California Community Colleges Student Mental Health Program

Final Evaluation Report

Pacific Institute
FOR RESEARCH AND EVALUATION

Prevention Research Center

Oakland, California

May 2015

Final Evaluation Report

California Community Colleges Student Mental Health Program

Executive Summary
The California Community Colleges Student Mental Health Program (CCC SMHP)

a. Key Objectives of the CCC SMHP

The purpose of the CCC SMHP is to support prevention and early intervention (PEI) strategies that address the mental health needs of students, and advance collaboration between local community colleges and county mental health. The overarching outcome of the CCC SMHP is to increase wellness and promote a positive campus community for all faculty, staff and students at the 112 community colleges in California. Ultimately, the long term goal of the CCC SMHP is to increase student success and retention through the development and enhancement of quality student services at all California's community colleges through the implementation of three major program components and an evaluation component. If successful, the program could be adopted by other colleges outside the state as well.

The goals and outcomes described above reflect the three strategic directions contained in the CCC SMHP's agreement with the California Mental Health Services Authority (CalMHSA), the organization funding the initiative. These are: 1) faculty and staff training, 2) peer-to-peer support and 3) suicide prevention as the critical unmet needs for student mental health within the California community colleges (CCC) system. To meet these needs, the CCC SMHP comprised three major components: Suicide Prevention Training for Faculty, Staff and Students, (SPT), Statewide Training and Technical Assistance (TTA), and a Campus-Based Grants (CBG) program. A brief description of each follows.

b. Components of the CCC SMHP

i. Suicide Prevention Training (SPT) – Kognito Solutions

The CCC SMHP SPT contractor, Kognito Solutions, was selected as the contractor to provide suicide prevention training to all interested faculty and staff using evidence-based programs that have been developed specifically for use by colleges and universities. The Suicide Prevention Training was available at no cost upon request to all California community colleges. At-Risk is an online interactive gatekeeper training that uses virtual students and role-playing simulations so learners can recognize when a student is exhibiting signs of psychological distress, and manage a conversation with the student with the goal of connecting them with the appropriate service. Readiness calls were conducted by Kognito Solutions in partnership with the Center for Applied Research Solutions (CARS), the technical assistance team, to ensure that the suicide prevention training would be supported by having adequate tools, resources and referral systems in place on each campus before launching the training.

Three Kognito SPT training modules were made available starting from the 2012 academic school year, and available through June 2015:

- At-Risk for Faculty and Staff
- At-Risk for Student Leaders
- Veterans on Campus: Faculty & Staff

Three additional Kognito training modules were launched at the start of the 2013 academic school year, and are available until June 2017:

- Veterans on Campus: Peer to Peer

- LGBTQ on Campus for Faculty and Staff (re: Lesbian, Gay, Bisexual, Transgender Queer or Questioning)
- LGBTQ on Campus for Students

ii. Training and Technical Assistance (TTA) - The Center for Applied Research Solutions (CARS)

The TTA component contractor was required to provide training and technical assistance services to support the implementation of campus-based grants, to provide regional trainings on priority student mental health topics, collaborate with community partners including county mental health departments, and develop tools and resources that could be used throughout the state in support of student mental health, including online resources. TTA services were made available to all California community colleges at no cost to them.

The CCC SMHP TTA contractor, the Center for Applied Research Solutions (CARS) addressed these requirements in the following ways:

- System wide assessment: In partnership with Kognito Solutions, CARS conducted a CCC system-wide assessment, contacting all 112 community college campuses to gather contact information and design a mechanism to request no-cost TTA and SPT services.
- CCC SMHP Website: CARS developed this website as a clearinghouse of information for all the key components of the CCC SMHP including the evaluation. It is also a collection of relevant resources and tools to support campuses in planning and implementing effective student mental health services. This website also includes products and resources developed specifically for the project as part of CARS' contract. The website can be found at http://www.cccstudentmentalhealth.org
- Customized technical assistance and training: Technical assistance tailored to meet the individual needs of a community college campus was also a part of the TTA services provided. Based on the type of request, a consultant or CARS team member could assist a campus through a series of consultation calls or on-site assistance to support its student mental health efforts.
- Webinars: The utilization of distance learning tools is an integral part of the technical assistance and training services. As part of the CCC SMHP TTA Project, webinars on relevant topics were offered on a regular basis and archived for future use. Users can download recordings and other materials for each topic.
- Regional trainings: In addition to the customized support that was available to campuses, the CCC SMHP TTA Project offered half-day and full-day regional and onsite trainings. CARS provided logistical support, including providing an expert trainer as well as marketing and training materials for the event. The "Welcome Home" trainings, developed initially as a pilot project with funding from the Zellerbach Foundation,[1] were an integral part of the TTA regional trainings for the CCC SMHP. In a few cases, CARS assisted in planning or facilitating Regional Strategizing Forums (RSF).

[1] The focus of the Welcome Home trainings were to provide faculty and staff information about the specific mental health and transition issues that face veterans returning to college after serving in the armed forces, such as post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), and others. For more information, please see the description on the CARS website.

In addition, CARS provided technical assistance to the California Community Colleges Chancellor's Office (CCCCO) and the Foundation for the California Community Colleges (Foundation) staff to facilitate the Chancellor's Office Advisory Group on Student Mental Health (COAGSMH).

iii. Campus Based Grant Program (CBG)

In addition to the system-wide components described above, community colleges were invited to apply for funds to further develop and enhance a student mental health program on their own campus. To be consistent with CalMHSA's funding objectives, the guidelines for CBG's fell under the umbrella of Prevention and Early Intervention (PEI) Statewide Projects to address the three strategic directions of the Student Mental Health Strategic Plan: 1) faculty and staff training; 2) peer-to-peer support; and 3) suicide prevention. CBG applicants were required to have existing capacity to support program implementation, as well as propose a program design that addressed at least one of these approaches. CBGs were also required to increase collaboration through implementing two regional strategizing forums (RSF) that included local University of California (UC) and California State Universities (CSU) campuses, county mental health, and other key community partners. This effort was expected to result in examples of model programs, services, strategies and tools that could be shared and disseminated to all of the California community colleges as well as to other colleges and universities.

There were 23 California community colleges CBGs funded to implement student mental health programs, including three consortium groups, bringing the total to 30 campuses that participated in the program. The focus of these grants was to expand and enhance their capacity on campus and through community linkages to address mental health prevention and early intervention needs for their faculty, staff and students. CBGs (grants) could not be used for direct services or supplant existing resources, but allowed for expanding and enhancing existing programs. Ultimately, the support received by this cohort of grantees was intended to be shared so as to benefit all of the California community colleges. The CBGs implemented a variety of programs, services and strategies many of which were identified in the application guidelines. Grantees provided training and other activities to improve the recognition and response to students at risk of experiencing mental health problems. Some of these programs were crisis or behavior intervention teams, "Student Health 101" and mental health wellness and/or events. Many of the CBGs supported the development of Active Minds and/or National Alliance on Mental Health (NAMI) chapters on their campus. To understand the unique needs of vulnerable populations (e.g. veterans, transitional age youth (TAY) and Lesbian, Gay, Bisexual, Transgender Queer or Questioning (LGBTQ), that may be at high-risk of mental health issues or suicide, CBGs instituted specific training activities on campus. Peer-to-peer train the trainer activities were developed and supported by the CBGs to reduce stigma associated with mental illness. Additionally, grantees supported the implementation of evidence-based suicide prevention activities, services and strategies through suicide prevention training such as Kognito Solutions, ASSIST, QPR or other in person trainings.

Summary and Recommendations

In addition to various activities that were conducted to evaluate the CCC SMHP's overall effectiveness and impact of the various program components described above, PIRE worked with the CalMHSA evaluator, RAND Corporation, in support of the overall evaluation goals identified for the Statewide Student Mental Health Projects. A key objective of this overall evaluation was to identify the demonstrated need for student mental health support. To do so, in the fall of 2013, RAND partnered

with PIRE to conduct a baseline survey of students attending California community colleges. RAND also conducted similar student surveys for the University of California (UC) and the California State Universities (CSU) systems. Results of these surveys suggested a number of findings:

- The 19% rate of psychological distress found for California community college students (and equivalent to students at UC and CSU) was substantially higher than the 3.5% rate commonly reported for the general population (Ward, Schiller, & Freeman, 2013), but comparable to rates reported in other studies of higher education populations (Hunt & Eisenberg, 2010);
- Rates of psychological distress varied across subgroups of students. Higher rates were reported by biracial students (22.9%), students with disabilities (36.2%), and LGBTQ students (29.1%);
- Despite similar rates of psychological distress, students from the CCC system reported consistently higher rates of impaired academic performance due to mental health issues than their counterparts in the other systems of higher education (CSU and UC);
- Despite experiencing comparable levels of psychological distress, students in the CCCs were half as likely to receive referrals for counseling or mental health services as their peers in the other state systems;
- CCC students who were referred for services (other than self-referral) were substantially more likely to report being referred for mental health services by a faculty member or teaching assistant (TA) than were UC or CSU students, consistent with higher rates of CCC faculty and staff reporting talking with a student about their mental health problems than UC and CSU faculty and staff;
- At baseline, fewer than half of the faculty and staff in all three systems reported being aware of the warning signs of psychological distress, or felt they had the necessary skills to discuss mental health issues with students or confident in their ability to help students address mental health issues;
- UC and CSU students reported much higher rates of receiving services on campus compared to the rates reported by CCC students. The lower rates of service among CCC students do not appear to be compensated by use of services off-campus.

All together, these findings support the case for addressing the mental health needs of students in California's community colleges, consistent with the original intent of the funding from CalMHSA.

As part of PIRE's evaluation of the CCC SMHP, three waves of a capacity survey were implemented across time, with the goal of understanding what resources and capacity exist among the colleges to address student mental health. We found that at baseline (survey conducted in February 2013):

- 85% of CCCs collected a student health fee;
- An estimated average 23% of those fees supported mental health services;
- 64% of colleges provided mental health services within their health centers, with an additional 15% providing services in a separate mental health center;
- Across a range of 9 broad types of capacity to address the mental health needs of students (e.g., screening system, peer-to-peer programs, referral system), a majority of colleges (over 50%)

reported some level of capacity, with the exception of peer-to-peer activities (49% of colleges) and electronic health reporting system (27% of colleges).

In addition, PIRE evaluated the extent to which the activities conducted under the CCC SMHP penetrated the large CCC system. The main body of the report documents the extensive range, types, and reach of the various components of the CCC SMHP from April, 2013 through June, 2014. (Note: Some CBG campuses received additional funding to continue the program beyond June 2104). Among the highlights are the findings that:

- Over 11,000 students completed the on-line training provided by Kognito Solutions;
- Over 5,000 faculty and staff also participated in the on-line trainings;
- 96% of all California community colleges participated in a TTA readiness calling;
- Nearly 30 webinars were developed and delivered by the TTA provider, CARS;
- 89 colleges participated in one or more of those webinars;
- 42 regional trainings were completed by CARS, reaching 1,700 college faculty, staff, and students who reported extremely high satisfaction (4.8 on a 5-point scale) with the training;
- CARS delivered 56 tailored, on-site trainings to nearly 3,000 participants;
- The TTA providers engaged in 35 one-on-one TA sessions with 138 participants from about 30% of all the community colleges;
- CARS also developed and continuously updated a comprehensive website for CCC SMHP that drew over 40,000 unique visitors viewing over 300,000 web pages;
- CARS produced 34 publications and products including training videos, online courses, and other resources and tools;
- Finally, this report documents the excellent progress the Campus-Based Grantees (CBGs) made on the enhanced activities they were able to undertake in addition to the system-wide training and TTA that was available to all community colleges in California.

And finally, an attempt to capture the impact of the CCC SMHP initiative was also included in the evaluation activities. It should be noted that measures of the CCC SMHP's impact must necessarily be treated with caution, but there does appear to be evidence of some immediate effects, even in the short span of time covered by the program. These include the following:

- The capacity surveys, completed by CCC campuses, showed increased efforts to improve capacity across a number of categories, with particular attention found in the implementation of peer-to-peer program activities (86% of the colleges) and stigma reduction efforts (96%);
- Participation in various CCC SMHP activities was, as expected, higher among the campus-based grantees (CBGs) and was reflected in increased capacity, but greater changes in capacity were found, relative to baseline, among the non-CBGs;
- CBGs reported greater levels of collaboration with both the TTA provider and with their county departments of mental health;
- Greater collaboration with the TTA provider was associated with increased capacity overall, and especially among non-CBGs;

- Students who completed the Kognito on-line training and participated in pre and post-training follow-up reported an increased number of peers who they referred to mental health services.
- Similarly, pre and post course surveys of CARS training participants indicated significant shifts in self-efficacy and intentions to engage with students in distress;
- An increase in referrals was also found among those faculty and staff who had not previously reported referring students to services compared to the Pretest;
- Measures of campus climate for students with mental health issues started out with good scores, but still showed an improvement over the period of the CCC SMHP's implementation;
- Using student surveys conducted at the beginning and end of the CCC SMHP, we found an increase in the prevalence of students who were themselves referred to mental health services, and this was especially pronounced among those who were "probable for suffering psychological distress;"
- The results suggest that while non-CBGs had a lower rate of self-reported student referrals compared to CBGs, they showed a relative greater improvement at the end of the CCC SMHP.

Recommendations

The recommendations that are provided in this section should be considered in a broader context. While they may seem clear and simple, each implies many unknown assumptions and details that may be contained within the scope of program implementation. Our process started with identifying resources and then understanding how well it "fits" within existing practices.

Nevertheless, we feel the data presented in this report and the evaluation team's experience with the CCC SMHP and the key collaborators allow us to proceed with several recommendations that could be considered for future enhancements to support all California community college students and those who are at risk of psychological distress. The baseline data from the faculty, staff and student survey(s) suggested that students with mental health needs in community colleges are half as likely to get services as their peers in the University of California or California State University systems. We also learned that this shortfall was not due to one or more structural barriers (e.g., lack of money or time) but rather a lack of knowledge about how to get those services, whether they were eligible for services, or just a simple ignorance of the existence of those services (see Table 1). The CCC SMHP certainly marshalled an effort to provide this information to students, so our recommendation is to:

Table 1. Reasons Students Did Not Access Services

Reason For Not Accessing Services	Percentage of UC Respondents Endorsing Reason	Percentage of CSU Respondents Endorsing Reason	Percentage of CCC Respondents Endorsing Reason
I didn't feel I needed services.	77%	75%	69%
I didn't have enough time.	34%	34%	26%
I didn't know what it offered.	18%	21%	33%
I didn't know how to access it.	18%	20%	29%
I didn't think it would help.	28%	24%	21%
I was embarrassed to use it.	22%	23%	21%

I had concerns about possible costs.	22%	18%	22%
I didn't know if I was eligible.	14%	17%	25%
I had never heard of it.	7%	10%	25%

Note. Multiple responses permitted per respondent.

Recommendation 1: Using a variety of channels of communication and outreach, continue to provide new and continuing CCC students with information about the availability of services for mental health problems, how they may be accessed and whether there are any eligibility requirements to obtain those services.

This should help boost the most common form of referrals, the self-referrals. We found that the CCC SMHP did appear to boost other sources of referrals via students and also faculty and staff. For CCC students in particular, staff and faculty referrals were a major source of referrals, with friends being the next most likely source. Our recommendation, then, is to:

Recommendation 2: Continue using on-line training for faculty, staff as well as for students, given that both appear to be key sources of referrals and can be trained to improve the rate of such referrals.

