</tr>
<tr>
<td>Roy A. Hunt Foundation</td>
<td>To facilitate the development of healthy and sustainable communities; protection and conservation of natural resources and healthy ecosystems; and, prevent youth violence.</td>
<td>188</td>
</tr>
<tr>
<td>Danford Foundation</td>
<td>Children/youth, services; Economically disadvantaged; Education; Elementary/secondary education; Family services; Health organizations; Higher education; Homeless, human services.</td>
<td>190</td>
</tr>
<tr>
<td>Dougherty Family Foundation</td>
<td>Children/youth, services; Education; Family services; Health care; Health organizations.</td>
<td>190</td>
</tr>
<tr>
<td>Dr. Seuss Foundation</td>
<td>Children/youth, services; Family services; Health organizations; Higher education; Human services.</td>
<td>190</td>
</tr>
<tr>
<td>Mark Hughes Family Foundation</td>
<td>Children/youth, services; Economically disadvantaged; Education; Family services; Human services; Mental health, treatment; Mental health/crisis services; Nutrition; Youth development.</td>
<td>191</td>
</tr>
<tr>
<td>Name</td>
<td>Field of Interest (abridged for purposes of index)</td>
<td>Page</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>Center for Community and Family Services</td>
<td>Children/youth, services; Community development; Education, early childhood education; Family services; Human services.</td>
<td>191</td>
</tr>
<tr>
<td>R.S. Hoyt, Jr. Family Foundation</td>
<td>Education; Family services.</td>
<td>192</td>
</tr>
<tr>
<td>The Ingebritson Family Foundation</td>
<td>Education; Family services.</td>
<td>192</td>
</tr>
<tr>
<td>Krishnan-Shah Family Foundation, Inc.</td>
<td>Community development; Education; Family services; Human services; Youth, services.</td>
<td>192</td>
</tr>
<tr>
<td>The Linden Family Foundation</td>
<td>Christian agencies &amp; churches; Education; Family services.</td>
<td>192</td>
</tr>
<tr>
<td>Lisa and Sidne Long Foundation</td>
<td>Education; Family services; Human services.</td>
<td>193</td>
</tr>
<tr>
<td>Dave and Roma McCoy Family Foundation</td>
<td>Education; Family services, domestic violence.</td>
<td>193</td>
</tr>
<tr>
<td>The Barry and Wendy Meyer Charitable Foundation</td>
<td>Children/youth, services; Education; Family services; Higher education; Human services.</td>
<td>193</td>
</tr>
<tr>
<td>Myers Family Foundation</td>
<td>Family services; Higher education; Protestant agencies &amp; churches; Secondary school/education.</td>
<td>194</td>
</tr>
<tr>
<td>Esper A. Petersen Foundation</td>
<td>Children/youth, services; Community development; Economically disadvantaged; Education; Family services; Human services.</td>
<td>194</td>
</tr>
<tr>
<td>Satterberg Foundation</td>
<td>Children/youth, services; Education; Family services; Health care; Housing/shelter, development; Human services; Youth development, centers/clubs.</td>
<td>194</td>
</tr>
<tr>
<td>Herman P. and Sophia Taubman Foundation</td>
<td>Children/youth, services; Education; Family services; Health organizations; Higher education; Hospitals (general).</td>
<td>195</td>
</tr>
<tr>
<td>Walter S. Johnson Foundation</td>
<td>Children/youth, services; Education; Elementary/secondary education; Family services; Leadership development; Youth development, services.</td>
<td>195</td>
</tr>
<tr>
<td>June &amp; Julian Foss Foundation</td>
<td>Children/youth, services; Education; Human services; Mental health, treatment; Youth development, adult &amp; child programs.</td>
<td>197</td>
</tr>
<tr>
<td>William Gorrill Swigert Foundation</td>
<td>Mental health association</td>
<td>197</td>
</tr>
<tr>
<td>All Stars Helping Kids, Inc.</td>
<td>Children development, education; Child development, services; Children/youth, services; Crime/violence prevention, youth; Education; Education, drop-out prevention; Education, early childhood education; Family services; Human services; Youth development.</td>
<td>197</td>
</tr>
<tr>
<td>The Bolton Family Foundation</td>
<td>Education; Health organizations; Human services; Media/communications; Mental health/crisis services; Performing arts; Recreation; Youth development.</td>
<td>198</td>
</tr>
<tr>
<td>Name</td>
<td>Field of Interest (abridged for purposes of index)</td>
<td>Page</td>
</tr>
<tr>
<td>----------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>The California Wellness Foundation</td>
<td>Children/youth, services; Crime/violence prevention; Family services; Leadership development; Medical care, community health systems; Mental health/crisis services; Public health; Public health, occupational health; Youth development, services; Youth, pregnancy prevention.</td>
<td>198</td>
</tr>
<tr>
<td>The Clorox Company Foundation</td>
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<td>201</td>
</tr>
<tr>
<td>S. H. Cowell Foundation</td>
<td>Economically disadvantaged; Education; Education, early childhood education; Housing/shelter; Human services; Minorities; Vocational education; Youth development.</td>
<td>202</td>
</tr>
<tr>
<td>Cupertino Electric Trust</td>
<td>Children/youth, services; Education; Human services; Youth development.</td>
<td>203</td>
</tr>
<tr>
<td>The Hall Charitable Trust</td>
<td>Elementary/secondary education; Environment, natural resources; Health organizations; Youth development.</td>
<td>204</td>
</tr>
<tr>
<td>Hilton Hotels Corporation Contributions Program</td>
<td>Elementary/secondary education; Homeless; Public affairs; Public policy, research; Youth development.</td>
<td>204</td>
</tr>
<tr>
<td>The Hut Foundation</td>
<td>Children/youth, services; Community development; Education; Health care; Youth development.</td>
<td>205</td>
</tr>
<tr>
<td>Napa Valley Wine Auction</td>
<td>Health care; Housing/shelter; Youth development.</td>
<td>205</td>
</tr>
<tr>
<td>Guess? Foundation</td>
<td>Children/youth, services; Education; Federated giving programs; Health care; Human services; Jewish agencies &amp; temples; Youth development.</td>
<td>206</td>
</tr>
<tr>
<td>Dreyer’s Grand Ice Cream Charitable Foundation</td>
<td>Education; Education, services; Elementary/secondary education; Higher education; Vocational education; Youth.</td>
<td>206</td>
</tr>
<tr>
<td>John and Marcia Goldman Foundation</td>
<td>Children/youth, services; Education; Family services; Health care; Human services; Recreation.</td>
<td>207</td>
</tr>
<tr>
<td>Synopsys Technology Education Opportunity Foundation</td>
<td>Education, services; Food banks; Foundations (community); Mathematics; Science; Secondary school/education</td>
<td>208</td>
</tr>
<tr>
<td>Community Bank Foundation</td>
<td>Children; Community development; Economic development; Economically disadvantaged; Education; Family services; Higher education; Human services; Women.</td>
<td>208</td>
</tr>
<tr>
<td>Northrop Grumman Corporation Contributions Program</td>
<td>Education; Elementary/secondary education; Employment; Environment; Family services; Health care; Human services; Public affairs; Youth development.</td>
<td>208</td>
</tr>
<tr>
<td>Save Mart Supermarkets Corporate Giving Program</td>
<td>Children, services; Education; Family services; Nutrition; Recreation.</td>
<td>209</td>
</tr>
</tbody>
</table>
### School-Based Mental Health Needs Assessment

#### Appendix C: Potential Grant Opportunities

<table>
<thead>
<tr>
<th>Name</th>
<th>Field of Interest (abridged for purposes of index)</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Stocker Foundation</td>
<td>Children/youth, services; Crime/violence prevention, domestic violence; Disabilities, people with; Economically disadvantaged; Education, early childhood education; Elementary school/education; Family services; Homeless, human services; Housing/shelter; Human services; Leadership development; Mental health/crisis services; Public affairs, citizen participation; Youth development, services.</td>
<td>210</td>
</tr>
<tr>
<td>Lawrence Weissberg Foundation</td>
<td>Children/youth, services; Education; Family services; Human services; Jewish agencies &amp; temples; Jewish federated giving programs.</td>
<td>210</td>
</tr>
<tr>
<td>Ludwick Family Foundation</td>
<td>Children/youth, services; Community development, neighborhood development; Disabilities, people with; Education; Environment; Family services; Health care; Housing/shelter, services.</td>
<td>211</td>
</tr>
<tr>
<td>Junior League of San Francisco, Inc.</td>
<td>Children; Elementary/secondary education; Family services.</td>
<td>212</td>
</tr>
<tr>
<td>Cross Ridge Foundation, Inc</td>
<td>Children/youth, services; Civil rights; Youth development, centers/clubs.</td>
<td>212</td>
</tr>
<tr>
<td>Epson America, Inc. Corporate Giving Program</td>
<td>Education, reading; Elementary/secondary education; Public affairs; Youth development, services.</td>
<td>213</td>
</tr>
<tr>
<td>Estelle Funk Foundation</td>
<td>Education; Health organizations; Hospitals (general); Human services; Jewish agencies &amp; temples; Jewish federated giving programs; Youth development.</td>
<td>213</td>
</tr>
<tr>
<td>The David B. Gold Foundation</td>
<td>Crime/violence prevention, child abuse; Environment, natural resources; Reproductive health, family planning; Youth development.</td>
<td>214</td>
</tr>
<tr>
<td>Koret Foundation</td>
<td>Community development; Elementary school/education; Higher education; Israel; Jewish agencies &amp; temples; Jewish federated giving programs; Secondary school/education; Youth development.</td>
<td>214</td>
</tr>
<tr>
<td>Robert C. &amp; Lois C. Braddock Charitable Foundation</td>
<td>Family services, domestic violence; Food services; Health organizations; Higher education; Human services.</td>
<td>216</td>
</tr>
<tr>
<td>George and Ruth Bradford Foundation</td>
<td>Children/youth, services; Education; Environment, natural resources; Family services; Health care; Higher education; Housing/shelter, temporary shelter; Human services; Museums; Recreation, camps; Youth development, centers/clubs</td>
<td>217</td>
</tr>
<tr>
<td>Grenell Family Foundation</td>
<td>Human services; Jewish agencies &amp; temples; Jewish federated giving programs; Media/communications; Museums; Performing arts; Youth development.</td>
<td>218</td>
</tr>
<tr>
<td>The Oakland Athletics Community Fund</td>
<td>Children; Crime/violence prevention; Economically disadvantaged; Education; Health care; Substance abuse, prevention.</td>
<td>218</td>
</tr>
<tr>
<td>The Bradley Foundation</td>
<td>Children/youth, services; Christian agencies &amp; churches; Education; Family services, domestic violence; Human services.</td>
<td>218</td>
</tr>
</tbody>
</table>
### Potential Grant Opportunities

<table>
<thead>
<tr>
<th>Name</th>
<th>Field of Interest (abridged for purposes of index)</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kosch-Westerman Foundation</td>
<td>Education, services.</td>
<td>219</td>
</tr>
<tr>
<td>World Affairs Council of Northern California</td>
<td>Education, services; International affairs.</td>
<td>220</td>
</tr>
<tr>
<td>The James Irvine Foundation</td>
<td>Community development; Community development, neighborhood development; Economic development; Employment, training; Foundations (community); Philanthropy/voluntarism; Public policy, research; Youth development, centers/clubs; Youth development, services.</td>
<td>220</td>
</tr>
<tr>
<td>William Sloane Jelin Charitable Foundation</td>
<td>Human services; Jewish agencies &amp; temples; Youth development, services.</td>
<td>223</td>
</tr>
</tbody>
</table>
Listing of Potential Funders

**Community Foundation of the Napa Valley**
3299 Claremont Way, Ste. 2  
Napa, CA 94558-3382  
*Telephone:* (707) 254-9565  
*Contact:* Maria Tofle, Dir., Philanthropic Svcs.  
*FAX:* (707) 254-7955  
*E-mail:* info@cfnv.org  
*Additional E-mail:* marla@cfnv.org  
[http://www.cfnv.org](http://www.cfnv.org)

_Type of grantmaker:* Community foundation.  
**Background:** Established in 1994 in CA.  
**Purpose and activities:** The mission of the foundation is to access, develop, and preserve community resources to meet community needs in Napa County, CA.  
**Fields of interest:** Agriculture/food; Arts; Education; Family services; Health care; Housing/shelter; Human services; Religion; Safety/disasters; Youth; Youth development.  
**Geographic focus:** California  
**Types of support:** General/operating support; Management development/capacity building; Program development; Scholarship funds; Seed money.  
**Limitations:** Giving primarily in the Napa County, CA, area.

