



Youth Suicide Prevention

Local Educational Agencies Lack the Resources and Policies Necessary to Effectively Address Rising Rates of Youth Suicide and Self-Harm

September 2020

REPORT 2019-125





CALIFORNIA STATE AUDITOR

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September 29, 2020
2019-125

The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California 95814

Dear Governor and Legislative Leaders:

As directed by the Joint Legislative Audit Committee, my office conducted an audit of suicide prevention efforts at a selection of school districts and charter schools, and we examined the role of state agencies in youth suicide prevention. The following report details the audit's findings and conclusions. From 2009 through 2018, the annual number of suicides of youth ages 12 through 19 increased 15 percent and incidents of self-harm increased 50 percent. Because students spend a significant amount of time in school, school personnel are well positioned to recognize the warning signs of suicide risk and to make appropriate referrals for help. To ensure that schools take the actions necessary to prevent youth suicides, we determined that they can more effectively assist students if they do the following:

- Implement appropriate suicide prevention policies.
- Train their faculty and staff to recognize and respond to youth who are at risk of suicide or self-harm.
- Employ an adequate number of professionals, such as school counselors, who can provide mental health services.

In addition to establishing requirements for suicide prevention training, the Legislature passed a law in 2016 requiring local educational agencies (LEAs) to include certain information in suicide prevention policies. However, the six LEAs we reviewed—three school districts and three charter schools—failed to adopt policies and provide training that meet those requirements. When policies and trainings do not meet statutory requirements, teachers and staff may not have the knowledge or confidence necessary to respond appropriately to students who are at risk. Further, the California Department of Education (Education) has recommended staffing ratios for the number of school counselors, school nurses, school social workers, and school psychologists, whom we refer to as mental health professionals, that LEAs should employ. However, of the 1,034 LEAs that submitted personnel information to Education for the 2018–19 academic year, none employed the number of mental health professionals that Education recommends. In the absence of adequate mental health professional staffing, the State's rates of youth suicide and self-harm have continued to climb.

One best practice for increasing students' access to mental health professionals is the establishment of school-based health centers. In 2007 the Legislature required the California Department of Public Health (Public Health) to establish a program to support the development of school-based health centers. However, as of July 2020, Public Health had not established the support program or requested funding to do so. A robust support program could assist LEAs in creating additional school-based health centers and enable them to better leverage available funding to improve student access to mental health services.

Respectfully submitted,

A handwritten signature in black ink that reads "Elaine M. Howle". The signature is written in a cursive, flowing style.

ELAINE M. HOWLE, CPA
California State Auditor

Selected Abbreviations Used in This Report

CDC	Centers for Disease Control and Prevention
CMS	Centers for Medicare and Medicaid Services
CSHA	California School-Based Health Alliance
IEP	Individualized education program
LEA	Local educational agency
MHSA	Mental Health Services Act

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SUMMARY

Results in Brief

Youth suicide is a growing health crisis in California. The annual number of suicides of youth ages 12 to 19 increased by 15 percent statewide from 2009 to 2018. In addition, instances of youth committing acts of self-harm—behavior that is self-directed and deliberately results in injury—increased by 50 percent during the same period. Because students spend a significant amount of time in school, school personnel are well positioned to recognize the warning signs of suicide risk and to make the appropriate referrals for help. Schools can more effectively assist students if they have appropriate suicide prevention policies in place, if they train their faculty and staff to recognize and respond to youth who are at risk of suicide or self-harm, and if they employ an adequate number of professionals, such as school counselors, who provide mental health services. The deficiencies we found in these areas during our review suggest that many county offices of education, school districts, and charter schools—known collectively as local educational agencies (LEAs)—could do more to address youth suicide and self-harm.

In 2016 the Legislature passed a law requiring LEAs that serve students in grades 7 to 12 to adopt suicide prevention policies. However, the six LEAs we reviewed—three school districts and three charter schools—have not adopted policies that fully address the statutory requirements and the best practices that the California Department of Education (Education) recommends in the model policy it created in response to the 2016 law. For example, some of the LEAs' policies did not establish response teams that convene after a student dies by suicide. A systematic and timely response to such incidents can reduce the likelihood of clusters of suicides. Until LEAs create clear policies that meet both legal requirements and Education's recommended best practices, they are depriving staff of a useful reference for effectively implementing suicide prevention processes and quickly reacting to crises.

In addition, the LEAs we reviewed conducted trainings that were missing elements that help school personnel identify warning signs and help prevent suicide. Although state law does not mandate suicide prevention training, it does require that if LEAs conduct such training, the materials must include information on when and how to refer youth and their families to appropriate mental health services. Although all six of the LEAs we reviewed provided suicide prevention training during the 2019–20 academic year, each failed to include one or more of the elements identified in state law or in Education's model policy. When selecting their suicide prevention trainings, some LEAs did not prioritize complying with state law and Education's best practices, while others contended

Audit Highlights . . .

Our audit of the role and effectiveness of LEAs in preventing youth suicide highlights the following:

- » *The six LEAs we reviewed have not adopted adequate youth suicide prevention policies and training.*
 - *Given proper policies and training, school personnel who regularly interact with students are well positioned to recognize the warning signs of suicide and assist students at risk of self-harm and suicide.*
 - *None of the six LEAs we audited had implemented suicide prevention policies and training that fully addressed statutory requirements and the best practices that Education recommends.*
- » *LEAs need more mental health professionals to help prevent youth suicide.*
 - *No LEA in the State reported employing the recommended number of school counselors, school nurses, school social workers, and school psychologists; and 25 percent did not employ even one such resource.*
- » *School-based health centers could provide students with better access to mental health professionals.*
 - *Despite the demonstrated benefits that such centers offer, the State has done little to foster their implementation.*
 - *Even with a statutory mandate to do so, Public Health had not established a support program that would help LEAs establish, retain, and expand school-based health centers.*

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» *LEAs should seek local and federal funding to help increase the number of mental health professionals on school campuses.*

- *Five of the six LEAs we reviewed were not aware that the Mental Health Services Act makes funding available to them through their local counties.*
- *Education and Health Care Services have not taken steps to ensure that all LEAs are aware of ways to decrease the administrative burden of obtaining reimbursement for some of the mental health services they provide.*

that their trainings were sufficient and referenced other efforts that they believed had addressed the pertinent issues. However, when trainings do not meet statutory requirements and best practices, teachers and staff may not have all the knowledge or confidence necessary to respond appropriately to students who are at risk.

We also found that of the 1,034 LEAs that submitted personnel information to Education for the 2018–19 academic year, none employed Education’s recommended number of school counselors, school nurses, school social workers, and school psychologists, which we collectively refer to as mental health professionals. Mental health professionals provide academic, career, and psychological counseling to students, as well as social development services and physical health services. Although these mental health professionals play a critical role in helping to reduce youth suicide, few of the State’s LEAs reported employing the recommended number of even one of the four types of professionals during the 2018–19 academic year. In fact, 260 LEAs—or 25 percent of the 1,034 LEAs reporting data to Education in academic year 2018–19—did not employ a single mental health professional. According to one of Education’s program consultants, a statewide program to fund mental health professionals is unlikely because of the State’s current focus on local control of education funding. Nonetheless, as the State’s rates of youth suicide and self-harm rise, these key positions remain understaffed.

One best practice for increasing students’ access to mental health professionals is the establishment of school-based health centers (school health centers). School health centers are clinics located on or near school grounds that may provide a variety of physical and mental health services, such as immunizations, substance abuse counseling, and mental health care. Community health centers or local health departments often support school health center operations and may employ the health professionals who work at them. Research has consistently demonstrated that school health centers increase youth access to mental health care. Further, they allow LEAs to leverage other sources of funding, including public and private health insurance, to pay for mental health services for students. Although both San Francisco Unified School District and the state of Oregon have used school health centers to successfully provide students with mental health services, as of 2019, only 4 percent of California’s kindergarten-through-grade 12 students attended a school with a school health center.

Despite the demonstrated benefits that school health centers offer, the State has done little to foster their implementation. In 2007 the Legislature required the California Department of Public Health (Public Health) to establish a program to support the development of school health centers (support program). However, as of

July 2020, Public Health had not yet done so. Public Health's Center for Healthy Communities' deputy director stated that the \$1.2 million the Legislature provided to Public Health for the support program across two fiscal years—2016–17 and 2017–18—was not adequate to establish a full program; however, she also stated that Public Health has not requested additional funding. Given the Legislature's mandate, it is unclear why Public Health has taken so little action to create and administer the support program for the past 13 years, including requesting adequate funding. A robust support program could assist LEAs in creating school health centers and enable them to better leverage available funding to improve student access to mental health services.

Although several of the LEAs we reviewed relied solely on state funding to pay their mental health professionals, others took advantage of local and federal funds for this purpose. The LEAs that used additional sources of funding spent more per student on mental health professionals and met more of the staffing levels for these professionals that Education recommends. In addition to local funds, such as those available through the Mental Health Services Act, LEAs may seek federal reimbursement of up to 50 percent of the costs of certain health-related services they have provided to students who are eligible for Medi-Cal through what is known as the billing option program. Although some LEAs consider the billing option program to be administratively burdensome, they can partner with their county offices of education to centralize the program's administrative costs and responsibilities. However, the Department of Health Care Services—which administers the billing option program—and Education have not done enough to ensure that all LEAs are aware of the opportunity to partner with their county offices of education, which has likely reduced the impact this program has had on increasing students' access to mental health care.

Summary of Recommendations

Education

To promote the adoption of the suicide prevention best practices that it has identified, Education should annually remind LEAs of the elements in its model policy.

Public Health

To support LEAs' efforts to provide mental health services, Public Health should establish the support program for school health centers, as state law requires. If Public Health lacks the funding to do so, it should request additional funds as needed. Public Health should use the support program to assist LEAs in establishing school health centers and in identifying and applying for available funding as authorized by law, such as Medi-Cal reimbursements.

Health Care Services

To ensure that LEAs take full advantage of Medi-Cal funds, Health Care Services should work with Education to inform LEAs that they can partner with their county offices of education to centralize the administrative responsibilities necessary to obtain reimbursement through the billing option program.

LEAs

To ensure that their teachers and staff have the information necessary to respond consistently, promptly, and appropriately to reduce suicide risk, the six LEAs we reviewed should revise their policies by March 2021 to comply with state law and incorporate the best practices in Education's model policy.

Agency Comments

Education and Health Care Services stated they would implement our recommendations. Public Health said that it would evaluate the resources necessary to establish the support program required by law. Several of the six LEAs described how they believe their suicide prevention efforts address the shortcomings we identified in their policies, but most stated that they would also update their policies to address those shortcomings.

INTRODUCTION

Background

Suicide prevention is an issue of state and national importance. According to the Centers for Disease Control and Prevention (CDC), in 2017 suicide was the second leading cause of death nationwide among young people ages 10 to 24.¹ Of even more concern, a 2019 United Health Foundation report found that the teen suicide rate increased by 25 percent nationwide from 2016 to 2019 and that California was one of seven states with the most significant increases in teen suicide rates during that same period. Based on the CDC's high school youth risk behavior survey results, the percentage of high school students nationwide who seriously considered suicide during the previous year increased from 14.5 percent in 2007 to 17.2 percent in 2017, while the percentage of attempted suicides increased from 6.9 percent to 7.4 percent. The increases in these already unacceptably high statistics point to a serious public health problem.

From 2009 through 2018, the annual number of suicides of youth ages 12 to 19 in California increased from 163 to 188 (15 percent), as Figure 1 shows. In addition, self-harm—which, as the text box defines, is behavior that is self-directed and that deliberately results in injury—has also increased in recent years. As Figure 2 shows, from 2009 through 2018, the annual number of reported youth self-harm incidents that led to emergency department visits or hospital stays increased from almost 10,900 to more than 16,300, an increase of 50 percent.

Definitions of Suicide and Self-Harm

Self-harm: Self-directed behavior that deliberately results in injury or the potential for injury. It can occur with or without suicidal intent.

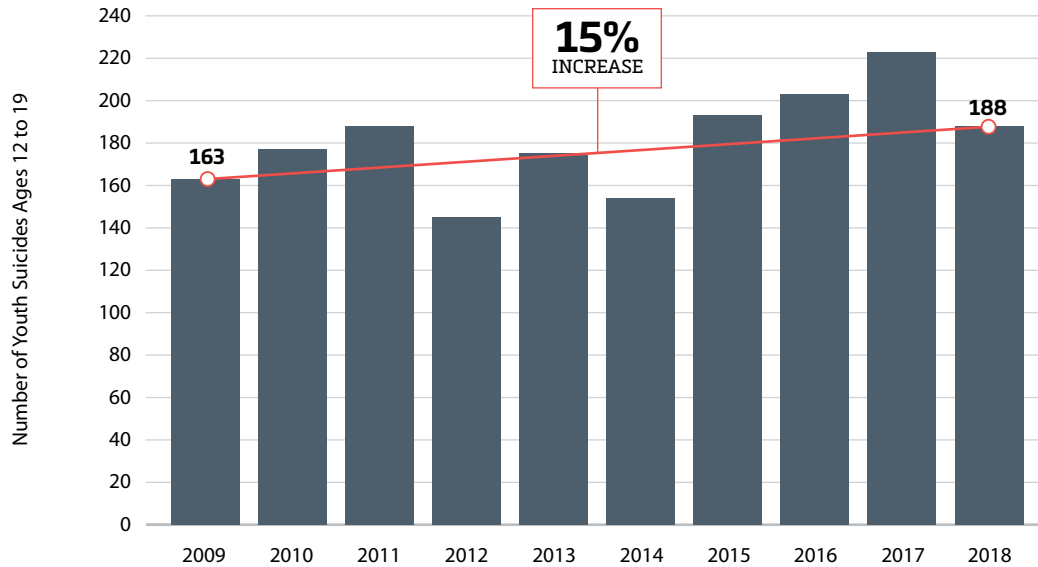
Suicide attempt: A self-injurious behavior for which the person had at least some intent to die; may result in death, injuries, or no injuries.

Suicide: Death caused by self-directed behavior with an intent to die as a result of the behavior.

Source: The National Institute of Mental Health's website and a model school district policy on suicide prevention created by the Trevor Project and other suicide prevention nonprofits.

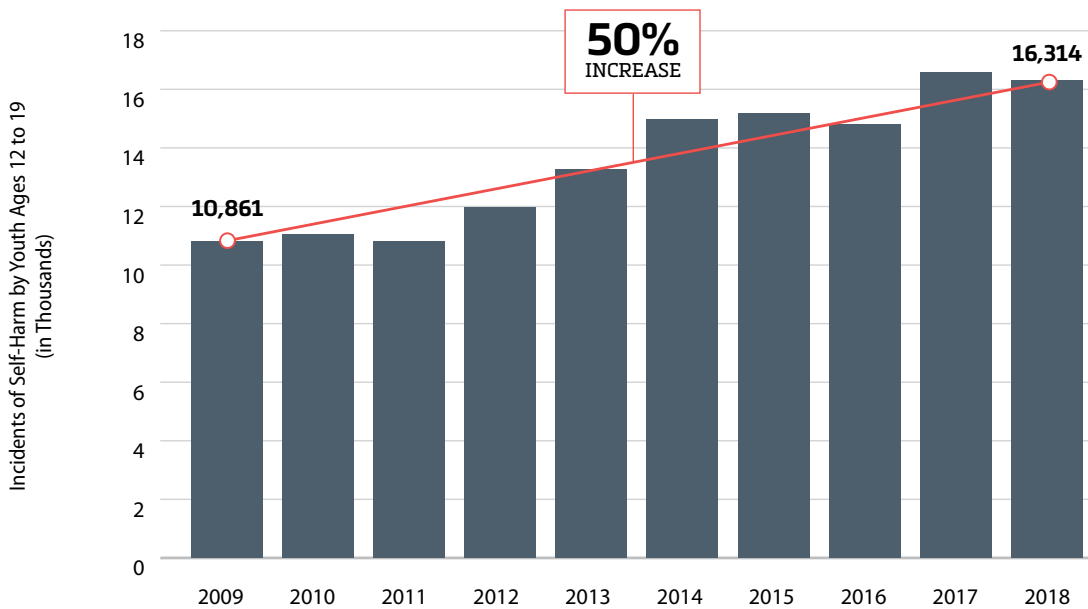
¹ Unintentional injury was the leading cause of death for young people during that same period.

Figure 1
The Number of Youth Suicides in California Increased From 2009 Through 2018



Source: Analysis of Public Health's vital death data.

Figure 2
Incidents of Youth Self-Harm Requiring Medical Attention Increased by 50 Percent From 2009 Through 2018



Source: Analysis of hospital encounter data from the Office of Statewide Health Planning and Development.

Note: We explain the methodology we used to create this figure in Appendix A, Objective 2.