Although we saw that training can boost referrals, participation rates for the on-line training were low, although not in absolute numbers. Several colleges used some form of incentive to boost participation rates, but in order to universally increase the likelihood that students needing mental health services will be encouraged to do so, we recommend that:

Recommendation 3: Some form of incentive be offered to increase participation in on-line training for faculty, staff, and students. Examples of such incentives could be: connect doing the training with course credit for students, recognition during performance reviews for faculty and staff, financial incentives (including a lottery) or perhaps requiring participation as part of suitable courses (e.g., in psychology or health sciences). Some CBG colleges that offered incentives showed greater participation in online training by faculty, staff and students.

It is one thing to boost referrals and thereby encourage students to seek help, but to increase the likelihood that they actually get those services, there should be some way of following up with students who self-refer or are referred by others. This, of course, is not a trivial challenge, but we would still recommend that:

Recommendation 4: Some type of tracking infrastructure be developed that would enable health services staff or mental health providers to contact students who are referred to services or have participated in services, so that colleges can determine how many such students actually receive services (on campus or elsewhere) and how many fall through the cracks in the system or otherwise fail to get needed services.

While developing these various sources of referrals, we wish to point out that a more active form of screening or "case finding" could be adopted. We would recommend:

Recommendation 5: Colleges explore the possibility of using a system of universal screening each fall semester to identify students in need. This could be done either on-line, during visits to health services, or as part of the orientation process.

Of course, an increase in referrals is likely to require an increase in the capacity of colleges to meet greater demands for service. While the increase in that demand is an excellent rationale for adding staff to those that provide mental health services, other strategies for coping with demand for services would be likely. We would recommend:

Recommendation 6: Continued collaboration with county behavioral health departments, regional service providers and nearby UC or CSU health or counseling centers so that new capacity might be found to provide students with easily-accessible mental health services.

A comprehensive system for identifying students in need of mental health services, and developing the capacity to respond to those needs would be a major undertaking for any college. It may well be that a coordinating office could seek out and identify pieces of such a system (e.g., software, materials) that could be shared across many colleges that individually may not be able to pay for or develop them on their own. Therefore, we would recommend that:

Recommendation 7: The California Community Colleges Chancellor's Office work with the directors and staff of community college health services to identify resources that could be shared across participating colleges. This could be done in conjunction with the existing Health Services Association of the CCCs (HSACCC), and the online searchable database already developed and available on the CCC SMHP website.

Finally, the evaluation team would be remiss is we did not also encourage evaluation as a tool to guide any of these possible activities. We would therefore recommend that:

Recommendation 8: The CCC system and participating colleges continue to adopt and refine data collection methods and tools that were developed for this project as part of the evaluation to help guide future development of a system to address their students' mental health needs, and to better demonstrate the value of those efforts to the students, the California community colleges, and the State of California as a whole.

I. Introduction: The California Community Colleges Student Mental Health Program (CCC SMHP) – Overview and Key Objectives

The purpose of the California Community Colleges Student Mental Health Program (CCC SMHP) is to support prevention and early intervention strategies that address the mental health needs of students, and advance collaboration between local community colleges and county mental health. The overarching outcome of the CCC SMHP is to increase wellness and promote a positive campus community for all faculty, staff and students at the 112 community colleges in California. Ultimately, the long term goal of the CCC SMHP is to increase student success and retention through the development and enhancement of quality student services at all California's community colleges through the implementation of three major components and an evaluation component. If successful, the program could be adopted by other colleges outside the state as well.

The goals and outcomes described above reflect the three strategic directions contained in the CCC SMHP's agreement with the California Mental Health Services Authority (CalMHSA), the organization funding the initiative. These are: 1) faculty and staff training, 2) peer-to-peer support and 3) suicide prevention as the critical unmet needs for student mental health within the California community colleges system. To meet these needs, the CCC SMHP comprised three major components: Suicide Prevention Training for Faculty, Staff and Students, (SPT), Statewide Training and Technical Assistance (TTA), and a Campus-Based Grants (CBG) program.

a. Key Components of the CCC SMHP

i. Suicide Prevention Training (SPT) – Kognito Solutions

The CCC SMHP SPT contractor, Kognito Solutions, was selected as the contractor to provide suicide prevention training to all interested faculty and staff using evidence-based programs that have been developed specifically for use by colleges and universities. The Suicide Prevention Training was made available at no cost upon request to all California community colleges. At-Risk is an online interactive gatekeeper training that uses virtual students and faculty in role-playing simulations so learners can recognize when a student is exhibiting signs of psychological distress, and manage a conversation with the student with the goal of connecting them with the appropriate service. Readiness calls were conducted by Kognito Solutions in partnership with the Center for Applied Research Solutions (CARS), the training and technical assistance contractor for the CCC SMHP, to ensure that the suicide prevention training would be supported by having adequate tools, resources and referral systems in place on each campus before launching the training.

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- At-Risk for Student Leaders
- Veterans on Campus: Faculty & Staff

Three additional Kognito training modules were launched at the start of the 2013 academic school year, available until June 2017:

- Veterans on Campus: Peer to Peer

- LGBTQ on Campus for Faculty and Staff (Lesbian, Gay, Bisexual, Transgender Queer or Questioning)
- LGBTQ on Campus for Students

ii. Training and Technical Assistance (TTA) - The Center for Applied Research Solutions (CARS)

The TTA component contractor was required to provide training and technical assistance services to support the implementation of campus-based grants (CBGs), provide regional trainings on priority student mental health topics, collaborate with community partners including county mental health agencies, and develop tools and resources that could be used throughout the state in support of student mental health, including online resources. TTA services were made available to all California community colleges at no cost to them.

The CCC SMHP TTA contractor, the Center for Applied Research Solutions (CARS) addressed these requirements in the following ways:

- System wide assessment: In partnership with Kognito Solutions, CARS conducted a CCC system-wide assessment, contacting all 112 community college campuses to gather contact information and design a mechanism to request no-cost TTA and SPT services.
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[2] The focus of the Welcome Home trainings were to provide faculty and staff information about the specific mental health and transition issues that face veterans returning to college after serving in the armed forces, such as post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), and others. For more information, please see the description on the CARS website.

In addition, CARS provided technical assistance to the California Community Colleges Chancellor's Office (CCCCO) and the Foundation for the California Community Colleges (Foundation) staff to facilitate the Chancellor's Office Advisory Group on Student Mental Health (COAGSMH).

iii. Campus Based Grant Program (CBG)

In addition to the system-wide components described above, community colleges were invited to apply for funds to further develop and enhance a student mental health program on their own campus. To be consistent with CalMHSA's funding objectives, CBG's were required to meet the intent of the Statewide Prevention and Early Intervention (PEI) Projects by addressing the three strategic directions of the Student Mental Health Strategic Plan: 1) faculty and staff training; 2) peer-to-peer support; and 3) suicide prevention. CBG applicants were required to have existing capacity to support program implementation, as well as propose a program design that addressed at least one of these approaches. CBGs were also required to increase collaboration through implementing two regional strategizing forums (RSFs) that included local University of California (UC) and California State Universities (CSU) campuses, county mental health, and other key community partners. This effort was expected to result in examples of model programs, services, strategies and tools that could be shared and disseminated to all of the California community colleges as well as to other colleges and universities.

There were 23 CBGs funded to implement student mental health programs, including three consortium groups, bringing the total to 30 campuses that participated in the program. The focus of these grants was to expand and enhance their capacity on campus and through community linkages to address mental health prevention and early intervention needs for their faculty, staff and students. CBGs (grants) could not be used for direct services or supplant existing resources, but could expand and enhance existing programs or services. Ultimately, the support received by this cohort of grantees was intended to be shared with other campuses so as to benefit all of the California community colleges. The CBGs implemented a variety of programs, services and strategies many of which were identified in the application guidelines. Grantees provided training and other activities to improve the recognition and response to students at risk of experiencing mental health problems. Examples of the types of programs that were implemented include: crisis or behavior intervention teams, "Student Health 101" and mental health wellness and/or events. Many of the CBGs supported the development of Active Minds and/or National Alliance on Mental Health (NAMI) chapters on their campus. To understand the unique needs of vulnerable populations (e.g. veterans, transitional age youth (TAY) and Lesbian, Gay, Bisexual, Transgender Queer or Questioning (LGBTQ), that may be at high-risk of mental health issues or suicide, other CBGs instituted specific training activities on campus. Peer-to-peer train the trainer activities were developed and supported by the CBGs to reduce stigma associated with mental illness. Additionally, grantees supported the implementation of evidence-based suicide prevention activities, services and strategies through suicide prevention training such as Kognito Solutions, ASSIST, QPR or other in person trainings.

II. Activities and Reach of the California Community Colleges Student Mental Health Program (CCC SMHP)

a. Overview of Suicide Prevention Training – Kognito Solutions

All of the At-Risk trainings were designed to increase referral services to mental health service providers, while the training modules for LGBTQ and student veterans also included information

specific to the needs of that population. Brief surveys were administered before the training (Pretest), after the training (Posttest), and 3 months later (Follow-Up). See Appendix A for more detailed information about the on-line surveys.

Table 1 summarizes participation rates for the different training titles. It shows, for example, that the average (mean) number of participants for the Faculty/Staff/Administrator (FSA) At-Risk training across the 112 campuses was 25, with a maximum of 273 on one campus, which represented about 25% of all faculty and staff.

Table 1. Descriptive Results on Kognito Trainings (N=112 campuses)

	Median	Mean (SD)	Maximum	Max Reach[1]
FSA At-Risk	6.5	25 (41)	273	25.4%
Student At-Risk	1	74 (172)	964	4.7%
Veterans on Campus (FSA)	2	14 (26)	146	16.5%
Veterans on Campus Peer 2 Peer (P2P)	0	9 (30)	229	1.7%
LGBTQ On Campus (FSA)	1	6 (15)	117	11.8%
LGBTQ On Campus (Students)	0	12 (38)	255	1.9%

[1] Reach (i.e., participation rate) based on maximum number of trainings.
Note: FSA = Faculty/Staff/Administrators, VOC = Veterans on Campus, P2P = Peer to Peer

Table 2 shows the participation rate on the campus level. FSA At-Risk was used by the largest number of campuses (80), and while Student At-Risk was adopted by fewer campuses (67), it had the highest number of trainees (8,543).

Table 2. Kognito Trainings by Type, Number of Campuses and Number of Trainees

		No. Campuses (% of CCC System)	No. Trainees
1	FSA At-Risk	80 (71%)	3,074
2	Student At-Risk	67 (60%)	8,543
3	Veterans on Campus (FSA)	67 (60%)	1,597
4	Veterans on Campus Peer 2 Peer (P2P)	46 (41%)	1,169
5	LGBTQ on Campus (FSA)	66 (59%)	704
6	LGBTQ on Campus (Students)	47 (42%)	1,495
	Any FSA Training	**81 (72%)**	**5,375**
	Any Student Training	**70 (63%)**	**11,207**
	Any Training	**84 (75%)**	**16,582**

Demographics of the Trainees were obtained for those that completed the Posttest survey. Demographic questions were administered at the Posttest instead of the Pretest to reduce the burden of taking the Pretest, so that potential trainees could get to the training as quickly as possible. As can be seen in Table 3, the majority of trainees were women and Caucasian, followed by Hispanic and Asian-Americans, then African-Americans.

Table 3. Demographics of Trainees

	Sample Size	Female	Trans-gender	Hispanic	Race (not mutually exclusive)				
					Caucasian	American Indian/ Native Alaskan	Asian	Black/ African American	Native Hawaiian/ Pacific Islander
FSA At-Risk	2286	70%	0.6%	20%	78%	5%	12%	6%	1%
Student At-Risk	6776	64%	0.5%	34%	45%	2%	17%	8%	1%
VOC (FSA)	1179	71%	0.5%	23%	62%	3%	13%	7%	1%
VOC P2P	961	66%	0.4%	34%	63%	8%	24%	10%	2%
LGBTQ OC (FSA)	489	73%	0.6%	18%	81%	6%	12%	8%	1%
LGBTQ OC (Students)	1181	65%	0.7%	33%	64%	8%	24%	10%	2%

b. Overview of Training and Technical Assistance (TTA) Activities

The Center for Applied Research Solutions (CARS) delivered training and technical assistance (TTA) to the California community college campuses in support of the California Community Colleges Student Mental Health Program (CCC SMHP). This report includes CARS TTA activities from April 2012 until June 2014.

This summary draws from several sources of data, described below:

(1) CARS TTA tracking data sheets which includes information on the delivery of all technical assistance and training events to CCC campuses, the colleges that attended, the topic areas covered, the type of TTA delivered and which campuses were reached;

(2) Attendance and satisfaction data from webinars, regional trainings and onsite trainings that occurred from April 2012 to June 2014;

Monthly CARS reports which includes all communications products developed by CARS and Google analytic findings from accessing the CCC SMHP website.

CARS TTA services included initial readiness calls, webinars, regional trainings, onsite trainings and one-on-one TA as well as accessing the SMHP website where additional tools and support can be obtained. In all, 26 topic areas were identified across all TTA activities. To ease interpretation of findings, the 26 topic areas were then organized into six larger categories.

The categories include:

1. **Mental Health Awareness** (i.e. mental health education and awareness, mental health 101, mental health stigma)

2. **Service Needs and Support for Under-served Populations** (i.e. support for LGBTQ, Veterans, Asian Americans, foster and adjudicated youth)

3. **Campus Mental Health Capacity Building** (i.e. development of mental health referral systems, building community partnerships, policy development, enhancing counseling skills, development of trauma informed care teams, reducing staff stress reduction, attending Regional Strategizing Forums)

4. **Peer-to-Peer Services** (e.g., BACCHUS)[3]

5. **Crisis Intervention Services** (i.e. Behavioral Intervention Team, Crisis Intervention, Active Shooter, Students in Distress, Threat Assessment)

6. **Suicide Prevention** (e.g., Suicide Risk Assessment, Active Minds and Send Silence Packing, suicide prevention plans and policies)

The six categories were created in partnership with CARS by reviewing all webinars, regional trainings, onsite training and technical assistance events and identifying 26 topical areas of TTA that these TTA activities represent, eventually distilling these to the six.

In the next section we report specific activities for each type of TTA provided by CARS to college campuses. These TTA activities included: (1) Initial Calls, (2) Webinars, (3) Regional Trainings, (4) Onsite Trainings, and (5) Individualized Training or TA, and product development. Using the same six topic framework, we report on participation of campuses for each type of TTA, and when available, the demographics of those reached and the self-report utility over time.

A main component of CARS activities was making initial contact with campuses to assess their TTA needs, described as the Initial Readiness Call. This call includes an in-depth needs assessment and discussion of possible training and technical assistance needs.

- As of June 2014, 96% of all campuses participated in the readiness call, (108 of 112 campuses).
- All 30 CBG campuses completed the Initial Readiness Calls.
- Of the non-CBG campuses, 95% participated in the initial readiness call.

i. Webinars

CARS participated in the delivery of 28 webinars that took place between April 2012 and June 30, 2014 (Table 4). Four of these webinars occurred at the beginning of the CCC SMHP start-up (May-June 2012), providing an overview of the CCC SMHP and TTA services offered by CARS. These webinars were hosted by CARS, but because they were kick-off webinars, no evaluation data were collected.

- 89 campuses (79% of all CCC campuses) attended one to thirteen webinars; although 23 campuses did not attend any of the webinars when they were scheduled, over half of these campuses (56%), viewed archived webinars (n=13).