**Five Bridges Foundation**
P.O. Box 194405  
San Francisco, CA 94119-4405  
*E-mail:* contact@fivebridges.org  
[http://www.fivebridges.org](http://www.fivebridges.org)

_Type of grantmaker:* Independent foundation.  
**Background:** Established in 1998 in CA.  
**Purpose and activities:** The foundation's mission is to promote and improve the quality of life for the residents of the greater San Francisco Bay Area, CA by funding organizations that have programs directed toward achievement of long-term, positive change, particularly in the areas of women's and children's health and welfare, education of young people, and other services to the disadvantaged and underprivileged.  
**Fields of interest:** AIDS; Children, services; Children/youth, services; Christian agencies & churches; Crime/violence prevention, domestic violence; Crime/violence prevention, youth; Disabilities, people with; Education; Family services; Food banks; Health care; Health care, infants; Health organizations; Human services; Legal services; Substance abusers; Women, centers/services.  
**Geographic focus:** California
Limitations: Giving limited to the ten Bay Area counties of Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano, and Sonoma, CA. No support for organizations that mainly distribute grants to other organizations. No grants to artistic and aesthetic programs, or for receptions, banquets, displays, shows, or other similar programs.

E. Richard Jones Family Foundation
(formerly The Jones Foundation)
P.O. Box 475402
San Francisco, CA 94147-5402
Telephone: (415) 440-7826
Contact: Stephanie Jones, V.P.
Donor(s): Jones Living Trust; Marilyn Jones; ERJ Living Trust.
Type of grantmaker: Independent foundation.
Background: Established in 1997 in CA and DE.
Purpose and activities: Giving to organizations that assist individuals in changing their lives and becoming self-sufficient.
Fields of interest: Education; Elementary/secondary education; Family services; Foundations (community); Health care; Higher education; Human services.
Geographic focus: California
Types of support: Annual campaigns; Seed money.
Limitations: Giving primarily in the San Francisco Bay Area, CA.

The Gamble Foundation
c/o Pacific Foundation Svcs.
1660 Bush St., Ste. 300
San Francisco, CA 94109-5308
Telephone: (415) 561-6540, ext. 205
Contact: Eric L. Sloan
FAX: (415) 561-6477
E-mail: esloan@pfs-llc.net
http://www.pfs-llc.net/gamble/gamble.html
Donor(s): Launce E. Gamble; Mary S. Gamble‡; George F. Gamble; MSG Charitable Trust; Launce L. Gamble; Mark D. Gamble; Aimee Gamble Price; George T. Gamble; Jim Gamble; Joan L. Gamble.
Type of grantmaker: Independent foundation.
Background: Established in 1968 in CA.
Purpose and activities: The foundation’s primary interest is to support organizations that serve disadvantaged children and youth in San Francisco, Marin and Napa counties. Within the field of youth development, the foundation focuses on educational and personal enrichment programs designed to open doors of opportunity for at risk youth in order to help them succeed in school and become productive, self-sufficient members of society. The foundation is particularly interested in
agricultural/environmental education, vocational training, and programs that prevent substance abuse and teen violence. To a lesser degree, the foundation supports environmental organizations that focus on land preservation and sustainability, animal welfare and management, and pollution control.

**Fields of interest:** Agriculture; Crime/violence prevention, abuse prevention; Crime/violence prevention, youth; Environmental education; Homeless, human services; Human services; Public health; Recreation; Youth development, services.

**Geographic focus:** California

**Types of support:** Equipment; Program development.

**Limitations:** Giving primarily in San Francisco and Napa counties, CA. No support for religious organizations. No grants to individuals, or for medical research, endowment funds, capital improvements, or annual appeals.
Roy A. Hunt Foundation

1 Bigelow Sq., Ste. 630
Pittsburgh, PA 15219-3030

Telephone: (412) 281-8734
Contact: Beatrice C. Carter, Exec. Dir.
FAX: (412) 255-0522
E-mail: info@rahuntfdn.org
http://www.rahuntfdn.org

Donor(s): Roy A. Hunt‡.
Type of grantmaker: Independent foundation.
Background: Established in 1966 in PA.
Purpose and activities: To improve the quality of life through grants for education, the arts and cultural programs, social services, the environment, health services, community development, and youth violence prevention.
Program area(s): The grantmaker has identified the following area(s) of interest:

Community Development: The purpose of this program is to facilitate the development of healthy and sustainable communities. Program priorities include: neighborhood revitalization and economic development. Grants range from $25,000 to $100,000.

Environment: The program’s goal is to facilitate the protection and conservation of natural resources and healthy ecosystems by supporting sustainable solutions to root causes of environmental damage. Program priorities include: 1) smart growth and land and forest management; 2) environmental education and research and strengthening the environmental community; 3) watersheds and conservation of fresh water ecosystems in North America; and 4) climate and atmosphere. Grants range from $25,000 to $50,000.

General Grants: The foundation funds a broad range of organizations reflecting the diverse interests of individual trustees. Most grants are awarded for general operating support in the areas of arts and culture, environment, health, and human services.

Next Generation Fund: Encompasses giving by the trustees who are great-grandchildren of the founder, Roy A. Hunt. Grants have been made in support of arts and culture, education, and international affairs, development, and peace.

Youth Violence Prevention: The mission of this program is to prevent youth violence by supporting projects that address the factors that contribute to it. The foundation is interested in age-appropriate, researched-based approaches to primary, secondary, and tertiary prevention. This includes strategies designed to address factors that increase the risk of violent behavior among youth. Grants will focus on those risk factors considered to be major predictors of violent behavior. Grants range from $20,000 to $50,000.

Fields of interest: Arts; Community development; Crime/violence prevention, youth; Elementary/secondary education; Environment; Health care; Higher education; Human services; Religion.

Geographic focus: California; Idaho; Maine; Massachusetts; New Hampshire; Ohio; Pennsylvania

Types of support: Annual campaigns; Building/renovation; Capital campaigns; Endowments;
General/operating support.

**Limitations:** Giving primarily in the Boston, MA, and Pittsburgh, PA, areas, also in CA, ID, NH, ME, and OH. No grants to individuals.
Danford Foundation
P.O. Box 4609
Foster City, CA 94404-0609
Telephone: (650) 349-4055
Contact: Katherine F. Fisher, Secy.
FAX: (650) 341-5155
Donor(s): Gladys B. Danford
Type of grantmaker: Independent foundation.
Background: Established in CA in 1982.
Purpose and activities: Giving primarily for health associations and medical research, children, youth, and social services, particularly for food, housing, job training, services for the homeless, and substance abuse programs.
Fields of interest: Animal welfare; Arts; Children/youth, services; Economically disadvantaged; Education; Elementary/secondary education; Eye diseases; Family services; Health organizations; Higher education; Homeless, human services; Hospitals (general); Human services; Libraries/library science; Medical research; Nerve, muscle & bone diseases; Performing arts; Roman Catholic agencies & churches.
Geographic focus: California
Types of support: Continuing support; Equipment; Research; Scholarship funds.
Limitations: Giving primarily in the San Francisco Bay Area, CA. No support for political organizations. No grants to individuals.

Dougherty Family Foundation
5380 Arezzo Dr.
San Jose, CA 95138-2201
Contact: Gregory Dougherty, Chair.
Donor(s): Gregory Dougherty; Nancy Dougherty.
Type of grantmaker: Independent foundation.
Background: Established in 2001 in CA.
Purpose and activities: Giving primarily for children's health care and services; some giving also for education, and the arts.
Fields of interest: Arts; Children/youth, services; Education; Family services; Health care; Health organizations; Hospitals (specialty); Performing arts, theater (musical); Roman Catholic agencies & churches.
Geographic focus: California
Limitations: Giving primarily in CA.

Dr. Seuss Foundation
7301 Encelia Dr.
La Jolla, CA 92037-5279
Telephone: (858) 454-7384
Contact: Audrey S. Geisel, Pres.

Donor(s): Theodor S. Geisel‡.

Type of grantmaker: Independent foundation.

Background: Incorporated in 1958 in CA.

Fields of interest: Arts; Children/youth, services; Family services; Health organizations; Higher education; Hospitals (general); Human services; Medical research; Museums.

Geographic focus: California

Limitations: Giving primarily in CA. No grants to individuals.

Mark Hughes Family Foundation
(formerly Herbalife Family Foundation)
10100 Santa Monica Blvd., Ste. 300
Los Angeles, CA 90067-4107
Telephone: (310) 772-2216
Contact: Conrad Lee Klein, Secy.
FAX: (310) 557-3925

Type of grantmaker: Independent foundation.

Background: Established in 1994 in CA.

Purpose and activities: The foundation contributes to organizations or programs that improve nutrition, support disadvantaged children and families, provide early interventions to life problems, or prevent physical and emotional abuse.

Fields of interest: Children/youth, services; Economically disadvantaged; Education; Family services; Human services; Mental health, treatment; Mental health/crisis services; Nutrition; Youth development.

Geographic focus: California

Types of support: Curriculum development; Emergency funds; Equipment; General/operating support; Program development.

Limitations: Giving primarily in CA, with emphasis on Los Angeles.

Center for Community and Family Services
565 N. Rosemead Blvd.
Pasadena, CA 91107
E-mail: Corp.Dir@ccafs.org
http://www.ccafs.org

Type of grantmaker: Public charity.

Background: Established in 1969 in CA.

Purpose and activities: The center works to support self-sufficiency for individuals and families, and to help build sustainable communities.

Fields of interest: Children/youth, services; Community development; Education, early childhood education; Family services; Human services; Nutrition.

Geographic focus: California
Limitations: Giving limited to CA.

**R.S. Hoyt, Jr. Family Foundation**
c/o Arizona Community Foundation
2201 E. Camelback Rd., Ste. 202
Phoenix, AZ 85016
**Type of grantmaker:** Public charity.
**Background:** Supporting organization of the Arizona Community Foundation.
**Fields of interest:** Education; Family services; Federated giving programs; Protestant agencies & churches.
**Geographic focus:** Arizona; California; Virginia
**Limitations:** Giving primarily in AZ, CA and VA.

**The Ingebritson Family Foundation**
c/o Arizona Community Foundation
2201 E. Camelback Rd., Ste. 202
Phoenix, AZ 85016
**Contact:** Jack Ingebritson, Pres.; Helen Ingebritson
**Type of grantmaker:** Public charity.
**Background:** Supporting organization of the Arizona Community Foundation.
**Fields of interest:** Education; Family services.
**Geographic focus:** Arizona; California; South Dakota
**Limitations:** Giving primarily in AZ, CA, and SD.

**Krishnan-Shah Family Foundation, Inc.**
P.O. Box 1525
Pennington, NJ 08534-1525
**Contact:** Lata Krishnan-Shah, Pres.
**Donor(s):** Ajay B. Shah; Lata Krishnan-Shah.
**Type of grantmaker:** Independent foundation.
**Background:** Established in 1997 in CA.
**Purpose and activities:** Giving to organizations for the health, education and cultural development of youth and families.
**Fields of interest:** Arts; Community development, service clubs; Education; Family services; Human services; Youth, services.
**Geographic focus:** California
**Limitations:** Giving primarily in CA.

**The Linden Family Foundation**
4041 MacArthur Blvd., Ste. 350
Newport Beach, CA 92660-2511
**Telephone:** (949) 223-5080
Contact: Thomas M. Linden, Pres.
Donor(s): Margaret I. Linden; Milton S. Linden.
Type of grantmaker: Operating foundation.
Background: Established in 1997 in CA.
Fields of interest: Christian agencies & churches; Education; Family services; Hospitals (general).
Geographic focus: California
Limitations: Giving primarily in CA.

Lisa and Sidne Long Foundation
1 Kaiser Plz., Ste. 1010
Oakland, CA 94612-3601
Donor(s): Sidne J. Long; Lisa K. Laird.
Type of grantmaker: Independent foundation.
Background: Established in 2005 in CA.
Fields of interest: Education; Family services; Human services.
Geographic focus: California
Limitations: Giving primarily in CA.