Factors That May Contribute to Youth Suicide

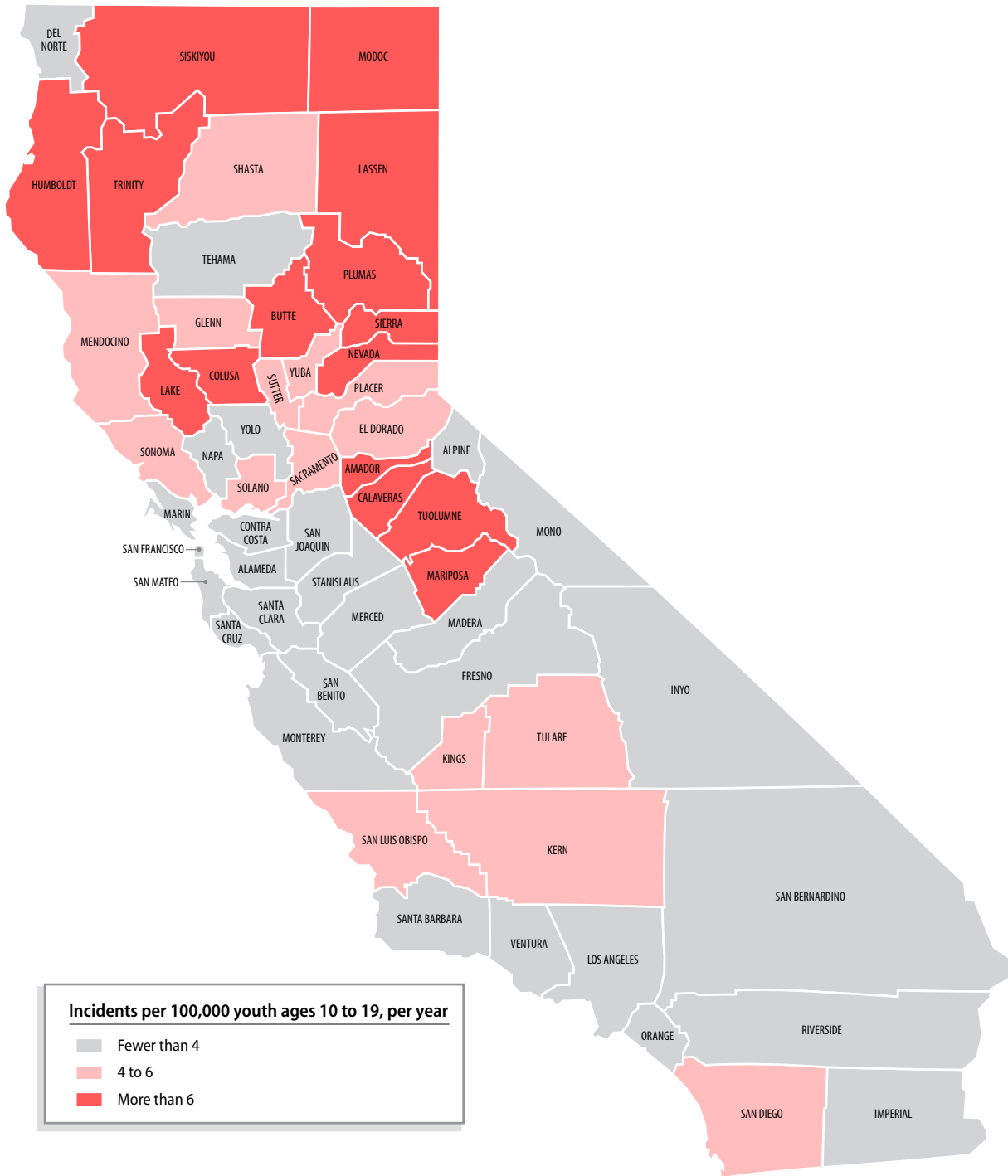
There is no single cause for suicide, but researchers report that it occurs most often when stressors and health issues converge to create feelings of hopelessness and despair. Youth are more vulnerable to suicide if they have certain characteristics and experiences, including mental health conditions, previous family suicide attempts, and exposure to prolonged stress, such as from harassment and bullying. Research has also identified youth in specific groups as having an elevated risk for suicide, including those with disabilities, those in foster care, and those who identify as lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ).

Although counties with metropolitan areas have the highest total number of youth suicides, our analysis of data from the California Department of Public Health (Public Health) shows that many of the State's northern rural counties have higher suicide and self-harm rates, as Figures 3 and 4 indicate. For example, Sierra County—a northern rural county with a population of less than 10,000—has the highest youth suicide rate in the State, 34 per year per 100,000 for persons ages 10 to 19. This is more than nine times the statewide rate. However, some counties with high suicide rates have a relatively low total number of suicides. For example, the three counties with the highest suicide rates are northern and rural counties that had only seven youth suicides from 2009 through 2018, compared to a total of 1,809 youth suicides statewide.

The higher rate of youth suicide rates in rural counties is likely affected by the availability of mental health professionals, which is generally lower in rural counties. Studies have generally found a positive association between increased access to care and lower suicide rates. However, in many rural communities, economic factors and sparse population density have led to shortages of mental health professionals, according to a report by the Rural Youth Suicide Prevention Workgroup.²

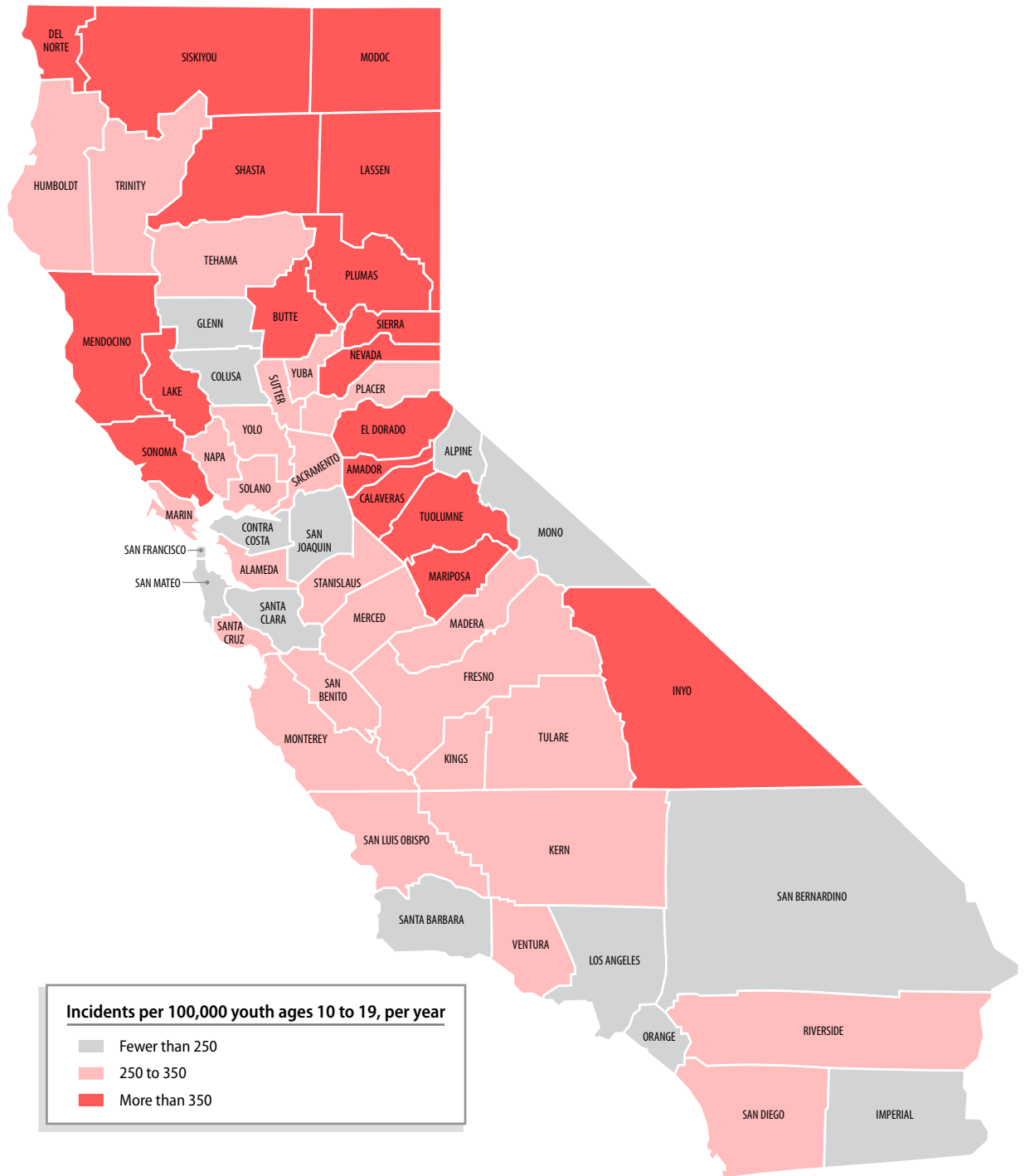
² This workgroup was convened by the federally funded nonprofit Suicide Prevention Resource Center and others.

Figure 3
Many of the State's Rural and Northern Counties Had Higher Rates of Youth Suicide From 2009 Through 2018



Source: Analysis of Public Health's vital death data and the U.S. Census Bureau's American Community Survey 2014 to 2018 five-year population estimate.

Figure 4
Many of the State's Rural and Northern Counties Had Higher Rates of Youth Self-Harm From 2009 Through 2018

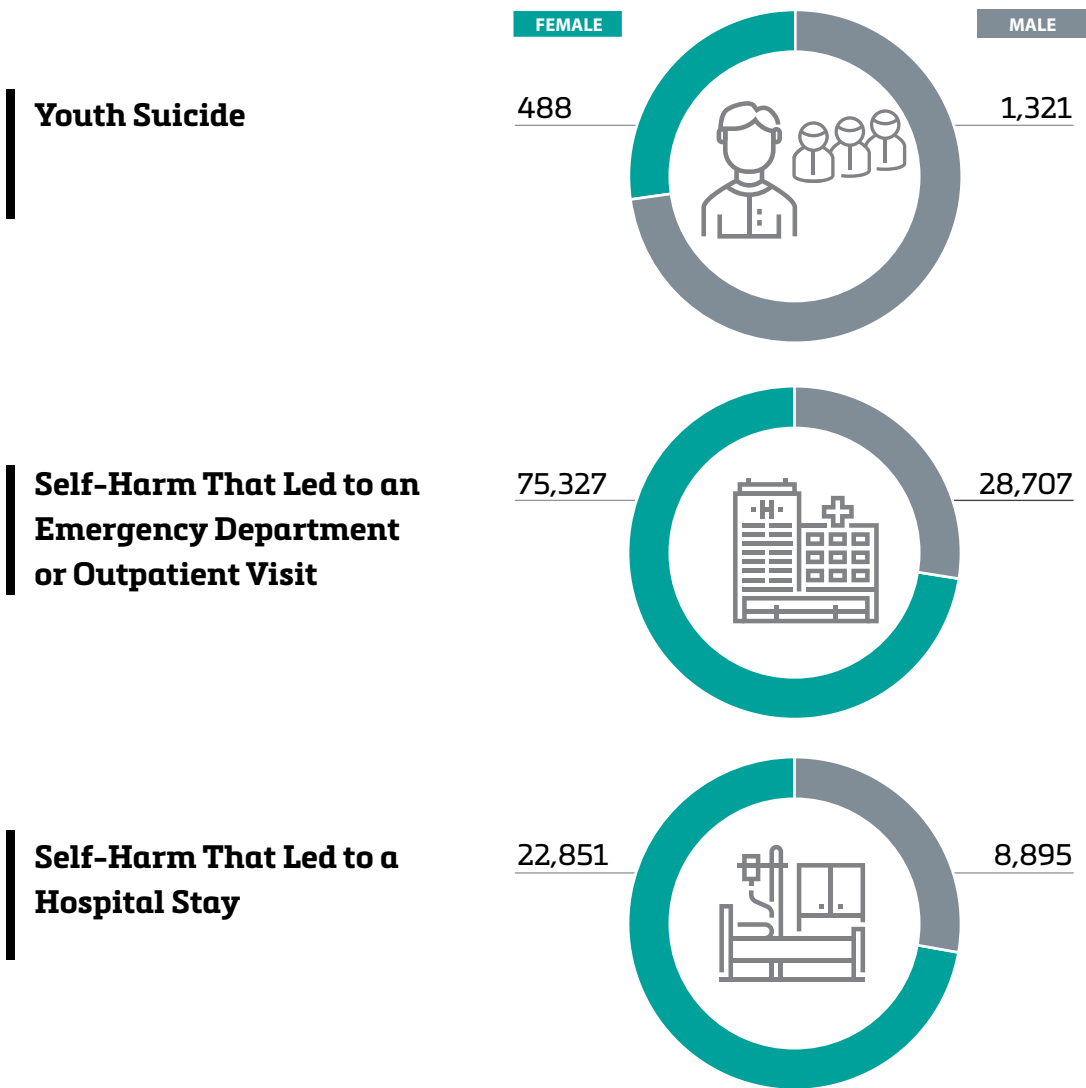


Source: Analysis of hospital encounter data from the Office of Statewide Health Planning and Development and the U.S. Census Bureau's American Community Survey 2014 to 2018 five-year population estimate.

In addition to varying by urban and rural areas, the rates of suicide and self-harm vary by gender. Our analysis of Public Health data from 2009 through 2018 found that males ages 12 to 19 years died by suicide at nearly three times the rate of females, as Figure 5 shows. Conversely, females in this same age group committed self-harm at nearly three times the rate of males. In fact, instances of self-harm by females increased 64 percent from 2009 to 2018, more than three times the rate of self-harm by males during the same period.

Figure 5

Incidents of Youth Suicide and Self-Harm Varied by Gender From 2009 Through 2018



Source: Analysis of Public Health’s vital death data and of the Office of Statewide Health Planning and Development hospital encounter data from 2009 through 2018 for youth aged 12 to 19.

Notes: The available data did not specify gender for fewer than 10 incidents of self-harm. We did not include these incidents in this figure.

We explain the methodology we used to create this figure in Appendix A, Objective 2.

The Role of Mental Health Services in Suicide Prevention

Research suggests that mental health care is a critical component of suicide prevention. The CDC lists barriers to accessing mental health treatment as one of the risk factors for suicide.³ Multiple studies have also identified positive associations between access to mental health care services—such as a higher density of psychiatrists in a given area—and reductions in suicide and in the factors leading to suicide. For example, a 2006 study of U.S. Census Bureau data and medical statistics found lower suicide rates in states with higher densities of psychiatrists, higher federal funding for mental health services, and lower rates of uninsured residents—correlations that the authors concluded support the importance of clinical intervention in preventing suicide. In a 2013 study, researchers found that states that enacted laws requiring that insurance plans cover mental health benefits experienced reduced suicide rates in the following years. Although identifying the exact correlation between mental health services and suicide prevention is an ongoing area of study, the current body of research indicates that increased access to mental health care reduces suicide rates.

California voters recognized the importance of mental health services in suicide prevention when they voted to approve Proposition 63—known as the Mental Health Services Act (MHSA)—in 2004. The MHSA expands services and treatment for children, adults, and seniors who suffer from mental illness or who are at risk of mental illness, in part through its focus on prevention and early intervention programs. The act cited the need to address untreated mental illness that may lead to suicide and concerns that children who are untreated often become unable to learn or participate in school. The MHSA imposes a 1 percent income tax on individuals earning more than \$1 million a year and allocates about 95 percent of these funds to local governments. It also established the Mental Health Services Oversight and Accountability Commission (Oversight Commission) to oversee county prevention and innovation programs. In each of the last three fiscal years, the State allocated more than \$1.8 billion in MHSA funds to local governments for mental health programs.

³ The National Alliance on Mental Illness indicates that barriers to accessing mental health treatment include the cost of mental health care and the difficulty of finding psychiatrists and other mental health care providers.

The Role of Local Educational Agencies in Suicide Prevention Efforts

In academic year 2018–19, California had more than 1,000 school districts, 58 county offices of education, and 1,300 charter schools, known collectively as local educational agencies (LEAs). As the text box shows, LEAs provide different types of mental health services. Some LEAs employ school counselors, school nurses, school social workers, and school psychologists, which we

collectively refer to as mental health professionals. Because students spend a significant amount of time in school, the personnel who interact with them every day are in a prime position to recognize the warning signs of suicide and make the appropriate referrals for help. According to the National Association of School Psychologists, youth who are contemplating suicide frequently give warning signs of their distress but are not likely to seek help directly. Thus, training school staff to respond to youth who exhibit warning signs of suicide is imperative. Figure 6 illustrates many of the efforts the Legislature has made to combat youth suicide and self-harm, including passing a law in 2016 that requires LEAs that serve students in grades 7 to 12 to adopt suicide prevention policies that address certain key topics, such as suicide intervention.

Mental Health Services in California Schools

According to Education, schools offer a broad range of mental health services, including the following:

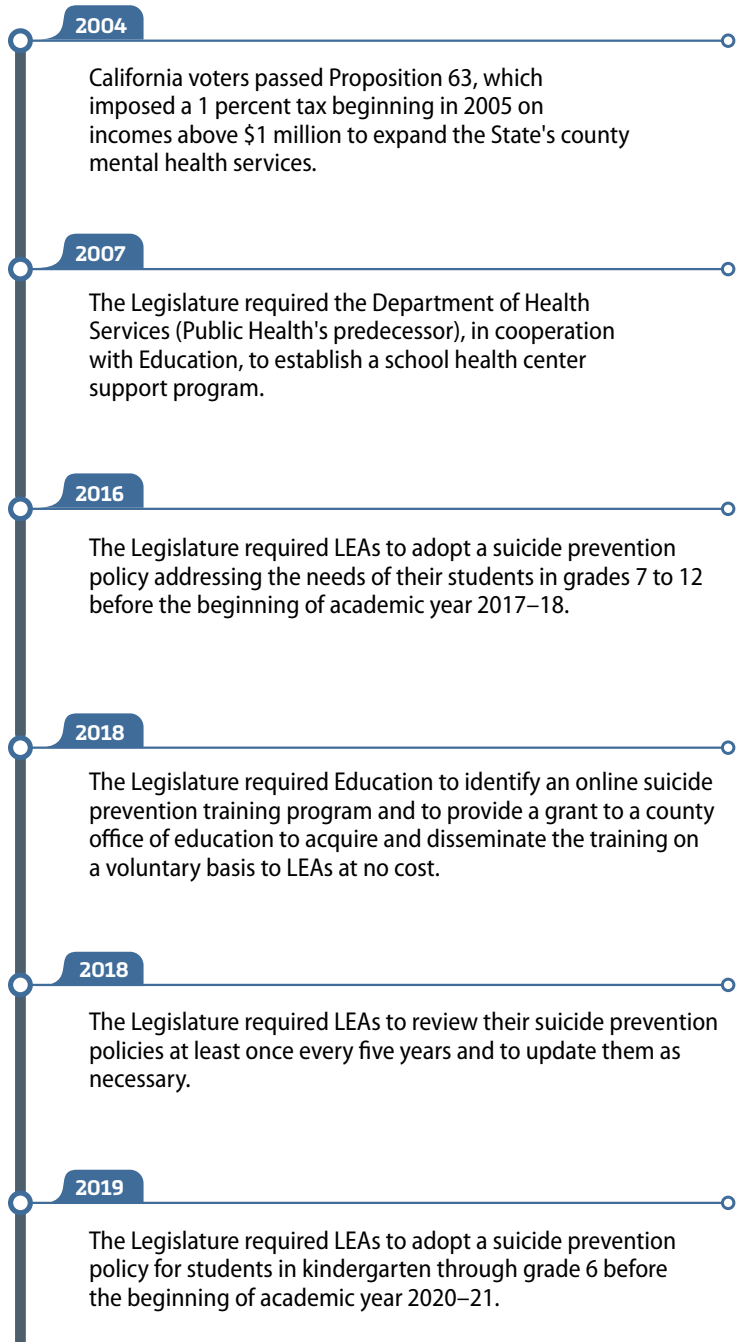
- Academic and personal counseling
- Interventions to address behavior issues
- Crisis intervention
- Assessments and referrals to other services

Education says that providing these services in a school setting helps address barriers to learning and supports student success both in and outside of school.

Source: Education's website and the Commission on Teacher Credentialing Pupil Personal Services Program Standards.

Historically, state agencies have had a limited role in LEAs' suicide prevention efforts. State law charges Public Health—whose mission is to advance the health and well-being of California's diverse people and communities—with the responsibility of establishing and maintaining the State's electronic reporting system for violent deaths; and in September 2020 the governor signed a bill requiring Public Health to establish the Office of Suicide Prevention, if funds are appropriated to do so. Moreover, until recently, the role of the California Department of Education (Education) in suicide prevention was to provide specific, limited resources and information to schools. However, when the Legislature required LEAs to adopt suicide prevention policies before the 2017–18 academic year, it also required that Education develop and maintain a model policy to assist the LEAs. Further, in 2018 the Legislature gave Education the task of identifying one or more online programs for LEAs to use when training school staff and students on suicide prevention.