[3] BACCHUS is an acronym for Boosting Alcohol Consciousness Concerning the Health of University Students, a nationally recognized peer education and training program that promotes health education and safety issues, including alcohol and drug abuse and mental health issues. BACCHUS is now officially part of the National Association of Student Affairs Professionals (NASPA). For more information, visit their website at https://www.naspa.org/constituent-groups/groups/bacchus-initiatives

- Across all webinars, the estimated total number of campus participants was 647. (It is important to note that data on college attendance were not available for four of the webinars, therefore results underestimate the number of colleges and participants in attendance).
- Overall, 83 campuses viewed archived webinars (74% of all campuses).
- When taking into account archived webinars, 99 campuses or 88% of all CCC campuses either attended a webinar or viewed an archived webinar.

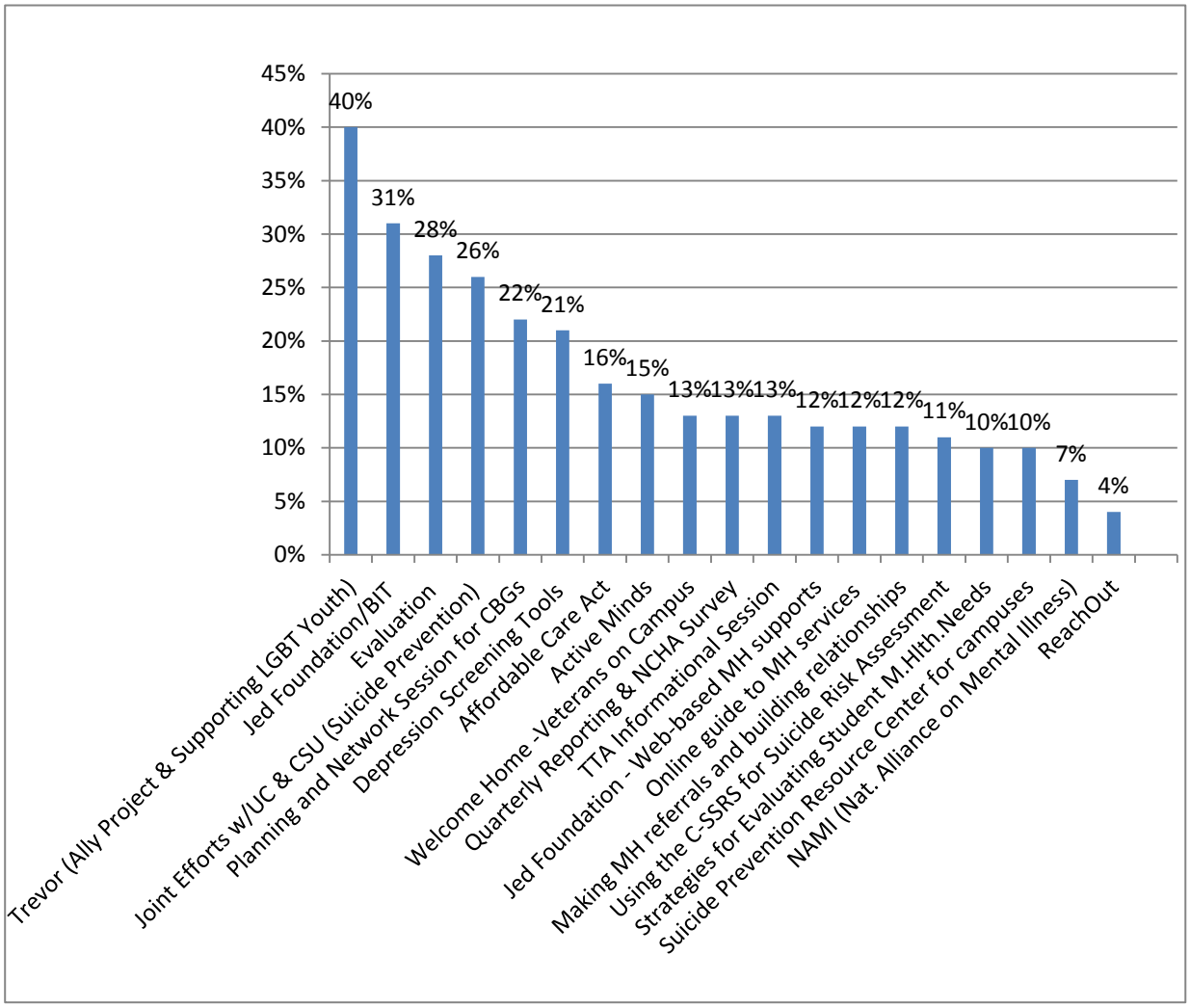
As can be seen in Table 4, the average number of webinars attended by the 112 CCC campuses was three and the largest number attended was 15. Described below is the percent distribution of webinars attended by colleges. Twenty-three percent of colleges attended five or more webinars while 56% attended 1-4 and 21% did not attend any webinars.

Table 4. The Number of Webinars Attended by Colleges

Number of Webinars Attended	Number of Colleges (%)
0	23 (21%)
1-2	33 (29%)
3-4	30 (27%)
5-6	8 (7%)
7-8	8 (7%)
9-10	8 (7%)
11 +	2 (2%)
Total	112 (100%)
Mean	3.1

Displayed in Figure 1 are the percentages of colleges attending each webinar topic (on some occasions, webinars were repeated). The average number of colleges to attend any webinar was 14. The webinar topic with the largest number of colleges in attendance was the "Trevor Project," which focused on supporting LGBTQ youth at risk of mental health problems and suicide. The second set of webinars with the highest college attendance was developing Behavioral Intervention Teams (BIT). The third most attended webinars included the CCC SMHP evaluation and a webinar on joint efforts with the University of California (UC) and the California State Universities (CSU) on suicide prevention (29 colleges attending). The webinar with the lowest attendance was "Reach Out" (4% or 5 colleges attending). "Reach Out," an informational webinar for a web-based mental health resource for youth, was scheduled at a time that may have conflicted with winter break schedules.

Figure 1. Percentages of Colleges Attending Each Webinar



Satisfaction surveys were completed online by webinar attendees after the completion of each webinar. For most satisfaction surveys, the scale rating was from 1 "not at all satisfied" to 4 "very satisfied." There were varied response rates to the satisfaction surveys (ranging from 23% to 84%). therefore satisfaction data should be interpreted with caution.

- Across all webinars the mean satisfaction score was 3.5 (with all scores converted to a 4 point scale) suggesting high satisfaction with the webinars. (For satisfaction scores for each webinar please see Appendix B).
- Across all webinars, 350 campuses were in attendance with a total of 647 attendees. Listed in Table 5 are all webinars organized by topical areas. As can be seen by Table 5, the general topic area with the largest number of webinars was mental health capacity building.

Table 5. Webinars by Topic Area, Number of Campuses and Number of Attendees

Webinars Topic		No. Campuses (% of CCC System)	No. Attendees*
Mental Health Capacity Building			
1	Planning and Networking Session for CBGs	10 (9%)	19
2	Planning and Networking Session for CBGs[4]	14 (13%)	20
3	Strategies to Evaluate Student Mental Health Needs: Conducting a Needs Assessment	11 (10%)	24
4	Quarterly Reporting Requirements and Admin. NCHA Survey	14 (13%)	27
5	Evaluation Capacity Survey of Campus Based Mental Health	16 (14%)	34
6	Training and Technical Assistance Informational Session	14 (13%)	28
7	CCC SMHP Evaluation Data Follow-up Discussion to CBG Meeting	15 (13%)	15
8	Making Referrals and Building Relationships	13 (12%)	22
9	Depression Screening Tools	23 (21%)	33
10	Affordable Care Act Outreach Methods	18 (16%)	42
Mental Health Awareness			
11	Introduction to Active Minds	10 (9%)	20
12	Introduction to Active Minds	7 (6%)	21
13	Online Guide to Mental Health Services - Website Module for College Websites	13 (12%)	24
14	NAMI – California Campus-Based Programs	8 (7%)	22
Suicide Prevention			
15	Reach Out Informational Session	5 (5%)	15
16	Suicide Prevention Resource (plans/policies/ strategies)	11 (10%)	25
17	Using the C-SSRS for Suicide Risk Assessment	12 (11%)	37
18	Joint Efforts with UC and CSUs to Support Suicide Prevention	29 (26%)	52
Service Needs and Support for High Risk/Underserved Students			
19	Welcome Home: Veterans on Campus	15 (13%)	24
20	Trevor Ally Workshop (LGBTQ Support)	17 (15%)	25
21	Trevor – Connect, Accept, Respond Empower LGBTQ Support	28 (25%)	33
Crisis Intervention Services			
22	JED Foundation's Mental Health Supports for Colleges – Web Resources	13 (12%)	27
23	Balancing Safety and Support on Campus – A Guide to BIT Teams-Jed Foundation	23 (21%)	37
24	BIT Team (Follow-up Discussion)	11 (10%)	21
	Totals	**350**	**647**

* ***Note***: The number of attendees does not include non-campus attendees (e.g., CARS, CCC SMHP, presenters or community or internal partners). Individuals and campuses may have attended more than one webinar.

College campus webinar attendees could include faculty, staff or students. In Table 6, we display the demographic characteristics of 251 webinar attendees who completed satisfaction surveys. This

[4] Here and below, Introduction to Active Minds, indicate that more than one session took place, on different dates.

sample represents 39% of the approximately 647 college attendees (251/647) and therefore findings should be interpreted with caution.

- The majority of the 251 webinar respondents were female (82%).
- 77% of respondents were Caucasian. The second most common racial/ethnic category was Hispanic (23%) and 10% were African American. Three percent of those attending webinar trainings were Veterans.
- 34% of those attending webinars were full-time faculty, 6% were adjunct faculty and 42% represented administrators or staff. 1% of attendees were students. Of non-student participants, approximately 60% had served in their role for five or more years. This is not a surprising finding, given that the primary audience were faculty, staff and administrators.

Table 6. Demographic Characteristics Webinar Attendees Who Completed Satisfaction Surveys

Webinar Trainings	Sample Size	Female	Race/Ethnicity							Veteran
			Caucasian	Hispanic	Black/ African American	American Indian/ Native Alaskan	Asian	Native Hawaiian/ Pacific Islander	Multiple Races Other	
	251	82%	77%	23%	10%	2%	6%	1%	9%	3%

Webinar Trainings	Sample Size	Position						Tenure (if not student)			
		Fulltime Faculty Member	Adjunct Faculty Member	Admin.	Staff	Student	Other	1 - 2 yrs.	3 - 4 yrs.	5 - 6 yrs.	6+ yrs.
	251	34%	6%	23%	19%	1%	17%	25%	16%	12%	47%

ii. Regional Trainings by Request

In addition to the customized support that was made available to campuses, the SMHP TTA project offered half-day and full-day regional trainings. From April 2012 to June 30, 2014, a total of 42 regional trainings were completed by CARS. These trainings tended to included more than one campus and were often hosted by an individual campuses or a community partner. As can be seen in Table 7, of the 42 regional trainings:

- 10 were Threat Assessment,
- 20 were Welcome Home Veterans trainings,
- 6 Peer-to-Peer trainings with BACCHUS,
- 3 were Gay Alliance Safe Zone trainings focused on LGBTQ youth, and
- 3 were Trauma Informed Care.

In total, the regional trainings reached 1,694 college faculty, staff and students. Sixty-one percent of attendees completed satisfaction surveys (1034/1694) with a high mean satisfaction rating of 4.8 on a 5 point scale. The highest level of participation was for threat assessment, with 64% of all colleges and 87% of CBGs attending. The next highest was the "Welcome Home" training, with 64% of all colleges and 76% of CBGs attending.

Table 7. Regional Training, Number of Campuses Attended, Overall Satisfaction Ratings, and Total Number of Attendees

	Regional Training Topic	No. Campuses Attended 1 or more trainings (% of CCC Campuses)	No. of Regional Trainings held	No. CBG Attended 1 or more trainings (% of CBG Campuses)	Mean Satisfaction	No. Attendees
1	Threat Assessment	72 (64%)	10	26 (87%)	4.6	430
2	Welcome Home – Veterans *	71 (63%)	20	23 (76%)	4.9	864
4	Safe Zone (LGBTQ)	18 (16%)	3	7 (23%)	4.9	101
3	Trauma Informed Care	23 (21%)	3	12 (40%)	4.9	104
5	Peer-to-Peer with BACCHUS	11 (10%)	6	5 (17%)	4.7	195
	Total		42	--	--	1694

*__Note__: An additional Welcome Home training occurred in October 2014 after the data collection period and therefore is not included in this report.

College campus attendees of regional trainings could include faculty, students or staff. In Table 8, we display the demographic characteristics of regional training attendees, limiting the analysis to those who completed satisfaction surveys (n=1034, 61% of attendees). The demographic characteristics were fairly similar to webinar respondents.

- The majority of the respondents were female (74%) and 67% were Caucasian. The second most common racial/ethnic category was Hispanic (30%). Ten percent were Asian and 7% were African American.
- Three percent (3%) of those attending regional trainings were veterans.
- Similar to the webinar trainings, the highest percentage of attendees were administrators and staff (38%), followed by fulltime and adjunct faculty (24% and 13% respectively).
- Eight percent (8%) of attendees were students, higher than webinar attendees where students comprised 1% of the respondents. It should be noted that students were not the target audience for the regional trainings, so this fact should be taken into consideration when viewing these findings.

Table 8. Demographic Characteristics of Regional Attendees and Who Completed Satisfaction Surveys

All Regional Trainings	Sample Size	Female	Race/Ethnicity							Veteran
			Caucasian	Hispanic	Black/ African American	American Indian/ Native Alaskan	Asian	Native Hawaiian/ Pacific Islander	Other	
	1034	74%	67%	30%	7%	3%	10%	1%	2%	3%

All Regional Trainings	Sample Size	Position					
		Fulltime Faculty Member	Adjunct Faculty Member	Admin.	Staff	Student	Other
	1034	24%	13%	12%	27%	8%	17%

Regional Strategizing Forums (RSF) were hosted or co-hosted by CBG campuses to build connections between campuses and their local community partners, share lessons learned, disseminate information and involve local organization and community providers in serving the mental health needs of students. As can be seen from Table 9, from April 2012 to June 30 2014:

- 46 Regional Strategizing Forums were implemented that were hosted by CBG campuses.
- RSFs occurred fairly regularly across the 28 month project period and were a requirement of CBG funding.
- CARS helped develop or facilitated RSFs for 26 of the 46 RSFs (57% of all RSFs).
- During the time frame under evaluation, 28 of the 30 CBGs (93%) hosted or co-hosted an RSF, with many campuses hosting more than one RSF.
- 23 CBGs (90% of all CBGs) reported attending RSFs hosted by other CBG campuses.

Table 9. Regional Strategizing Forums

Regional Strategizing Forums	No. of RSF	No. CBGs Hosted/Co-Hosted RSF (% of CBGs)	No. CBGs that Attended RSFs Hosted by Other Campuses (% of CBGs)	No. CBG Did Not Attend RSF or Host/Cohost	Facilitated by CARS (% of RSF)	Avg. Attendance
	46	28 (93%)	23 (90%)	1 (3%)	26 (57%)	89

iii. Onsite Trainings

CARS delivered onsite trainings to campuses. Onsite trainings were often customized to meet campus-specific needs. Between April 2012 and June 30 2014, there were 56 onsite trainings reaching 2,925 participants. To ease interpretation, each training was placed under the six topic areas used throughout the report and we indicate the proportion of the CCC system that was reached (Table 10, last column). Campuses that had more than one training on a given topic area were counted once in order to calculate the percentage of the CCC system reached. It should be noted however that several campuses held sequential onsite trainings on the same topic suggesting greater in-depth dissemination of that topic

at the campus level. Appendix B includes a figure that displays campuses in attendance and the number of onsite trainings held at each campus for each topic area.