Dave and Roma McCoy Family Foundation
484 Rocking K Dr.
Bishop, CA 93514
Telephone: (760) 934-0779
Contact: Gary McCoy, Pres.
Donor(s): David R. McCoy.
Type of grantmaker: Independent foundation.
Fields of interest: Athletics/sports, water sports; Education; Family services, domestic violence.
Geographic focus: California; Nevada
Types of support: General/operating support.
Limitations: Giving primarily in CA and NV. No grants to individuals

The Barry and Wendy Meyer Charitable Foundation
9460 Wilshire Blvd., Ste. 600
Beverly Hills, CA 90212-2712
Telephone: (310) 888-3630
Contact: Wendy Meyer, Pres.; Barry Meyer, Secy. and C.F.O
Donor(s): Wendy Meyer, Ph.D.; Barry Meyer.
Type of grantmaker: Independent foundation.
Background: Established in 1999 in CA.
Fields of interest: Children/youth, services; Education; Family services; Higher education; Human services; Jewish agencies & temples; Reproductive health, family planning.
Geographic focus: California; New York
Limitations: Giving primarily in CA, with some giving in NY.

**Myers Family Foundation**
1114 State St., Ste. 232
Santa Barbara, CA 93101-9650
Contact: Mary H. Myers-Kauppila, Tr.
Donor(s): Members of the Myers family.
Type of grantmaker: Independent foundation.
Background: Established in 1984 in CA.
Purpose and activities: Giving primarily for family services and the arts.
Fields of interest: Arts; Family services; Higher education; Hospitals (general); Protestant agencies & churches; Secondary school/education.
Geographic focus: California
Limitations: Giving primarily in CA.

**Esper A. Petersen Foundation**
3535 Washington St.
Gurnee, IL 60031-3328
Donor(s): Esper A. Petersen‡.
Type of grantmaker: Independent foundation.
Background: Incorporated in 1944 in IL.
Fields of interest: Arts; Children/youth, services; Community development; Economically disadvantaged; Education; Family services; Health care; Hospitals (general); Human services.
Geographic focus: California; Illinois
Types of support: Building/renovation; General/operating support; Research.
Limitations: Giving primarily in CA and IL. No grants to individuals.

**Satterberg Foundation**
810 Securities Bldg.
1904 3rd Ave.
Seattle, WA 98101-1126
Telephone: (206) 441-3045
Contact: Peter F. Helsell, Treas.
FAX: (206) 374-9336
E-mail: info@satterberg.org
http://www.satterberg.org
Donor(s): Virginia S. Helsell; Judy P. Swenson; William A. Helsell.
Type of grantmaker: Independent foundation.
Background: Established in 1990 in WA.
Purpose and activities: The mission of the foundation is to maintain and enjoy the interconnection of its family and to provide funds to non-profit organizations that enrich and support its communities.
Fields of interest: Children/youth, services; Education; Family services; Health care; Housing/shelter,
development; Human services; Youth development, centers/clubs.

**Geographic focus:** California; Washington

**Types of support:** Income development; Management development/capacity building.

**Limitations:** Giving primarily in CA and WA. No support for evangelical groups. No grants to individuals.

**Herman P. and Sophia Taubman Foundation**

C/o Bank of Oklahoma, N.A.
P.O. Box 880
Tulsa, OK 74101-0880

*Application address:* c/o Bank of Oklahoma, N.A., P.O. Box 1620, Tulsa, OK 74101-1620, tel.: (918) 588-6407

**Donor(s):** Herman P. Taubman‡; Sophia Taubman‡.

**Type of grantmaker:** Independent foundation.

**Background:** Trust established in 1955 in OK.

**Fields of interest:** Arts; Children/youth, services; Education; Family services; Health organizations; Higher education; Hospitals (general); Jewish agencies & temples; Jewish federated giving programs; Museums (children's).

**Geographic focus:** California

**Types of support:** Building/renovation; General/operating support; Program development; Research.

**Limitations:** Giving primarily in CA; some giving nationally. No grants to individuals.

**Walter S. Johnson Foundation**

525 Middlefield Rd., Ste. 160
Menlo Park, CA 94025-3441

*Telephone:* (650) 326-0485

*Contact:* Pancho Chang, Exec. Dir.

*FAX:* (650) 326-4320

*E-mail:* info@wsjf.org

[http://www.wsjf.org](http://www.wsjf.org)

**Donor(s):** Walter S. Johnson

**Type of grantmaker:** Independent foundation.

**Background:** Established in 1968 in CA.

**Purpose and activities:** Giving primarily to help improve youth and educational services in Northern California and Washoe County, Nevada.

**Program area(s):** The grantmaker has identified the following area(s) of interest:

**Children, Youth and Families:** 1) Youth Development -- Children: The foundation supports efforts that create or upgrade the quality of programs that provide substantive youth development and comprehensive supports for school-age children and youth. Adolescents: The foundation is interested in supporting programs that offer adolescents opportunities to participate in meaningful roles within organizations, build working relationships, learn technical skills, and develop personal characteristics that will enable them to succeed in becoming resourceful and productive adults, and engage youth and
young adults in civic involvement in response to pressing social issues and local needs. 2) High-Risk and Adjudicated Youth -- The foundation has a strong interest in reaching high-risk youth, many of whom have dropped out of school and are having difficulty making a successful transition to adulthood. Currently, the foundation is interested in supporting efforts to engage community organizations and alternative schools in establishing meaningful, long-term relationships with adjudicated and high-risk youth; establish a continuum of care in which public and private organizations work together with youth, families, and communities to facilitate the transition of adjudicated youth from offender to productive community member; and encourage thoughtful investment of public funds to prevent juvenile crime and to rehabilitate youthful offenders.

**Special Projects:** On occasion, the foundation makes grants outside the regular guidelines. Often they provide an opportunity to explore potential new areas for future grantmaking subject to full board approval. Each year the trustees of the foundation authorize small general support grants to organizations representative of the charities to which Walter S. Johnson contributed during his lifetime. The foundation does not accept applications for these grants.

**Strengthening Public Education:** 1) Teacher Development -- The foundation supports opportunities for educators to continue to learn and develop their knowledge and skills using research about effective teaching and learning strategies as a basis. The foundation is particularly interested in supporting teacher professional development efforts that allow educators to reflect on their teaching and to revise their practice based on what they have learned; and enable schools and school systems to create new roles for teachers. 2) New Teacher Support -- The foundation has a strong interest in assisting teachers early in their careers in order to improve the quality of teaching and reduce the high level of attrition that often occurs within the first few years. The foundation’s interest is focused on efforts that create intensive, high-quality support programs for beginning teachers, building on the state-funded Beginning Teacher Support and Assessment Program (BTSA); stimulate research to identify best practices in new teacher support and to assess the impact of quality induction support on teacher retention, teacher quality, and student learning; and promote the development of sound state-level policies that encourage the provision of high-quality induction support to new teachers. 3) School Reform -- K-12 School Reform: The foundation supports a vision of schooling wherein educators, students, and parents are all highly involved in the process of learning and there is a focus on the particular strengths and needs of individual students. High School Reform: The foundation is interested in supporting high schools that are exploring new ways to prepare all their students, especially those who have traditionally been underserved, to pursue productive postsecondary paths.

**Fields of interest:** Children/youth, services; Education; Elementary/secondary education; Family services; Graduate/professional education; Leadership development; Youth development, services.

**Geographic focus:** California; Nevada

**Types of support:** General/operating support; Program development; Program-related investments/loans; Seed money; Technical assistance.

**Limitations:** Giving primarily in northern CA and Washoe County, NV. No support for religious organizations for sectarian purposes or for private schools. No grants to individuals, or for annual campaigns, deficit financing, memorial funds, capital or endowment funds, matching gifts, scholarships,
fellowships, publications, or conferences.

**June & Julian Foss Foundation**
6824 19th St. W., PMB 116
University Place, WA 98466-5528
E-mail: administrator@fossfoundation.org
http://www.fossfoundation.org

*Type of grantmaker:* Independent foundation.
*Background:* Established in 1997 in WA.
*Purpose and activities:* Funding primarily for children and youth, and children and young adults with major mental illness.
*Fields of interest:* Children/youth, services; Education; Human services; Mental health, treatment; Youth development, adult & child programs.
*Geographic focus:* Arizona; California; Florida; Minnesota; Oregon; Washington
*Types of support:* Curriculum development; Program development; Seed money.
*Limitations:* Giving primarily in Phoenix, AZ, the San Francisco Bay Area, CA, Miami, FL, Minneapolis, MN, Portland, OR, and Tacoma, WA. No grants to individuals.

**William Gorrill Swigert Foundation**
56 Peninsula Rd.
Belvedere, CA 94920-2326
Telephone: (415) 381-0681
Contact: Juliette Swigert Bonelli, Pres.

*Type of grantmaker:* Independent foundation.
*Fields of interest:* Mental health association
*Geographic focus:* California
*Types of support:* General/operating support.
*Limitations:* Giving primarily in CA. No grants to individuals.

**All Stars Helping Kids, Inc.**
970 Main St.
Redwood City, CA 94063-1996
Telephone: (650) 363-1395
Contact: Marlon S. Evans, Exec. Dir.
FAX: (650) 363-1194
E-mail: marlon@allstarshelpingkids.com
http://www.allstarshelpingkids.com

*Type of grantmaker:* Public charity.
*Background:* Established in 1989.
*Purpose and activities:* The organization provides funding for youth organizations for the development of children educationally, physically, and emotionally.
*Fields of interest:* Child development, education; Child development, services; Children/youth, services;
Crime/violence prevention, youth; Education; Education, drop-out prevention; Education, early childhood education; Family services; Human services; Youth development.

**Geographic focus:** California; Texas

**Limitations:** Giving limited to Los Angeles and the San Francisco Bay Area, CA, and the Dallas, TX, area.

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**The Bolton Family Foundation**

882 Western Way  
Florence, Oregon 97439-9295  
*Telephone:* (541) 997-3248  
*Contact:* Elizabeth Bolton Newell, Pres.  
*Type of grantmaker:* Independent foundation.  
*Background:* Established in 2004 in CA.  
*Fields of interest:* Arts; Education; Health organizations; Human services; Media/communications; Mental health/crisis services; Performing arts; Recreation; Youth development.  
*Geographic focus:* California; Oregon  
*Types of support:* General/operating support; Program development.  
*Limitations:* Giving primarily in CA and OR.

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**The California Wellness Foundation**

6320 Canoga Ave., Ste. 1700  
Woodland Hills, CA 91367-7111  
*Telephone:* (818) 702-1900  
*Contact:* Joan C. Hurley, Dir., Grants Mgmt.  
*FAX:* (818) 702-1999  
*E-mail:* tcwf@tcwf.org  
*Branch Office address:* 575 Market St., Ste. 1850, San Francisco, CA 94105, tel.: (415) 908-3000, fax: (415) 908-3001  
[http://www.tcwf.org](http://www.tcwf.org)  
*Donor(s):* Health Net Corp.  
*Type of grantmaker:* Independent foundation.  
*Background:* Established in 1991 in CA; converted from Health Net HMO.  
*Purpose and activities:* The foundation's mission is to improve the health of the people of California by making grants for health promotion, wellness education and disease prevention. The foundation pursues the following goals through grantmaking: 1) to address the particular health needs of traditionally underserved populations, including low-income individuals, people of color, youth and residents of rural areas; 2) to support and strengthen nonprofit organizations that seek to improve the health of underserved populations; 3) to recognize and encourage leaders who are working to increase health and wellness within their communities; and 4) to inform the development of public policies that promote wellness and enhance access to preventive health care.  
*Program area(s):* The grantmaker has identified the following area(s) of interest:  
**Diversity in the Health Professions:** Grants that address the issue of diversity in the health professions.
are commonly given to organizations that provide pipeline programs, scholarships, outreach and retention programs, internships, fellowships and loan repayment programs for ethnic minorities that are underrepresented in the health professions. Careers in medicine, nursing, public health and other allied health professions are included. Organizations that support leadership development for people of color in the health professions are also eligible for funding. In addition, the foundation funds organizations that educate policymakers and advocate for public and institutional policies that promote diversity in the health professions. In Dec. 2005, the Board of Directors of TCWF approved a $1 million grant to Ogilvy Public Relations Worldwide to implement a public education campaign with two main objectives: to inform policy makers, opinion leaders and the general public that increasing diversity in the health professions is a key strategy for improving the health of the people of California; and to inform underrepresented minority youth about available health profession opportunities. Ogilvy Public Relations was funded to launch the campaign for a one-year period, beginning in 2006. In the judgment of the foundation, annual proposals may be requested by the foundation for a total period of up to five years, based upon the performance of the grantee and the effectiveness of the campaign. The campaign is one component of a comprehensive approach the foundation uses to address this issue. Another element of this approach is the annual Champions of Health Professions Diversity Award, which recognized three individuals who have significantly contributed to the diversification of California’s health workforce.