Figure 6
The Legislature Has Made Efforts to Address Youth Suicide and Self-Harm



Source: Review of state laws.

The Department of Health Care Services (Health Care Services) generally does not work directly with LEAs to address youth suicide prevention. LEAs can receive reimbursement for some mental health care services they provide through the State's Medicaid program: the California Medical Assistance Program (Medi-Cal). Health Care Services administers Medi-Cal through an agreement, known as the state plan, with the federal Centers for Medicare and Medicaid Services (CMS). State law requires Health Care Services to oversee a program called the Local Education Agency Medi-Cal Billing Option Program (billing option program). Through the billing option program, participating LEAs receive federal reimbursement for 50 percent of the costs of certain health-related services they provide to Medi-Cal-eligible students under age 22. In fiscal year 2017–18, the year for which the most recent data concerning the billing option program is available, more than 500 LEAs participated in the program and claimed nearly \$134 million in federal reimbursement.

The Role of Local Partners and Organizations in Preventing Youth Suicides

A variety of organizations focus on suicide prevention and assist schools with their suicide prevention policies. For example, the Trevor Project, a national organization providing suicide prevention and crisis intervention services to LGBTQ people under age 25, cooperated with a number of tax-exempt organizations to create and publish a model policy for schools with procedures to assess the risk of, prevent, intervene, and respond to suicide. Another suicide prevention organization, the HEARD Alliance, a community alliance of health care professionals located in the San Francisco Bay Area, works to increase collaboration among primary care, mental health care, and education professionals to enhance the community's ability to prevent suicide in adolescents and young adults, among other things. In 2013 it created a toolkit designed to support school communities—including parents, teachers, school personnel, counselors, and health providers—in preventing youth suicide, and in 2017 it updated this toolkit to reflect statutory requirements enacted in 2016.

In addition, LEAs sometimes partner with community-based organizations to provide mental health and counseling services to their student populations. Some LEAs also partner with community-based organizations to provide services on-site, including mental health assessments, individual counseling sessions, and crisis counseling. LEAs may also refer at-risk students to off-site community-based mental health services.

To assess suicide prevention at the local level, we reviewed the efforts of six LEAs across the State. We selected three counties based on their geography and their rates of youth suicide and self-harm. We then chose one school district and one charter school within each of these three counties. In Mendocino County, we selected Ukiah Unified School District (Ukiah Unified) and Charter Academy of the Redwoods (Redwoods Charter); in San Francisco County, we selected San Francisco Unified School District (San Francisco Unified) and Gateway Public Schools (Gateway Charter), and in Kern County, we selected Kern High School District and Heartland Charter School (Heartland Charter). We selected Heartland Charter because it conducts much of its instruction via distance learning, a method of instruction that has become increasingly common as LEAs adapt to the COVID-19 pandemic.

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AUDIT RESULTS

None of the Six LEAs We Reviewed Have Adopted Adequate Youth Suicide Prevention Policies

To ensure that LEAs take the actions necessary to prevent youth suicides, the State has established suicide prevention policy requirements and identified best practices. However, none of the six LEAs we reviewed have adopted policies that fully met these requirements and best practices. State law required that before the beginning of the 2017–18 academic year, all California LEAs that serve pupils in grades 7 through 12 adopt suicide prevention policies that address certain key topics, including suicide intervention and prevention. In addition, state law required that the LEAs consult with school and community stakeholders, school-employed mental health professionals, and suicide prevention experts when adopting these policies. At the Legislature’s direction, Education published a model policy in May 2017 for the LEAs’ use. This model policy highlights best practices that suicide prevention organizations recommend, such as identifying primary and secondary liaisons to whom staff report known or suspected suicidal intentions and providing students with education about mental health challenges.

Although state law does not require LEAs to adopt Education’s model policy, the model policy contains numerous best practices, and therefore we expected the LEAs to have incorporated the concepts it contains into their own policies. Nonetheless, all six of the LEAs we reviewed lacked suicide prevention policy elements that either state law or the model policy identify. As Table 1 shows, these missing elements include the appointment of a suicide prevention point of contact and establishment of a response team—also known as a postvention team—to convene after a suicide. Without these elements, the LEAs may be unprepared to identify warning signs or provide resources for students at risk. For example, the establishment of a response team is important because the suicidal behavior of one student may reduce other students’ inhibitions against suicide. A systematic response can reduce the likelihood of clusters of suicides by providing at-risk students with support and guidance.

When we discussed these deficiencies with the LEAs, they offered a number of different reasons for deviating from Education’s model. The three charter schools acknowledged the gaps we identified, and their administrators stated they would update their policies as necessary. The three school districts explained that their policies were based on a model that the California School Boards Association (School Boards Association) published in March 2017, two months before Education introduced its model policy. The School Boards Association is a nonprofit organization that provides

All six of the LEAs we reviewed lacked suicide prevention policy elements that either state law or the model policy identify.

districts with sample policies and administrative procedures, among other services. The director of instruction at Kern High School District indicated that the district began developing its policy before Education released its model but would update its policy to include the missing elements. Staff at both Ukiah Unified and San Francisco Unified stated that some of the required elements missing from their policies exist in other documents and processes. Although incorporating materials into a policy by reference to other documents is reasonable, their suicide prevention policies did not contain references to those relevant documents.

Table 1
The LEA Suicide Prevention Policies We Reviewed Lacked Crucial Elements

REQUIREMENT OR BEST PRACTICE	SAN FRANCISCO UNIFIED	UKIAH UNIFIED	KERN HIGH SCHOOL DISTRICT*	GATEWAY CHARTER	REDWOODS CHARTER*	HEARTLAND CHARTER*
Requirements in State Law						
Addresses suicide prevention, intervention, and postvention procedures	✓	✓	✓	✓	X	✓
Addresses needs of at-risk groups, such as LGBTQ youth and youth in foster care	✓	✓	✓	X	X	✓
Constructed in consultation with community stakeholders	X	X	X	X	✓	X
Education's Best Practices						
Includes provision to share policy and other information with parents, guardians, and caregivers	✓	✓	✓	✓	X	X
Appoints an individual or team to serve as a suicide prevention point of contact to assist other staff	X	X	✓	✓	X	✓
Identifies a primary and secondary suicide prevention liaison to whom staff should report a student's known or suspected suicidal intentions	✓	✓	✓	✓	X	X
Requires annual professional development training related to suicide prevention for staff	✓	X	✓	✓	X	✓
Outlines how suicide prevention education will be provided to students	✓	✓	✓	✓	X	X
Requires establishment of a postvention response team	✓	X	✓	✓	X	X
Includes an action plan for in-school suicide attempts	✓	✓	✓	✓	X	†
Includes an action plan for out-of-school suicide attempts	X	X	X	✓	X	✓

Source: State law, suicide prevention materials from Education, and LEA policies.

Note: Education's model policy is located at <https://tinyurl.com/suicidepreventionCA>.

* We reviewed suicide prevention policies that were in effect during the 2019–20 academic year. After we notified the LEAs of the deficiencies we identified, they indicated that they had updated their policies to address some of our concerns.

† Heartland Charter is a home-study school and does not have protocols for in-school suicide attempts.

Although Education’s program consultant for mental health services (program consultant) believes that the School Boards Association’s policy is sufficient for compliance with state law, the policy omits several best practices that Education’s model includes. For example, the School Boards Association’s policy discussed suicide prevention training but did not recommend that LEAs provide it annually as the model does. In addition, the policy did not address creating an action plan for incidents of suicide or self-harm that occur outside of school. According to the program consultant, LEAs should adopt robust policies to ensure that the schools have adequate processes and training in place to respond to mental health crises. Nonetheless, an assistant executive director at the School Boards Association stated that most of the State’s school districts and county offices of education have access to the School Boards Association’s model, and many may have relied on it when developing their suicide prevention policies. Widespread reliance on a policy that does not include many best practices may mean that numerous LEAs do not have the best tools available to prevent youth suicide.

According to one of Education’s program consultants, the School Boards Association developed its model without collaborating with Education. Although the program consultant was aware of the alternative policy, Education has not contacted the School Boards Association to ensure that the policy contains necessary requirements and sufficient detail. The program consultant acknowledged that increased coordination could have benefited both entities’ model policies. She asserted that Education intends to contact the association in the future but did not have time to do so before the 2017–18 academic year when state law required the policies to take effect.

In addition, none of the LEAs we reviewed could demonstrate that they obtained feedback from all of the relevant stakeholders when constructing their policies. As the text box shows, state law and Education’s model policy identify the groups that LEAs must or should involve when developing suicide prevention policies. However, we found that the actual stakeholders and experts that LEAs involved varied. For example, Kern High School District convened a suicide prevention committee that included mental health professionals, school district law enforcement representatives, school administrators, and other school staff. In contrast, Ukiah Unified’s superintendent

Groups That LEAs Must or Should Consult When Developing LEA Suicide Prevention Policies

State law requires LEAs to develop their suicide prevention policies in consultation with four groups:

- School stakeholders
- Community stakeholders
- School-employed mental health professionals
- Suicide prevention experts

Education’s model policy provides the following examples of specific groups with whom LEAs should consult when planning, implementing, and evaluating strategies for suicide prevention and intervention:

- School-employed mental health professionals (such as school counselors, psychologists, social workers, and nurses)
- Administrators
- Other school staff members
- Parents/guardians/caregivers
- Students
- Local health agencies and professionals
- Law enforcement
- Community organizations

Source: State law and Education’s model policy.

explained that the LEA primarily relied on its board and school counselors to approve and update its policy. In particular, we noted that the LEAs generally did not involve community stakeholders or suicide prevention experts. Only Redwoods Charter was able to demonstrate that it involved a representative from a community organization.

The LEAs gave different reasons for not including all required stakeholders. Heartland Charter's executive director explained that the charter school organization to which it previously belonged provided the suicide prevention policy and that Heartland Charter was unaware of the requirements to consult stakeholders. San Francisco Unified's director of safety and wellness explained that although the district did consult with local community organizations and the county's department of public health, it did not keep records of the meetings. Administrators at Gateway Charter, Kern High School District, and Ukiah Unified all asserted that they involved the groups necessary for creating an effective policy. However, the LEAs' consistent failure to include community groups suggests that they may not fully recognize the benefits of doing so. For example, individuals in certain groups at higher risk of suicide can benefit from policies, procedures, and resources specifically tailored to their needs. The lack of outside stakeholder involvement may result in some LEAs' policies failing to meet the specific needs of their communities.

Some LEAs We Reviewed Have Not Provided Adequate Training to Their Faculty, Staff, and Students on Preventing Suicide

The LEAs' inadequate training programs may limit the effectiveness of their suicide prevention efforts.

The LEAs' inadequate training programs may limit the effectiveness of their suicide prevention efforts. Although the State does not mandate training for school personnel, state law does outline which elements such training must include if LEAs provide it—such as identifying school-based mental health services and how to refer students to them. In addition, a number of organizations recommend suicide prevention training for all personnel. However, only one of the six LEAs provided training to their faculty and staff that included all the legally required elements we reviewed. Compounding these deficiencies, some LEAs did not provide training to all staff or they provided training months after the school year began. Further, some LEAs provided only limited education to students regarding suicide prevention, even though studies have identified positive associations between providing students with suicide education and improvements in factors related to reducing suicide rates. The LEAs' failure to adequately educate their faculty and staff about suicide prevention is likely due in part to the costs associated with effective training.

Some of the LEAs We Reviewed Did Not Fully Train Staff on Identifying and Assisting Students at Risk of Suicide

Because school personnel are in an ideal position to observe student behavior and to recognize and respond to signs of crises, a coalition of organizations engaged in suicide prevention efforts, including the American Foundation for Suicide Prevention, recommends providing all school personnel with training regarding youth suicide prevention. Similarly, Education’s model policy recommends that LEAs train staff to recognize suicide warning factors and risk factors and that LEAs identify local populations of students who are at an elevated risk for suicide, including LGBTQ youth. Although state law does not mandate training on suicide prevention, it does require that if LEAs conduct such training, the training materials must include information on how to identify appropriate mental health services—both at the school site and within the larger community—and when and how to refer youth and their families to those services.

Although all six LEAs we reviewed provided suicide prevention training during the 2019–20 academic year, each failed to include one or more of the elements in state law or Education’s model policy. These deficiencies may leave teachers and staff unprepared to identify and assist students at risk of self-harm and suicide. Of the six LEAs we reviewed, five did not include components mandated by state law for training their teachers and staff. For example, as we show in Table 2, Gateway Charter, Kern High School District, Heartland Charter, and Ukiah Unified used training materials that did not include information on community-based mental health services and procedures for referring students to them. In contrast, San Francisco Unified’s training materials included simple flowcharts identifying whom staff should contact for assessing students who are at risk of harming themselves or others, as well as alternatives if the initial contact is not readily available. These flowcharts also emphasize the importance of an immediate referral and describe the mental health resources available both on-site and off-site.

Deficiencies in training may leave teachers and staff unprepared to identify and assist students at risk of self-harm and suicide.

Table 2
In Academic Year 2019–20, None of the LEAs’ Trainings We Reviewed Included All of the Elements Identified in State Law and Education’s Best Practices

	SAN FRANCISCO UNIFIED	UKIAH UNIFIED	KERN HIGH SCHOOL DISTRICT	GATEWAY CHARTER	REDWOODS CHARTER	HEARTLAND CHARTER
State law requires training to:						
Identify school-based mental health services and when and how to refer students to them	✓	X	X	✓	X	X
Identify community-based mental health services and when and how to refer students to them	✓	X	X	X	✓	X
Education recommends training to:						
Discuss high-risk groups	✓	X	✓	X	X	✓
Discuss all three elements of suicide identification: risk factors, warning factors, and protective factors	X	X	✓	X	✓	✓
Discuss trends identified in data on self-harm incidents and suicides within the LEA’s region	✓	X	X	X	X	X

Source: Analysis of state law, Education’s suicide prevention model policy, interviews with Education personnel, and academic year 2019–20 training materials at the six LEAs.

In addition, all of the LEA training programs we reviewed lacked one or more of the suicide prevention training and education elements that Education describes in its model policy. Specifically, Education recommends that suicide prevention training include discussion of suicide risk factors, warning factors, and protective factors, as Table 3 indicates. However, as Table 2 shows, three of the LEAs did not train teachers and staff on all three elements. Youth who are contemplating suicide frequently exhibit signs of their distress, and teachers and staff trained to identify these warning signs are in key positions to obtain help and prevent suicide attempts.

Even though Education’s model policy indicates that training should include additional information regarding high-risk groups of students, such as LGBTQ youth, three LEAs that provided training did not follow this best practice. According to the 2012 National Strategy for Suicide Prevention produced by the Office of the U.S. Surgeon General and the National Action Alliance for Suicide Prevention, some risk and protective factors may be more important to one group than another. For example, San Francisco Unified’s training material includes statistics on the demographics of its students who have attempted or have considered suicide categorized by gender, sexual orientation, and race. When San Francisco Unified found that a higher than average percentage

of its Filipino middle school population had seriously considered suicide, it developed additional training specific to this group and identified culturally appropriate resources. In contrast, when LEAs do not identify and provide training related to high-risk groups, teachers and staff may not be aware of the relevant warning signs, risk factors, and resources, which may impede their ability to reduce suicide risk in the populations that most need the help.

Table 3
Education Recommends That Suicide Prevention Training Include Specific Elements

KEY ELEMENTS	DESCRIPTION	EXAMPLES	IMPACT OF TRAINING
Risk factors	Characteristics of a student that increase the likelihood of suicide.	<ul style="list-style-type: none"> • Prior suicide attempt(s) • Mental disorder(s) • Access to lethal means of harm 	Staff are aware of students experiencing risk factors and can keep watch for changes in their behavior.
Warning factors	Behaviors that indicate immediate risk for suicide.	<ul style="list-style-type: none"> • Giving away prized possessions • Searching online for methods to end life • Showing rage or displaying extreme mood swings 	Staff can more effectively identify students who show signs of suicidal thinking and can take immediate steps to help.
Protective factors	Characteristics that help protect a student from suicide.	<ul style="list-style-type: none"> • Effective behavioral health care • Connectedness to family and community 	Staff can create an environment that enhances protective factors and reduces likelihood of suicide attempts.

Source: Education’s model policy, HEARD Alliance’s Toolkit for Mental Health Promotion and Suicide Prevention, Suicide Prevention Resource Center’s website, and American Foundation for Suicide Prevention website.

Some LEAs appear to have prioritized convenience over compliance with state law and Education’s best practices when selecting suicide prevention training materials. For example, according to the charter school organization to which it previously belonged, Heartland Charter selected the training video it uses from a list of options preapproved by its insurance plan, without its staff reviewing any of the other options. Kern High School District’s human resources administrator stated that it chose its online training program—even though it lacked certain elements—because it allowed employees to easily complete a number of required trainings before the start of the academic year. When we discussed missing elements in their training material, staff at both San Francisco Unified and Ukiah Unified referenced other efforts that they believed addressed the missing concepts. However, because this information was not included in the training, it is not clear if it was provided to all faculty and staff. When LEAs do not proactively work to ensure that their trainings meet requirements in state law and best practices, teachers and staff may not have all the knowledge or confidence necessary to respond appropriately when students are at risk of suicide.

Some of the LEAs We Reviewed Did Not Provide Training to All Teachers and Staff in a Timely Manner

Only four of the six LEAs provided training to both teachers and staff, even though Education recommends that training be provided to all adults at school sites at least annually. We reviewed the training provided by one school overseen by each of the six LEAs, and only four provided suicide prevention training to both teachers and staff, as Table 4 shows. According to Gateway Charter’s assistant principal, the school does not require some staff members in nonteaching and support positions, such as coaches, security guards, and secretaries, to receive suicide prevention training because they are needed to supervise the students while teachers are attending the training. Ukiah Unified’s director of alternative education, on the other hand, stated that by providing training to teachers, the district’s policy exceeds the State’s requirements. Although providing suicide prevention training to all staff may present challenges, many different individuals at a school communicate with its students throughout the day. In acknowledgement of this, a 2019 report on mental health services in public schools suggested that school districts should teach everyone who works with students—including teachers, staff, bus drivers, and cafeteria workers—how to identify and respond to a student in crisis and what resources are available.