As seen in Table 10, the training topics that reached the largest percentage of the CCC system were:

- Introduction to Mental Health and Mental Health Screenings (28% of the CCC system), and
- Active Shooter (11% of the CCC system).

Trainings reaching between 7% to 4% of CCC campuses included:

- Enhancing Counseling Skills (7% of the CCC system)
- Cultural Competency and Working with Diverse Student Populations (5% of the CCC system)
- Responding to Difficult, Disruptive or Distressed Students (4% of the CCC system)
- Service and Support for the LGBTQ community (4% of the CCC system)
- Mental Health Needs of Asian Americans and Pacific Islanders (4%)

The remaining trainings reached 3% or less of the CCC system and are listed in Table 10. Because these are customized to individual needs, the small percentage of reach is not unusual.

Table 10. Onsite Trainings, Topic Areas, Number or Trainings and Colleges in Attendance

	General Topic Area	Titles	No. Trainings	Total No. Attend.	No Coll. (% CCC Campuses)
Mental Health Awareness (31% of campuses)					
1	**Mental Health Screening/ Mental Health 101**	• Mental Health First Aid • Mental Health 101 (Part I) • Mental Health 101 • Mental Health Screening	**4**	**263**	**31 (28%)**
2	**Mental Health and Wellness**	• Partnering for Peace & Wellness • Mental Health & Wellness for Student Success • Tapestry of Well Being	**3**	**345**	**3 (3%)**
Service Needs and Support for High Risk/Underserved Students (16% of campuses)					
3	**Cultural Competency, working with Diverse Populations**	• Practical Tools for Recognizing and Managing Unconscious Bias • At-Risk and Ethnically Diverse Students • Building Multicultural Bridges of MH for Student Success • Cultural awareness, competence and responsiveness • Reaching Out to Our Diverse Student Body for Mental Health and Wellness • Working with Diverse Students • The Challenges and Opportunities for Faculty and Staff Working with Increasingly Diverse Students (Mock)* • Indigenous perspectives on American Mental Health and restorative practices for caregivers (Grey)*	**8**	**530**	**6 (5%)**
Service Needs and Support for High Risk/Underserved Students (16% of campuses)					

4	**LGBTQ**	• Safe Zone • LGBTQ • Transgender training • LGBTQ • LGBTQ training to improve their awareness, sensitivity, and service delivery systems	**5**	**90**	**4 (4%)**
5	**Service Needs of Asian Americans/Pacific Islanders**	• Affirmative Reactions: Attending to the Physical and Mental Health of AAPI Students • Challenges of Asian and Pacific Islander students transition to college • Depression/Suicidality among Asian females	**3**	**119**	**4 (4%)**
6	**Stigma associated with Diverse Groups**	• Psychodrama performance about stigma • Reduce stigma across campus and connect with minority group	**2**	**200**	**2 (2%)**
7	**Foster and Adjudicated Youth**	• Best practices for staff that work with high-risk youth, many time foster and adjudicated youth	**1**	**24**	**1 (<1%)**
8	**Student Veterans**	• Working with Student Veterans	**1**	**NA**	**1 (<1%)**

Table 10 (cont.). Onsite Trainings, Topic Areas, Number or Trainings and Colleges in Attendance

	General Topic Area	Titles	No. Trainings	Total No. Attend.	No Coll. (% CCC Campuses)
Crisis Intervention Services (17% of campuses)					
9	**Active Shooter**	• Active Shooter	**4**	**431**	**12 (11%)**
10	**Behavioral Intervention Teams (BIT)**	• Behavioral Intervention Teams (BIT)	**1**	**20**	**1 (<1%)**
11	**Threat Assessment (BIRT)**	• Threat Assessment	**1**	**10**	**1 (<1%)**
12	**Responding to Difficult, Disruptive or Distressed Students**	• Crisis Services • Ability to deal with disruptive students • Don't Panic-Stress Management • Preventing and managing disruptive behavior, identifying distressed students • Improving capacity to deal with distressed students • Disruptive Students in the Classroom • Responding to Difficult or Distressed Online Students: Mental Health Assessment and Referrals	**7**	**160**	**6 (5%)**
Mental Health Capacity Building (8% of campuses)					
13	**Enhancing Counseling Skills**	• Enhancing Counselor's Assessment/Intervention Skills • Optimizing Team Effort to Meet Mental Health Challenges • Counseling staff challenges and interview techniques • Making Psychiatric Referrals	**4**	**171**	**8 (7%)**
Mental Health Capacity Building (8% of campuses)					
14	**ACHA-NCHA Survey Results**	• Overview of CCC ACHA-NCHA survey results	**1**	**100**	**1 (<1%)**
15	**Trauma Informed**	• Trauma Informed Care	**2**	**53**	**1 (<1%)**

	Care				
Suicide Prevention (4% of campuses)					
16	**Suicide Prevention**	• Suicide Prevention	**4**	**189**	**5 (4%)**
Other (9% of campuses)					
17	**Other**	• Non-Violent Sexuality • Transforming Violence - LA Consortium • Am. Sign Language Interpreters and SMH • Supporting Students with Math • Student Panel (Part III)	**5**	**220**	**10 (9%)**
		Total	**56**	**2925**	**97**

*indicates name of trainer

College campus attendees of Onsite Trainings, similar to other training approaches, could include faculty, students or staff. In Table 11, we display the demographic characteristics of Onsite Training attendees. It is important to note that for half of the onsite trainings (28 of the 56 trainings), satisfaction surveys were not available for analysis. Limiting the analysis to those who completed satisfaction surveys (n=766, 26% of attendees), the demographic characteristics were fairly similar to other training venues (webinars and regional trainings). The majority of the respondents were female (71%) and 61% were Caucasian. The second most common racial/ethnic category was Hispanic (27%). Thirteen percent were Asian and 10% were classified as "Other".

Table 11. Demographic Characteristics of Onsite Training Attendees Who Completed Satisfaction Surveys

			Race/Ethnicity							
Onsite Training Respondents	**Sample Size**	**Female**	**Caucasian**	**Hispanic**	**Black/ African American**	**American Indian/ Native Alaskan**	**Asian**	**Native Hawaiian/ Pacific Islander**	**Other**	**Veteran**
	766	71%	61%	27%	14%	2%	13%	0%	10%	766

		Position					
Onsite Training Respondents	**Sample Size**	**Fulltime Faculty Member**	**Adjunct Faculty Member**	**Admin.**	**Staff**	**Student**	**Other**
	766	27%	12%	19%	28%	4%	11%

In this next analysis, we narrow the sample to attendees of regional and onsite trainings that completed Posttest surveys asking about perceived skills (self-efficacy) and intentions to engage with students in distress. This included 1040 regional training participants and 319 onsite training participants who received surveys that asked about perceived pre- and post-training self-efficacy and intentions.

Designated satisfaction surveys included questions about perceived skills (self-efficacy) related to interactions with students who may be in distress as well as intentions to engage in conversations or take other actions when encountering students in distress. Respondents were asked how strongly they agreed with a series of statements about their skills related to addressing the mental health needs of students, ranging from 1 (Strongly Disagree) to 5 (Strongly Agree). They were also asked about the likelihood

they would take actions with students in distress ranging from 1 (Not at likely) to 5 Very likely. Respondents were asked immediately following the training what they perceived their skills and intentions were *before* the training occurred (referred to as retrospective reporting) and *after* the training. The items for the self-efficacy and intention measures and their corresponding alpha reliability are listed in Table 12.

As can be seen in Table 13, both regional and onsite trainings respondents showed significant shifts in perceived self-efficacy and intentions comparing Posttest responses to retrospective reporting at Posttest. These findings were consistent when stratifying the sample by occupational role or respondent (data not shown). We also found no significant difference in these impacts comparing regional to onsite trainings (data not shown).

Table 12. Measures of Self-Efficacy and Intentions to Engage with Students

	Response	Alpha*
Self-efficacy (5 items) I can identify where to refer students. I have easy access to materials. I am comfortable discussing mental health issues with students. I am confident in my ability to help colleagues address mental health issues. I am aware of the warning signs of mental health distress.	Strongly Disagree (1) - Strongly Agree (4)	.89
Intentions (8 items) *If a student showed signs that s/he might be experiencing mental health distress, how likely would you be to ...* Encourage the student to get professional help. Call a crisis line with person present. Encourage the student to talk to their parents or friend. Provide guidance about how the students can help others. Take to get help. Give a specific number or person to call. Ask specific questions to assess level of stress. Call security/administrator to deal with a student.	Very Unlikely (1) - Very Likely (4)	.89

* ***Note***: Cronbach's Alpha is used to assess internal consistency of survey items. Alpha levels >.70 is deemed acceptable.

Table 13. Change in Perception of Skills and Intentions Comparing Pre- to Post-Training (range 1-5)

	n	Pretest Mean (SD)	Posttest Mean (SD)	*t* test	d	*p*
Self-efficacy to Engage with Students in Distress						
Regional Trainings	758	3.92 (.84)	4.43 (.60)	21.26	.78	***
Onsite Trainings	223	3.87 (.87)	4.37 (.63)	10.89	.73	***
Intentions to Engage with Students in Distress						
Regional Trainings	757	3.17 (.74)	3.58 (.52)	20.01	.73	***
Onsite Trainings	220	3.11 (.75)	3.54 (.57)	9.42	.63	***

* $p < .0001$

iv. One-on-One TA Sessions

One-on-One technical assistance (TA) sessions took place over the phone or in person with college staff. TA sessions were initiated either by the CARS TA provider or campus staff, based on their needs and circumstances. As illustrated in Table 14, TA sessions were organized by topic areas to ease interpretation of the data. Campuses that had more than One-on-One session on a given topic area were counted once in order to calculate the percentage of the CCC system reached by One-on-One TA sessions. TA sessions were ordered in Table 14 based on those that reached the largest proportion of the CCC system (Table 14, last column). Appendix B includes a figure that displays all campuses in attendance and the number of trainings each campus attended for each training and topic area.

- There was a total of 35 One-on-One TA sessions between April 2012 and June 2014 reaching 138 campus participants and 30% of the CCC system overall.

- The topic areas discussed with the highest proportion of the CCC system included developing mental health capacity building (13%), suicide prevention (9%) and developing Behavioral Intervention Teams (4%).
- When examining the proportion of the CCC system that engaged in any One-on-One TA with CARS, we found that 24 colleges engaged in One-on-One TA one or more times (Table 14). Four colleges had two One-on-One TA sessions and two colleges were involved in three One-on-One sessions (Table 15).
- When comparing participation by CBG status, we found that 33% of CBG campuses and 22% of non-CBG campuses availed themselves of One-on-One TA. (Table 15).

Table 14. One-on-One Technical Assistance, Topic Areas, Number of TA Sessions, Participants, and Colleges Participation

	General Topic Area	One On One Descriptions	No. TA Sessions	No. Participants	No Coll. (% CCC Campuses)
Mental Health Capacity Building (13%)					
1	**Developing Referral Systems**	• Making Student Referrals	**13**	**47**	**13 (12%)**
2	**Workforce**	• Developing an Intern Handbook	**1**	**1**	**1 (<1%)**
3	**Strategic Planning**	• Strategic Planning	**3**	**18**	**3 (2%)**
Suicide Prevention (9%)					
4	**Suicide Prevention**	• Suicide Prevention –Active Minds	**10?**	**10**	**10 (9%)**
Crisis Intervention (4%)					
5	**Behavioral Intervention Team Development**	• BIT Development • BIT strategic planning session • BIT Development/Threat Assessment	**4**	**39**	**4 (4%)**
Service Needs and Support for High Risk/Underserved Students (1%)					
6	**Cultural Competency, working with Diverse Populations**	• Develop cross-cultural conflict resolution training	**1**	**4**	**1 (<1%)**
7	**Veterans**	• De-escalation between student Veterans and staff	**1**	**3**	**1 (<1%)**
8	**Foster Youth**	• Foster Youth- mental health wellness	**1**	**5**	**1 (<1%)**
Mental Health Awareness (<1%)					
9	**Mental Health 101**	• Mental Health 101 Curriculum/Training	**1**	**21**	**1 (<1%)**
		Totals	**35**	**148**	**35 (30%)**

Table 15. Percentage of Campuses attending One-on-One TA Sessions

Any One-on-One TA	N (% of Campuses)
Any One-on-One TA - All Campuses	**28 (25%)**
0 TA Sessions	84 (75%)
1 TA session	22 (20%)
2 TA session	4 (4%)
3 TA session	2 (1%)
Total	**112 (100%)**
Any One-on-One TA - CBG	**10 (33%)**
Any One-on-One TA - Non CBG	**18 (22%)**

Following TTA assignments, campuses were sent an Initial and Follow-up survey to assess satisfaction with TTA services and utility (the extent to which they were using what was learned from the TTA). The Initial survey was sent 30 days post training, and the Follow-up survey was sent 90 days post training. There were 148 potential TTA recipients between December 2012 and June 2014 who received the surveys. Among these TTA recipients, 105 completed the Initial survey (71%) and 102 completed the Follow-up survey (69%). Described below are the findings from the satisfaction surveys.

Initial Follow-up Results (Table 16)

- Follow-up results indicate that TTA recipients were highly satisfied with the training and technical assistance they received.
- Respondents indicated that the process for receiving TTA services was clear, and scored the competency of the TTA providers highly (mean=3.74 out of 4.0).
- Respondents also had high means scores responding to the likelihood that they would share the information with others (mean=3.75), apply concepts to their department operations (mean 3.64) or use the information to implement strategies on campus (3.62).

Implementation Follow-up Results (Table 17)

The survey asked about activities that campuses were actively pursuing related to building mental health capacity on their campuses and how useful the TTA services were to these efforts.

- Eighty percent or more of respondents indicated that they were "actively pursuing" expanding their colleges':
  (1) Mental health assessment, referral and treatment system (81%),
  (2) Partnerships with county mental health or community based service providers (78%),
  (3) Mental health programs/services, trainings or policies (83%),
  (4) Faculty, staff or student awareness of student mental health issues (85%) and
  (5) Awareness of mental health resources available on campus or within the community (81%).

- Among those who responded that they were actively pursuing these areas, they were asked how useful TTA was to these efforts.
  - The mean score for each of these areas was 3.0, suggesting that the TTA services were "mostly useful" to these efforts.
- When asked if they would recommend TTA services to their colleagues 99% indicated "yes".

Table 16. 30 Day Satisfaction Results (n=105)

	Mean Score (n=105)
Satisfaction Measures:	Range: 1(Strong Disagree) - 4 (Strongly Agree)
Process for receiving TA was clear	3.68
Process happened in a time frame that met my needs	3.73
Competency of TTA provider (5 items) (promptly responds, prepared, understands needs, culturally competent, knowledgeable)	3.74
Likelihood will:	Possible Range: 1 (Not at all likely) – 4 (Very likely)
Share information, skills or knowledge with others	3.75
Apply concepts to department operations	3.64
Use materials to implement strategies on campus	3.62

Table 17. 90 Day Utility Results (n=102)

Did you actively pursue developing or expanding…	**% Yes**	**If Yes, how useful was the TTA in this Effort?** 1 (Not at all Useful) - 4 (Extremely Useful)
Your campus's mental health assessment, referral and treatment system	81%	3.12
Partnerships with county mental health or community based service providers?	78%	2.97
Mental health programs/services, trainings or policies	83%	3.19
Faculty, student or staff awareness of student mental health issues	85%	3.33
Faculty, student or staff awareness of mental health resources available on campus or within the community	81%	3.25
Would you recommend the TTA services to your colleagues in the CCC system	99%	--

v. Product Development and Website Access

A significant portion of CARS time was spent developing publications and other communication products, key to building campus mental health infrastructure. As noted in the CARS June 2014 report, over the 26 month period CARS developed 34 publications and products. These included:

- 9 Publications
- 4 Training videos

- 2 development resources and tools
- 1 training presentation
- 16 Monthly newsletters reaching 1,800 contacts

Listed in Table 18 is a description of each product organized by the topic area excluding the 16 monthly newsletters. As one can see, the largest focus has been on dissemination products describing overviews of mental health needs of students (n=4), followed by suicide prevention, Veteran needs, working with distressed students and Behavioral Intervention Teams.