**Employee Matching Gifts:** The foundation matches the contributions of its employees to charitable organizations.

**Environmental Health:** Grants that address the issues of environmental health are commonly given to organizations that provide environmental health education and awareness activities, community organizing to promote environmental health, screening and testing for exposure to environmental toxins; leadership development; and collaborations such as partnerships between public health departments and community-based health programs to improve environmental health. The foundation also funds efforts to inform policymakers and advocate for policies that could improve environmental health among underserved populations.

**Healthy Aging:** Grants that address the issue of healthy aging are commonly given to organizations that provide clinical preventive services, falls prevention programs, food and nutrition programs, in-home support and kinship caregiving. Also funded are organizations that support relationships between youth and older adults through activities such as intergenerational volunteering and mentoring. In addition, the foundation funds agencies that educate policymakers and advocate for policies that promote healthy aging, as well as organizations that provide leadership development programs for seniors.

**Mental Health:** Grants that address the issue of mental health are commonly given to organizations that provide services for transition-age youth (ages 16-23) – with a focus on those in, or exiting from, foster care and on runaway/homeless youth. In addition, the foundation funds organizations that provide leadership development programs for mental health professionals, as well as organizations that inform policymakers and advocate for effective mental health programs and policies for transition-age youth.

**Sabbatical Program:** The program was created to improve the long-term effectiveness of health service nonprofits by providing their executives with the rest they need to continue to direct their organizations' missions. The program offers $30,000 grants to nonprofit health organizations in California, enabling
their executive directors to take a paid leave of up to six months. Up to $5,000 will also be awarded to each organization for the professional development of managers and staff who will assume extra responsibilities during the absence of the sabbatical awardees. The award is in the form of a grant to sabbatical recipients’ organizations, which will disburse the money. TCWF staff will review all of the applications and make recommendations to the foundation’s board of directors for approval. The sabbatical application may be found on the foundation website: http://www.tcwf.org/pdf_docs/sabbatical/Sabbatical_Application_Form_Final.pdf. Questions should be directed to e-mail: sabbaticalprogram@tcwf.org.

**Special Projects Fund:** Each year, the foundation sets aside a pool of dollars to respond in a timely fashion to opportunities that fit its mission, but are outside the health issues prioritized for funding. The foundation places an emphasis on grants to support and strengthen safety net providers of health care, to help low-income consumers understand and navigate the health care system, and to inform public decision making through policy analysis and advocacy. The foundation also provides funding to address the healthcare needs of the Cal/Mex border population, the urban homeless, and culturally appropriate programs for underserved ethnic populations.

**Teenage Pregnancy Prevention:** Grants that address the issue of teenage pregnancy prevention are commonly given to organizations that provide outreach activities for reproductive health care, access to contraceptive services, and comprehensive programs for pregnant teens. An emphasis is placed on funding peer-provider clinics and other reproductive health organizations that work with high-risk, sexually active underserved teen populations. The foundation also funds organizations that provide leadership development activities for reproductive health care workers and organizations that inform policymakers and opinion leaders about effective policies and programs to prevent teen pregnancy.

**Violence Prevention:** Grants that address the issue of violence prevention are commonly made to mentoring programs for youth, (ages 12-24) including mentoring programs, gang intervention programs, reentry programs, community-based violence prevention programs and after-school programs. An emphasis is placed on funding organizations that work with at-risk youth, including gang-affiliated and previously incarcerated youth. Grants are also made to organizations that provide leadership development activities to those working in the field of violence prevention, as well as organizations that inform policymakers and advocate for public policies that prevent violence against youth.

**Women’s Health:** Grants that address the issue of women’s health are commonly given to organizations that provide reproductive health care, prenatal care, community-based comprehensive health care services, HIV/AIDS programs for women of color, case management, and supportive housing for homeless women. Priority is given to organizations that create welcoming environments for women in underserved communities. The foundation also funds organizations that provide leadership development activities for women and those that educate policymakers and advocate for effective policies and programs that promote women’s health.

**Work and Health:** Grants that address the issue of work and health are commonly given to organizations that provide health care services to farm workers, in-home health workers, garment workers, day laborers and other low-income workers. Worker centers that provide culturally sensitive and linguistically appropriate services such as health education and access to health care for low-wage workers are also prioritized for funding. In addition, the foundation funds organizations that provide
leadership development programs for low-wage workers. Organizations that educate policymakers about the connections between work and health and advocate for policies that could improve the health of low-income workers are funded as well.

**Fields of interest:** Aging; Children/youth, services; Crime/violence prevention; Family services; Leadership development; Medical care, community health systems; Mental health/crisis services; Public health; Public health, occupational health; Youth development, services; Youth, pregnancy prevention.

**Geographic focus:** California

**Types of support:** Conferences/seminars; Continuing support; Employee matching gifts; General/operating support; Grants to individuals; Program development; Program evaluation; Publication; Research; Seed money; Technical assistance.

**Limitations:** Giving limited to CA; national organizations providing services in CA are also considered. No support for religious or sectarian organizations. No grants to individuals (except for research fellowships and awards), or for annual fund drives, building campaigns, major equipment, or biomedical research.

**The Clorox Company Foundation**

1221 Broadway
Oakland, CA 94612-1888

*Telephone:* (510) 208-3223

*E-mail:* cloroxfndt@eastbaycf.org

*Mailing address:* c/o East Bay Community Foundation, De Domenico Bldg., 200 Frank Ogawa Plz., Oakland, CA 94612


**Donor(s):** The Clorox Co.

**Type of grantmaker:** Company-sponsored foundation.

**Background:** Incorporated in 1980 in CA.

**Purpose and activities:** The foundation supports organizations involved with arts and culture, K-12 education, disaster relief, youth development, and civic affairs. Grants are administered by the East Bay Community Foundation.

**Program area(s):** The grantmaker has identified the following area(s) of interest:

- **Arts Mini-Grants Initiative:** The foundation annually awards 25 $1,000 grants to nonprofit organizations involved with arts and culture.

- **Commitment Awards:** The foundation awards $300 grants to nonprofit organizations with which employees of Clorox have volunteered at least 24 hours.

- **Culture/Civic Programs:** The foundation supports programs designed to advance civic and cultural initiatives; and increase awareness of, participation in, and appreciation of arts and culture.

- **Education and Youth Development:** The foundation supports programs designed to prepare young people to participate successfully in an increasingly global society and to contribute back to the communities in which they live. Special emphasis is directed toward programs designed to improve the academic performance of children, especially through strategies that foster reform within the public schools; prepare young people for the world of work and for community leadership; and promote positive relationships among young people from diverse cultural and ethnic groups.
School-Based Mental Health Needs Assessment
Appendix C: Potential Grant Opportunities

**Employee Matching Gifts:** The foundation matches contributions made by full-time employees of Clorox to nonprofit organizations from $10 to $2,500 per employee, per year and to institutions of higher education on a one-for-one basis from $10 to $5,000 per employee, per year.

**Fields of interest:** Arts; Disasters, preparedness/services; Elementary/secondary education; Public affairs; Voluntarism promotion; Youth development.

**Geographic focus:** California

**Types of support:** Donated products; Emergency funds; Employee matching gifts; Employee volunteer services; General/operating support; Program development; Scholarship funds.

**Limitations:** Giving primarily in areas of company operations, with emphasis on the Oakland, CA, area; giving on a national and international basis for disaster relief. No support for national organizations, religious organizations not of direct benefit to the entire community, political parties, candidates, or organizations, or exclusive membership organizations. No grants to individuals, or for fundraising, athletic events or league sponsorships, travel, advertising or promotional sponsorships, tickets, conferences, conventions, meetings, or similar events, media production, political activities, dues, debt reduction, capital campaigns, or individual school projects.

**S. H. Cowell Foundation**
120 Montgomery St., Ste. 2570
San Francisco, CA 94104-4335
*Telephone:* (415) 397-0285
*Contact:* Lise Maisano, Dir. of Grants
*FAX:* (415) 986-6786
[http://www.shcowell.org](http://www.shcowell.org)

**Donor(s):** S.H. Cowell.

**Type of grantmaker:** Independent foundation.

**Background:** Trust established in 1955 in CA.

**Purpose and activities:** The goal of the foundation is to improve the quality of life of children and families living in poverty in northern California by making grants that directly support and strengthen children, families, and the neighborhoods where they live. Priority is given to communities where Cowell has made, or could make, place-based complementary grants in Northern California towns and neighborhoods where there is widespread and acute poverty and there are strong working relationships among residents and institutional leaders. The foundation funds efforts to increase a town or neighborhood's capacity to engage and serve its low-income families. These guidelines apply across all program areas: Community Infrastructure including Affordable Housing, Family Resources Centers, K-12 Public Education, Responsive, and Youth Development.

**Program area(s):** The grantmaker has identified the following area(s) of interest:

**Affordable Housing Grants:** The program's priority is to sustain and deepen support in the towns and neighborhoods where Cowell has recently made place-based complementary grants. Proposals are considered for: 1) preservation, rehabilitation, and construction of specific family housing properties; 2) facilities for resident/neighborhood services; 3) pre-development working capital for early upfront costs including land acquisition; 4) expanded capacity to address neighborhood housing issues; and 5)
advocacy and community organizing for affordable housing.

**Education Grants:** The foundation makes grants to public elementary and secondary schools and school districts and in some cases to organizations working in partnership with the public schools in a particular community. Grants support focused projects, usually of two to three years' duration, to improve the quality of teaching in a particular domain or the quality of support provided to students who are habitually under-served by the local schools. The foundation also makes grants to increase the reach and capacity of organizations that support the induction and career professional development of teachers who serve in high-poverty neighborhood public schools.

**Family Resource Center Grants:** The program's priority is to sustain and deepen support of Family Resource Centers (FRCs), the towns and neighborhoods where the foundation has recently made place-based complementary grants. The foundation is interested in proposals for: 1) strengthening and start-up comprehensive FRCs that can demonstrate how they work with other organizations focused on improving the quality of community life; and 2) capital projects, especially for mature FRCs that can demonstrate long-term sustainability and progress toward family and community improvement.

**Youth Development Grants:** The foundation makes grants to organizations whose programs and practices are rooted in principles of positive youth development, and whose program spaces are appropriate settings for essentially any interested youth in a given neighborhood. These settings may include schools, boys and girls clubs, summer camps, arts or media centers, or other community-based institutions where youth are able to participate, learn and contribute. The foundation is particularly interested in projects that involve young people in program design and leadership, and programs that allow youth to practice real-world skills of creativity, collaboration, and production. Capital requests are considered from established youth organizations when fifty percent of needed funds have been raised from other sources.

**Fields of interest:** Economically disadvantaged; Education; Education, early childhood education; Housing/shelter; Human services; Minorities; Vocational education; Youth development.

**Geographic focus:** California

**Types of support:** Building/renovation; Capital campaigns; Consulting services; Employee matching gifts; Equipment; Land acquisition; Matching/challenge support; Program development; Program-related investments/loans; Seed money.

**Limitations:** Giving limited to northern CA. No support for projects restricted to people with specific medical, physical, or health conditions, daycare centers, drug or alcohol abuse programs, environmental or conservation programs, health clinics or other medical service projects, political lobbying, population programs, post-secondary education, projects that are the responsibility of government agencies (except for school districts in the event of emergency funding and budget crises), or sectarian, politically partisan, or religious projects. No grants to individuals, or for general operating support, special events and conferences, books, films, videos, academic or medical research, or capital requests (when less than fifty percent of total funds have been raised).

*Cupertino Electric Trust*

170 State St., Ste. 220
Los Altos, CA 94022-2812

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Allen, Shea and Associates
December 2007
Contact: Eugene A. Ravizza, Tr.
Donor(s): Cupertino Electric, Inc.; Cascade Controls, Inc.
Type of grantmaker: Company-sponsored foundation.
Purpose and activities: The trust supports organizations involved with education, youth development, children and youth, and human services.
Fields of interest: Children/youth, services; Education; Human services; Youth development.
Geographic focus: California
Types of support: General/operating support.
Limitations: Giving primarily in CA. No grants to individuals.

The Hall Charitable Trust
c/o BFW
2029 Century Park E., Ste. 500
Los Angeles, CA 90067-2906
Contact: Julia Hall, Tr.
Type of grantmaker: Independent foundation.
Background: Established in 1997 in CA.
Fields of interest: Elementary/secondary education; Environment, natural resources; Environment, water resources; Health organizations; Youth development.
Geographic focus: California
Limitations: Giving primarily in CA.