Table 4
Only Four of the LEAs We Reviewed Provided Suicide Prevention Training to Both Teachers and Other Staff During Academic Year 2019–20

	SAN FRANCISCO UNIFIED	UKIAH UNIFIED	KERN HIGH SCHOOL DISTRICT	GATEWAY CHARTER	REDWOODS CHARTER	HEARTLAND CHARTER
	CIVIC CENTER SECONDARY SCHOOL GRADES 7–12	UKIAH HIGH SCHOOL GRADES 9–12	BAKERSFIELD HIGH SCHOOL GRADES 9–12	GATEWAY PUBLIC HIGH SCHOOL GRADES 9–12	ACCELERATED ACHIEVEMENT ACADEMY GRADES 4–12	HEARTLAND CHARTER SCHOOL GRADES K–12
Provided suicide prevention training to teachers	✓	✓	✓	✓	✓	✓
Provided suicide prevention training to other staff	✓	X	✓	X	✓	✓
Provided training within three months of students beginning classes	X	X	✓	✓	✓	✓

Source: Auditor analysis of attendance records and staffing information at all six LEAs we reviewed for academic year 2019–20.

Note: We selected one school for review from each LEA we visited.

Some LEAs we reviewed also did not ensure that teachers and staff members obtained suicide prevention training in a timely manner, which may have limited the impact of the training. Our analysis of Public Health's suicide data from 2009 through 2018 indicated that the number of youth suicides increased by 16 percent during the first three months of the academic year. The HEARD Alliance suggests educating teachers and key staff before the school year begins or during staff development days. However, two of the six LEAs did not conduct their training within the first three months of their school years. For example, Ukiah High School did not provide training until more than five months after students began attending classes. According to Ukiah Unified's superintendent, the school held other staff trainings before providing the suicide prevention training because state law does not require the suicide prevention training to be held by a particular date. The social worker responsible for providing the suicide prevention training at San Francisco Unified's Civic Center Secondary School stated that he did not provide the training until six months after students began attending classes because he did not have the time to effectively do so. However, if teachers, school counselors, and others who work closely with students do not receive training in a timely fashion, they may be ill-equipped to spot the signs of a student in distress during a period when the rate of youth suicide has historically increased.

Some of the LEAs We Reviewed Are Not Educating Students on Suicide Awareness and Prevention

LEAs can bolster their suicide prevention efforts by providing students with comprehensive suicide awareness and prevention education. Multiple studies have identified positive associations between providing student suicide education and improvements in factors related to reducing suicide rates. For example, a 2015 study of Connecticut high school students found that a program intended to increase the students' abilities to identify warning signs of suicide and depression and to understand the importance of seeking help resulted in significantly fewer self-reported suicide attempts over the following three months. It also resulted in more favorable student attitudes toward seeking help for themselves and friends. Education recommends that LEAs provide developmentally appropriate curriculum to students about the warning signs of mental health issues, including suicide. Although such a curriculum encourages students to seek and receive potentially lifesaving services, state law does not currently require LEA suicide prevention policies to address self-harm or suicide prevention education for students.

If those who work closely with students do not receive training in a timely fashion, they may be ill-equipped to spot the signs of a student in distress.

The LEAs we reviewed have taken different approaches toward educating students about suicide prevention. Gateway Charter, Kern High School District, and San Francisco Unified incorporate suicide prevention lessons into student curricula. In contrast, although Ukiah Unified's suicide prevention policy requires the provision of suicide prevention education as part of its health curriculum, its director of alternative education admitted that in practice it is not consistently provided. Meanwhile, Redwoods Charter explained that it does not require any suicide-related lessons before students' senior year. Redwoods Charter's codirector explained that while the school's policies do not require student suicide prevention lessons, it does offer occasional mental health outreach activities, such as student-organized compilations of mental health resources that resulted in teacher-led discussions. However, we question the value of this approach because ensuring that students receive comprehensive suicide prevention education in accordance with Education's best practices may help reduce the stigma associated with seeking help and increase the number of students who seek assistance.

We also have concerns about the approach that Heartland Charter used. As the Introduction describes, Heartland Charter conducts much of its instruction through distance learning. Because of the limited in-person interaction between instructors and students, we expected Heartland Charter to provide a robust student education suicide prevention program to ensure that its students are comfortable contacting an adult if they are experiencing a mental health crisis. However, Heartland Charter did not provide any suicide prevention education to its students when we initially spoke to school representatives. According to Heartland Charter's executive director, it generally does not provide standard curricula to all its students because doing so would be contrary to its structure as a home-study school. After discussing this issue with the audit team, the executive director indicated that she would explore adding curriculum elements related to suicide prevention, and Heartland Charter subsequently distributed activity plans and resources on this subject to parents.

Omission of suicide prevention education may occur in distance learning environments as it did at Heartland Charter, particularly as many of the State's LEAs have transitioned to distance learning because of the COVID-19 pandemic.

We are concerned that such omissions may occur in other distance learning environments, particularly as many of the State's LEAs have transitioned to distance learning recently because of the COVID-19 pandemic. Education's program consultant stated that Education is in the process of creating information regarding suicide prevention to distribute to educators and parents, but as of July 2020, it had not finalized a plan. Without appropriate guidance and resources, the lack of suicide prevention education we identified at Heartland Charter may be present at other LEAs conducting instruction through distance learning.

Education and the San Diego County Office of Education Have Provided an Online Suicide Prevention Training Program, but Few LEAs Will Have Access to It

According to Education's program consultant, many LEAs struggle to provide suicide prevention training for their teachers and staff because of a lack of funding. For example, Redwoods Charter's principal explained that because of a lack of funding and difficulties in identifying available training in the Ukiah area, the school encourages its teachers to attend a training that the Mendocino County Office of Education provides at no cost to Redwoods Charter. The Mendocino County Office of Education's special projects manager pointed out that although some LEAs rely on that free training, others do not take advantage of it because of the limited availability of substitute teachers and the costs associated with hiring them while their teachers are at the training. She also stated that this training is not specific to suicide prevention but rather is designed to teach participants how to help adolescents experiencing mental health or addiction challenges. Education's program consultant explained that the training in question is basic in nature, does not incorporate all of the best practices identified in Education's model policy, and should not be used as an LEA's annual suicide prevention training.

The struggle to establish and provide adequate suicide prevention training extends beyond the LEAs in Mendocino County. According to the program consultant at Education, many LEAs, including some in rural counties such as Trinity and Mendocino counties, as well as others in urban counties such as Los Angeles, Orange, and Contra Costa, do not have the resources to establish their own training or to pay for their staff's time to take the training. A 2012 study shows that suicide prevention training increases school personnel's perceived knowledge about and confidence in responding to distressed youth. Without adequate training, LEAs reduce the likelihood that their faculty and staff will respond appropriately to students at risk of self-harm and suicide.

The Legislature provided Education with an opportunity to facilitate statewide suicide prevention training. In 2018 it passed a state law requiring Education to identify an online training program that LEAs could use to train both staff and students on suicide awareness and prevention. The law required Education to provide funding to a county office of education to acquire and disseminate the program to other LEAs statewide, and the Legislature appropriated a one-time amount of \$1.7 million for these purposes. In October 2019, Education selected the San Diego County Office of Education (SDCOE) to provide and promote the online suicide prevention training program. SDCOE entered into a \$1.3 million contract with a vendor to create an online suicide

Many LEAs do not have the resources to establish their own training or to pay for their staff's time to take the training.

The training Education has selected will currently be provided to a small proportion of the State's teachers and staff—only 600 individuals in each county—while many LEAs must continue to rely on their current trainings.

prevention training. The vendor supplied its preexisting online training and agreed to provide it to a total of 66,000 school personnel and students. According to Education, the funding the Legislature appropriated could not meet the training needs of all middle and high school staff and students in California, but it is advocating for the State to continue funding the training program in subsequent years. However, we question whether this is a cost-effective approach to providing such training. At the rate the vendor charged for the licenses, it will cost more than \$13.5 million per year to provide this training to every LEA teacher and staff member throughout the State.

The training Education has selected will currently be provided to a small proportion of the State's teachers and staff—only 600 individuals in each county—with the remainder allocated to students. Consequently, many LEAs must continue to rely on their current trainings. Further, Education's program consultant stated that many LEAs may not be interested because they offer their own training already or contract through a vendor, and Education will consider the program a success if all 66,000 licenses are used. As we describe previously, each of the suicide prevention trainings provided by the LEAs we reviewed lacked one or more of the elements described in state law or Education's best practices. However, because none of the LEAs we reviewed incorporated all of the elements in their trainings, it is likely that many other LEAs throughout the State are also providing training that lacks one or more of the elements that the law requires. To ensure that these trainings adequately address the needs of at-risk students, Education should reach out to LEAs throughout the State to encourage them to adopt the legally required elements.

None of the State's LEAs Employ the Recommended Number of Mental Health Professionals

None of the State's LEAs employ the recommended number of each type of mental health professional even though research indicates that access to mental health professionals decreases the likelihood of youth suicide. Mental health professionals provide academic, career, and psychological counseling to students, as well as social development and physical health services. In 2001 the Legislature required Education to perform a comprehensive study to determine the appropriate ratios of school counselors and other student support service personnel to students in California schools. Based on recommendations from professional associations, Education's study established recommended mental health professional-to-student ratios for the four positions the text box describes.

Research indicates that access to mental health professionals decreases the likelihood of youth suicide. One study that examined the use of health and mental health care services among youth who died by suicide and comparable youth who did not found that the likelihood of suicide significantly decreased when youth had more frequent mental health visits. Moreover, research has shown that school counselors—one type of mental health professional—can improve academic outcomes while also helping to reduce the risk factors associated with higher rates of suicide, such as impulsive or aggressive tendencies, isolation, and a history of alcohol or substance abuse. In fact, studies have found that better student-to-counselor ratios were associated with improved discipline, attendance, and graduation rates. Further, according to a 2010 study, increased funding for school counselors or adopting a minimum counselor-to-student ratio in elementary schools resulted in fewer teachers reporting problems with students fighting, cutting class, and using drugs.

Despite the importance of these support staff, many of the LEAs in the State reported that they did not employ the recommended number of mental health professionals in even a single category during the 2018–19 academic year. Education requires LEAs to submit staffing data, and we used those data to determine whether they met Education’s recommended ratios. We found that none of the 1,034 LEAs that reported staffing information met Education’s recommended ratios in all four of the mental health professional categories.⁴ In fact, 25 percent of the LEAs reported they did not have mental health professionals in any of the four categories. Further, fewer than 5 percent reported having the recommended number of mental health professionals in the individual categories of school counselors, school nurses, and school social workers, as Table 5 shows. To account for schools with a surplus of certain types of mental health professionals and deficiencies in others, we also standardized the four ratios into one and analyzed the data using this broader combined ratio. Even so, only 3 percent of LEAs met this combined ratio.

Education’s Recommended Ratios of Mental Health Professionals to Students

School Counselors: 1-to-250

- Provide academic, career, personal, and social development counseling and guidance.
- Advocate for high academic achievement and social development.
- Provide schoolwide prevention and intervention strategies and counseling services.

School Psychologists: 1-to-1000

- Perform educational assessments to identify special needs.
- Design strategies and programs to address problems of adjustment.
- Provide psychological counseling and other therapeutic techniques.
- Coordinate intervention strategies for managing individual and schoolwide crises.

School Social Workers: 1-to-800

- Assess home, school, personal, and community factors that may affect a student’s learning.
- Identify and provide intervention strategies for children and their families, including counseling, case management, and crisis intervention.
- Coordinate resources on behalf of students.

School Nurses: 1-to-750

- Assess and address physical needs of students.
- Coordinate medical treatment with, among others, parents, primary care providers, and teachers.
- Make referrals for necessary services.

Source: State law, the California Commission on Teacher Credentialing Pupil Personnel Services standards, and Education’s ratio study.

⁴ We aggregated data from individual schools into their districts’ data and from charter schools into their authorizing agencies’ data.

Table 5
The State's LEAs Reported Employing Fewer Than the Recommended Number of Mental Health Professionals During the 2018–19 Academic Year

TYPE	RECOMMENDED PROFESSIONAL-TO-STUDENT RATIO	NUMBER OF THE 1034 LEAs THAT MET THE RECOMMENDED RATIO	PERCENTAGE OF LEAs THAT MET THE RECOMMENDED RATIO	NUMBER OF THE 1034 LEAs WITH NO PROFESSIONALS	PERCENTAGE OF LEAs WITH NO PROFESSIONALS
School counselors	1:250	33	3%	350	34%
School nurses	1:750	28	3	547	53
School social workers	1:800	11	1	937	91
School psychologists	1:1000	248	24	433	42
Met all four ratios		0	0	260	25
Combined ratio*	15:2000*	35	3	NA	

Source: Education's 2003 Study of Pupil Personnel Ratios, Services, and Programs, and analysis of Education's staffing and enrollment data.

* For every 2,000 students, LEAs should employ a combined total of 15 school counselors, school nurses, school social workers, and school psychologists.

When we asked Education why so few LEAs met the recommended ratios, one of its program consultants stated that budgetary constraints limit LEAs' ability to hire and retain mental health professionals. In addition, he said that LEAs face pressure to increase salaries for faculty and staff, and that LEAs have little leverage to earmark funds to hire and retain mental health professionals because state funds are not restricted for specific purposes. Nonetheless, given that the State's rate of youth suicide has continued to rise, we are concerned that LEAs are consistently prioritizing other expenditures.

Much like LEAs in the rest of the State, the six LEAs we reviewed did not employ the recommended number of mental health professionals. According to their payroll data for fiscal year 2018–19, none employed the recommended number of mental health professionals in every category, as Table 6 shows. For example, San Francisco Unified met only two of the four ratios, even though its staffing levels were, on average, the closest to the recommended ratios of the six LEAs we reviewed. In contrast, Kern High School District employed only 21 percent of the school nurses and 53 percent of the school psychologists required to meet the recommended ratios. Even more concerning, each of the three charter schools employed only one of the four types of mental health professionals. Gateway Charter and Redwoods Charter indicated that they want to increase mental health services but that they currently lack funding to do so. Heartland Charter's executive director indicated that Heartland Charter has increased its staffing since the 2018–19 school year and that she believes it is meeting its students' needs. However, even with the increase she described, Heartland Charter would be employing only 44 percent of the

school nurses, 15 percent of the school counselors, and none of the school social workers required to meet Education’s recommended standards. Consequently, students attending these schools do not have access to the recommended level of mental health professionals, despite the fact that the suicide rates in Kern and Mendocino counties exceed those of the majority of the counties in the State.

Table 6
The Six LEAs Failed to Meet Most of Education’s Recommended Ratios for Mental Health Professionals During Fiscal Year 2018–19

PROFESSIONAL-TO-STUDENT RATIO		STAFFING LEVEL MET					
		SAN FRANCISCO UNIFIED	UKIAH UNIFIED	KERN HIGH SCHOOL DISTRICT	GATEWAY CHARTER	REDWOODS CHARTER	HEARTLAND CHARTER
School counselors	1:250	106%	115%	84%	127%	84%	*
School nurses	1:750	76	47	21	0	0	*
School psychologists	1:1000	102	163	53	*	0	59*
School social workers	1:800	95*	0	64	0	0	0

Source: Analysis of Education’s enrollment data, documentation from Gateway Charter and Heartland Charter, and payroll data from Heartland Charter, Kern High School District, Redwoods Charter, San Francisco Unified, and Ukiah Unified.

Note: In the categories above, we included individuals whose position descriptions indicated they provided mental health services to students, regardless of their educational attainment or certification status.

* The LEA informed us that there were individuals providing services in this category of mental health professional; however, they were unable to quantify the time these individuals spent providing services. Therefore, we did not include them in our analysis.

Education’s program consultant acknowledged the undeniable need for student service staff and student support programs to prevent youth suicide. However, he asserted that a statewide program to fund mental health professionals at LEAs is unlikely because of the State’s current focus on local control of education spending. Nonetheless, ensuring that youth have access to mental health services is crucial to addressing the State’s rising suicide rates.

School-Based Health Centers Could Effectively Provide Mental Health Services to Students

Our review of effective suicide prevention practices found that school-based health centers (school health centers) that provide mental health services can help offset school staffing shortages by leveraging other funding sources. School health centers are located on or very near school grounds and, depending on the health professionals they employ, may provide a variety of physical and mental health services, such as mental health care, immunizations, substance abuse counseling, oral health care,

and nutrition education. Other entities, such as community health centers or local health departments, often support school health center operations and may employ the physicians, nurse practitioners, mental health professionals, and other medical support staff. Our review found that both the state of Oregon and San Francisco Unified have successfully established school health centers that provide positive outcomes for students. The State attempted to address this issue in 2007 when it required Public Health's predecessor to establish a program to support the development of health centers, a responsibility it later assigned to Public Health. However, as we discuss later, Public Health never developed the program, and at present, school health centers only serve a small proportion of California's students.

Oregon and San Francisco Unified's School Health Centers Increase Access to Mental Health Care

Research has consistently demonstrated that school health centers increase youth access to mental health care, which is associated with a reduction in the factors that lead to youth suicides and self-harm. For example, a 2003 comparison of high school students' use of school health centers and of community health clinics found that a significantly higher percentage of visits to the school health centers were for mental health reasons, leading the authors to conclude that these centers have a unique role in increasing youths' use of mental health services. A 2018 review of studies on school health centers concluded that they increase access to health care, decrease the cost of care, and are well positioned to provide mental health services. These studies suggest that students use school health centers when they are available and that school health centers can provide the mental health services that serve as protective factors against suicide.

Studies suggest that students use school health centers when they are available and that such health centers can provide the mental health services that serve as protective factors against suicide.

Oregon's school health centers illustrate how California could increase the provision of mental health services to students. According to a 2018 study, Oregon students at schools with health centers offering additional mental health services were less likely to think about or attempt suicide. In addition, annual reports from the Oregon Health Authority (Oregon Health) on its school health centers indicate that the centers provide mental health services to students who might not otherwise have access to them. In 2020 Oregon Health reported that all 79 certified school health centers in the state employed on-site behavioral health providers, a category that encompasses mental health and substance abuse services, and that 42 percent of all visits from clients of ages 5 through 21 during the 2018–19 academic year were for behavioral health reasons. Further, 67 percent of the school health centers were located in health professional shortage areas, a federal designation

for defined geographic areas that have a shortage of primary care, dental, or mental health providers relative to the local population. California has a large number of such areas; in fact, in 2020 there were 1,623 health professional shortage areas in the State. Oregon's example illustrates how California could use school health centers to increase the provision of mental health services to students and thus decrease the likelihood of suicide attempts in areas with limited access to care.

In addition to state appropriations, Oregon's health centers rely on a number of sources of revenue, including grants, health insurance billing, and donations. Oregon provided counties with about \$60,000 per school health center each year from 2017 through 2019. According to Oregon Health, currently the total cost to the state for the health center program—including staff at the state level—is \$18.5 million. However, for every dollar of state public health funding, school health centers obtain more than three and a half dollars from other sources, such as federal Medicaid funds. About 59 percent of the individuals receiving services from the school health centers were insured through public programs, and another 21 percent were covered through private insurance.⁵ Thus, school health centers are able to draw on other funding sources for a significant portion of the services they provide. We discuss opportunities for California's LEAs to take similar advantage of federal funding later in this report.