Table 18. Publication and Products Developed by CARS

Topic Area	Type of Product	Title of Product
Mental Health 101	Online Tool	1. Online Guide to Mental and Behavioral Health, Resources for College students
	Publication	2. Student Mental Health: An important element of student success.
	Training Video	3. College Student Mental Health: Understanding the Basics.
	Training Video	4. A Student Panel on Mental Health Needs
Suicide Prevention	Publication	5. Suicide Prevention Gatekeeper Training
	Publication	6. Suicide Prevention of College Campuses

Table continues…

Table 18 (cont.). Publication and Products Developed by CARS

Topic Area	Type of Product	Title of Product
Supporting Student Veterans	Publication	7. Supporting Student Veterans
	Training Resource	8. Welcome Home: Veterans on Campus Training Resource
Working with Distressed Students	Publication	9. Sample Policy Working with Distressed Students
	Training Presentation	10. Responding to Difficult or Distressed Online Students: Mental Health Assessment and Referrals
Behavioral Intervention Teams/Threat Assessment	Publication	11. Considerations for Naming Your Behavioral Intervention Team
	Training Resource	12. Best Practices in Campus Threat Assessment Training Resources
Supporting the LGBTQ Community	Publication	13. Supporting the Lesbian, Gay, Bisexual and Transgender Students
Support Foster Care and Adjudicated Youth	Publication	14. Supporting Transition Aged Foster Youth
CBG Profiles	Publication	15. Campus Based Grant Profiles
Violence Prevention	Training Video	16. Transforming Violence
Referral System Development	Resources and Tools	17. MOU Planning Guide and Template
Other	Training Video	18. Mental Health American Sign Language Interpreting in a College Setting

Throughout the 26 month contract, CARS built and modified the CCC SMHP website to meet the evolving needs of campuses. The website was recently expanded to include tools, resources templates and products developed by other colleges and a searchable data base. Currently the website has 64 resources to access. Based on analysis by CARS staff, 40,923[5] unique visitors accessed the CCC SMHP website and viewed 300,830 webpages.

vi. TTA Activities by Topic Areas

In this section we report on the mean number of TTA events that campuses attended, organized by topic area. As can be seen by Table 19, the area of TTA that campuses utilized the most was mental health systems capacity building. On average, campuses attended 3.5 TTA activities specific to building capacity in their system. This category is fairly broad and includes developing new policies, building partnership with community mental health services, establishing referral systems, reducing staff stress and establishing trauma informed care teams.

The second most frequently accessed TTA service (mean=2.38) was developing Crisis Intervention Services which includes Active Shooter trainings, Behavioral Intervention Teams, Threat Assessment and Addressing the Needs of Students in Distress. The third most commonly accessed CARS TTA was focused on increasing awareness and meeting the service needs of high risk and underserved populations (including LGBTQ, Asian, Veterans, and foster/adjudicated youth). The two types of CARS TTA less likely to be accessed by campuses included TTA related to Suicide Prevention or Peer-to-Peer training (BACCHUS trainings) (mean = .82 and .12, respectively).

Table 19. Number of CARS TTA Activities Attended by Topic Area

		All CCC Campuses (N=112)		
	Topic Area	**Mean**	**SD***	**Max**
1	Mental Health Capacity Building	3.46	2.96	18.00
2	Crisis Intervention Services	2.38	1.94	8.00
3	Service Needs of underserved populations (LGBTQ, Asian, Veterans, foster/adjudicated youth)	1.99	1.56	7.00
4	Mental Health Awareness	1.20	1.21	5.00
5	Suicide Prevention	.82	.93	4.00
6	Peer-to-Peer	.12	.37	2.00

* SD: Standard Deviation

When comparing utilization of CARS TTA by CBG status, we found that CBG campuses were significantly more likely to access CARS TTA across all six topics areas than non-CBG campuses. This was most pronounced for trainings focused on building mental health capacity (mean = 6.4 vs. 2.39, respectively). Graphic stacked bar charts illustrating the utilization of CARS TTA by non-CBG and CBG campus can be found in Appendix B.

[5] CARS staff initially used Google analytics to calculate usage, but found it wasn't functioning properly, so staff compiled web usage data themselves.

Table 20. Campus Utilization of CARS TTA by Topic Area and CBG Status

	Non-CBG (n=82)		CBG (n=30)		*t* test	Significance
	Mean	SD*	Mean	SD*	t	*p*
Mental Health Capacity Building	2.39	1.71	6.40	3.64	-7.91	.00
Crisis Intervention Services	1.94	1.86	3.60	1.63	-4.32	.00
Service Needs of underserved populations (LGBTQ, Asian, Veterans, foster/adjudicated youth)	1.65	1.34	2.93	1.74	-4.15	.00
Mental Health Awareness	1.02	1.09	1.67	1.40	-2.56	.012
Suicide Prevention	.68	.84	1.20	1.06	-2.67	.009
Peer-to-Peer	.07	.26	.23	.57	-2.04	.04
Total (All topic areas)	7.76	4.57	16.03	6.24	-7.66	.00

Note: SD = standard deviation.

c. Campus-Based Grants (CBGs)

In order to capture the various activities generated by the CBGS, this section summarizes quarterly reporting data that CBGs provided to PIRE from July 1, 2012 through June 30, 2014 (see Appendix C). Unless otherwise noted, the data are cumulative and cover the entire project period. This summary is organized by the following topics:

- Ratings of Project Progress
- Mentors and Mentee[6]
- Training of Trainers
- Presentations, Trainings, and Seminars
- Mental Health Services

Each quarter, CBG staff members were required to report on their progress towards achieving ten goals that were common to most CBG grantees. This section provides the campuses' final ratings. To help increase the stability of the ratings, we took the truncated average of the final two quarters as the final disposition.[7] Highlighted in green are the number and percentage of campuses that reported making a lot of progress or that the activity was nearly/fully complete.

6 Mentors and Mentees was the description provided by PIRE to the CBGs for the purposes of reporting. This is also known as peer to peer activities, which is the term used more broadly in this report and the one that was provided in the original CalMHSA RFA.

[7] By "truncated average" we mean that we rounded down to the nearest whole number. For example, an average rating of 4.5 would be rounded down to 4. This is a more conservative approach to the ratings, but counter-balances any inflation of ratings that may have occurred through the self-report of progress.

Campus Wide Assessment of Needs

	Frequency	Percent
Not yet begun	1	4.3
Very early	1	4.3
Some progress	0	n/a
Lot of progress	1	4.3
Nearly or fully complete	18	78.3
N/A	2	8.7
Total	23	100.0

Establishing Identification and Referral System

	Frequency	Percent
Not yet begun	1	4.3
Very early	0	n/a
Some progress	1	4.3
Lot of progress	5	21.7
Nearly or fully complete	14	60.9
N/A	2	8.7
Total	23	100.0

Developing Resources

	Frequency	Percent
Not yet begun	0	n/a
Very early	0	n/a
Some progress	1	4.3
Lot of progress	7	30.4
Nearly or fully complete	14	60.9
N/A	1	4.3
Total	23	100.0

Developing a System for Campus Threat Assessment

	Frequency	Percent
Not yet begun	0	n/a
Very early	1	4.3
Some progress	3	13.0
Lot of progress	7	30.4
Nearly or fully complete	10	43.5
N/A	2	8.7
Total	23	100.0

Meeting CCC SMHP Goal of Providing Suicide Prevention Training for Faculty, Staff & Students

	Frequency	Percent
Not yet begun	0	n/a
Very early	1	4.3
Some progress	1	4
Lot of progress	8	34.8
Nearly or fully complete	13	56.5
NA	0	n/a
Total	23	100.0

Meeting CCC SMHP Goal of Providing Mental Health Training for Faculty, Staff & Students

	Frequency	Percent
Not yet begun	0	n/a
Very early	0	n/a
Some progress	2	8.7
Lot of progress	12	52.1
Nearly or fully complete	9	39.1
N/A	0	n/a
Total	21	100.0

Fostering Collaboration with Other Campuses

	Frequency	Percent
Not yet begun	0	n/a
Very early	0	n/a
Some progress	5	21.7
Lot of progress	8	34.7
Nearly or fully complete	10	43.5
N/A	0	n/a
Total	23	100.0

Fostering Relationships with County MH Agencies and Providers

	Frequency	Percent
Not yet begun	0	n/a
Very early	0	n/a
Some progress	0	n/a
Lot of progress	10	43.4
Nearly or fully complete	13	56.5
N/A	0	n/a
Total	23	100.0

Leveraging Resources Related to Mental Health Services

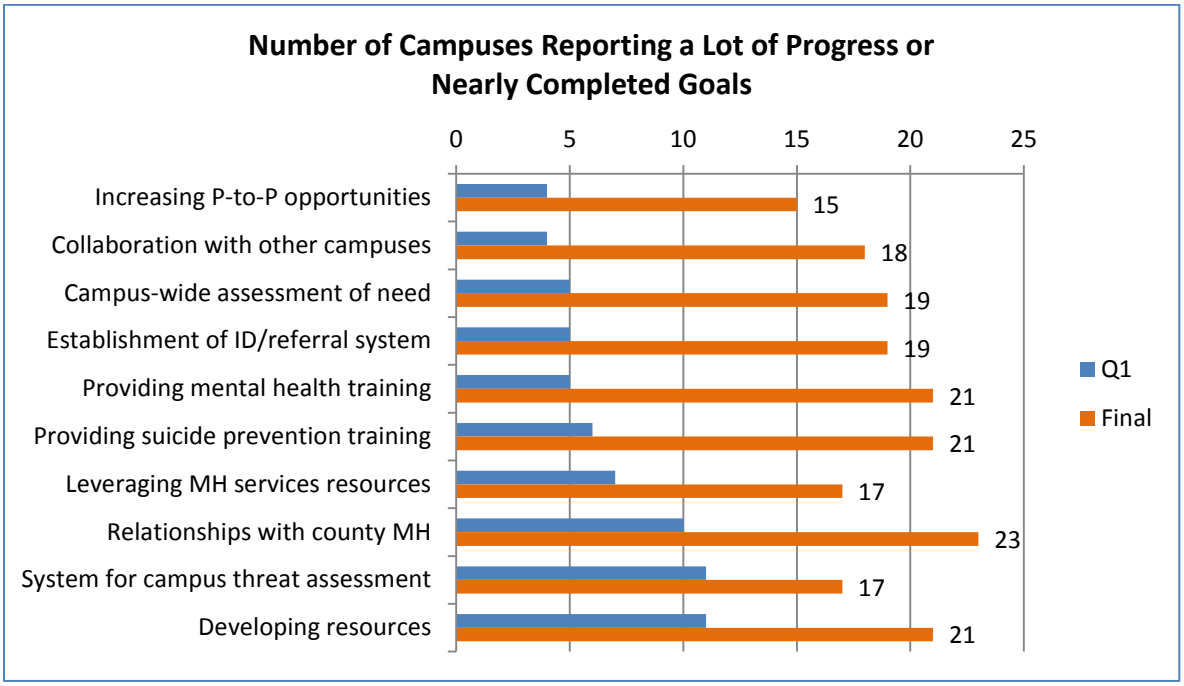
	Frequency	Percent
Not yet begun	0	n/a
Very early	0	n/a
Some progress	4	17.3
Lot of progress	9	39.1
Nearly or fully complete	8	34.8
N/A	2	8.7
Total	23	100.0

Meeting CCC SMPH Goal of Increasing Peer-to-Peer Opportunities

	Frequency	Percent
Not yet begun	0	n/a
Very early	0	n/a
Some progress	6	26.0
Lot of progress	9	39.1
Nearly or fully complete	6	26.1
N/A	2	8.7
Total	23	100.0

The figure below compares the final analysis with data from the first quarter of the project. As expected, limited progress towards reaching project goals was reported during Quarter 1, whereas campuses reported a substantial amount of progress by the end of the project. The extent of progress by the end of the project ranged from a low of 15 campuses (65%) reporting they made a lot of progress or completed the goal of increasing peer-to-peer opportunities, to a high of all 23 campuses (100%) reporting they made a lot of progress or completed the goal of developing relationships with county mental health agencies. Other than the goal of peer-to-peer opportunities, a lot of progress was made on each goal by at least 74% of the CBGs by the end of the project.

Figure 2. Progress on Major Goals



Each quarter, campuses reported on the number of active peer mentors and mentees they were supporting with CBG funds. Peer mentors refer to students who were trained to engage other students in issues related to mental health and wellness and to identify/refer students of concern. Peer mentees refers to students who met regularly with peer mentors to receive support around issues related to mental health and wellness.

The following tables display the number of active mentors and mentees reported for each quarter. As can be seen, activity for mentors peaked in Quarter 6, during which time the CBGs reported the most number of sites with mentors, the most mentors, and the highest mean number of mentors per site. The strongest periods for mentees were Quarters 3, 4, and 7.

Table 21. Active Mentors Reported for Each Quarter

Reporting Period	Quarter	Number of Sites with Mentors	Highest Number of Mentors per Site	Total Number of Mentors	Mean Number of Mentors per Site
July 1 – December 31, 2012	1	8	19	63	7.9
January 1 – March 31, 2013	2	1	2	101	10.1
April 1 – June 30, 2013	3	16	30	145	9.1
July 1 – September 30, 2013	4	**18**	22	167	9.3
October 1 – December 31, 2014	5	15	20	130	8.7
January 1 – March 31, 2014	6	**18**	**188**	**388**	**21.6**
April 1 – June 30, 2014	7	16	28	164	10.3

* Highest numbers per columns are shown in bold.

Table 22. Active Mentees Reported for Each Quarter

Reporting Period	Quarter	Number of Sites with Mentees	Highest Number of Mentees per Site	Total Number of Mentees	Mean Number of Mentees per Site
July 1 – December 31, 2012	1	3	142	160	53.3
January 1 – March 31, 2013	2	8	240	491	61.4
April 1 – June 30, 2013	3	5	950	1007	**201.4**
July 1 – September 30, 2013	4	**11**	900	1550	140.9
October 1 – December 31, 2014	5	10	110	1721	172.1
January 1 – March 31, 2014	6	10	323	740	74.0
April 1 – June 30, 2014	7	**11**	**1500**	**2047**	189.1

* Highest numbers per columns are shown in bold.

Table 23 displays information about campus Training of Trainers (TOT) events that occurred during the project. Across all campuses there were 156 TOT events, reaching 6,579 people (with individuals potentially counted more than once), and spanning 773 hours.