Hilton Hotels Corporation Contributions Program
c/o Contribs. Review Comm.
9336 Civic Center Dr.
Beverly Hills, CA 90210-3604
Telephone: (310) 278-4321
Contact: Kathy Shepard, V.P., Corp. Comms.
FAX: (310) 205-7678
E-mail: corporate_communications@hilton.com
Sponsoring company: Hilton Hotels Corporation
Type of grantmaker: Corporate giving program.
Purpose and activities: Hilton makes charitable contributions to nonprofit organizations involved with K-12 education, youth development, public policy, homelessness, and civic affairs. Support is given primarily in areas of company operations.
Program area(s): The grantmaker has identified the following area(s) of interest:
Golden H.E.A.R.T.S. Volunteer Service Grants: Through the Golden H.E.A.R.T.S. Volunteer Service Grants program, Hilton makes charitable contributions of $300 to nonprofit organizations involved with K-12 education, health, youth development, public policy, and civic affairs with which employees volunteer at least 50 hours per year.
H.E.A.R.T.S. Volunteer of the Year Award: Through the H.E.A.R.T.S. Volunteer of the Year Award program, Hilton annually awards one $5,000 grant to the nonprofit organization chosen by an employee who has gone above and beyond in their service to the community.

Fields of interest: Elementary/secondary education; Homeless; Public affairs; Public policy, research; Youth development.

Geographic focus: California; Tennessee

Types of support: Annual campaigns; Building/renovation; Continuing support; Curriculum development; Donated equipment; Donated products; Employee volunteer services; Employee-related scholarships; General/operating support; In-kind gifts; Matching/challenge support; Program development; Scholarship funds; Sponsorships; Use of facilities.

Limitations: Giving primarily in areas of company operations, with emphasis on CA, including Los Angeles and San Francisco, and TN, including Memphis; giving also to national organizations. No support for sport teams, religious organizations not of direct benefit to the entire community, government-supported organizations (over 20 percent of budget), hospitals, private schools, pre-schools, or day care facilities, film and video production, or promotional materials. No grants to individuals (except for employee-related scholarships), or for fellowships, sports activities, debt reduction, capital campaigns or endowments, film or video projects, or promotional merchandise.

The Hut Foundation
19 Sutter St.
San Francisco, CA 94104-4901
Telephone: (415) 834-2464
Contact: James C. Hormel, Jr., Secy.-Treas.
Donor(s): James C. Hormel, Jr.; Kathleen Hormel; Bernard L. Webb; Alison Hormel Webb; Cecil T. Holt; Anne Holt; Sarah Hormel von-Quillfeldt; Elizabeth M. Hormel; Heather N. Hormel; Andrew Kramp.
Type of grantmaker: Independent foundation.
Background: Established in 1998 in CA.
Purpose and activities: Giving primarily for arts and culture, youth programs, and community development.
Fields of interest: Arts; Children/youth, services; Community development; Education; Health care; Youth development.
Geographic focus: California; Virginia
Limitations: Giving primarily in CA and VA. No grants to individuals.

Napa Valley Wine Auction
P.O. Box 141
St. Helena, CA 94574-0141
http://www.napavintners.com/anv/
Type of grantmaker: Public charity.
Background: Established in CA.
Purpose and activities: The auction works to raise funds for health care, youth service, and low-income
housing charities in Napa County, California.

**Program area(s):** The grantmaker has identified the following area(s) of interest:

**Auction Napa Valley Funding Program:** Grants are available to non-profit organizations in Napa Valley that take a leadership role in identifying and responding to unmet needs in the county, and that assess the health of the Napa County community by evaluating and prioritizing health care, education, and human service needs. Specifically, priority will be given to programs that focus on: health care education, illness prevention, and treatment; improving the success of young children in school; helping teens transition into responsible adulthood; creation of low-cost housing; sustainability of farmworker housing programs; and support of low-income, transitional, or safety-net housing programs.

**Fields of interest:** Health care; Housing/shelter; Youth development.

**Geographic focus:** California

**Limitations:** Giving limited to Napa County, CA.

**Guess? Foundation**
1444 S. Alameda St.
Los Angeles, CA 90021-2433

**Donor(s):** Guess ?, Inc.

**Type of grantmaker:** Company-sponsored foundation.

**Background:** Established in 1994 in CA.

**Purpose and activities:** The foundation supports organizations involved with education, health, youth development, human services, and Judaism.

**Fields of interest:** Children/youth, services; Education; Federated giving programs; Health care; Human services; Jewish agencies & temples; Youth development.

**Geographic focus:** California

**Limitations:** Giving primarily in CA. No grants to individuals.

**Dreyer’s Grand Ice Cream Charitable Foundation**
5929 College Ave.
Oakland, CA 94618-1325

**Telephone:** (510) 450-4586

**Contact:** Kelly M. Su'a, Secy.-Treas.

**FAX:** (510) 610-4400

**Tel. for Rocky Road Community Bus Program:** (925) 847-0747 or (800) 445-0444

**http://www.dreyersinc.com/dreyersfoundation/index.asp**

**Donor(s):** Dreyer’s Grand Ice Cream, Inc.

**Type of grantmaker:** Operating foundation.

**Background:** Established in 1987 as a company-sponsored operating foundation.

**Purpose and activities:** The foundation supports programs designed to promote family, school, and community environments that build skills and foster talents in young people. Special emphasis is directed toward programs designed to affect a significant number of young people; foster the concept that it is better to teach young people how to learn than to simply give them answers to their problems;
and programs that are unique and creative.

**Program area(s):** The grantmaker has identified the following area(s) of interest:

**Employee Community Involvement Fund:** The foundation awards $200 grants to nonprofit organizations with which employees of Dreyer's volunteer at least eight hours per month.

**Large Grants:** The foundation supports programs designed to serve young people from preschool to grade 12 in Oakland and East Bay; promote K-12 public education; and help students succeed in core academic subjects and graduate to post secondary education and/or vocational training. Special emphasis is directed toward in-school or after school programs provided in sequential, consistent basis to students throughout the year; and programs designed to support low and middle income youth and minority youth. Grants over $3,000 are awarded.

**Rocky Road Community Bus Program:** The foundation provides free bus transportation available to schools and other nonprofit organizations within a 60-mile radius of Pleasanton, California for short field trips ranging up to 150 miles in radius. Special preference is given to youth oriented groups.

**Small Grants and Product Donations:** The foundation awards small grants and donates ice cream products and gift certificates and auction items to nonprofit organizations for events. Grants of up to $3,000 are awarded.

**Fields of interest:** Education; Education, services; Elementary/secondary education; Higher education; Vocational education; Youth.

**Geographic focus:** California

**Types of support:** Capital campaigns; Continuing support; Donated products; Employee volunteer services; Equipment; General/operating support; Program development.

**Limitations:** Giving primarily in the East Bay, Oakland, and Pleasanton CA, area. No support for religious organizations not of direct benefit to the entire community or political organizations or candidates. No grants to individuals, or for raffle tickets, one-time conventions or meetings, semi-pro athletic sponsorships, benefit advertising, field trips or tours, independent film or video productions, or endowment projects.

**John and Marcia Goldman Foundation**
(Formerly The John and Marcia Goldman Fund)
10400 Deer Valley Rd
Brentwood, CA 94513-4933
Telephone: (925) 978-0320
Contact: Janet Lindsay, Exec. Dir.
E-mail: janet-goldmanfound@sbcglobal.net

**Donor(s):** John D. Goldman; Marcia L. Goldman.

**Type of grantmaker:** Independent foundation.

**Background:** Established in 1997 in CA.

**Purpose and activities:** Giving primarily to underprivileged children and youth.

**Fields of interest:** Arts; Children/youth, services; Education; Family services; Health care; Human services; Recreation.

**Geographic focus:** California
Types of support: Annual campaigns; Building/renovation; Capital campaigns; Equipment; Internship funds; Program development; Program evaluation; Research; Scholarship funds; Seed money; Technical assistance.

Limitations: Giving primarily in CA, with emphasis on San Francisco’s Mid-Peninsula, specifically San Mateo and Santa Clara counties. No support for sole-denomination religious charities. No grants for salaries, or general operating support

_Synopsys Technology Education Opportunity Foundation_
(formerly Synopsys Technology Opportunity Scholarship Foundation)
700 E. Middlefield Rd.
Mountain View, CA 94043-4024
http://www.synopsys.com
Telephone: (650) 584-1772
Contact: Erin Brennock, C.O.O.
Donor(s): Synopsys, Inc.
Type of grantmaker: Company-sponsored foundation.
Background: Established in 1998 in CA.
Purpose and activities: The foundation supports community foundations and organizations involved with education, hunger, and science.
Program area(s): The grantmaker has identified the following area(s) of interest:
Employee Matching Gifts: The foundation matches contributions made by employees of Synopsys to educational institutions and nonprofit organizations up to $200 per employee, per year.
Fields of interest: American Red Cross; Education; Education, services; Food banks; Foundations (community); Mathematics; Science; Secondary school/education.
Geographic focus: California
Types of support: Annual campaigns; Employee matching gifts; Fellowships; Program development; Scholarship funds; Sponsorships.
Limitations: Giving primarily in CA

_Community Bank Foundation_
790 E. Colorado Blvd.
Pasadena, CA 91101-2113
Telephone: (626) 568-2140
Contact: Wendy Welch-Keller
Donor(s): Community Bank; Charles and Dorothy Cook Living Trust; Charles and Dorothy Cook Residuary Trust.
Type of grantmaker: Company-sponsored foundation.
Background: Established in 1990 in CA.
Purpose and activities: The foundation supports organizations involved with arts and culture, education, animal welfare, human services, community development, children, women, and economically disadvantaged people.
Program area(s): The grantmaker has identified the following area(s) of interest:

Community Service: The foundation supports programs designed to enrich the lives of low income families, especially women and children.

Education: The foundation supports programs designed to promote education. Special emphasis is directed toward programs designed to benefit disadvantaged students.

Human Services: The foundation supports programs designed to promote the well-being of low-and moderate households, and promote community and economic development in lower income areas.

Fields of interest: Animal welfare; Arts; Business/industry; Children; Community development; Economic development; Economically disadvantaged; Education; Family services; Higher education; Human services; Women.

Geographic focus: California

Types of support: General/operating support; Program development; Scholarship funds.

Limitations: Giving primarily in Los Angeles, Orange, Riverside, and San Bernardino counties, CA. No grants to individuals.

Northrop Grumman Corporation Contributions Program
(formerly Northrop Corporation Contributions Program)
c/o Corp. Dir., Diversity, EEO, and Contrbs.
1840 Century Park E., 131/CC
Los Angeles, CA 90067-2199
Telephone: (310) 553-6262
http://www.northropgrumman.com/com_rel/community_main.html

Sponsoring company: Northrop Grumman Corporation

Type of grantmaker: Corporate giving program.

Purpose and activities: As a complement to its foundation, Northrop Grumman also makes charitable contributions to nonprofit organizations directly. Support is given primarily in areas of company operations.

Program area(s): The grantmaker has identified the following area(s) of interest:

Career and Employment Counseling: Northrop Grumman supports programs designed to provide access to employment counseling, vocational training, job referrals, and employment opportunities for a wide spectrum of job seekers.

Environmental, Civic, and Cultural Organizations: Northrop Grumman makes charitable contributions to nonprofit organizations involved with arts and culture, the environment, and civic affairs.

Health Services: Northrop Grumman supports programs designed to provide community access to health services.

Human Services: Northrop Grumman supports programs designed to improve the lives and living conditions of the company's neighbors.

Pre-College Education: Northrop Grumman supports programs designed to inspire students of all ages and to acknowledge their efforts toward academic excellence.

Youth Programs: Northrop Grumman supports programs designed to give young people every opportunity for character growth as well as mental and physical recreation to strengthen them to meet...
School-Based Mental Health Needs Assessment  
Appendix C: Potential Grant Opportunities

tomorrow’s challenges.

**Fields of interest:** Arts; Civil rights; Education; Elementary/secondary education; Employment; Environment; Family services; Health care; Human services; Public affairs; Youth development.

**Geographic focus:** California

**Types of support:** Continuing support; Employee volunteer services; General/operating support.

**Limitations:** Giving primarily in areas of company operations, with emphasis on southern CA; giving also to national organizations. No support for religious organizations, political organizations, or fraternal organizations. No grants to individuals.

**Save Mart Supermarkets Corporate Giving Program**
c/o Corp. Contrbs.
1800 Standiford Ave.
Modesto, CA 95350-0180
Telephone: (209) 577-1600
Contact: Sally Sanborn, Dir., Mktg.

**Sponsoring company:** Save Mart Supermarkets

**Type of grantmaker:** Corporate giving program.

**Purpose and activities:** Save Mart makes charitable contributions to nonprofit organizations involved with education, nutrition, sports, children, and families. Support is given primarily in areas of company operations.