San Francisco Unified's wellness initiative (wellness program), which includes 18 school health centers, has also reduced barriers to students' obtaining mental health services. From 2009 through 2018, San Francisco County had one of the lowest youth suicide and self-harm rates of California's counties. San Francisco Unified initiated its wellness program in 2000 with two pilot school health centers and has since expanded it to include centers at all of its high schools. School health centers such as these reduce barriers to care, such as cost and transportation, by offering services on campus at no cost to students or their families. According to the vendor that maintains San Francisco Unified's health care service database, the wellness program has consistently served more than half of the student population.

San Francisco Unified collaborates with a number of other organizations to provide the wellness program, and several factors have contributed to the program's success. According to its safety and wellness director, its partnerships with two county agencies—the Department of Children, Youth and Their Families and the San Francisco Department of Public Health—allow the district to

For every dollar of state public health funding, school health centers obtain more than three and a half dollars from other sources, such as federal Medicaid funds.

⁵ The remaining clients were either uninsured or of unknown insurance status.

leverage existing resources. Specifically, these resources include a mixture of local, state, and federal funds that are used to support the wellness program. He also stated that San Francisco Unified's partnership with a local nonprofit organization, Richmond Area Multi-Services, Inc. (RAMS), has allowed the district to expand its provision of mental health services.

Public Health Has Not Established a School Health Center Support Program as the Law Requires

More than a decade ago, the Legislature took steps to support the creation of additional school health centers, but Public Health's inaction has impeded these efforts. In 2007 a state law required Public Health's predecessor, the Department of Health Services, to establish the Public School Health Center Support Program (support program) to provide assistance to LEAs in establishing, maintaining, and expanding school health centers.⁶ It also directed the support program to provide LEAs—including charter schools—with technical assistance, which may include identifying sources of funding, such as local grants and federal Medi-Cal reimbursement programs, to create new school health centers or expand those already in place. The then-governor stated that this law was a step toward his goal of creating 500 school health centers. In 2009 the Legislature added a grant component—which is contingent on funding—to the support program law authorizing Public Health to provide grants to improve existing health centers or to develop new health centers.

Public Health had not established the support program, thus depriving LEAs of the assistance in establishing, retaining, and expanding school health centers that such a program would provide.

However, as of July 2020, Public Health had not established the support program, thus depriving LEAs of the assistance in establishing, retaining, and expanding school health centers that such a program would provide. According to Public Health's Center for Healthy Communities deputy director (deputy director), Public Health has not put into place activities to assist schools because of a lack of staff and resources. Nonetheless, it received a total of \$1.2 million across two fiscal years—2016–17 and 2017–18—which she acknowledged was for the support program. She stated that these funds were not enough to sustain a full support program; however, she also stated that Public Health has not requested additional funds. The Legislature mandated that Public Health create and administer the support program, and it provided Public Health with more than \$1 million with which it could have

⁶ The Department of Health Services ceased to exist in 2007, and Public Health was designated the successor for public health responsibilities.

done so. Thus, we expected Public Health to have created the support program and, if unable to do so, to have requested any necessary additional funding.

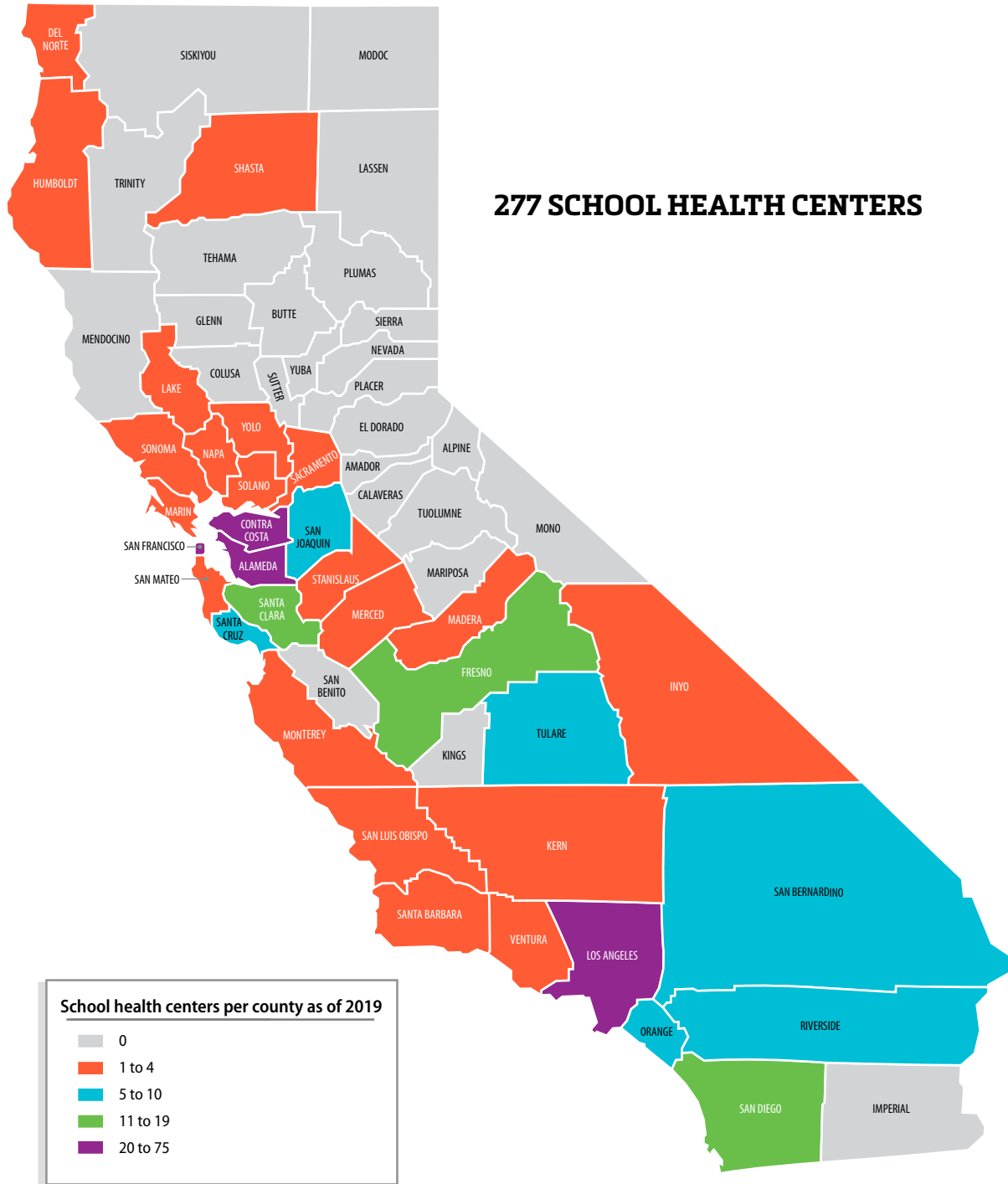
Although Public Health has not met the statutory requirement to create the support program, it has gathered some information that could inform the development of such a program. Specifically, it used portions of the \$1.2 million that the Legislature appropriated to complete two reports in 2018. These reports provide information on how other states fund and staff similar programs, as well as the results of school health center administrator surveys describing school health center needs, services, challenges, and funding sources. In addition, Public Health established a work group that includes representatives of Education and the California School-Based Health Alliance (CSHA).

Public Health's deputy director also stated that it has no formal plans to establish the support program because it has not identified a sustainable funding source. As we previously describe, none of the six LEAs we reviewed—or any of the other 1,034 LEAs reporting staffing information to Education—employed the recommended number of mental health professionals in all four categories during the 2018–19 academic year. Further, according to CSHA, fewer than 280 school health centers had been established across the State as of 2019—as Figure 7 shows—and these school health centers provide access to services for just 4 percent of the total number of students enrolled in kindergarten through grade 12. A robust support program could assist LEAs in creating additional school health centers and leveraging existing MHSA and Medi-Cal funds to improve mental health professional-to-student ratios.

Legislative funding for the grant component established in 2009 could facilitate the creation of school health centers in underserved counties with high rates of suicide and self-harm. For example, Mendocino County—which has a higher-than-average rate of youth suicide—has nine schools that each serve more than 100 high school students. Using Oregon's school health center funding formulas for state assistance, establishing nine school health centers would cost about \$855,000 in planning costs and an additional \$504,000 annually for operating costs. State law requires the support program to provide assistance to LEAs, which may include identifying additional funds, such as federal and local grants, to cover the additional costs and would require grantees receiving funds for operating costs to become Medi-Cal providers.

A robust support program could assist LEAs in creating additional school-based health centers and leveraging existing MHSA and Medi-Cal funds to improve mental health professional-to-student ratios.

Figure 7
As of 2019, Few School Health Centers Existed in the State



Source: California School-Based Health Alliance.

Given the demonstrated benefits that school health centers offer, it is unclear why the State has not done more to ensure their implementation, particularly in its underserved areas. In the absence of adequate mental health professional staffing, the State's rates of suicide and self-harm have continued to climb. Had the support program been established, it would have required grantees to provide or have a plan for providing a variety of services in response to community needs, including mental health services.

Some LEAs Have Not Sought Local and Federal Funding That Could Increase Students' Access to Mental Health Professionals

All of the LEAs we reviewed rely on state funding for the majority of their spending on mental health professionals. However, by seeking federal and local funding, they could increase the number of mental health professionals they employ and thus better ensure that students have adequate access to mental health care. For example, the San Francisco County Department of Public Health uses MHSAs to pay for mental health professionals on San Francisco Unified's campuses. In addition, the State's billing option program—which we describe in the Introduction—allows LEAs to receive federal reimbursement for 50 percent of the costs of certain health-related services. Although some LEAs consider the administration of the billing option program to be overly burdensome, they can partner with their county offices of education to centralize administrative responsibilities. However, Education and Health Care Services—the agency that administers the program for the State—have not adequately ensured that all LEAs are aware of the opportunity to partner with their county offices of education.

Some LEAs Have Not Pursued MHSAs Funding for On-Campus Mental Health Care

According to Education's program consultant, because state law does not mandate specific levels of spending or staffing, LEAs decide how much to spend on mental health services. Not surprisingly, the LEAs we reviewed spent significantly different amounts per student on mental health care, as Table 7 shows. For example, San Francisco Unified's total spending per student on mental health professionals exceeded \$800 per student, whereas Kern High School District spent \$511 per student. The LEAs that spent the most per student on mental health professionals—San Francisco Unified and Ukiah Unified—met more of the staffing ratios Education recommends, as we previously describe.

Given the demonstrated benefits that school health centers offer, it is unclear why the State has not done more to ensure their implementation, particularly in its underserved areas.

Table 7
The Six LEAs' Spending on Mental Health Professionals Differed Substantially During Fiscal Year 2018–19

	SAN FRANCISCO UNIFIED*	UKIAH UNIFIED	KERN HIGH SCHOOL DISTRICT	GATEWAY CHARTER	REDWOODS CHARTER	HEARTLAND CHARTER
Total spending on mental health professionals	\$20,858,000	\$2,371,000	\$20,393,000	\$360,000	\$92,000	\$237,000
Number of students enrolled at middle and high schools	25,320	3,164	39,884	788	297	3,396
Mental health professional spending per student	\$824	\$749	\$511	\$457	\$310	\$70

	SCHOOL DISTRICTS	CHARTER SCHOOLS
Average mental health professional spending per student	\$695	\$279

Source: Analysis of Education's enrollment data, documentation from Gateway Charter and Heartland Charter, and payroll data from Heartland Charter, Kern High School District, Redwoods Charter, San Francisco Unified, and Ukiah Unified.

* San Francisco Unified's mental health spending includes the cost of a contract with RAMS to provide mental health professionals in its school health centers that is paid by the San Francisco Department of Public Health.

Although on average the three school districts we reviewed spent considerably more on mental health professionals per student than the three charter schools—\$695 and \$279, respectively—the charter schools stated that they leveraged resources from other entities to provide some additional mental health services. For example, Gateway Charter administrators indicated that two San Francisco Unified school psychologists work at Gateway Charter two or three days per week and that Gateway Charter does not pay for these positions. Heartland Charter's deputy executive director explained that mental health professionals from the charter school organization to which it belonged at the time provided services to it and other charter schools. Finally, Redwoods Charter's chief financial officer stated that staff refer students with mental health issues to community organizations that provide services at no cost. Because we could not quantify the services that these other entities provided to the charter schools, they are not reflected in our analysis. However, even under a generous interpretation of the additional capacity represented by these other resources, the three charters did not provide sufficient numbers of mental health professionals to meet Education's recommended staffing ratios.

The LEAs that spent the most per student were able to do so in part because they obtained funds from other sources to augment what they spent from their state appropriations. As Table 8 shows, all of the LEAs we reviewed relied on state funding for more than half of their budgets for mental health professionals. Moreover, two of

the charter schools relied on state funding for 100 percent of these expenditures. However, state funds represented only 56 percent of mental health professional expenditures at San Francisco Unified, which came the closest to meeting Education’s staffing ratios. Similarly, Ukiah Unified’s percentage of state spending for mental health professionals represented 74 percent, and it was also the second closest to meeting the recommended staffing ratios.

Table 8
LEAs Relied on State Funds for the Majority of Mental Health Professional Spending in Fiscal Year 2018–19

	SAN FRANCISCO UNIFIED	UKIAH UNIFIED	KERN HIGH SCHOOL DISTRICT	GATEWAY CHARTER*	REDWOODS CHARTER	HEARTLAND CHARTER
Total mental health professional spending†	\$20,858,000	\$2,371,000	\$20,393,000	\$360,000	\$92,000	\$237,000
Percent of mental health professional spending from federal sources	6%	24%	7%	0%	26%	0%
Percent of mental health professional spending from state sources	56	74	93	100	74	100
Percent of mental health professional spending from local sources	38	2	0	0	0	0

Source: Analysis of documentation from Gateway Charter and payroll data from Heartland Charter, Kern High School District, Redwoods Charter, San Francisco Unified, and Ukiah Unified.

* Gateway Charter indicated all of its funding came from state sources; however, because Gateway Charter does not actively track how it uses specific funding sources, we could not confirm the sources of the funds it used for mental health services.

† Mental health costs consist of salary and benefit costs associated with personnel providing services directly to students. We excluded administrative positions.

Although augmenting state funds with funding from other sources appears to be crucial to improving staffing ratios, five of the six LEAs we reviewed were not even aware of one of these other sources of funding—local MHSAs from their respective counties. As the Introduction describes, the State passed the MHSAs in 2004 in part to expand mental health care services for children with a focus on prevention and early intervention services. Nonetheless, only San Francisco Unified used MHSAs to employ mental health professionals. Specifically, the San Francisco Department of Public Health uses some MHSAs funds, in addition to local and federal funds, to pay for the services that RAMS provides to San Francisco Unified. Representatives from the other five LEAs we reviewed indicated that they were unaware of MHSAs funds.

LEAs Have Not Consistently Used the Billing Option Program to Obtain Federal Reimbursement for Providing Mental Health Services

Health Care Services oversees the billing option program, which allows LEAs to seek federal reimbursement for 50 percent of their costs to provide medically necessary health-related services to Medi-Cal-eligible students by qualified medical practitioners. During fiscal year 2017–18, LEAs received nearly \$134 million through the billing option program. In late April 2020, Health Care Services received approval to expand access to Medi-Cal reimbursement through the program. Before 2020, reimbursement for Medi-Cal-eligible students without an individualized education program (IEP) was limited. An IEP is a plan created for those students with a learning disability or health impairment. For example, a student without an IEP was limited to six hours of counseling per fiscal year; however, the program's expansion in 2020 eliminated this restriction. Additionally, CMS made this approval effective July 2015, allowing LEAs to claim reimbursement for services they had already provided. Based on the California Health and Human Services Agency's data, more than 49 percent of the State's population under the age of 20, or more than five million individuals, were eligible for Medi-Cal as of July 2019.

To decrease the administrative burden of the billing option program, LEAs can partner with their county offices of education. According to Health Care Services' Medi-Cal Claims and Services Branch Chief (branch chief), LEAs' participation in the billing option program is voluntary because some do not have the capability to handle the administrative tasks and costs. Ukiah Unified's director of student services echoed this concern, indicating that submitting claims through the billing option program requires LEAs to either hire additional staff or use existing staff who do not have the time or necessary expertise. However, Ukiah Unified has addressed these constraints by partnering with the Mendocino County Office of Education, which performs all of the administrative tasks necessary to obtain reimbursement. According to the Medi-Cal manager at Mendocino County Office of Education, this approach centralizes the administrative responsibilities at the county level and reduces the burden to the LEA of obtaining reimbursement for the services it provides. The billing option program allows LEAs to pool resources, such as sharing practitioners' and administrative staff, to provide services. The Health Care Services branch chief identified an additional advantage of centralizing these administrative responsibilities: it decreases the number of LEAs that must register with Health Care Services as Medi-Cal providers. Of the state's 58 county offices of education, 54 are already registered through Health Care Services as Medi-Cal providers.

The billing option program allows LEAs to pool resources, such as sharing practitioners' and administrative staff, to provide services.

Although the billing option program represents a significant potential source of funds for LEAs, according to Health Care Services data, only 600 of the State's 2,400 LEAs participate in the program, including Kern High School District, San Francisco Unified, and—through the Mendocino County Office of Education—Ukiah Unified. Health Care Services was unable to tell us which LEAs were not participating in the program because, like Ukiah Unified, some LEAs participate through their respective county offices of education. Thus, it is unclear how many of the 1,800 LEAs that are not Medi-Cal providers participate in the billing option program.

Education and Health Care Services could better inform LEAs of the option to partner with their county office of education. By seeking reimbursement for the services they have provided, LEAs could supplement their existing mental health services budgets. State law assigns Health Care Services the responsibility of communicating with LEAs and collaborating with Education to increase LEA participation in the billing option program. Although Health Care Services has conducted some outreach regarding the program's expansion through in-person and online trainings, these efforts were primarily focused on existing participants because Health Care Services does not actively send information about the program to nonparticipating LEAs. According to its branch chief, Health Care Services does not have the staff necessary to conduct additional outreach efforts, and it does not actively track which LEAs do not participate in the program; rather, it relies on Education to forward information on the billing option program to nonparticipating LEAs.

Education's administrator for school health and safety indicated that it has sent some information about the billing option program expansion to all LEAs on behalf of Health Care Services. However, as we describe earlier, it is unclear how many of the 1,800 LEAs across the State that are not Medi-Cal providers take advantage of this program. Further, according to the branch chief for Health Care Services, it has not informed LEAs of the option to leverage county offices of education to handle the administrative tasks associated with the billing option program. Until Health Care Services and Education take a coordinated approach to informing LEAs about this option, some LEAs are less likely to take advantage of these federal funds, which they could use to improve students' access to the mental health care they need.