Table 23. Training of Trainer Events

Event Category	Number of Events	Number Attending by Type				Total Number of Hours
		Faculty/ Staff	Students	Other	Total Attending	
Early Recognition of Students of Concern	24	724	214	15	977	114
Crisis or Behavioral Intervention	23	526	52	0	601	70
Suicide Prevention	32	390	118	35	575	205
General Health Promotion	38	278	1211	86	1613	173
Peer to Peer	26	618	1822	177	2643	112
Other	13	102	32	23	170	100
Total	**156**	**2,638**	**3,449**	**336**	**6,579**	**773**

Table 24 displays information about campus presentation, training, and seminar events that occurred during the project. (Data from Kognito training are not included in this table.) Across all campuses, there were more than 1,000 events, reaching nearly 77,000 people (with individuals potentially counted more than once), and spanning more than 3,000 hours.

Table 24. Campus Presentation, Training, and Seminar Events

Event Topic Category	Number of Events by Type				Number Attending by Type				Total Number of Hours
	Presentation	Training	Seminar	Total Events	Faculty/ Staff	Students	Other	Total Attending	
Early Recognition of Students of Concern	98	77	2	177	2688	4384	236	7308	427
Crisis or Behavioral Intervention	29	37	2	68	1224	282	77	1583	282
Suicide Prevention	59	63	0	122	2325	19,168	310	21803	465
General Health Promotion	318	93	27	438	4088	28,173	634	32895	1066
Peer to Peer	117	31	9	157	757	6420	53	7230	309
Other*	90	54	7	151	1165	4497	456	6118	553
Total	**711**	**355**	**47**	**1,113**	**12,247**	**62,924**	**1,766**	**76,937**	**3,102**

* The "Other" event topic category includes LGBTQ equality and sensitivity, veterans' issues, nutrition and stress, strengths approach to reduce risk, safety zone, outreach, and body-mind wellness.

Table 25 examines whether the CBG campuses track their mental health services, comparing data from the beginning and end of the project. There was generally little change from baseline to the end of the project. For example, nearly all campuses (21 of 23) tracked the number of individuals who received mental health services on campus, at baseline and the end of the project. This could be because one of the eligibility criteria for the grants was to have some existing capacity or infrastructure to address student mental health needs and issues. The biggest gain was in the tracking of sources of referrals to the campus health or mental health center. At the beginning of the CBG, only two campuses reported tracking such information, whereas 8 campuses reported tracking those data by the end of the project. Notably, only one campus reported tracking whether students who were referred for off-campus services actually received those services. Despite the fact that most campuses reported that they enhanced their ID/referral systems and their relationships with county mental health agencies (Figure 2), only one-third (8) reported that they track their referral sources and only one campus indicated it tracks whether their referrals result in services.

Table 25. Characteristics of Referral Systems

Do you track…	Baseline	End of Project
Number of individuals who received MH services on campus?	21	21
Sources of referrals to the campus MH center?	2	8
Number of students that the MH center referred for off-campus MH services?	9	10
Whether students who were referred for off-campus services received them?	1	1

II. Descriptive Overview of Baseline Conditions

Before describing the possible impact or effects of the California Community Colleges Student Mental Health Program (CCC SMHP), it helps to get a good idea of the scope of the challenge of both the project and the evaluation, as well as to provide some context by which to better appreciate the population that the CCC SMHP was meant to serve.

a. Student Mental Health Issues

The RAND Corporation is a nonprofit institution that helps improve policy and decision making through research and analysis and was chosen to be CalMHSA's statewide evaluator for all PEI projects, including student mental health. RAND was chosen for this function after PIRE was selected to be the CCC SMHP's evaluator, therefore, some adjustments to the CCC SMHP evaluation plan and deliverables were required. One of the deliverables for RAND's evaluation was to conduct campus-wide online surveys of the University of California (UC) and California State University (CSU) colleges and university faculty, staff, and students during the spring and fall of 2013. PIRE worked with RAND to modify the questionnaire and follow through with implementation of a survey in the California community colleges, which was an adjustment as noted above to PIRE's original evaluation plan. RAND noted that the purpose of these surveys was to understand (1) experiences and attitudes related to student mental health, (2) perceptions of how campuses are serving students' mental health needs, and (3) perceptions of overall campus climate toward student mental health and well-being. The PIRE team also developed additional items to get a picture of how the CCC SMHP may have affected the likelihood of students being referred to mental health services.

This section on baseline student health is taken largely, but not exclusively from the RAND report for CalMHSA that included findings from the University of California (UC), California State University (CSU), as well as the California Community Colleges (CCC) campuses that participated in the 2013 baseline survey (Sontag-Padilla, et.al, 2014). See Appendix D for more detailed information about the survey.

As part of a larger evaluation of the CalMHSA Student Mental Health Activities in higher education institutions, the evaluators conducted a voluntary and confidential web-based survey of students and faculty/staff on UC, CSU, and CCC campuses. UC and CSU invited all of their campuses to participate. CCC invited a subset (30 campus-based grantees [CBGs] and 30 campuses without campus-based grants to participate. Between April 2013 and December 2013, participating campuses emailed invitations to students, staff, and faculty to complete the online survey. All the CCC colleges (and some others) were asked to send invitations to all students, staff, and faculty via email blasts, while other campuses sent invitations to a random sample of students, staff, and faculty, with a goal of generating a minimum of 150 student and 150 staff and faculty responses per campus. Reminder emails were sent once a week for three weeks to encourage participation in the survey. The study was approved by the RAND and PIRE Institutional Review Boards (IRB) and the respective IRBs of participating institutions, as needed.

RAND developed the questionnaires in collaboration with the CalMHSA program partners of the higher education programs (UC, CSU, and CCC) with customized items added by PIRE for the CCC versions. RAND derived the majority of items from standardized and valid measures of student mental health (e.g., U.S. National Health Interview Survey (NHIS), Kessler (K6) Psychological Distress Scale

(Pratt, 2009), as well as measures currently utilized in the California higher education systems (e.g., National College Health Assessment (NCHA).

A total of 39,091 students completed the higher education survey. 15,869 students participated across eight UC campuses; 7,375 students participated across nine CSU campuses, and 15,847 students participated across 34 CCC campuses (including 11 CBG and 23 non-CBG campuses). Key demographic information is presented in Table 26.

Table 26. SMHP Student Survey Respondent Demographics

	CCC		All Students	
	N	Percent	N	Percent
Age				
17-25	9,490	62%	28,154	73%
26-59	5,398	36%	10,195	26%
60-84	304	2%	421	1%
85+	1	<1%	7	<1%
Gender				
Male	5,568	35%	13,674	36%
Female	10,000	64%	24,023	63%
Other (e.g., Transgender)	63	<1%	179	<1%
Latino or Hispanic origin	5,291	34%	9,671	26%
English as primary language	12,620	81%	25,956	83%
Undergraduate student	13,746	90%	30,973	83%

From Table 26, we can see that community college students in the survey sample were older and a bit more likely to report being Latino/Hispanic, but were otherwise not too different from the sample overall.

i. Prevalence of key problems among all students surveyed (UC, CSU and CCC)

Students reported their general level of distress and functioning over the last 30 days (Table 27). Using a recommended cutoff score indicating probable psychological distress (Kessler et al., 2003), approximately 19% of students (n = 7,203) met or exceeded the established threshold for probable psychological distress during the 30 days prior to the survey, which is comparable to rates reported in other studies of higher education students (Hunt & Eisenberg, 2010). However, as illustrated in Table 27, rates indicative of probable psychological distress varied substantially across campuses within each system. When asked about symptoms commonly related to depression, 10% to 12% of students across all systems reported feeling hopeless most or all of the time, and 8% to 10% reported feeling so depressed nothing could cheer them up all or most of the time (not shown in table).

Table 27. Rate of Probable Psychological Distress among Students

	Probable Psychological Distress	
	Average %	Range across Campuses
UC	19%	14% - 24%
CSU	18%	12% - 23%
CCC	19%	5% - 27%
Total	19%	--

Table 28 focuses just on subgroups of students in community colleges. Distress may be somewhat higher among Asian and Biracial students. Higher rates of distress are reported by students who identified as LGBTQ and students with disabilities. Rates of probable psychological distress were a bit higher among the CBG colleges compared to other community colleges in the sample.

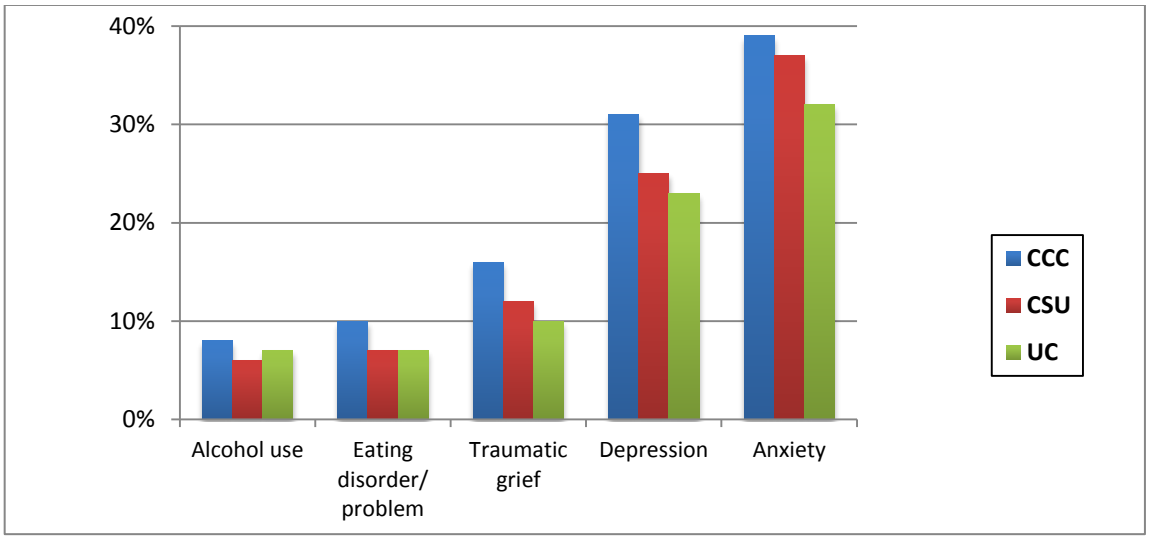
Table 28. Rate of Probable Psychological Distress among Selected Subgroups of CCC Students

CCC Sample Only	Probable Psychological Distress (%)
Male	17.7
Female	19.7
Latino	19.6
White	17.5
Black	16.9
Asian	21.5
Biracial	22.9
LGBTQ	29.1
Foster /adjudicated youth	22.0
Veteran	22.0
Students w/ Disabilities	36.2
Parents	19.3
CBG	19.6
Non-CBG	17.0

ii. How mental health issues affect academic achievement

Students also reported whether various symptoms, behaviors, or stressful situations had impacted their academic performance in the prior 12 months. Impairment for each mental health issue was assessed separately, allowing students to report impairment due to multiple issues. As illustrated in Figure 3, students across all higher education systems reported academic performance impairment from anxiety or depression in high numbers. Notably, CCC students reported higher levels of negative effects across the various issues (e.g., alcohol use, depression).

Figure 3. Percentage of Students Who Reported Impairment to Academic Performance, by Mental Health Issue



Note. Impairment reported independently for each mental health issue.

b. Community College Mental Health Services

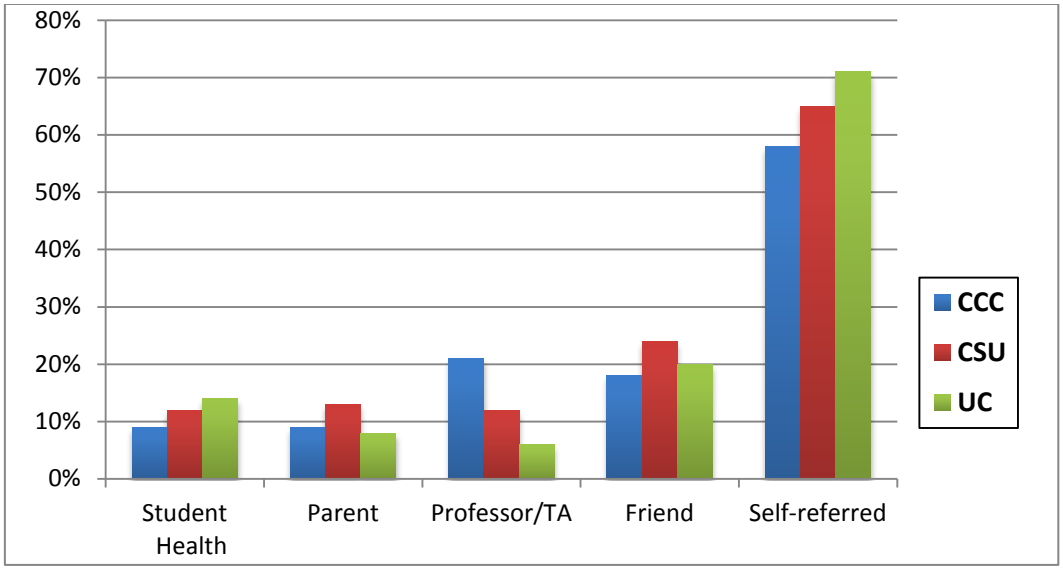
i. Patterns and prevalence of referrals

Given the prevalence of mental health issues among the college students who responded to this survey, the question arises as to how many students take advantage of mental health services offered on their campus. On average for all students across all systems, 17% (n = 6,451) had either (1) used counseling or mental health services provided by their current college/university campus' counseling or health services center, or (2) were referred to such services. Approximately 1 out of 5 students in the UC system (23%) and the CSU system (19%) reported using or receiving referrals for these services, while approximately 1 of 10 CCC students (10%) reported using or receiving referrals for these services. This disparity in the use of services is likely due to community colleges being non-residential (and students therefore spending less time on campus), but it may also reflect community college students having obligations that might place other demands on them (e.g., family obligations or work demands).

The survey format permitted students to report any and all sources of referrals they may have received for counseling or mental health services, even multiple sources. Across all systems, the most common sources of referral among students who either used or were referred for counseling or mental

health services (*n* = 6,451) were self-referrals (i.e., individual student initiated the process of seeking services), and referrals by friends, professors, or teaching assistants (TAs). In the UC and CSU systems, friends were the most common source of referral second to self-referral. In the CCC system, however, professors/TAs were the second most common source of referral after self-referral. This may be due to non-residential students having more contact with instructors relative to friends on campus, but since the prevalence of referral by friends is not so different from students in the other higher education systems, it could reflect instructors at the community colleges being either more likely to notice students in need of referral, or more assertive about making such referrals. Figure 4 illustrates the referral sources across the three higher education systems.

Figure 4. Sources of Referrals for Student Mental Health Services



Note. Multiple responses permitted per respondent.

Among those students who sought or were referred for mental health services or counseling (*n* = 6,451), approximately 67% (n = 4,341) sought services on campus. The rate of accessing services on campus varied across the systems, with an average of 77% of UC students (*n* = 2,760), 71% of CSU students (*n* = 553) and 41% (*n* = 622) of CCC students receiving such services on campus. The lower rate among CCC students may reflect their spending less time on campus (either because they don't live on campus or because they spend less unscheduled time there) so that going to the counseling center may be more difficult. It also could be that if relatively quick appointments were made available, CCC students may have more difficulty accessing these services for any reason (e.g., limited staff or hours).

For those students who received services on campus, 75% of UC students rated the quality of service received (e.g., delivery, usefulness) as good or excellent, and 66 % of CSU and CCC students rated the quality as good or excellent. It would seem, then, that when students at community colleges do seek and receive services, they are just as satisfied as students in other systems.