**Fields of interest:** Children, services; Education; Family services; Nutrition; Recreation.

**Geographic focus:** California

**Types of support:** Donated products; General/operating support; In-kind gifts; Sponsorships.

**Limitations:** Giving primarily in areas of company operations in CA.

**The Stocker Foundation**
401 Broadway Ave., Ste. C
Lorain, OH 44052-1749
Telephone: (440) 246-5719
Contact: Patricia O’Brien, Exec. Dir.
FAX: (440) 246-5720

**E-mail:** contact@stockerfoundation.org

**Additional e-mails:** pobrien@stockerfoundation.org (Patricia O’Brien)
mwilson@stockerfoundation.org (Melanie R. Wilson)
dgolba@stockerfoundation.org (Dawn Golba)

http://www.stockerfoundation.org

**Donor(s):** Beth K. Stocker‡.

**Type of grantmaker:** Independent foundation.

**Background:** Incorporated in 1979 in OH.

**Purpose and activities:** Emphasis on short-term youth development programs; social service agencies offering solutions to specific problems, such as literacy, hunger, and homelessness; education (including early childhood, elementary, secondary, and higher education); aid to the disabled; self-help programs;
theater and the performing arts, and other cultural programs; women's issues and the strengthening of families.

**Program area(s):** The grantmaker has identified the following area(s) of interest:

- **Arts and Culture:** Supports the operation and expansion of arts organizations that provide access to the arts, especially among youths.
- **Community:** Supports community revitalization efforts that promote sustainable practices and partnerships. Special preference is shown to organizations that possess a can-do attitude.
- **Education:** Supports education organizations that promote personal growth and development through traditional and non-traditional methods of teaching children and adults.
- **Health:** Supports organizations that provide basic medical services and equipment to those in need, with emphasis on programs that serve disadvantaged and underserved populations.
- **Social Services:** Supports organizations which provide direct services to people in crisis as well as long-term efforts that help people to help themselves.
- **Women's Issues:** Supports programs that teach girls to grow into strong contributing members of society and for women to achieve their full potential.

**Fields of interest:** Adult education--literacy, basic skills & GED; Aging, centers/services; Arts; Arts education; Children/youth, services; Civil liberties, reproductive rights; Crime/violence prevention, domestic violence; Disabilities, people with; Economically disadvantaged; Education, early childhood education; Elementary school/education; Family services; Homeless, human services; Housing/shelter; Human services; Leadership development; Mental health/crisis services; Public affairs, citizen participation; Reproductive health, family planning; Residential/custodial care, hospices; Secondary school/education; Voluntarism promotion; Women, centers/services; Youth development, services.

**Geographic focus:** Arizona; California; New Mexico; Ohio; Washington

**Types of support:** Building/renovation; Curriculum development; Emergency funds; Endowments; Equipment; General/operating support; Matching/challenge support; Program development; Seed money; Technical assistance.

**Limitations:** Giving primarily in Pima County, AZ, San Francisco and Alameda counties, CA, Dona Ana and Bernalillo counties, NM, Lorain and Cuyahoga counties, OH, and King County, WA. No support for religious organizations for religious purposes, governmental services, or public school services required by law. No grants to individuals, or for annual campaigns, conferences, deficit financing/debt reduction, mass mailings, research projects and tickets or advertising for fundraising activities; no loans. Generally no grants for capital requests except when specific criteria are met.

**Lawrence Weissberg Foundation**

100 Spear St., Ste. 520
San Francisco, CA 94105-1524

*Telephone:* (415) 777-0414

*Contact:* Frederick Weissberg, Pres.

**Donor(s):** Lawrence Weissberg; Frederick Weissberg; Marvin Weissberg; William Weissberg.

**Type of grantmaker:** Independent foundation.

**Background:** Established in 1986 in CA.
Purpose and activities: Support for organizations that (1) provide charity for Jewish people; (2) train or educate parents to rear their children in a healthy environment; or (3) educate or assist in the education of underprivileged children. At least 80 percent of the grants awarded are earmarked to foster the charitable purposes of Jewish people.

Fields of interest: Children/youth, services; Education; Family services; Human services; Jewish agencies & temples; Jewish federated giving programs.

Geographic focus: California; New York

Limitations: Giving primarily in CA and NY.

Ludwick Family Foundation
P.O. Box 1796
Glendora, CA 91740-1796
Telephone: (626) 852-0092
Contact: Deanna Monaghan, Prog. Off.
FAX: (626) 852-0776
E-mail: ludwickfndn@ludwick.org
URL: http://www.ludwick.org

Donor(s): Arthur J. Ludwick; Sarah Lynne Ludwick.
Type of grantmaker: Independent foundation.
Background: Established in 1990 in CA.

Purpose and activities: The purpose of the foundation is to assist a broad array of groups working to make a positive difference.

Fields of interest: Animal welfare; Arts; Children/youth, services; Community development, neighborhood development; Disabilities, people with; Education; Environment; Family services; Health care; Housing/shelter, services; Science.

Geographic focus: California

Types of support: Building/renovation; Equipment.

Limitations: Giving on a national basis, with emphasis on CA. No support for voter registration organizations, or for schools, universities, libraries, or hospitals (unless invited), or for daycare centers, fiscal agents, sponsors, or churches. No grants to individuals, or for salaries, general operating expenses, scholarships, endowment funds, fundraising, advertising, or for capital campaigns, travel or research, or for insurance or maintenance contacts.

Junior League of San Francisco, Inc.
2226A Fillmore St.
San Francisco, CA 94115-2222
Telephone: (415) 775-4100
Contact: Stacey Fleece, Pres.
FAX: (415) 775-4599
E-mail: hq@jlsf.org
http://www.jlsf.org
Type of grantmaker: Public charity.

Background: Established in 1911 in CA.

Purpose and activities: The league is committed to promoting volunteerism, developing the potential of women, and improving communities through the effective action and leadership of trained volunteers.

Program area(s): The grantmaker has identified the following area(s) of interest:

Community Program Grants: Awards $5,000 to $40,000 and volunteer support to educational organizations in San Francisco, Alameda, Marin, or San Mateo counties. For more information, e-mail cpd@jlsf.org.

Enabling Funds Grants: Awards of up to $5,000 for emergency/bridge funding to non-profit organizations facing an urgent and unexpected short-term financial need that will lead to a disruption of service.

Fields of interest: Children; Elementary/secondary education; Family services; Voluntarism promotion; Women.

Geographic focus: California

Types of support: Emergency funds.

Limitations: Giving primarily in San Francisco, Alameda, Marin, or San Mateo counties, CA. No support for organizations lacking 501(c)(3) designations.

Cross Ridge Foundation, Inc.
c/o Davidson, Dawson & Clark
60 E. 42nd St., 38th Fl.
New York, NY 10017-3811
Contact: Berkeley D. Johnson, Jr., Secy.

Donor(s): Amy Klose‡.

Type of grantmaker: Independent foundation.

Background: Established around 1958.

Purpose and activities: Giving primarily for organizations in which a family member is active or particularly interested, with emphasis on youth development and services, and civil rights.

Fields of interest: Children/youth, services; Civil rights; Youth development, centers/clubs.

Geographic focus: California; New York; Vermont

Types of support: Building/renovation; Capital campaigns; Continuing support; General/operating support; Land acquisition; Seed money.

Limitations: Giving primarily in northern CA, Westchester County, NY, and VT.

Epson America, Inc. Corporate Giving Program
3840 Kilroy Airport Way
Long Beach, CA 90806-2469
Telephone: (562) 290-5161
Contact: Janette Reynolds, Mgr., Public Affairs
FAX: (562) 290-5131
E-mail: janette_reynolds@ea.epson.com
School-Based Mental Health Needs Assessment
Appendix C: Potential Grant Opportunities

**Sponsoring company:** Epson America, Inc.

**Type of grantmaker:** Corporate giving program.

**Purpose and activities:** Epson makes charitable contributions to nonprofit organizations involved with arts and culture, education, and civic affairs. Special emphasis is directed toward programs designed to offer supplemental learning and enrichment experiences to young people, grades K-12, that incorporate skill development in the areas of scanning, digital photography, or digital printing for academic or arts-based projects; develop productivity and leadership skills of young people, grades K-12; enhance existing educational opportunities through programs that establish literacy as a high priority for young people, grades K-12; and support cultural activities, services, and facilities, including the performing arts, libraries, and museums, that provide opportunities for intellectual and artistic enrichment to broad segments of society. Support is given primarily in areas of company operations.

**Fields of interest:** Arts; Education; Education, reading; Elementary/secondary education; Public affairs; Youth development, services.

**Geographic focus:** California; District of Columbia; Florida; Illinois; Indiana; New York

**Types of support:** Capital campaigns; Donated products; In-kind gifts; Seed money; Sponsorships.

**Limitations:** Giving primarily in areas of company operations, with emphasis on Long Beach, San Francisco, and the greater Los Angeles, CA, area, Washington, DC, Miami, FL, Chicago, IL, Indianapolis, IN, and New York, NY. No support for sectarian organizations, fraternal, political, labor, or social organizations, government agencies, organizations located outside the U.S., or correctional facilities. No grants to individuals or inmates.

**Estelle Funk Foundation**
11077 E. Rush St.
South El Monte, CA 91733-3546

**Contact:** Myron H. Funk, Dir.

**Donor(s):** Myron H. Funk.

**Type of grantmaker:** Operating foundation.

**Background:** Established in 1996 in CA.

**Purpose and activities:** Giving primarily for health, Jewish organizations, and human services.

**Fields of interest:** Arts; Education; Health organizations; Hospitals (general); Human services; Jewish agencies & temples; Jewish federated giving programs; Medical research; Youth development.

**Geographic focus:** California; New York

**Limitations:** Giving primarily in CA and NY.

**The David B. Gold Foundation**
44 Montgomery St., Ste. 3750
San Francisco, CA 94104-4826

**Telephone:** (415) 288-9530

**Contact:** Elaine Gold, Dir.

**FAX:** (415) 288-9549

**E-mail:** mail@goldfoundation.org
http://www.goldfoundation.org/

Donor(s): David B. Gold.

Type of grantmaker: Independent foundation.

Background: Established in 1992 in CA.

Purpose and activities: Giving for to early childhood and youth development, natural resource conservation and protection, democratic society and Jewish culture.

Program area(s): The grantmaker has identified the following area(s) of interest:

Children, Youth, and Families: The foundation supports programs that promote the well-being of young people (birth to age 21) and provide them with opportunities to be responsible and caring people. The foundation focuses on the following goals: in the Children, Youth, and Families Program areas: Focus: Support Early Childhood Development Programs--The foundation supports programs that advocate for and/or demonstrate best practices in the field of early childhood development. Focus: Promote Enrichment Programs for School Age Youth--The foundation supports enrichment programs that promote the well-being of youth, including healthy living, academic enrichment, literacy, life skills, environmental education, sports, and recreational opportunities. Focus: Reduce Domestic Violence--The foundation supports direct service and advocacy programs that work to prevent domestic violence and teen dating violence. It funds intervention programs, including domestic violence shelters and services for child witnesses of domestic violence. Focus: Improve the Welfare of Children--The foundation supports programs that focus on the welfare of foster youth, homeless youth, and runaway youth by providing advocacy, family support, housing, mental health services, job skills development, mentoring programs or access to high quality education. Focus: Help Prevent Teen Parenthood--The foundation supports direct service and advocacy programs that encourage delaying parenthood until adulthood, by providing comprehensive reproductive education and services to young people.

Democratic Values: The foundation supports programs that foster a respect for basic democratic principles, including integrity in government, separation of church and state, protection of civil liberties, and the right to privacy.

Environment: The foundation is committed to protecting natural resources, improving the quality of the environment, and promoting environmental stewardship. It supports programs that work to reduce toxic emissions and waste, preserve open space, and educate the community about conservation and other environmental issues. Focus: Reduce Toxic Emissions--The foundation supports organizations with a demonstrated record of effectiveness in working to strengthen environmental laws that reduce toxic emissions into the air, on the ground, and in the water. Focus: Preserve Open Space--The foundation supports programs that acquire undeveloped land for future use as public space. Focus: Promote Sustainable Energy Policy--The foundation supports programs that advocate for a sustainable energy future, including reducing dependency on fossil fuels and encouraging the use of alternative sustainable energy sources.

Jewish Culture: The foundation supports programs that foster an understanding and appreciation of Jewish culture.

Fields of interest: Crime/violence prevention, child abuse; Environment, natural resources; Reproductive health, family planning; Youth development.