By seeking reimbursement for the services they have provided, LEAs could supplement their existing mental health services budgets.

Recommendations

Legislature

To increase students' access to mental health services, the Legislature should provide funding for Public Health to award grants for a pilot program that would establish school health centers at a selection of LEAs located in counties with high rates of youth suicide and self-harm. The Legislature should require Public Health to collaborate with Education to collect data on the pilot program and to provide annual reports on the effectiveness and cost of the program. If the school health center program is deemed affordable and effective, the Legislature should consider expanding it to LEAs throughout the State.

Education

To promote the adoption of the best practices that it has identified, Education should remind LEAs of the elements in its model policy. To do so, it should annually send a notice to all LEAs that describes suicide prevention resources, such as the model policy, and encourages their use. Education should also work with external organizations that maintain model policies, including the School Boards Association, to encourage the development of policies that are consistent with state law and best practices by no later than September 2021.

To encourage LEAs to incorporate elements of suicide prevention training that provide teachers and staff with the knowledge necessary to assist students at risk of self-harm and suicide, Education should remind all LEAs of the statutorily required elements for suicide prevention training.

To support the provision of suicide prevention education to students at LEAs operating through distance learning, Education should complete and issue to LEAs the resources and guidance it is developing on how to conduct suicide prevention education remotely.

Health Care Services

To ensure that LEAs take full advantage of federal funds for Medi-Cal-eligible students, Health Care Services should work with Education to inform LEAs that they may partner with their county offices of education to centralize the administrative responsibilities necessary to obtain reimbursement through the billing option program.

Public Health

To support LEAs' efforts to provide mental health services, Public Health should establish the support program for school health centers as state law requires. If Public Health lacks the funding to do so, it should request additional funds as needed. The support program should assist LEAs in establishing school health centers and in identifying and applying for available funding as authorized by law, such as Medi-Cal reimbursement and MHSA funds.

LEAs

To ensure that their teachers and staff have the information necessary to respond consistently, promptly, and appropriately to reduce suicide risk, the six LEAs we reviewed should revise their policies by March 2021 to comply with state law and incorporate the best practices in Education's model policy.

To ensure that their teachers and staff have the knowledge necessary to identify and assist students at risk of self-harm and suicide, the six LEAs we reviewed should do the following:

- Revise their suicide prevention training materials by June 2021 to align with state law and incorporate the best practices in Education's model policy.
- LEAs that provide suicide prevention training should conduct it at the beginning of the school year.

To improve their students' access to mental health professionals, Kern High School District, Ukiah Unified, Gateway Charter, Redwoods Charter, and Heartland Charter should coordinate with their respective counties to request MHSA funding to employ additional school counselors, school nurses, school social workers, and school psychologists.

We conducted this performance audit in accordance with generally accepted government auditing standards and under the authority vested in the California State Auditor by Government Code 8543 et seq. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on the audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Respectfully submitted,



ELAINE M. HOWLE, CPA
California State Auditor

September 29, 2020

Appendix A

Scope and Methodology

The Joint Legislative Audit Committee (Audit Committee) directed the California State Auditor to perform an audit of selected LEAs’ and charter schools’ youth suicide prevention efforts as well as several other related objectives. Table A lists the audit objectives and the methods we used to address them.

Table A
Audit Objectives and the Methods Used to Address Them

AUDIT OBJECTIVE	METHOD
<p>1 Review and evaluate the laws, rules, and regulations significant to the audit objectives.</p>	<p>Reviewed relevant laws, regulations, policies, procedures, and other related background material.</p>
<p>2 Provide and analyze statistical information related to suicide and self-inflicted injuries of youth ages 12 to 19 in California during the past 10 years. To the extent possible, summarize this information by county.</p>	<ul style="list-style-type: none"> • Analyzed Public Health and Office of Statewide Health Planning and Development data to calculate the suicide and self-harm rates by county from 2009 through 2018 for youth ages 12 to 19. We calculated the incidents per 100,000 youth ages 10 to 19, per year using population data from the U.S. Census Bureau. • Analyzed Public Health and Office of Statewide Health Planning and Development data and calculated the number of individuals ages 12 to 19 that hospitals admitted for instances of self-harm from 2009 through 2018. Self-harm incidents we identified before October 2015 may not be comparable with those identified in or after October 2015. Beginning in October 2015, health care organizations shifted from reporting medical information under the International Classification of Diseases (ICD) Ninth Revision, to the ICD Tenth Revision which allows for more specificity. For this reason, Public Health advises against comparing incidents reported before October 2015 with incidents reported after that date. However, Public Health also acknowledged that an instance classified as self-harm in the ICD Ninth Revision would also generally be classified as self-harm under the Tenth Revision. In our presentation of the total number of self-harm instances, we chose not to distinguish between the Ninth and Tenth Revisions.
<p>3 Identify and analyze the roles of state-level entities, including Public Health, in overall suicide prevention and as it relates to LEAs and charter schools.</p>	<ul style="list-style-type: none"> • Interviewed staff and reviewed relevant materials from Education, Health Care Services, the Oversight Commission, and Public Health to determine their roles in the oversight of youth suicide prevention. • Reviewed Education’s model suicide prevention policy and determined that it is in compliance with state law.
<p>4 Interview relevant stakeholders and subject matter experts to identify best practices to prevent suicides—including for students in categories with high suicide rates—that may be appropriate for LEAs or charter schools to implement.</p>	<ul style="list-style-type: none"> • Interviewed staff from the Trevor Project, the American Foundation for Suicide Prevention, and the California Coalition for Youth and reviewed related resources regarding best practices for suicide prevention programs. • Reviewed the efforts of a selection of other states that have enacted laws and programs related to youth suicide prevention in schools. • Interviewed staff at the Assembly Select Committee on Youth Mental Health to obtain its perspective on youth suicide prevention. • Interviewed staff at a selection of local mental health agencies that partner with LEAs to provide mental health services. • Examined academic and nonprofit research to determine what factors reduce the incidence of youth suicide. • Reviewed selected provisions of Education’s model policy to verify that they reflect best practices.

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AUDIT OBJECTIVE	METHOD
<p>5 For a selection of five LEAs and charter schools, perform the following related to their suicide prevention efforts:</p>	<p>Based on suicide and self-harm rates, we selected Kern, Mendocino, and San Francisco counties for review. We then selected the largest LEA within each of these counties: Kern High School District in Kern County, Ukiah Unified in Mendocino County, and San Francisco Unified in San Francisco County. Additionally, we selected one charter school from each county: Heartland Charter in Kern County, Redwoods Charter in Mendocino County, and Gateway Charter in San Francisco County.</p>
<p>a. Identify the extent to which each LEA and charter school tracks student suicides and attempted suicides.</p>	<ul style="list-style-type: none"> • Interviewed staff at each LEA to determine whether it tracked suicide or self-harm data. None of the school districts or charter schools we selected track aggregate suicide or self-harm data. • To the extent available, reviewed LEAs' counseling records to determine the percentage of the student population that received mental health services over the last three academic years. However, the LEAs did not consistently track or record data. As a result, it was not possible to calculate comparable rates of mental health service use.
<p>b. Determine whether the LEA and charter school have a pupil suicide prevention policy and whether that policy complies with relevant criteria.</p>	<ul style="list-style-type: none"> • Analyzed selected LEAs' suicide prevention policies and procedures to determine compliance with state law and Education's model policy. • Interviewed staff at Education and the School Boards Association to discuss the development and adoption of published suicide prevention model policies.
<p>c. Assess the process used to develop each LEA and charter school's pupil suicide prevention policy, and determine whether it ensured that the policy was developed in conjunction with appropriate stakeholders and experts.</p>	<p>Interviewed staff and reviewed policy development meeting notes from the selected school districts and charter schools to assess whether they developed suicide prevention policies and procedures in conjunction with the types of stakeholders and community organizations identified in state law and Education's model policy.</p>
<p>d. Analyze any suicide prevention training provided by the LEA and charter school, and perform the following:</p>	
<p>i. Identify who receives this training.</p>	<ul style="list-style-type: none"> • Reviewed training policies and procedures to determine whether the LEAs conduct suicide prevention training and which staff receive the training. • Reviewed and analyzed training records from charter schools and one campus at each school district to determine whether teachers and staff received suicide prevention training during the 2019–20 academic year.
<p>ii. Identify how often and how the training is provided.</p>	<p>Interviewed staff and reviewed training policies, procedures, and materials to determine how and how often the selected school districts and charter schools conduct the training.</p>
<p>iii. Analyze the extent to which training includes how to identify appropriate mental health services within the school and community, and when and how to refer those services.</p>	<p>Analyzed training materials to determine whether they include the mental health services available at the school and in the community, and when and how to refer students to those services.</p>
<p>iv. Identify the content of the training, including any content related to LGBTQ and other students in categories with elevated risk.</p>	<p>Reviewed training materials to assess whether they included content related to students in categories with an elevated risk of suicide.</p>
<p>e. Assess each LEA and charter school's preparedness for responding to and assisting students after incidents of student suicide and attempted suicide.</p>	<p>Assessed whether the policies include crisis intervention plans and response plans, as well as whether those plans incorporate best practices such as student reentry protocols after a suicide attempt.</p>

AUDIT OBJECTIVE	METHOD
<p>f. Identify and assess efforts by the LEA and charter school to help students, including but not limited to the provision of mental health services and access to hotlines, materials, and other resources.</p>	<ul style="list-style-type: none"> Identified employed and contracted mental health professional positions at the selected LEAs and analyzed documents and data to determine mental health professional staffing levels at middle and high schools and their related cost for fiscal year 2018–19. Further, we identified the state, federal, and local revenue sources that LEAs used to fund those positions. Identified enrollment of students at middle and high schools at each of the selected LEAs, calculated ratios of mental health professionals to students for fiscal year 2018–19, and compared these ratios to the ratios that Education recommended. Additionally, we calculated the average cost of mental health professionals per student for fiscal year 2018–19. Obtained suicide prevention-related posters, handouts, and presentations to determine if LEAs performed outreach, and reviewed student IDs at each LEA to ensure that they included a suicide hotline phone number in compliance with state law. Five of the six LEAs included the required information on student IDs; the sixth, Redwoods Charter, did not but stated it will do so beginning in the 2020–21 academic year.
<p>g. Determine the extent to which the LEA and charter school's practices align with best practices identified in Objective 4.</p>	<ul style="list-style-type: none"> Reviewed the compliance of the selected LEAs' suicide prevention policies identified in Objective 5b with elements of Education's model policy representing best practices.
<p>6 Identify best practices used at the selected LEAs that could be implemented by charter schools and best practices used at selected charter schools that could be implemented by LEAs, and areas where charter schools and LEAs would benefit from coordinating their efforts.</p>	<ul style="list-style-type: none"> Interviewed staff at each charter school to determine the level of coordination of suicide prevention and mental health services between the charter school and its authorizing LEA. Reviewed school district and charter school suicide prevention policies and procedures to identify best practices.
<p>7 Review and assess any other issues that are significant to the audit.</p>	<ul style="list-style-type: none"> Interviewed LEA staff and analyzed funding sources for mental health professional spending to determine whether the selected LEAs use MHSA funds to pay for mental health providers. Interviewed staff at Health Care Services to determine how LEAs become Medi-Cal providers. We obtained and reviewed documents describing CMS approval of billing option program changes and when the changes took effect. Analyzed state law to identify the entities eligible to participate in the billing option program and determined the total number of eligible LEAs. We obtained Health Care Services billing option program provider data to determine the number of LEAs that participated in the program as Medi-Cal providers. We interviewed the selected LEAs to determine whether they were aware of, or participating in, the billing option program. Interviewed staff at Education and Health Care Services to determine how both agencies provide information about the program and its benefits to participating and nonparticipating LEAs. We obtained and reviewed Health Care Services' email list to identify the number of LEAs and organizations to which it was providing billing option program information as of July 2020. Interviewed staff at the Mendocino County Office of Education and Ukiah Unified regarding their method of consolidating billing option program administrative responsibilities at the county office of education. We reviewed the memorandum of understanding between the parties to identify their responsibilities under the partnership. Additionally, we reviewed the Mendocino County Office of Education Medi-Cal provider enrollment form to identify the LEAs participating in the billing option program through the county office of education during fiscal year 2019–20. Interviewed staff at Alameda and Fresno counties, which the Mental Health Services Oversight and Accountability Commission identified as examples of counties collaborating with LEAs to provide students with mental health services, to determine how they used MHSA funds. Fresno uses some MHSA funds to increase the number of mental health providers on school campuses, while Alameda uses MHSA funds to promote the services it provides at its school-based health centers.

Source: Audit Committee's audit request number 2019-125, planning documents, and information and documentation identified in the table column titled Method.

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Appendix B

Methods Used to Assess Data Reliability

In performing this audit, we relied on electronic data files that we obtained from multiple state and local agencies. The U.S. Government Accountability Office, whose standards we are statutorily obligated to follow, requires us to assess the sufficiency and appropriateness of computer-processed information we use to support our findings, conclusions, or recommendations. Table B describes the analyses we conducted using data from the information systems we used, our methods for testing them, and the results of our assessments.

Table B
Assessment of Data Reliability

DATA SOURCE	PURPOSE	METHOD AND RESULT	CONCLUSION
Education California Longitudinal Pupil Achievement Data System (CALPADS) and DataQuest, which is populated from CALPADS.	To determine the reported number of enrolled students and staff at each LEA, and to determine LEA middle and high school enrollment by grade.	Performed dataset verification procedures, electronic testing of key data elements, and reviewed existing information, and did not identify any significant issues.	Sufficiently reliable for the purposes of this audit. However, we did not evaluate the accuracy of the LEA-reported information.
Public Health Vital Death Data	To determine the number of incidences of youth (ages 12–19) suicide by county.	Performed dataset verification procedures, electronic testing of key data elements, and reviewed existing information, and did not identify any significant issues.	Sufficiently reliable for the purposes of this audit.
Office of Statewide Health Planning and Development Hospital Encounter Data	To determine the number of instances of youth (ages 12–19) self-harm by county.	Performed dataset verification procedures, electronic testing of key data elements, and reviewed existing information, and did not identify any significant issues.	Sufficiently reliable for the purposes of this audit.
Payroll and staffing data for: San Francisco Unified Kern High School District Heartland Charter Ukiah Unified Redwoods Charter	To determine mental health professional staffing levels, their associated costs, and the source of funding.	We performed dataset verification procedures, electronic testing of key data elements, and reviewed existing information. In addition, we shared the results of our analysis with each LEA, and obtained their confirmation of the results. However, we did not perform accuracy or completeness testing because the supporting documentation is maintained at various facilities across the state and COVID-19 made travel to these sites to conduct such testing impractical.	We concluded that the data are of undetermined reliability. Although we recognize that this limitation may affect the precision of the numbers we present, there is sufficient evidence in total to support our audit findings, conclusions, and recommendations.

DATA SOURCE	PURPOSE	METHOD AND RESULT	CONCLUSION
California Health and Human Services Agency Open Data Portal	To determine the number of individuals enrolled in Medi-Cal by age 20 as of July 2019	We performed electronic testing of key data elements and reviewed existing information. We did not identify any issues.	Because these data are used primarily for background or contextual information and do not materially affect findings, conclusions, or recommendations, we determined that a data reliability assessment was not necessary.
Department of Finance Demographic Research Unit Population Projections	To determine the State's population through age 20 as of July 2019.	We performed electronic testing of key data elements. We did not identify any issues.	Because these data are used primarily for background or contextual information and do not materially affect findings, conclusions, or recommendations, we determined that a data reliability assessment was not necessary.
Health Care Service's Billing Option Program Billing Option Program LEA Master List	To determine the total number of LEAs participating in the LEA billing option program.	We performed dataset verification procedures and electronic testing of key data elements. We did not identify any issues.	Because these data are used primarily for background or contextual information that do not materially affect findings, conclusions, or recommendations, we determined that a data reliability assessment was not necessary.
Health Care Services LEA billing option program email listserv	To determine the total number of LEAs and organizations on Health Care Services billing option program mailing list.	We performed dataset verification procedures and electronic testing of key data elements. We did not identify any issues.	Because the data are used primarily for background or contextual information that do not materially affect findings, conclusions, or recommendations, we determined that a data reliability assessment was not necessary.

Source: Analysis of documents, interviews, and data from Education, Public Health, the Office of Statewide Health Planning and Development, Health Care Services, Department of Finance, California Health and Human Services Agency, and selected LEAs.



**CALIFORNIA DEPARTMENT
OF EDUCATION**

TONY THURMOND
STATE SUPERINTENDENT OF
PUBLIC INSTRUCTION

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September 3, 2020

Elaine M. Howle, State Auditor
California State Auditor
621 Capitol Mall, Suite 1200
Sacramento, CA 95814

Subject: *Youth Suicide Prevention: Local Educational Agencies Lack the Resources and Policies Necessary to Effectively Address Rising Rates of Youth Suicide and Self-Harm*, Report Number 2019-125, September 2020

Dear Ms. Howle:

The California Department of Education (Education) appreciates the opportunity to provide comments and address the recommendations outlined in the California State Auditor's (CSA) Audit Report titled, *Youth Suicide Prevention: Local Educational Agencies Lack the Resources and Policies Necessary to Effectively Address Rising Rates of Youth Suicide and Self-Harm*, which offered helpful insight into how six of California's Local Educational Agencies (LEAs) are addressing youth suicide prevention.

The State Superintendent of Public Instruction (SSPI), Tony Thurmond, is deeply committed to addressing students' mental health wellness and needs, including leading the charge to provide mental health services to kids to help combat the pressures of bullying, the impact of trauma, and other barriers to success. The SSPI's dedication to student and staff wellness is stronger than ever as we continue to face emotional challenges that stem from COVID-19 and ongoing struggles for racial justice. The SSPI's call to action to assist students with mental health support is documented in Education's News Release at <http://www.cde.ca.gov/nr/ne/yr20/yr20rel43.asp>, where several links to Education's resources for educators, families, and students are provided.

To further assist LEAs and school communities in appropriately addressing the complex issues of student wellness and mental health needs, Education has developed and implemented programs, supports, and resources, which can be accessed at <https://www.cde.ca.gov/ls/cq/mh/mhresources.asp> and <https://www.cde.ca.gov/ci/se/index.asp>.

Education plans to implement the CSA's recommendations as described below.

Ms. Elaine M. Howle, State Auditor
September 3, 2020
Page 2

Recommendation 1

To promote the adoption of the best practices that it has identified, Education should remind LEAs of the elements in its model policy. To do so, it should annually send a notice to all LEAs that describes suicide prevention resources, such as the model policy, and encourages their use.