For students who did not receive referrals for services (*n* = 31,597; 88% of all respondents) or did not use services on campus (*n* = 2,043), the most common reasons for not accessing services was feeling the services were not necessary (73%), not having enough time (30%), not knowing it was offered (26%) and not knowing how to access it (24%). As illustrated by Table 29, students from community

colleges were less likely to report not having enough time, but more likely to report that they "didn't know what it offered," "how to access it," whether they were "eligible," or had ever "heard of it."

This picture is actually good news for the CCC, in that the barriers to accessing services seem less "structural" (e.g., not having time), nor due to global attitudes (e.g., that it "wouldn't help"), and instead a simpler matter of finding better ways to inform CCC students about the availability of services. Also, the information provided should include not only the existence of services, but other details, such as eligibility and access.

Table 29. Reasons Students Did Not Access Services

Reason For Not Accessing Services	Percentage of UC Respondents Endorsing Reason	Percentage of CSU Respondents Endorsing Reason	Percentage of CCC Respondents Endorsing Reason
I didn't feel I needed services.	77%	75%	69%
I didn't have enough time.	34%	34%	26%
I didn't know what it offered.	18%	21%	33%
I didn't know how to access it.	18%	20%	29%
I didn't think it would help.	28%	24%	21%
I was embarrassed to use it.	22%	23%	21%
I had concerns about possible costs.	22%	18%	22%
I didn't know if I was eligible.	14%	17%	25%
I had never heard of it.	7%	10%	25%

Note. Multiple responses permitted per respondent.

The suggestion that CCC students may be in need of information is carried through rather dramatically by the responses shown in Figure 5. Over 40% of students in the UC and CSU system reported receiving information from their campuses about alcohol and other drugs, stress reduction, and depression/anxiety. This is further reinforced by the responses by topic area, which show that for no topic did more than 30% of CCC students report having received information from their campuses.

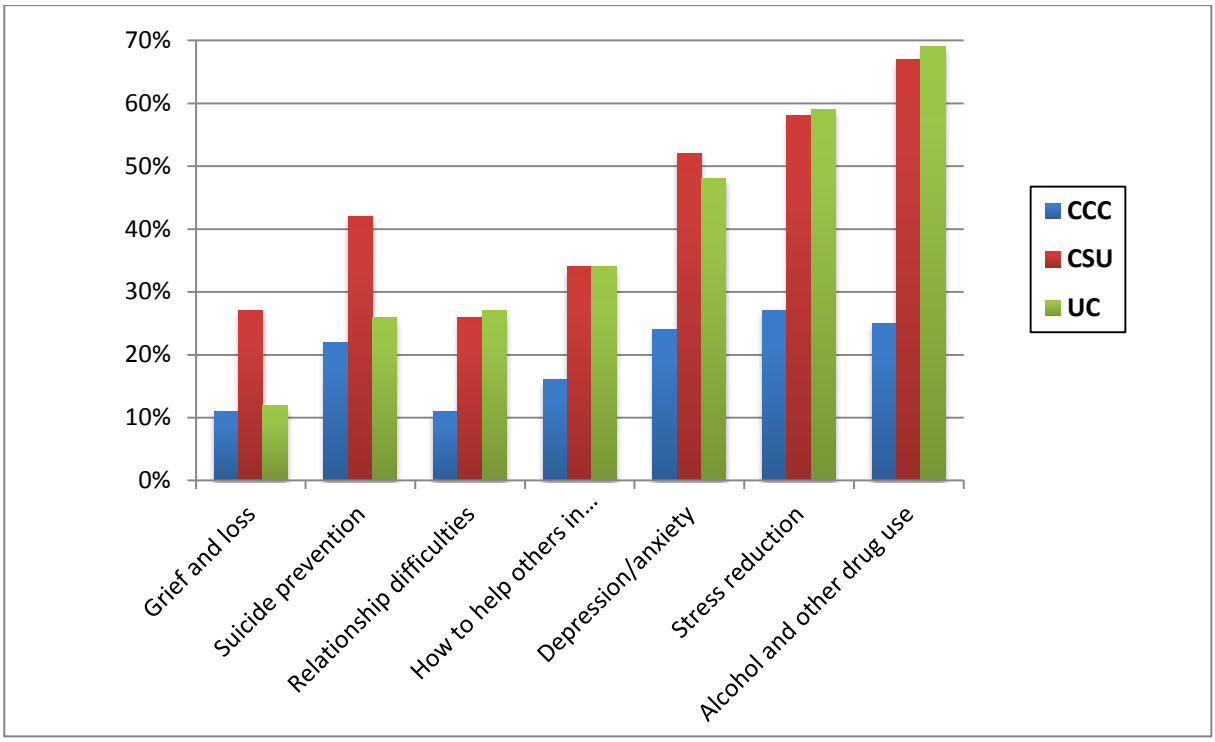
Faculty and Staff Survey

As we have seen, faculty and staff at community colleges play perhaps an even more important role in helping students with mental health issues than do their peers in the other college and university systems in California. Their perspective on mental health topics is also likely to be unique and informative about the nature of the problem and how it's being addressed.

A total of 14,922 faculty and staff completed the higher education survey as follows: 9,914 faculty and staff participated across eight UC campuses; 2,919 faculty and staff participated across nine CSU campuses; and 2,089 faculty and staff participated across 21 CCC campuses (including 9 CBGs and 12 non-CBGs). The majority of respondents for the full sample of faculty/staff (81%) were between 26 and 59 years of age (n = 11,667). For the CCC system, 73% for were between 26 and 59 years old, with 21% of CCC faculty/staff were older being older. Sixty-seven percent of respondents identified themselves as

female, 33% as male, and <1% as other (e.g., transgender). For CCC, the sample was 70% female, 29% male and <1% other. Fifteen percent were Latino (17% for CCC). Respondents reported an array of roles at their campus and a variety of educational backgrounds.

Figure 5. Student Mental Health Information Received from Campus by Topic



Faculty/staff answered questions about the extent to which they believed their campuses provided adequate services and programs to address student mental health needs. Most faculty and staff (57%) reported that support, resources, or programs for students with mental health needs were in place. Findings were generally comparable across the higher education systems, with the exception of one item (Table 30). When asked about the adequacy of services for students with unique needs (including students from diverse ethnic, language, cultural, and socioeconomic groups), CCC faculty/staff were somewhat less likely to believe that their campus provided adequate services for these students (51% at CCC versus 56% and 59% at CSU and UC campuses respectively).

Table 30. Extent to Which Faculty/Staff Feel Campuses Provide Adequate Services and Programs

Item	Percentage of UC Respondents Agreeing	Percentage of CSU Respondents Agreeing	Percentage of CCC Respondents Agreeing
Campus provides adequate services for unique needs students	59%	56%	51%
Campus provides effective support for depression, stress, drug use	57%	58%	57%
Campus provides adequate MH services for students	57%	57%	54%
Campus emphasizes helping students with emotional/social/behavioral needs	55%	58%	56%

In addition to faculty/staff perceptions about campus climate and campus services/programs for students, we assessed faculty and staff efforts to support student mental health.

Forty-three percent of UC faculty/staff (*n* = 3,857), 59% of CSU faculty/staff (*n* = 1,718) and 71% of CCC faculty/staff (*n* = 1,482) reported talking to students about mental health problems at least once in the prior 6 months. This again reinforces the notion that CCC faculty and staff may play a relatively greater role in responding to the mental health needs and issues of their students.

Faculty and staff reported confidence in using a variety of approaches to support students with mental health problems (Figure 6). The majority of faculty and staff across the higher education systems reported they can identify resources for students with mental health needs, with 55% of UC faculty/staff, 66% of CSU faculty/staff, and 66% of CCC faculty/staff reporting that they can identify places or people to which they should refer students to receive support for mental health needs or distress; however, less than 40% of faculty/staff across all three systems believed they have the skills to directly help students with mental health problems.

Figure 6. Faculty/Staff Preparedness to Address Student Mental Health Issues

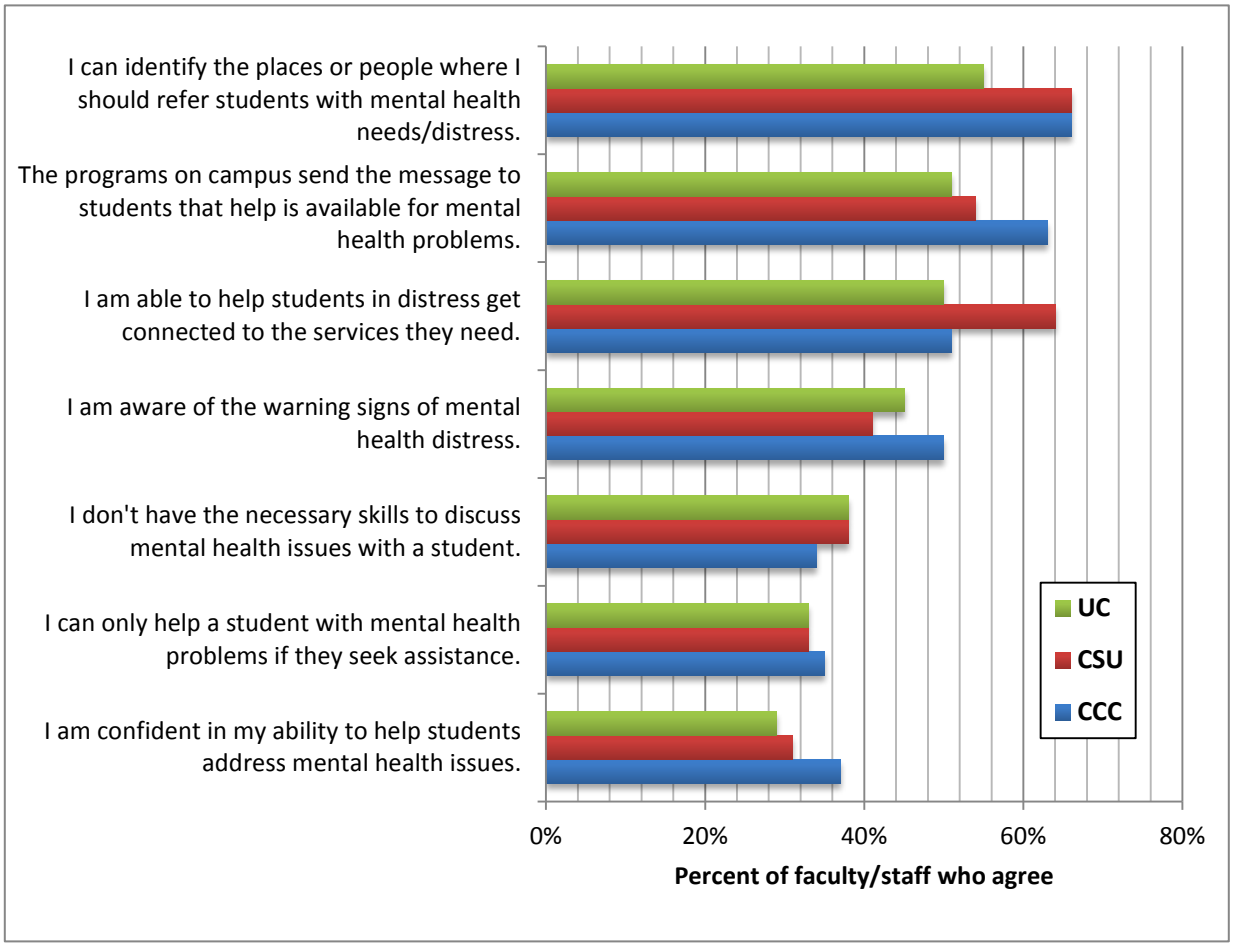


Figure 6 suggests that CCC faculty and staff feel at least as prepared as or even more prepared to address mental health needs of the students than their peers in the other systems. The majority of faculty and staff across the higher education systems reported they can identify resources for students with mental health needs, with 55% of UC faculty/staff, 66% of CSU faculty/staff, and 66% of CCC faculty/staff reporting that they can identify places or people to which they should refer students to receive support for mental health needs or distress; however, less than 40% of faculty/staff believed they have the skills to directly help students with mental health problems, which is comparable to the faculty and staff at both UC and CSU, as noted above.

ii. Describing capacities, including staffing

As part of the CCC SMHP evaluation conducted by PIRE, a Capacity Survey of Campus Based Mental Health Services was implemented to track change in mental health service capacity across the California community colleges. Three waves of capacity data were collected from one key (most knowledgeable) respondent. In many cases, the most knowledgeable respondent was the Director of the Student Health Services. The Wave 1 survey captured measures of capacity by the end of June 2012, which represented a (retrospective) baseline, as well as data collected later in 2012 (see below). The surveys comprised both CBGs and non-CBGs, and covered the period from July through December, 2012 (Wave 1), January through September, 2013 (Wave 2) and October, 2013 through June, 2014 (Wave 3). Survey links were sent to contacts for 107 community college campuses and 77 (72%) participated. Further details regarding the survey may be found in Appendix E.

A single question near the beginning of the survey asked "Does your campus have a health center on campus that provides mental health services?" Response options to this question provided basic information about the structure available on campus for provision of mental health services. In Table 31 we present the numbers (and percentages) of responses at Wave 1; we also show the numbers and percentages of responses for those campuses with data at all three waves because these are the colleges we use later to show change from baseline to post-implementation of the CCC SMHP.

Table 31. Structure on Campus for Mental Health Services (Wave 1 Data)

Does your campus have a health center on campus that provides mental health services?		
Response	**Number (%) of all cases (n=73)[8]**	**Number (%) of cases with all three waves (n=55)**
No	7 (9.6)	5 (9.1)
Yes, mental health services are provided within a health center	47 (64.4)	39 (70.9)
Yes, mental health services are provided within a separate mental health center	15 (20.5)	11 (20.0)
Does not have a health or MH center that provides services, but has another office that faculty, staff or students would contact related to student MH issues or concerns	4 (5.5)	-

[8] This indicates that there were 73 valid responses so the n differs from the number of respondents that participated (77).

A survey question asked whether the college charged a student health fee, and a follow-up question asked the respondent to estimate the percentage of the fee going to mental health services and to other health services. Table 32 presents summary results taken from the Wave 1 data for (a) all campuses responding at Wave 1, and (b) campuses that had data at all waves.

Table 32. Student Health Fee (Wave 1 Data)

Does your college charge a student health fee?		
Response	**All campuses**	**Campuses with all waves of data**
Yes	Number (%) (n=72)	Number (%) (n=55)
	65 (90.3)	50 (90.9)
No	7 (9.7)	5 (9.1)
	Mean (range) (n=44)	Mean (range) (n=36)
Average estimated percentage going to mental health services	25.8 (0-100)	27.8 (0-100)
Average estimated percentage going to other health services	74.5 (0-100)	75.3 (50-100)

A survey question asked how many total hours per week were worked by the staff in the campus health center that provided mental health services to students. An additional question asked for the number of staff by categories that provided mental health services to students.

Table 33 presents summary results (hours worked by staff) taken from the Wave 1 data for (a) all campuses responding at Wave 1, and (b) campuses that had data at all waves. Table 34 presents summary results (staff by categories) from the Wave 1 data for (a) all campuses responding at Wave 1, and (b) campuses that had data at all waves.