Geographic focus: California; Minnesota
Types of support: Building/renovation; Capital campaigns; Continuing support; General/operating support; Land acquisition; Program development.

Limitations: Giving primarily to organizations that have an impact on the San Francisco Bay Area, CA, with emphasis on Alameda and San Francisco counties and in the Twin Cities of Minneapolis/St. Paul, MN; some funding to national projects that are particularly relevant to the foundation's mission. No support for sectarian organizations, except for those organizations that fall within the foundation's Jewish Culture program area. No grants to individuals.

Koret Foundation
33 New Montgomery St., Ste. 1090
San Francisco, CA 94105-4526
Contact: Gale Mondry, Chief Prog. Off.
FAX: (415) 882-7775
E-mail: info@koretfoundation.org
http://www.koretfoundation.org

Donor(s): Joseph Koret; Stephanie Koret.
Type of grantmaker: Independent foundation.

Background: Established in 1966 in CA.

Purpose and activities: Koret seeks to address societal challenges and to strengthen Bay Area life. The foundation seeks to invest in strategic, local solutions to help to inspire a multiplier effect- encouraging collaborative funding and developing model initiatives. Koret promotes educational opportunity, the community of Israel, and free market expansion.

Program area(s): The grantmaker has identified the following area(s) of interest:

Bay Area General Community: Focuses on development and support of K-12 public education, youth development, higher education, arts and culture.

Bay Area Jewish Community: Funding for Jewish education and Jewish studies, strengthening Jewish communal organizations and Jewish identity.

Education: Supports promising efforts for reform of K-12 public education through public policy change and support of programs that provide models of excellence.

Higher Education: The foundation funds capital projects, Jewish studies, and provides limited scholarship support.

Israel: The foundation primarily supports economic reform/development.

Israel and International Jewish Organizations: Supports economic development and Free Market initiatives in Israel, Koret Israel Economic Development Fund, higher education in Israel, Jewish life in the Former Soviet Union.

Israel Economic Development Funds: Provides guarantees for small business loans to stimulate job creation.

Koret Jewish Book Awards: Annual awards in multiple categories to heighten the visibility of the best new Jewish books and their authors.

Koret Prize: Recognizes outstanding achievements by individuals working in areas of special interest to the foundation.
Public Policy: This funding interest includes support of development, research and community projects that advance the public agenda in the following areas: economic development, and selected issues of community concern; selected human rights issues.

Youth Development: Aims to strengthen community-based, youth-serving organizations and their afterschool educational enrichment programs in grades K-12.

Fields of interest: Arts; Community development; Elementary school/education; Higher education; Israel; Jewish agencies & temples; Jewish federated giving programs; Secondary school/education; Youth development.

Geographic focus: California

Types of support: Annual campaigns; Building/renovation; Capital campaigns; Continuing support; Fellowships; General/operating support; Internship funds; Matching/challenge support; Professorships; Program development; Program evaluation; Publication; Research; Scholarship funds; Seed money.

Limitations: Giving limited to the Bay Area counties of San Francisco, Alameda, Contra Costa, Marin, Santa Clara, and San Mateo, CA; giving also in Israel and on a national basis for Jewish funding requests. No support for private foundations, or veterans', fraternal, military, religious, or sectarian organizations whose principal activity is for the benefit of their own membership. No grants to individuals (except for the Koret Prize), or for general fundraising campaigns, scholarships, endowment funds, equipment funds, deficit financing, or emergency funds; no loans.

Robert C. & Lois C. Braddock Charitable Foundation
1221 Broadway, 21st Fl.
Oakland, CA 94612-1867
Telephone: (510) 451-3300
Contact: Robert C. Braddock, Jr., Tr.
http://www.braddockfoundation.org/

Donor(s): Robert C. Braddock; Lois C. Braddock.

Type of grantmaker: Operating foundation.

Background: Established in 1990; classified as a private operating foundation in 1992.

Purpose and activities: The foundation directs funding efforts toward projects that enhance the well being of children, youth, the elderly, the disabled and veterans. The foundation is dedicated to assisting these groups in the areas of basic life necessities, education, job training, rehabilitation, and environmental issues that have an impact upon people's lives.

Fields of interest: Arthritis; Business school/education; Cancer; Christian agencies & churches; Environment; Environment, natural resources; Family services, domestic violence; Food services; Health organizations; Higher education; Human services; Libraries (public); Space/aviation; YM/YWCAs & YM/YWHAs.

Geographic focus: California; Florida

Limitations: Giving primarily in San Leandro and Oakland, CA, and central FL (Also lists grants from 2005 in San Francisco, Palo Alto, S. Lake Tahoe, Fresno & Santa Cruz).
George and Ruth Bradford Foundation
P.O. Box 720
Ukiah, CA 95482
Contact: Myrna Oglesby, Dir.
Donor(s): Ruth Bradford.
Type of grantmaker: Independent foundation.
Background: Established in 1985 in CA.
Purpose and activities: Giving for education, youth, health care and human services.
Fields of interest: Children/youth, services; Education; Environment, natural resources; Family services; Health care; Higher education; Housing/shelter, temporary shelter; Human services; Museums; Recreation, camps; Youth development, centers/clubs.
Geographic focus: California
Types of support: General/operating support; Scholarship funds.
Limitations: Giving limited to the San Francisco Bay Area and Mendocino, CA. No grants to individuals.

Grenell Family Foundation
101 N.E. 62nd St.
Seattle, WA 98115-6534
Telephone: (206) 328-0262
Contact: Gary Grenell, Pres.
Donor(s): Bernard B. Grenell; Barbara Grenell.
Type of grantmaker: Independent foundation.
Background: Established in 1990 in CA.
Fields of interest: Athletics/sports, racquet sports; Health organizations; Hospitals (general); Human services; Jewish agencies & temples; Jewish federated giving programs; Media/communications; Museums; Performing arts; Youth development; Zoos/zoological societies.
Geographic focus: California
Limitations: Giving primarily in CA. No grants to individuals.

The Oakland Athletics Community Fund
McAfee Coliseum
7000 Coliseum Way
Oakland, CA 94621-1917
Telephone: (510) 563-2261
Contact: Kendall R. Pries, Dir.
E-mail: community@oaklandathletics.com.
Additional contact: Detra G. Paige, tel.: (510) 563-2241
Donor(s): Athletics Investment Group, LLC; Hofmann Foundation; Citation Homes Central; Teammates for Kids Foundation; The Gifford foundation.
Type of grantmaker: Company-sponsored foundation.
Background: Established in 1981 in CA.

Purpose and activities: The foundation supports programs designed to improve education; aid the underprivileged; promote crime and drug prevention; promote health awareness; and champion children and senior welfare.

Program area(s): The grantmaker has identified the following area(s) of interest:

Bay Area All-Star Program: The foundation awards $3,000 scholarships to successful students residing within the Bay Area's nine counties.

Buses for Baseball: The foundation, in partnership with MLB Players Trust, allows underprivileged children to attend baseball games as guests of Oakland Athletics, meet the Oakland A's players, and receive souvenirs and food vouchers.

Little A's: Through the Little A's program, the foundation invites Bay Area non-profit organizations to bring low to moderate income children to enjoy an Oakland A's game. Groups receive game tickets and souvenirs.

Oakland Athletics Community Days: The foundation provides non-profit groups with complimentary Oakland A's tickets to select regular season home games.

Fields of interest: Aging; Children; Crime/violence prevention; Economically disadvantaged; Education; Health care; Substance abuse, prevention.

Geographic focus: California

Types of support: Capital campaigns; Donated products; Equipment; General/operating support; Grants to individuals; In-kind gifts; Program development; Scholarships--to individuals; Sponsorships.

Limitations: Giving limited to CA, with emphasis on the Bay Area counties.

The Bradley Foundation
1672 Main St., Ste. E-364
Ramona, CA 92065-5257
Contact: Barbara Teets
Donor(s): W.R. Bradley.

Type of grantmaker: Independent foundation.

Background: Established in 1997.

Fields of interest: Children/youth, services; Christian agencies & churches; Education; Family services, domestic violence; Human services.

Geographic focus: California

Types of support: General/operating support; Grants to individuals.

Limitations: Giving primarily in CA, with emphasis on San Diego; some funding nationally.

Kosch-Westerman Foundation
c/o Pepper Westerman
897 Oak Park Blvd., Ste. 240
Pismo Beach, CA 93449

Donor(s): Brian Westerman; Pepper Westerman.

Type of grantmaker: Operating foundation.
Background: Established in 1999 in CO.
Fields of interest: Education, services.
Geographic focus: California
Types of support: General/operating support.
Limitations: Giving primarily in CA. No grants to individuals.

World Affairs Council of Northern California
312 Sutter St., Ste. 200
San Francisco, CA 94108
Telephone: (415) 293-4600
Contact: Jane Wales, Pres. and C.E.O.
FAX: (415) 982-5028
http://www.itsyourworld.org
Type of grantmaker: Public charity.
Background: Founded in 1947.
Purpose and activities: The organization promotes public understanding of international affairs by offering public forums.
Program area(s): The grant maker has identified the following area(s) of interest:
Asilomar Scholarships: Awards scholarships to at least 10 pre-collegiate teachers and 80 high school, undergraduate, and graduate students annually giving them the opportunity to attend the council's annual conference in early May.
Study Abroad Scholarship: Awards 2 to 3 scholarships of up to $4,000 or more every year to high school students for the Youth for Understanding (YFU) study abroad program. The scholarship covers a portion of the cost of spending a summer, semester, or academic year with a host family in Chile, France, Thailand, or any of the other 35 participating countries worldwide. Sophomores, juniors, or seniors who attend Northern California high schools and have a cumulative GPA of 3.0 or above are eligible to apply.
Fields of interest: Education, services; International affairs.
Geographic focus: California
Types of support: Scholarships--to individuals.
Limitations: Giving primarily in San Francisco and northern CA.

The James Irvine Foundation
575 Market St., Ste. 3400
San Francisco, CA 94105-2858
Telephone: (415) 777-2244
Contact: Kelly Martin, Grants Mgr.
FAX: (415) 777-0869
Southern CA office: 865 S. Figueroa St., Ste. 2308, Los Angeles, CA 90017-5430, tel.: (213) 236-0552, FAX: (213) 236-0537
http://www.irvine.org
Donor(s): James Irvine
Type of grant maker: Independent foundation.
Background: Incorporated in 1937 in CA.
Purpose and activities: The mission of the foundation is to expand opportunity for the people of CA to participate in a vibrant, successful, and inclusive society. Giving primarily for the arts, higher education, workforce development, civic culture, sustainable communities, and children, youth, and families.
Program area(s): The grant maker has identified the following area(s) of interest:
Arts: The goal of the program is to promote a vibrant and inclusive artistic and cultural environment in California. The foundation believes that a healthy arts system in today's environment must have the ability to create art and connect it to diverse communities, opportunities to explore innovative and risk-taking approaches that can help the sector conduct its business more effectively in the future, and well-run arts organizations. This holistic approach, which considers diverse arts disciplines, audiences, and regions, as well as a broad range of the state's artistic and cultural organizations, allows the foundation to make grants that support the following priority areas: 1) Artistic creativity - promote the creation and reinterpretation of art, infusing the arts field with new ideas and methods of creative expression; 2) Connection through cultural participation - support the active engagement of Californians from all socioeconomic and ethnic backgrounds with quality art from a variety of sources and cultures; and 3) Arts leadership - foster an environment in which arts and culture flourish in California through support to the state's largest premier cultural institutions and to leading arts organizations in the non-metropolitan areas of California.
California Perspectives: The goal of the program is to inform public understanding, engage Californians, and improve decision-making on significant state issues. At this time, the foundation is addressing the issue of effective governance at the state and local levels in California. In order to promote more effective governance, the foundation has identified three priority areas for funding. Within these priorities, the foundation supports a range of activities including policy research and analysis, strategic communications, public outreach and education, and advocacy: 1) Informing Californians: improve public understanding about state governance issues and other significant issues of long-term consequence to the state; 2) Mobilizing Californians: Encourage voting and involvement in public decision making among populations who traditionally have been less engaged in public affairs (including people in low-income, ethnic, and immigrant communities, as well as young voters). The underlying rationale is that effective governance, characterized by responsiveness and accountability to those governed, depends on people voting and expressing their views to public officials; and 3) Infusing new ideas and perspectives: Support innovative, nonpartisan policy development to address significant issues of long-term consequence to the state and improve state governance. The foundation also aims to inform related policy discussions by illuminating the perspectives of new and diverse voices through polling and other strategies.
Employee Matching Gifts: The foundation matches the contributions of its employees to charitable organizations.
Leadership Awards: These awards recognize individual leaders who are making a demonstrable difference to California's future. The foundation anticipates making four-to-six awards, the program's inaugural year. The leaders the foundation seeks to recognize may be working within any sector - nonprofit, public, or private - and within any field, such as education, health, the arts, housing, economic...
development, or the environment. What these leaders have in common is that they are all advancing innovative and effective solutions to some of the challenging issues facing California, and they are making a significant difference to everyone's shared future. Award recipients will each receive $125,000 of flexible support for their work to benefit the people of California. At least $100,000 will be designated for core support of the leader's project or organization and up to $25,000 for the leader's own professional development, as determined by the recipient. The award also includes strategic communications activities, undertaken together by the award recipients and the foundation, to educate policymakers and practitioners of the effective solutions implemented by these leaders. If you know a leader with the qualities mentioned above, the foundation invites you to nominate him or her for the Leadership Awards. Nominations are due by Jan. 19. Please see the foundation's Web site for further nomination criteria. The selection process will have several stages, over approximately five months. After nominations are received, Irvine staff will conduct an initial review of the nominations and begin to check references and conduct due diligence. An independent selection committee, composed of nine leading Californians, will review the nominations and will develop a short list of award candidates. At this stage of the selection process, foundation staff and an expert in the nominee's field of work will visit each finalist and his or her organization or project to more deeply understand the nominee's work and style of leadership. The Selection Committee will then select four to six award recipients, who will be announced in June. If you have any questions about the awards program or nomination process, please contact: Sarah Ihn, Prog. Assoc., California Perspectives program, tel.: 415.356.9927 or e-mail: leadershipawards@irvine.org.