Education should also work with external organizations that maintain model policies, including the School Boards Association, to encourage the development of policies that are consistent with state law and best practices by no later than September 2021.

Education's Comments

Concur. Currently, Education encourages the use of the model suicide prevention policy by making it available on its web page, [Youth Suicide Prevention](#). To further this effort, Education will send a letter annually and use other communication channels to remind LEAs of their responsibility to adopt, implement, and review their policies, along with resources, best practices, activities, programs, and trainings related to suicide prevention.

In addition, Education will collaborate with the California School Boards Association and other organizations in an effort to align policies and request the inclusion of the same elements as Education's model suicide prevention policy by September 2021.

Recommendation 2

To encourage LEAs to incorporate elements of suicide prevention training that provide teachers and staff with the knowledge necessary to assist students at risk of self-harm and suicide, Education should remind all LEAs of the statutorily required elements for suicide prevention training.

Education's Comments

Concur. Education will include information in the annual reminder letter sent to all LEAs regarding the statutorily required elements for suicide prevention training as required by *EC* Section 215.

Recommendation 3

To support the provision of suicide prevention education to students while LEAs operate through distance learning, Education should complete and issue to LEAs the resources and guidance it is developing on how to conduct suicide prevention education remotely.

Ms. Elaine M. Howle, State Auditor
September 3, 2020
Page 3

Education's Comments

Concur. Education is in the process of developing guidance and resources for LEAs to use as part of their suicide prevention virtual programming; dissemination is anticipated to occur by October 2020. In addition, Education will collaborate with external partners to identify programs that can be delivered virtually to LEAs.

If you have any questions regarding the Education's comments and/or corrective actions, please contact Kimberly Tarvin, Director, Audits and Investigations Division, by phone at 916-323-1547 or by email at ktarvin@cde.ca.gov.

Sincerely,



Stephanie Gregson, Ed.D.
Chief Deputy Superintendent of Public Instruction

SG:kl

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SANDRA SHEWRY, MPH, MSW
Acting Director

State of California—Health and Human Services Agency
California Department of Public Health



GAVIN NEWSOM
Governor

September 3, 2020

Elaine Howle
California State Auditor
1621 Capitol Mall, Suite 1200
Sacramento, CA 95814

Dear Ms. Howle:

The California Department of Public Health (CDPH) has reviewed the California State Auditor's draft audit report titled "Youth Suicide Prevention: Local Educational Agencies Lack the Resources and Policies Necessary to Effectively Address Rising Rates of Youth Suicide and Self-Harm." CDPH appreciates the opportunity to respond to the report and provide our assessment of the recommendation contained therein.

Below we reiterate the audit finding pertaining to CDPH and our response to the auditor's specific recommendation.

Finding 1: "Public Health Has Not Established a School Health Center Support Program Required by Law"

Recommendation to CDPH:

To support LEAs' efforts to provide mental health services, CDPH should establish the support program for school health centers as state law requires. If CDPH lacks the funding to do so, it should request additional funds as needed. The support program should assist LEAs in establishing school health centers and in identifying and applying for available funding as authorized by law, such as Medi-Cal reimbursement and MHSAs funds.

Management Response:

CDPH will evaluate the resources necessary to establish and implement the Public School Health Center Support Program (PSHCSP) as written in the Health and Safety Code §124174-124174.6.

CDPH works continuously to reduce physical and mental health disparities among vulnerable and underserved communities to achieve health equity throughout California.

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Internet Address: www.cdph.ca.gov



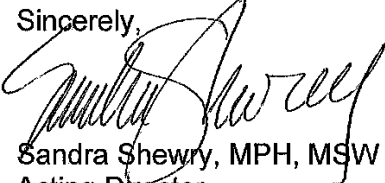
* California State Auditor's comment appears on page 57.

Elaine Howle
September 3, 2020
Page 2

As a part of this work, CDPH will continue its collaboration and active partnership with the California School-based Health Alliance and their member school-based health centers to improve understanding of the needs of, and to share resources with, school-based health centers.

We appreciate the opportunity to respond to the audit. If you have any questions, please contact Monica Vazquez, Chief, Office of Compliance, at (916) 306-2251.

Sincerely,



Sandra Shewry, MPH, MSW
Acting Director

Comment

CALIFORNIA STATE AUDITOR'S COMMENT ON THE RESPONSE FROM PUBLIC HEALTH

To provide clarity and perspective, we are commenting on the response to our audit report from Public Health. The number below correspond to the number we placed in the margin of Public Health's response.

Although state law requires it to do so, Public Health does not commit to establishing the support program. After evaluating the resources necessary to do so, Public Health should establish the support program in accordance with the requirements in state law described on page 34, or request the funds necessary to do so.

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State of California—Health and Human Services Agency
Department of Health Care Services



GAVIN NEWSOM
GOVERNOR

September 2, 2020

Elaine M. Howle*
California State Auditor
621 Capitol Mall, Suite 1200
Sacramento, CA 95814

DRAFT REPORT RESPONSE

Dear Ms. Howle:

The California Department of Health Care Services (DHCS) is submitting the enclosed response to the California State Auditor's (CSA) draft report titled, "Youth Suicide Prevention: Local Educational Agencies Lack the Resources and Policies Necessary to Effectively Address Rising Rates of Youth Suicide and Self-Harm." CSA issued one recommendation for DHCS.

DHCS agrees with the recommendation and has prepared a corrective action plan to implement. After reviewing, DHCS has also noted four areas of the report containing incorrect or misleading information:

1. The draft report page 64 states "Health Care Services oversees the billing option program which allows [Local Educational Agencies (LEA)] to seek federal reimbursement for 50% of their costs to provide **medically necessary** health related services performed by **qualified medical practitioners.**"
 - a. The bolded language must be added to the sentence as the term medically necessary is nowhere mentioned in the report but is a requirement of the program as is the requirement only certain specified practitioners may perform each medically necessary service. Requirements must be met in order to receive federal funding. ①
 2. The draft report page 65 states "The health care services branch chief identified an additional advantage of centralizing these administrative responsibilities: it decreases the number of LEAs that must register with Health Care Services as Medi-Cal Providers."
 - a. The language is incorrect because all Medi-Cal providers must be registered providers. Under Welfare and Institutions Code section 14132.06 the LEAs ②
- ③

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* California State Auditor's comments begin on page 61.

Ms. Howle
Page 2
September 2, 2020

- “shall be considered the provider of services.” As providers of services, LEAs who voluntarily agree to participate in the LEA Billing Option Program (BOP) must submit a Provider Participation Agreement, a Data Use Agreement, and an annual report to DHCS.
- ④ b. In addition, the correct title is “Medi-Cal Claims and Services Branch Chief” rather than “health care services branch chief.”
3. The draft report page 66 states “Health Care Services does not actively send information about the program to nonparticipating LEAs.”
- ⑤ a. The statement is incorrect. DHCS works closely with school associations to provide information regarding the LEA BOP to nonparticipating LEAs. In addition, the LEA BOP website is an information source concerning all aspects of the program to any LEA interested in participating in the voluntary program.
4. The draft report page 66 states “Further, according to the branch chief of health care services, it has not informed LEAs of the option to leverage county offices of education to handle the administrative tasks associated with the billing option program.”
- ⑥ a. The statement is incorrect. DHCS regularly informs LEAs on the stated option; however, DHCS does not have any formal written guidance in the area.
- ④ b. In addition, the correct title is “Medi-Cal Claims and Services Branch Chief” rather than “health care services branch chief.”

If you need additional information about the above comments, please contact Brian Fitzgerald, Chief, Local Governmental Financing Division, at (916) 345-8690 or via email at Brian.Fitzgerald@dhcs.ca.gov.

DHCS appreciates the work performed by CSA and the opportunity to respond to the draft report. If you have any other questions, please contact Internal Audits at (916) 445-0759.

Sincerely,



Will Lightbourne
Director

Enclosure

cc: See Next Page

Comments

CALIFORNIA STATE AUDITOR'S COMMENTS ON THE RESPONSE FROM HEALTH CARE SERVICES

To provide clarity and perspective, we are commenting on the response to our audit report from Health Care Services. The numbers below correspond to the numbers we placed in the margin of Health Care Services' response.

During the publication process for the audit report, page numbers shifted. Therefore, the page numbers cited by Health Care Services in its response do not correspond to the page numbers in the final published audit report.

At Health Care Services' suggestion, we have revised the sentence on page 40. To clarify that elective health services are not covered through this program; we have replaced the phrase certain health related services—which is the term Health Care Services uses in its published materials for this program—with medically necessary health related services, and added the term qualified medical practitioners.

Health Care Services has misconstrued the nature of its branch chief's statement. As we describe on page 40, LEAs can partner with their respective county offices of education to centralize responsibilities and reduce the administrative burden of obtaining reimbursement for the services the LEA provides. For example, Ukiah Unified partners with the Mendocino County Office of Education. The Mendocino County Office of Education is listed in Health Care Services' list of Medi-Cal providers participating in the billing option program, but Ukiah Unified is not and does not need to be. As Health Care Services LEA Onboarding Handbook describes, multiple LEAs can pool their resources and bill Medi-Cal under one provider identifier number. Thus, the number of LEAs registered with Health Care Services is lower than it would be if those entities were registered as individual Medi-Cal providers.

To simplify the report text for readers, we abbreviated the title of "Medi-Cal Claims and Services Branch Chief" to "branch chief."

Health Care Services' statement does not align with the information it provided during the course of the audit. We repeatedly requested information and documentation from Health Care Services regarding its billing option program outreach. Because it was unable to provide evidence that it had provided information to nonparticipating LEAs, we spoke with the branch chief who informed us that Health Care Services delegates such outreach to Education, as we describe on page 41. Further, we do not dispute

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that the billing option program website may be a useful resource; however, our statement in the report addresses sending information to nonparticipating LEAs. Without informing the LEAs of the program's existence, it is unclear how they would learn of the website that Health Care Services describes.

- ⑥ Health Care Services' statement does not align with the information it provided during the course of the audit. We requested information and documentation from Health Care Services regarding its efforts to inform LEAs of the option to leverage county offices of education to handle the administrative tasks associated with the billing option program. Because it was unable to provide evidence that it had provided this information to nonparticipating LEAs, we spoke with the branch chief who confirmed that Health Care Services did not inform LEAs about the option to partner with county offices of education to handle the administrative tasks associated with the program, as we describe on page 41.



September 3, 2020

Elaine M. Howle, CPA
California State Auditor

Dear Ms. Howle:*

On behalf of Gateway Public Schools, I want to thank you for the opportunity to respond to the draft report titled “*Local Educational Agencies lack the Resources and Policies Necessary to Effectively Address Rising Rates of Youth Suicide and Self-Harm*”, which details the results of audit that you conducted with our organization.

The goal of our response is to address the items that you identified as being insufficient at our organization related to suicide prevention. Some of these items represent welcome opportunities for continued improvement on this important topic. We believe other areas of identified deficiencies do not fully reflect the policies and activities that we do pursue each year to support our students. Below are the items from the tables in the report that we are responding to.

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Table 1 - The LEA Suicide Prevention Policies We Reviewed Lacked Crucial Elements

Requirement or Best Practice	Gateway Charter - Response
Addresses needs of at-risk groups, such as LGBTQ youth and youth in foster care	Gateway provides a broad support system for at-risk youth and is committed to ensuring that all future suicide prevention trainings emphasize high risk groups, including LGBTQ youth and youth in foster care.
Constructed in consultation with community stakeholders	Gateway’s suicide prevention policy was initially developed in collaboration between administrators and school site counselors across schools. Moving forward, Gateway will ensure that additional stakeholders, particularly students, families, and other community members, are involved in updating the policy.

* California State Auditor’s comments begin on page 67.



Table 2 - In Academic Year 2019-20 None of the LEA's Trainings We Reviewed Included ALL of the Elements Identified in State Law and Education's Best Practices

State law requires trainings to:	Gateway Charter - Response
② Identify community-based mental health services and when and how to refer them	Gateway mental health counselors have provided referrals to many outside agencies and have partnered closely with several community-based organizations in providing support for our students. And teachers know to work through our counselors for these referrals. Moving forward, we will also ensure that all faculty will be trained in when and how to refer students to community-based mental health services. However, the referral process has been happening successfully.
Education recommends trainings to:	Gateway Charter - Response
Discuss high risk groups	Gateway is committed to ensuring that all future trainings emphasize high risk groups, including LGBTQ youth and youth in foster care.
Discuss all three elements of suicide identification - risk factors, warning factors, and protective factors	Future suicide prevention training will include all three elements of suicide identification, including a review of risk factors, warning factors, and protective factors.
③ Discuss trends identified in data on self-harm incidents and suicides within the LEA's region	Gateway will continue to use data trends to guide suicide prevention policies and trainings. We will ensure that data from our local region continues to be included in this practice.



Table 4 - Only four LEA's Provided Suicide Prevention Training to Both Teachers and Other Staff During School Year 2019-2020.

Requirement or Best Practice	Gateway Charter - Response
Provided suicide prevention training to other staff	Gateway will ensure that all staff, including coaches, security guards, and secretaries, are required to attend suicide prevention training moving forward.

Thank you again for the opportunity to respond to your draft report. We remain available for additional questions and we are confident that this audit process will only strengthen our organization's ongoing efforts in suicide prevention.

Sincerely

Sharon Olken
Executive Director
Gateway Public Schools

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Comments

CALIFORNIA STATE AUDITOR'S COMMENTS ON THE RESPONSE FROM GATEWAY CHARTER

To provide clarity and perspective, we are commenting on the response to our audit report from Gateway Charter. The numbers below correspond to the numbers we placed in the margin of Gateway Charter's response.

We stand by our audit conclusions. Our review of Gateway Charter's suicide prevention policies and training found that they failed to fully address statutory requirements and did not include all of the best practices that Education recommends, which we discuss on pages 17 through 25.

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Gateway Charter does not have a method to ensure that teachers are aware of the process it describes. Although some of its staff may be aware of the community-based mental health services available and how to refer students to them, this element was not included in the suicide prevention training Gateway Charter conducted, as indicated in Table 2 on page 22. Further, Gateway Charter did not provide the training to all teachers and staff during academic year 2019–20. Thus, as we discuss on page 24, some Gateway Charter personnel may not be aware of the relevant resources or properly equipped to identify and respond to a student in crisis.

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Gateway Charter's statement is misleading. As Table 2 on page 22 indicates, we found that Gateway Charter's suicide prevention training did not discuss trends identified in data on self-harm incidents and suicides within its region. Therefore Gateway Charter should alter its training to include this information.

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Heartland Charter School

September 3, 2020

Via electronic mail and USPS

California State Auditor

Elaine M. Howle, CPA

621 Capital Mall, Suite 1200

Sacramento, CA 95814

Dear Ms. Howle:

I write in response to the California State Auditor's draft report entitled Youth Suicide Prevention received by Heartland Charter School on August 28, 2020. First, I would like to thank you and your staff for conducting this audit and for the insight provided to Heartland as a result of your review of our school's suicide prevention plan. We desire to serve and protect our students' emotional well-being and do all we can to prevent this heartbreaking problem of youth suicide within California.

Heartland recognizes the areas of improvement needed in its school suicide prevention as identified in the report. While the audit covered our first year of operation when we were under a charter management organization that served us in this area, we are now independent and have certainly grown in this. We do plan to take the following necessary steps to further align our practices with the administrative requirements of the California Education Code and will be prepared to implement any future changes in state law.

In response to the recommendations in the report, Heartland will make the following changes:

- Incorporate our local partners including our public health department and California Medical Assistance Program (Medi-Cal) to support our efforts and serve students utilizing all that is available to them.
- We will organize a postvention response team
- Heartland has since created a suicide prevention tool kit and improved training for our staff which identifies trends within our region.
- Currently the report states we were understaffed in school nurses, counselors, and social workers. Last year these positions were employed by the charter management organization while serving our school. This year, as an independent school, we employ these positions directly. We also utilize outsourcing with contracted NPAs when needed to ensure we are meeting the needs of students. And it is with great joy that we have learned that Heartland qualifies for MHSA to employ more mental healthcare professionals.

Heartland is committed to improve the safety of our students and meet the suicide prevention safeguards required by state law.

Sincerely,

Courtney McCorkle

Executive Director

Heartland Charter School



KERN HIGH SCHOOL DISTRICT

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Brenda Lewis Ed.D.
Associate Superintendent, Instruction

To: Elaine Howle, California State Auditor*
From: Dr. Brenda Lewis, Associate Superintendent of Instruction
RE: California State Suicide Prevention Audit
Date: September 4, 2020

The Kern High School District is in receipt of the August 28, 2020 draft findings report prepared by the California State Auditor's Office related to its audit of the suicide prevention efforts of local educational agencies in California. Having reviewed the draft report, the District offers the following response:

The Kern High School District is a dedicated grade 9 – 12 high school District located in Kern County, California. The District educates over 40,000 students each day at its 18 comprehensive high school campuses, 5 continuation schools, and numerous satellite programs. The District has a deep and ongoing commitment to the health and well-being of its students and allocates significant resources annually toward aiding students in all aspects of academic achievement, social and emotional development, addressing mental health and substance abuse issues, and overall emotional support, while creating a safe and open learning environment where students feel empowered to succeed, positively contribute to school climate, and express themselves as they grow. The District employs 123 Counselors, 46 full-time and 17 part-time School Community Specialists, 24 School Social Workers, 26 School Psychologists, 21 Licensed Behavior Specialists, 23 Interventionists, 20 School Mental Health Clinicians, 8 Substance Abuse Specialists, and 2 Outreach Specialists for a total of 310 individuals dedicated to addressing all aspects of student mental and emotional health and academics. The District's budget for these support professionals is approximately \$35 million which constitutes approximately 7.7% of the overall budget. The District is very proud of its work to support all students, including our students suffering with mental health concerns.

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It is important to note that while the KHSD developed its Suicide Prevention Guidelines, numerous specialists were engaged as the KHSD Suicide Prevention Guidelines Committee

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The Kern High School District (KHSD) is committed to ensuring equal, fair, and meaningful access to employment and education services. KHSD prohibits discrimination, harassment (including sexual harassment), intimidation, or bullying in any employment practice, education program, or educational activity on the basis and/or association with a person or group with one or more of these actual or perceived characteristics of age, ancestry, color, ethnic group identification, gender, gender identity or expression, genetic information, immigration status, marital status, medical information, national origin, physical or mental disability, parental status, political affiliation, pregnancy and related conditions, race, religion, retaliation, sex, sexual orientation, Military Veterans status, homelessness, foster status, or any other basis prohibited by California state and federal nondiscrimination laws consistent with Education Code 200 and 220, Government Code 11135, and Title IX.

If you believe you have been subjected to discrimination, harassment (including sexual harassment), intimidation, or bullying you should contact your school site principal and/or the District's Chief Equity Compliance and Title IX Officer, Dr. Dean McGee, 5801 Sundale Avenue, (661) 827-3149, dmcgee@kernhigh.org. A copy of KHSD's Uniform Complaint policy and Nondiscrimination policy are available at www.kernhigh.org and upon request.

* California State Auditor's comments begin on page 73.

completed research as it prepared the final guideline document. As noted above, the District employs considerable staff in areas of student mental health and utilized its in-house professionals. The KHSD took this process seriously and involved mental health experts, school psychologists, social workers, counselors, intervention counselors, district directors, the Chief of the Kern High School District Police Department, as well as school site administrators on the Committee.

- ③ The District's original staff training developed by the KHSD Suicide Prevention Committee, "Suicide Prevention – Kern High School District," met all legal standards for suicide prevention training as was noted by the auditors and included the relevant current trend data and local community resources. Staff training was transitioned to an online outside vendor, however, and that training did not include the data and local resources but did comply with all other required training components. The KHSD has supplemented the online training to ensure that all staff are provided the trends data and community resources and are appropriately trained in compliance with the law.
- ④ Lastly, District policies have been updated to clarify that the District's response to an attempted suicide is the same whether the attempt takes place at school, or outside of school.
- ④ The District agrees with the three findings and recommendations and has already corrected the issues identified, if possible, as noted above.

The District appreciates the work performed by the CSA and the opportunity to respond to the findings.

Regards,



Dr. Brenda Lewis
Associate Superintendent of Instruction
Kern High School District

Comments

CALIFORNIA STATE AUDITOR'S COMMENTS ON THE RESPONSE FROM KERN HIGH SCHOOL DISTRICT

To provide clarity and perspective, we are commenting on the response to our audit report from Kern High School District. The numbers below correspond to the numbers we placed in the margin of Kern High School District's response.

Although Kern High School District employs a large number of mental health professionals, it failed to employ the recommended number in every category, as Table 6 on page 31 shows. For example, it employed only 21 percent of the school nurses and 53 percent of the school psychologists required to meet the recommended ratios, as discussed on page 30.

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Kern High School District's statement does not address the individuals that it failed to include when creating its suicide prevention policy. As we describe on page 19, Kern High School District was unable to demonstrate that it obtained feedback from external stakeholders when constructing its suicide prevention policy. State law and Education's model policy identify the groups that LEAs must or should involve when developing suicide prevention policies.

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Kern High School District has misrepresented our conclusions. Contrary to Kern High School District's statement, we did not determine that its original staff training met all legal standards for suicide prevention training. We assessed the adequacy of suicide prevention training conducted during the 2019–20 academic year. As we show in Table 2 on page 22, the training Kern High School District used during that year failed to fully address statutory requirements and include best practices that Education recommends, potentially depriving teachers and staff of all the knowledge or confidence necessary to respond appropriately when students are at risk of suicide.

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We look forward to reviewing Kern High School District's responses describing its progress in implementing these recommendations at 60 days, 6 months, and 1 year after the publication of this report.

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San Francisco Unified School District

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September 3, 2020

Elaine M. Howle, CPA, California State Auditor*
621 Capitol Mall, Suite 1200
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Dear Ms. Howle,

Thank you for the opportunity to review the draft report entitled “Youth Suicide Prevention: Local Educational Agencies Lack the Resources and Policies Necessary to Effectively Address Rising Rates of Youth Suicide and Self Harm.” Our relevant student health staff have reviewed the draft report and have provided the following feedback and clarifications, organized by page number in the draft report:

(P. 5,6) The SFUSD Wellness Initiative model is not the same as a "school-based health center." Rather, it is a model of service devised by the district to reach students in schools with necessary services and acting as a mechanism to refer to community based or primary care services when needed. School based health centers provide primary care as well as other sexual health medical services not available in Wellness centers. However, SFUSD does have one DPH school based health center co-located in a Wellness center, and two DPH sexual health clinics co-located within Wellness centers.

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(P. 11) "Committed suicide" should be changed to "died by suicide" per American Foundation for Suicide Prevention - Reporting on Suicide Guidelines

③

(P. 17 Figure 5) It does not appear that this chart considers suicide or self harm by transgender or gender non conforming students, is that correct? The chart does not acknowledge whether this was considered.

④

(P. 19) Recommend changing "commits suicide" to "died by suicide" for reason stated above.

⑤

(P. 20/21) In interviews with auditors, SFUSD shared that staff regularly collaborate with community based organizations for both consultation and services, including the Comprehensive Crisis Services (a program of DPH), Edgewood’s CSU, SF Suicide Prevention and Richmond Area Multi Services Agency. It is inaccurate to broadly conclude that “LEAs consistent failure to include community groups suggests that they may not fully recognize the benefits of doing so.” This conclusion ignores the meaningful collaborations between SFUSD and community stakeholders based solely on the absence of a sign-in sheet related to policy development. Recognizing the benefits of community stakeholder support goes beyond collecting feedback on

⑤

* California State Auditor’s comments begin on page 79.

a written policy; the more impactful and meaningful support comes from working collaboratively to support students and their families when an incident occurs, and in developing the operational protocols that implement the broad goals of a policy.

⑤ Additionally, this broad statement that LEAs fail to recognize the value of community input also ignores the fact that SFUSD employs internal experts that bring expertise from community organizations. For example, SFUSD employs a school social worker (SSW) who is a former board member of the American Foundation for Suicide Prevention and a member of the American Association of Suicidology; another SSW who is an expert in the field of Filipino mental health; and a SSW who is known nationally for work with LGBTQ students. These employees were ongoing consultants and presenters of the training for the district.

⑥ **(P. 22 Table 2)** Please provide clarity in the report about what element is missing from the SFUSD training program. The current report's content may be misleading in that it implies that SFUSD's training failed to include information about suicide risk factors or warning signs. Table 2 lists the 3 recommended elements (risk factors, warning factors, protective factors) and indicates with a red X that SFUSD failed to "discuss all three elements." The report states that "all of the LEAs we reviewed lacked one or more of the elements." But the report is vague about precisely what element or elements are missing from SFUSD's training.

However, in the narrative there is a singular focus on risk factors and warning signs. The report explains that "These deficiencies may leave teachers and staff unprepared to identify and assist students at risk of self harm and suicide." The report also states that "Youth who are contemplating suicide frequently exhibit signs of their distress, and teacher and staff trained to identify these warning signs are in key positions to obtain help and prevent suicide attempts." [Emphasis added]. These conclusions may be misleading as they suggest that what is missing from the LEA training is information about risk factors and warning signs; and highlight the dangers of teachers failing to recognize risk factors and warning signs.

The SFUSD training does cover these topics; therefore we request that the report describe the specific factor that was missing (protective factors). SFUSD will add a slide to its training to list possible protective factors. However, the term "protective factors" can be misleading as having these factors does not "protect" students from suicide attempts or deaths. Several suicides have occurred involving students who did have such "protective factors."

⑦ **(P. 25/26)** The report broadly concludes that "two LEAs did not conduct this [suicide prevention] training within the first three months of the beginning of the school year." SFUSD has 13 middle schools, 15 high schools and 6 county schools. The audit reviewed one county school with an enrollment of 73 students to support the broad conclusion that the LEA does not provide timely training. For charter schools or smaller LEAs the selection of one school may provide statistical significance; but it is misleading to suggest an "apples to apples" comparison of training practices at one charter to those at an entire LEA based on the review of one school. Therefore, we request that the report be more transparent that its conclusions regarding training are based on the review of one of the LEA's 34 middle, high and county schools. Currently there is only one small-print note below Figure 4 that acknowledges the review was based on review of one school.

(P. 27) The report states that SFUSD is missing an action plan for out of school suicide attempts. This distinction is confusing as the SFUSD protocols for responding to student suicide attempts do apply to “out of school” attempts; and in fact there has never been an “in school” suicide attempt. However, the district will clarify the applicability of its protocols to “out of school” suicide attempts in its Administrative Regulation. The Regulation will also include a single point of contact regarding suicide prevention and response.

(P. 37) The last paragraph should read San Francisco Unified High School Wellness Initiative, which includes 18 wellness centers. ⑧

(P. 53 Table A, 5(a)) This Table lists the Audit Goals and Methods Used to Address Them. Goal 5(a) is “Identify the extent to which each LEA and charter school tracks student suicides and attempted suicides.” In the “Method” column the report states that none of the LEAs tracked aggregate suicide or self harm data. SFUSD does track suicide ideation, attempts, and self harm via the CDC Youth Risk Behavior Survey. The district tracks completed suicides in individual student records because staff need to know if a student has died by any reason, especially suicide; but this information is not maintained in a searchable database. ⑨

Thank you for your consideration of our comments and clarifications.

Sincerely,

Angela Miller, Sr. Deputy General Counsel
San Francisco Unified School District

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Comments

CALIFORNIA STATE AUDITOR'S COMMENTS ON THE RESPONSE FROM SAN FRANCISCO UNIFIED

To provide clarity and perspective, we are commenting on the response to our audit report from San Francisco Unified. The numbers below correspond to the numbers we placed in the margin of San Francisco Unified's response.

During the publication process for the audit report, page numbers shifted. Therefore, the page numbers cited by San Francisco Unified in its response do not correspond to the page numbers in the final published audit report.

①

San Francisco Unified has misinterpreted the terminology we used to define school health centers for the purpose of this report. As we describe on page 31, the services that a school health center provides depend on the health professionals they employ, and may include a variety of physical and mental health services, such as mental health care, immunizations, substance abuse counseling, oral health care, and nutrition education. As a result, for the purposes of our report we defined school health centers broadly. Because San Francisco Unified's wellness centers deliver on-campus mental health care we describe them as school health centers.

②

During the editing process we revised some terminology to consistently match language commonly used when discussing youth suicide prevention. Specifically, we removed the term committed suicide from pages 10 and 17.

③

As we state in the footnote to Figure 5 on page 10, the available data did not specify gender for fewer than 10 incidents of self-harm. We did not include those incidents in Figure 5.

④

As we describe on page 20, San Francisco Unified was unable to demonstrate that it obtained feedback from external stakeholders when constructing its suicide prevention policy. Notwithstanding its ongoing collaboration with community organizations and their involvement in its suicide prevention training, state law and Education's model policy identify the groups that LEAs must or should involve when developing their suicide prevention policies.

⑤

Our analysis of suicide prevention trainings on page 22 does not describe which specific elements of suicide identification LEAs did not include. During the audit, we informed San Francisco Unified's staff which element their training was missing on several occasions. Because Education's model policy and best practices created by

⑥

suicide prevention organizations do not prioritize one factor over another, we considered all three to be crucial elements of an effective suicide prevention training.

- ⑦ As we describe on page 24, and in the footnote to Table 4 on page 24, we selected one school from each LEA for review. Further, we describe the specific San Francisco Unified school that we reviewed in Table 4 and on page 25. Although a larger selection of schools may have provided additional context, our review illustrates that LEAs throughout the State can improve their provision of suicide prevention training.
- ⑧ We revised the text to more clearly indicate that the term wellness program is used to describe San Francisco Unified's Wellness Initiative.
- ⑨ San Francisco Unified's description of how it maintains information does not conflict with our determination. As we state in the Appendix on page 46, San Francisco Unified does not track aggregate suicide or self-harm data. We did not attempt to review information in individual files due to the time it would take to compile such information, and we agree with San Francisco Unified that it does not aggregate such data into a searchable database.



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September 3, 2020

Sent Via E-Mail/U.S. Mail
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Ms. Elaine M. Howle*
California State Auditor
c/o Aaron Fellner, Team Leader

*Re: Local Educational Agencies Lack the Resources and Policies Necessary
To Effectively Address Rising Rates of Youth Suicide and Self-Harm*

Dear Ms. Howle:

On behalf of the Ukiah Unified School District's ("District"), I submit the attached response to the above-referenced Draft Report.

Sincerely yours,

A handwritten signature in cursive script that reads "Nancy L. Klein".

Nancy L. Klein, Senior Associate General Counsel
School & College Legal Services of California

Enc.

* California State Auditor's comments begin on page 85.

Ukiah Unified School District**Response to Draft Report**

Re: *Local Educational Agencies Lack the Resources and Policies Necessary to Effectively Address Rising Rates of Youth Suicide and Self-Harm*

On June 13, 2017, in response to the enactment of Education Code section 215, effective January 1, 2017, the District adopted Board Policy and Administrative Regulation 5141.5.

Although not required by Section 215, as originally enacted or as subsequently amended in 2019 and 2020¹, the District has provided annual suicide prevention training for staff. The training included identification of school-based mental health services and how to refer students for such services.

Until fall, 2020, the District used QPR training, which the California Department of Education (“CDE”) cites as a training resource at page 6 of its Model Youth Suicide Prevention Policy.

The specific QPR training materials used by the District, which were submitted in the course of the audit, list National Resource numbers and crisis lines. A full list of local crisis response resources is included in the District’s suicide intervention protocol, which is distributed to all district counselors, including the school social-emotional counselors whose specific duties include provision of school-based mental health services. The counseling staff maintains notes throughout a student’s enrollment in the District to ensure through the years that staff, as appropriate, are kept informed of a student’s prior history of social-emotional needs.

In the District’s QPR training materials, high risk groups are specifically addressed, as are Risk Factors (e.g., mental illness, substance abuse, trauma victims, depression, alcohol, psychosis and bipolar disorder, trauma and bullying) and warning factors, (e.g., introduction to warning signs, signs of suicide, direct verbal clues, indirect verbal clues, behavioral cues, situational cues, and acute suicide warning signs).

The District is in the process of reviewing CDE’s model policy. After consulting with “community stakeholders” through the District’s Health Advisory Committee and Counselors’ Network, district administration plans to take a revised policy to the Governing Board for a first reading in November, 2020, and for a final reading and approval by March, 2021.

The District provided suicide prevention training this fall for all staff. The District has never limited training to teachers. (See f.n. 1 - Ed. Code sec. 215) At the recommendation of the California State Auditor’s team, the District discontinued use of QPR training. The District is reviewing its current online training to ensure that, by June, 2021, it aligns with the recommendations in the Draft Report.

¹ “The policy shall address any training to be provided to **teachers** of pupils in grades 7 to 12, inclusive, on suicide awareness and prevention.” (Ed. Code sec. 215(a)(3)(A)) (Effective January 1, 2017 – December 31, 2019)

“The policy shall address any training on suicide awareness and prevention to be provided to **teachers** of pupils in all of the grades served by the local educational agency. (Ed. Code sec. 215(a)(4)(A)) (Effective January 1, 2020)

Ukiah Unified School District

Response to Draft Report

Re: *Local Educational Agencies Lack the Resources and Policies Necessary to Effectively Address Rising Rates of Youth Suicide and Self-Harm*

The District posts continuously to hire school nurses to no avail. Despite district efforts, no applicant has accepted the District's offer of employment since July 1, 2018. The District believes the inability to hire school nurses is due largely to the considerably higher compensation available in the private sector. The District would welcome the state allocation of funding for the employment of school nurses and other professional staff.

⑦

⑧

To meet students' needs, the District has a district-wide Crisis Response Team that responds to suicides and other social-emotional crises that occur in and out of school. In addition to school counselors and school psychologists, the District employs at all sites health technicians who work directly with students. The District also employs at least one bilingual Family and Community Liaison at each site and two district-wide Family Community Liaisons for a total of 13 district wide.

⑨

In response to the District's request for information regarding MHSA funds, the California State Auditor's Office shared the Mendocino County MHSA three-year plan. Staff will be reviewing the plan and contacting Mendocino County Health and Human Services Agency to determine if there is an "application process" for the District to access MHSA funds for school counselors, school nurses, school social workers, and school psychologists.

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Comments

CALIFORNIA STATE AUDITOR'S COMMENTS ON THE RESPONSE FROM UKIAH UNIFIED

To provide clarity and perspective, we are commenting on the response to our audit report from Ukiah Unified. The numbers below correspond to the numbers we placed in the margin of Ukiah Unified's response.

Ukiah Unified's statement does not align with the documentation that it provided to us. As we discuss on page 21 and show in Table 2 on page 22, the training materials that Ukiah Unified provided did not include information about school or community-based mental health services and procedures for referring students to them, which is required by state law.

①

Ukiah Unified is describing information that it could not document. Although the suicide intervention protocol that Ukiah Unified describes does list crisis response resources, that protocol is not referenced in any of its suicide prevention training materials. Thus, as we discuss on page 23, Ukiah Unified teachers and staff may not know what resources are available when responding to a student in crisis.

②

Ukiah Unified has overstated the extent to which its training addresses high-risk groups. Ukiah Unified provided us with additional documentation concerning this subject after it reviewed the draft of this report. However, that documentation only lists a number of high-risk groups and does not include any further discussion of those groups, such as specific characteristics. Without this information teachers and staff may not be aware of the warning signs, risk factors, and resources specific to those groups which, as we discuss on page 23, may impede their ability to reduce suicide risk in the populations that most need help.

③

Ukiah Unified's assertion does not address all three elements of suicide identification. Ukiah Unified provided additional documentation after it reviewed the draft of this report and the documentation it provided to us describes risk factors and warning factors, but it does not address protective factors. Our analysis of suicide prevention trainings on page 22 does not describe which specific elements of suicide identification LEAs did not include. Because Education's model policy and best practices created by suicide prevention organizations do not prioritize one factor over another, we considered all three to be crucial elements of an effective suicide prevention training.

④

- ⑤ Ukiah Unified's statement is misleading. Although it may not have prohibited other staff from attending the training, during the audit Ukiah Unified's director of alternative education confirmed that only teachers received the training, and that Ukiah Unified intended to add additional staff in future years.
- ⑥ Ukiah Unified has misstated the nature of our recommendations. The staff that performed this audit did not recommend that Ukiah Unified discontinue its use of the QPR training. During the course of the audit we did discuss with Ukiah Unified the elements we describe in Table 2 on page 22 that the training did not address.
- ⑦ Ukiah Unified's narrow focus on hiring additional school nurses does not account for other methods for obtaining their services. We encourage Ukiah Unified to review pages 31 through 34 of the report describing how school health centers increase youth access to mental health care, how school health centers allow schools to leverage access to additional funds—such as federal Medicaid funds—and how other entities such as community health centers or local health departments may employ the necessary medical support staff.
- ⑧ Ukiah Unified is already provided funds that can be used for this purpose. As page 38 describes, according to a program consultant at Education, state funds for LEAs are not restricted for specific purposes.
- ⑨ Ukiah Unified's discussion of its crisis response team does not alleviate the shortcomings we identified in its suicide prevention policy. As we state on page 18, some suicide prevention policy elements may be included in other documents and processes. However, we did not identify any references to the crisis response team in Ukiah Unified's suicide prevention policy. Thus, we are concerned that Ukiah Unified has not clearly established the course of action to be taken to ensure timely response after a death by suicide.