New Connections Fund: The NCF has two goals: 1) to identify nonprofit organizations doing high-quality work that is well-aligned with selected program strategies, particularly in regions of priority interest; and 2) to increase the number of new organizations in Irvine's grants portfolio. The foundation provides open and competitive funding through this fund for organizations that have new projects, new ideas, or which have not previously received a grant from the foundation. Grants of up to $50,000 are available, over one- or two-year grant periods, and small and mid-sized organizations (with budgets between $100,000 and $2 million) are particularly encouraged to apply. Currently applications for funding are being accepted through Mar. 8 (5:00 p.m. Pacific Time). Submit the application online. Please see the foundation's Web site for additional information.

Youth: The goal of the program is to increase the number of low-income youth in California who complete high school on time and attain a postsecondary credential by the age of 25. Through the Youth program, the foundation seeks to address the achievement gap for low-income youth in California in secondary and postsecondary education and career training, placing special emphasis on youth whose life circumstances further diminish their opportunities for success. To achieve these goals, the Youth program is currently focusing on grantmaking strategies that achieve the following: 1) Promote academically challenging career and technical education in California high school; 2) Improve instruction and student support services in high schools and community colleges; 3) Promote innovative educational alternatives to the traditional high school; and 4) Increase parent and family knowledge for student success (through the New Connections Funds). Concluding initiatives: CORAL: Increase the academic achievement of youth (with an emphasis on elementary school students) by involving students, families schools, and organizations in high-quality, out-of-school learning opportunities. The
### Initiative

The initiative will come to a planned conclusion in 2007. Campus Diversity Initiative: Increase the success of underrepresented students in higher education and better educate all students for leadership in an increasingly diverse state. The initiative will come to a planned conclusion in 2006.

**Fields of interest:** Arts councils; Arts, cultural/ethnic awareness; Arts, folk arts; Arts, multipurpose centers/programs; Civil rights, race/intergroup relations; Community development; Community development, neighborhood development; Economic development; Employment, training; Foundations (community); Foundations (public); Higher education; Higher education reform; Higher education, college; Higher education, university; Nonprofit management; Performing arts; Performing arts centers; Performing arts, ballet; Performing arts, dance; Performing arts, opera; Performing arts, orchestra (symphony); Performing arts, theater; Philanthropy/voluntarism; Public policy, research; Voluntarism promotion; Youth development, centers/clubs; Youth development, services.

**Geographic focus:** California

**Types of support:** Employee matching gifts; General/operating support; Matching/challenge support; Program development; Program evaluation; Seed money; Technical assistance.

**Limitations:** Giving limited to CA. No support for agencies receiving substantial government support. No grants to individuals.

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### William Sloane Jelin Charitable Foundation

c/o Holthouse, Carlin and Van Trigt, LLP  
1601 Cloverfield Blvd., Ste. 300S  
Santa Monica, CA 90404-4085  
(310) 566-1900  
Contact: Deborah Newmyer, Tr.

**Donor(s):** William S. Jelin.  
**Type of grantmaker:** Independent foundation.  
**Background:** Established in 1996 in ME.  
**Purpose and activities:** Giving primarily to Jewish agencies and children’s services.  
**Fields of interest:** Arts; Cancer; Human services; Jewish agencies & temples; Youth development, services.  
**Geographic focus:** California; Maine  
**Limitations:** Giving primarily in CA and ME. No grants to individuals.
Appendix D
Methodology
School-Based Mental Health Needs Assessment
Appendix D: Methodology

Methodology

Planning Group
This project was proposed by Napa County Office of Education in partnership with Napa County Health and Human Services. The project was overseen by representatives from these agencies. The individuals who participated on the oversight team are listed below:

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Felix A. Bedolla</td>
<td>MHSA Project Manager</td>
<td>Napa County Health and Human Services Agency, Mental Health Division</td>
</tr>
<tr>
<td>Terry Longoria</td>
<td>Director, Napa-Vallejo Safe Schools/Healthy Students Initiative</td>
<td>Napa County Office of Education</td>
</tr>
<tr>
<td>Jeannie Morris</td>
<td>Coordinator, Napa-Vallejo Safe Schools/Healthy Students Initiative and Designated Educational Liaison for Foster and Homeless Youth</td>
<td>Napa County Office of Education</td>
</tr>
<tr>
<td>Halsey Simmons, MFT</td>
<td>Assistant Behavioral Health Manager</td>
<td>Napa County Health and Human Services Agency, Mental Health Division</td>
</tr>
<tr>
<td>Jeanne Title</td>
<td>Safety and Wellness Prevention Coordinator</td>
<td>Office of Safety and Wellness, Napa County Office of Education</td>
</tr>
<tr>
<td>Shirin Vakharia</td>
<td>Prevention and Youth Treatment Services Coordinator</td>
<td>Napa County Health and Human Services Agency</td>
</tr>
</tbody>
</table>

Project Design

The project was designed as a qualitative needs assessment from the perspective of three stakeholder groups: schools, providers and parents. The project proposed interviews with representatives from each of the stakeholder groups, and sample selection was done with input of the oversight team.
School interviews began the project, provider interviews followed and then parents were interviewed. The order of the interviews was in part due to the timing of the project. School personnel needed to be interviewed prior to summer break. Providers and parents were interviewed over the summer months. The order was also intended to help with trust-building and sample selection. Each of the stakeholder groups interviewed referred individuals from other stakeholder groups to the project. The final portion of the project was an online survey designed to collect a broader view of how mental health needs and services are viewed by school administrators, counselors and teachers. This survey was sent out to the schools in the fall after school began.

The project was also designed to give the participants feedback about the project. Portions of this report have been reviewed by the stakeholders interviewed, and all who have participated will be sent a copy of the final report.

The Safe Schools, Healthy Students Initiative, a school-based mental health services and supports program, developed a mental health screening tool in partnership with other providers and school personnel. To aide in data comparability and to honor the work that was done to arrive at an agreed upon set of categories, these categories were used in the school and provider interviews and in the online survey. The categories used for this report are as follows:

- Alcohol and Drug Use
- Adult Relations (Non-Family Members)
- Anger Management/Conflict Resolution
- Anxiety
- Depression
- Family Relations
- Peer Relations
- Other Issues

The interviewees generally indicated they understood the categories, and further definitions were not given. For the online survey two additional categories: Bullying and School Connectedness were added. These additional categories were mentioned in the interviews and were part of the California Healthy Kids Survey.

**Sampling**

Though every effort was made to include a wide variety of experiences, the sampling was non-random and limited by who was available to be interviewed, who was referred for an interview, and the constraints of the project schedule and budget.

**Schools**

The school sample was chosen to be representative of a variety of school settings in Napa County. Overall, eleven interviews were completed with fifteen school personnel. Though originally eight schools were selected for interviews, ten schools were represented in the final sample.
Several interviews had more than one person participating. Overall, seven principals, seven school counselors and one school nurse were interviewed for this report. All interviews were conducted using a protocol that addressed the following questions:

- What are the most pressing mental health needs facing students at your school?
- How do the following issues affect the students at your school? How well do the current school-based mental health services address these issues? (Issues: Alcohol/Drug Use, Anger Management/Conflict Resolution, Depression, Anxiety, Adult Relations, Family Relations, Peer Relations)
- What barriers are there to providing and accessing school-based mental health services? How could these barriers be addressed?
- What types of funding are used to provide the current school-based mental health services? Who are the partners that provide the services?
- Scenarios involving three students: What types of services are available for a student in this situation? How do they access these services?
- Would you describe the current system of school-based mental health services as fragmented or integrated? Why?
- What one thing would you change about the current system of school-based mental health services?
- What one thing is going really well with the current system of school-based mental health services?

Providers
Providers were identified through the school interviews and by the oversight team. Those who were interviewed were selected based on where in the county they provided services, the type of intervention they provided and how many students they served. All providers interviewed provided mental health services and/or supports on a school-campus. Consideration was also given to the individuals’ role in the agency. Some of the interviews were with direct service staff and other interviews were with agency or program administrators. To ensure confidentiality, providers were assured that their agency and/or their position would not be identified.

Overall, sixteen interviews were conducted with providers from nine agencies. Six of the providers served middle and high school students exclusively, and the remainder served students at all grade
levels. Generally providers and/or their agencies served students throughout Napa County. Three of the providers interviewed delivered services in one area of the county only.

The protocol used for the school interviews was modified to address providers and all of the previously described topic areas were discussed.

Parents
Service providers, who were interviewed for this project, were asked to identify parents whose children have used school-based mental health services. Service providers contacted parents and obtained their consent to be interviewed. Fifteen parents were interviewed with the understanding that all information would be aggregated and anonymous.

The term, “parent,” in this report refers to a variety of caregivers. Interviews were conducted with grandparents, foster parents, step parents and biological parents. For the purposes of this summary, all caregivers are intentionally referred to as parents to protect the identity of the families who shared their experiences. Eight of the fifteen families had more than one child who has received services. While fifteen families represents a very small percentage of the total number of families who receive services, their perspective offers a greater richness to the information collected from school administrators, counselors, teachers and service providers.

Five of the parents interviewed were mono-lingual Spanish-speaking and were interviewed in Spanish. Interviews took place in American Canyon, Napa and Calistoga, and parents were given the choice of where and how they would like to be interviewed. Some parents chose office settings, service provider settings, or phone interviews and others invited the interviewer to come to their home.

A partial listing of concerns that were identified in the children of the parents interviewed included: anxiety, depression, trauma, autism, ADD, ADHD, emotional disturbances and learning disabilities. Many families were working to address more than one concern at the time of the interview.

The interviews began with a protocol that followed the progress of the child from the point of initial concern, through diagnosis and treatment to the specific circumstances of the child and family today. Once the interviews began, it became apparent the each family had a story. The interviewers encouraged families to tell the story of what happened for their family and used the protocol to prompt further information from areas that were not covered. Interviews were scheduled for 45-60 minutes, and several spanned two hours as parents described their experiences.

School Survey
After the school interviews were complete, an online survey was developed to reach a larger sample of schools. During the school and provider interviews, it became apparent that teachers were very involved in the identification of students and in initiating referrals. After discussion, it was decided that the online survey would be sent to the schools administrators, counselors and teachers. The survey was distributed to administrators, counselors and teachers in the Napa Valley Unified School District and to administrator and counselors in the St Helena Unified School District.
Overall, responses were received from eighteen administrators, three counselors and 85 teachers. The majority of the respondents reported that they served students in the City of Napa.

For the 85 teachers who responded, over half taught elementary school students (54%), 28% taught at a middle school and 13% worked in a high school setting. Five percent of respondents indicated they worked in more than one setting. 87% of the teachers reported they worked in the Napa community, 10% in American Canyon and the remainder worked throughout the county.

The teachers who responded reported an average of 17 years experience working with school-aged children. This ranged from 1 year to 37 years.

![Number of Years Teachers Reported Working with School-Aged Children](image)

Teachers’ responses regarding the mental health needs of students and the available services and supports were integrated into the report in the school perspective.