Table 33. Hours Worked by Staff Providing Student Mental Health Services (Wave 1 Data)

Of all staff in your college's health center who provide mental health services to students, how many total hours per week do the staff work (e.g., three people working 12 hours each, would report 36 hours)?		
Response	**All campuses**	**Campuses with all waves of data**
Estimated number of hours worked by staff	50.1 (n=65)	59.7 (n=48)

Table 34. Staffing for Student Mental Health Services (Wave 1 Data)

Of all staff on your campus who provide mental health services to students, how many fall within each of the following categories?		
Response	**Average (n responding)**	
	All campuses	**Campuses with all waves of data**
Number of psychiatrists or other licensed prescribers	.84 (31)	1.0 (25)
Number of full-time mental health counselors/therapists	.56 (36)	.62 (29)

Number of part-time mental health counselors/therapists	3.4 (51)	4.3 (37)
Number of mental health counseling interns or trainees	2.6 (52)	2.9 (43)
Number of nurses	3.0 (50)	3.4 (39)
Number of other types of staff	1.6 (28)	2.0 (21)

IV. Early Signs of Program Impact: Proximal Outcomes

The period covered by this evaluation report was about two years, with several of our measures of program outcomes covering an even shorter period of time to collect data. It would be unrealistic to expect to find significant changes in ultimate outcomes, such as the prevalence of psychological distress or of academic impairment due to mental health issues, given the short timeframe for program implementation. We can, however, look to see if the CCC SMHP may have resulted in some short-term or proximal measures of program effects.

In this section we will be identifying immediate and short-term outcomes that are likely to be associated with the CCC SMHP. The language here may sound unduly cautious, but there are reasons for that, both methodologically and substantively. First, our simple pre/post evaluation design with variable participation of individuals and colleges across different data sources means that we have to be more conservative in our conclusions than one might be if we were engaged in a randomized trial with treatment and control groups, for example.

Nevertheless, with those caveats, we identified a number of outcomes that seem to be attributable to the overall CCC SMHP and the efforts of the community colleges, the California Community Colleges Chancellor's Office and Foundation staff, CARS, Kognito and other partners in the program.

a. Developing Capacity

Changes in the capacity to provide mental health services (including prevention and early identification services) can be seen as both part of the CCC SMHP activities and as effects of those activities insofar as developing capacity may influence long-term enhancements in a college's infrastructure.

The Capacity Survey was originally designed to be a simple pre/post survey filled out by one key (most knowledgeable) respondent from each college in the sample. As mentioned earlier, this respondent was usually the Director of Student Health Services. When the CCC SMHP was given a no-cost extension, we were able to add a third wave to the survey in order to better discover any effects of the CCC SMHP on the college's capacity. The surveys comprised both CBGs and non-CBGs, and covered the period from July through December, 2012 (Wave 1), January through September, 2013 (Wave 2) and October, 2013 through June, 2014 (Wave 3). The number of participating colleges in each wave was 75, 96, and 74, respectively.

We first looked at potential changes in some of the "structural" measures of capacity, along with two items that had bearing on training and the perceived impact of that training:

For those campuses for which we had a baseline measure and at least one follow-up measure, we compared data from baseline and the latest wave for the following items

- Presence of student health fee;
- Estimated proportion of health fee allocated for student mental health;
- Number of staff hours on student mental health services (per week);
- Number of staff who provide mental health services;
- Reported trainings received targeting capacity change;
- Perceived impact of trainings.

Table 35 shows that there were small increases among all campuses in percentages or means for: (1) the presence of a reported student health fee, (2) number of staff hours on student mental health services, (3) reported numbers of trainings focused on capacity building, and (4) perceived impact of these trainings. There were decreases over time (between baseline and the last wave of data) in the reported proportion of health fee for mental health services and for number of staff who provide mental health services.

Table 35. All Campus Status on Capacity Related Variables

	N	Baseline % / mean	Post % / mean
Campus has student health fee	70	90%	91%
Proportion of health fee for mental health	38	24.7%	23.9%
Number of staff hours on student mental health services	60	53.7	55.2
Number of staff who provide mental health services	62	8.8	7.0
Reported trainings received targeting capacity change	59	1.6	2.1
Perceived impact of trainings	32	2.5	2.9

Table 36 shows that there were increases among CBG campuses in percentages or means for: (1) proportion of health fee for mental health, (2) number of staff hours on student mental health services, (3) reported numbers of trainings focused on capacity building, and (4) perceived impact of these trainings. There was a decrease in mean number of staff providing student mental health services. In other results, we defined two “readiness” measures and found that the changes among CBG campuses on both readiness measures was statistically significant (<.05). When we tested for differential effects by CBG versus non-CBG the difference among CBG campuses on the second readiness measure was significant (<.05). That is, CBG campuses increased the readiness of their referral systems more so than did non-CBG campuses.

Table 36. CBG Status on Capacity Related Variables

	N	Baseline % / mean	Post % / mean
Campus has student health fee	26	100%	100%
Proportion of health fee for mental health	15	24.4%	26.0%
Number of staff hours on student mental health services	22	68.4	74.8
Number of staff who provide mental health services	23	9.7	7.7
Reported trainings received targeting capacity change	22	2.5	3.0
Perceived impact of trainings	14	2.8	3.3

The capacity survey included 19 different areas in which the evaluators anticipated there may be some form of capacity development. For each of those areas, the key informant was asked to report whether there had, in fact been any development or expansion of capacity in that area (yes/no response). Table 37 shows the percentages of campuses reporting change in each specific type of mental health capacity that was asked about in the survey. The table shows that for each of the 19 types (except for suicide prevention policies), there was an increase in the proportion of campuses reporting change between Wave 1 and Wave 2, while between Waves 2 and 3, there were both decreases and increases.

Two types of capacity showed very large increases between Waves 1 and 2 – (p) Campus-based mental health related clubs / chapters / support groups increased from 38.5 to 58.2, and (q) Stigma & discrimination reduction activities related to accessing mental health services increased from 59.3 to 81.8 (shown in green in Table 37). Other types of capacity showed increases as well, if not as large as the ones noted.

Table 37. Specific Types of Capacity Development by Time Periods (by Percentages of Campuses)

Type of Capacity Development Reported	Wave 1	Wave 2	Wave 3
a) System to refer students of concern to appropriate center or office	76.4	85.5	85.2
b) System for center staff to conduct appropriate assessments	61.1	70.4	75.9
c) System for staff to refer students of concern to needed mental health services	79.6	81.8	81.5
d) Screening processes at on-campus center to identify student MH issues	38.9	46.3	40.7
e) Depression Screening Day events	35.8	40.0	42.6
f) Faculty / staff / student suicide prevention gatekeeper training	64.8	76.8	74.1
g) Other suicide prevention activities	59.3	69.1	79.6
h) Suicide prevention policies	28.3	24.5	31.5
i) One-on-one services with a MH professional offered on campus	66.7	70.9	83.3
j) Group services with a mental health professional offered on campus	44.2	48.2	50.0
k) Behavioral intervention teams or crisis intervention and response teams	66.7	78.6	83.3
l) Threat assessment protocols	52.8	67.3	63.0
m) Electronic health reporting system	25.0	34.5	31.5

n) Peer to peer training	31.5	47.3	42.6
o) Other peer to peer activities	46.3	56.4	53.7
p) Campus-based mental health related clubs / chapters / support groups	38.5	58.2	63.0
q) Stigma & discrimination reduction activities related to accessing MH services	59.3	81.8	92.6
r) Mental health service resources available on college website	70.4	80.0	90.7
s) MH service resources available through other strategies (flyers, etc.)	68.5	83.6	77.8

Note: Number of missing cases = 2 to 5 (Wave 1), 1 to 4 (Wave 1), 3 (Wave 3).

To get an overall picture of capacity development, we looked at the average score (or mean) across all the 19 topic areas. For example, if someone reported a "yes" for having developed 12 of the 19 topic areas (and a "no" for 7), their mean score would be a 0.63. Table 38 shows that the mean for Capacity Development showed a moderate increase (from .54 to .64) between Waves 1 and 2, and a very small increase (.64 to .65) between Waves 2 and 3. This suggests that looking at the campuses (both CBG and non-CBG) that provided data from all waves, there was a greater increase in capacity building when comparing the first two periods (July-December 2013 to January-September 2014). Note, however, that the minimum score for Wave 3 is higher (.21) than that for Waves 1 and 2, suggesting that there may have been some "catching up" among those colleges that previously reported little development.

Table 38. Mean Capacity Development by Time Periods

Capacity Development	N	Min	Max	Mean	sd
Wave 1	55	.05	1.00	.54	.265
Wave 2	56	.05	1.00	.64	.239
Wave 3	54	.21	1.00	.65	.216

In order to both simplify our measures of capacity change and to make the topic areas similar to the TTA topics, we reduced the 19 areas to the nine shown in Table 39. Within seven of nine categories of types of capacity, we computed the mean of multiple items (from two to four items). However, for two capacity measures, we used single survey items (electronic health reporting system and stigma / discrimination reduction activities).

Table 39. Computation of Measures Used in This Section of Report

Capacity Change by Specific Categories of Capacity		
RefSys	Mean of 3 Yes/No items	a) System to refer students of concern to appropriate center or office b) System for center staff to conduct appropriate assessments c) System for staff to refer students of concern to needed mental health services
Screen	Mean of 2 Yes/No items	d) Screening processes at on-campus center to identify student MH issues e) Depression Screening Day events
Suicide	Mean of 3 Yes/No items	f) Faculty / staff / student suicide prevention gatekeeper training g) Other suicide prevention activities h) Suicide prevention policies
MHsvcs	Mean of 2 Yes/No items	i) One-on-one services with a MH professional offered on campus j) Group services with a mental health professional offered on campus
Teams	Mean of 2 Yes/No	k) Behavioral intervention teams or crisis intervention and response teams

	items	l) Threat assessment protocols
E-Report	One Yes/No item	m) Electronic health reporting system
Peer2peer	Mean of 3 Yes/No items	n) Peer to peer training o) Other peer to peer activities p) Campus-based mental health related clubs / chapters / support groups
Stigma	One Yes/No item	q) Stigma & discrimination reduction activities related to accessing MH services
Resources	Mean of 2 Yes/No items	r) Mental health service resources available on college website s) MH service resources available through other strategies (flyers, etc.)
Total	Mean of all items	

To look at changes over the life of the CCC SMHP, we looked at the difference in scores between Wave 1 (baseline) and either Wave 2 or Wave 3, depending on whichever was the last report we received from that school. Table 40 presents results showing overall change and differential change, comparing CBG and non-CBG, over time for each type of reported capacity. The results show that there were statistically significant increases across all measures of capacity change (with the exception of mental health services), but there were no significant effects for differential change. That is, there was an overall increase in capacity across all campuses, but not specifically for CBGs when compared to non-CBGs.

Table 40. Overall and Differential Change In Organizational Capacity (Wave 1 to Wave 2 OR Wave 3)

	Overall Change (*t*)	Diff. Change by CBG (*t*)
Screen	2.05*	.36
Suicide	3.64**	-.63
Teams	2.57**	.93
Peer2peer	2.53**	1.52
Stigma	4.50**	-1.56
RefSys	2.65**	.90
MHsvcs	1.69	.74
E-Report	2.74**	-.60
Resources	4.08**	-1.55
Total	4.40**	.44

Another overview of capacity development is given by Figure 7, which shows the percentage of campuses reporting some capacity for each of nine areas at baseline, and the percentage of campuses reporting adding or changing some of each type of capacity over the evaluation period (at Waves 1, 2 or 3). This figure is based on those campuses that reported data across all three waves (n=57). The figure enables one to see which areas were already well-established at baseline, which may not have been given as much attention for whatever reason (e.g., electronic health reporting), and where the greatest change occurred (e.g., peer-to-peer and stigma reduction).

Figure 8 shows the percentage of just the CBG campuses reporting some capacity for each of nine areas at baseline, and the percentage of campuses reporting adding or changing some of each type of

capacity over the evaluation period (at Waves 1, 2 or 3). This figure is based on those CBG campuses that reported data across all three waves (n=23). The figure is similar to the previous one (Figure 7) but with more topics reported at 100% by the end of the period covered here.

Figure 7. Capacity All Campuses with Data at Each Time Period (Present at Baseline & Any Change After Baseline)

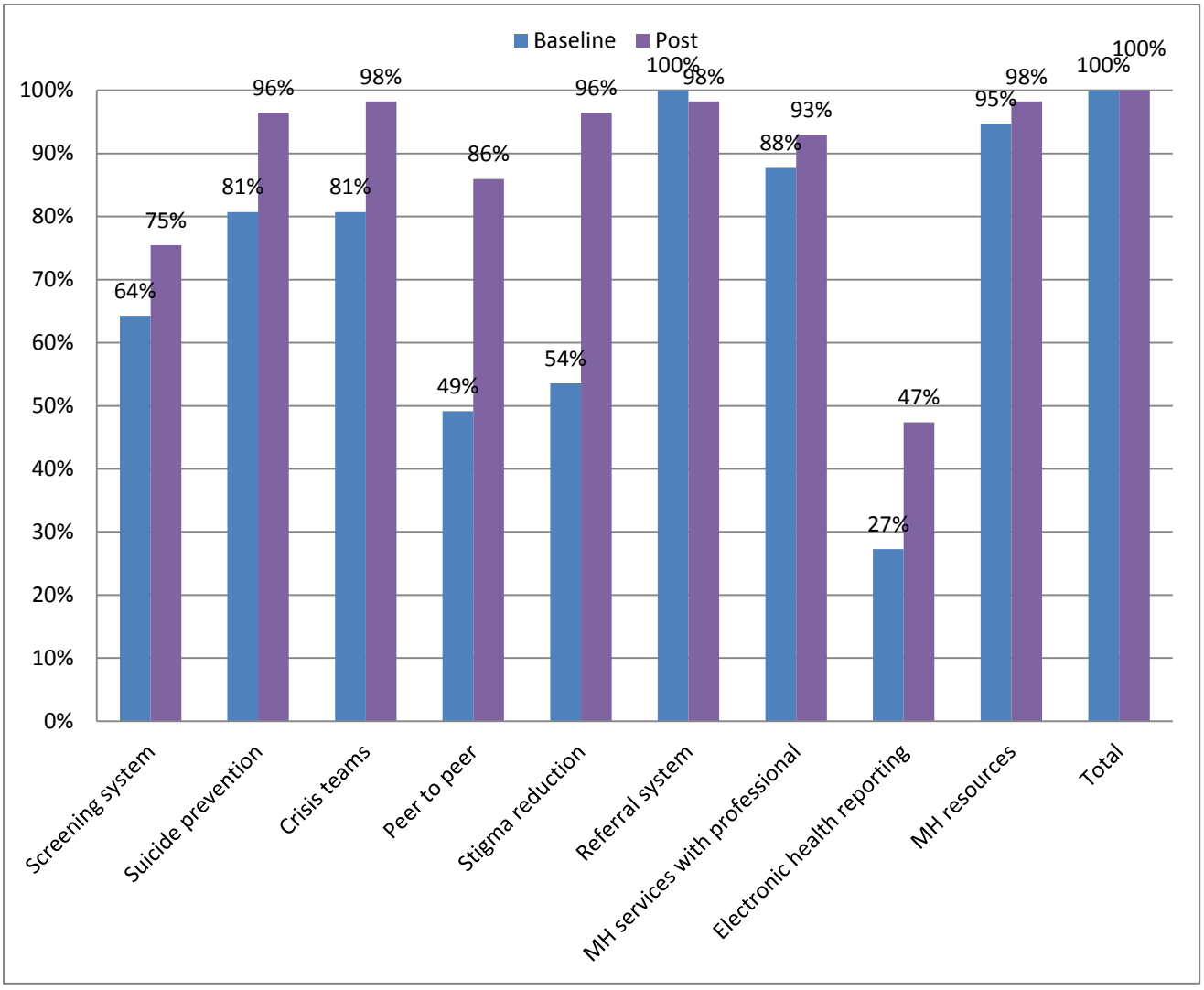
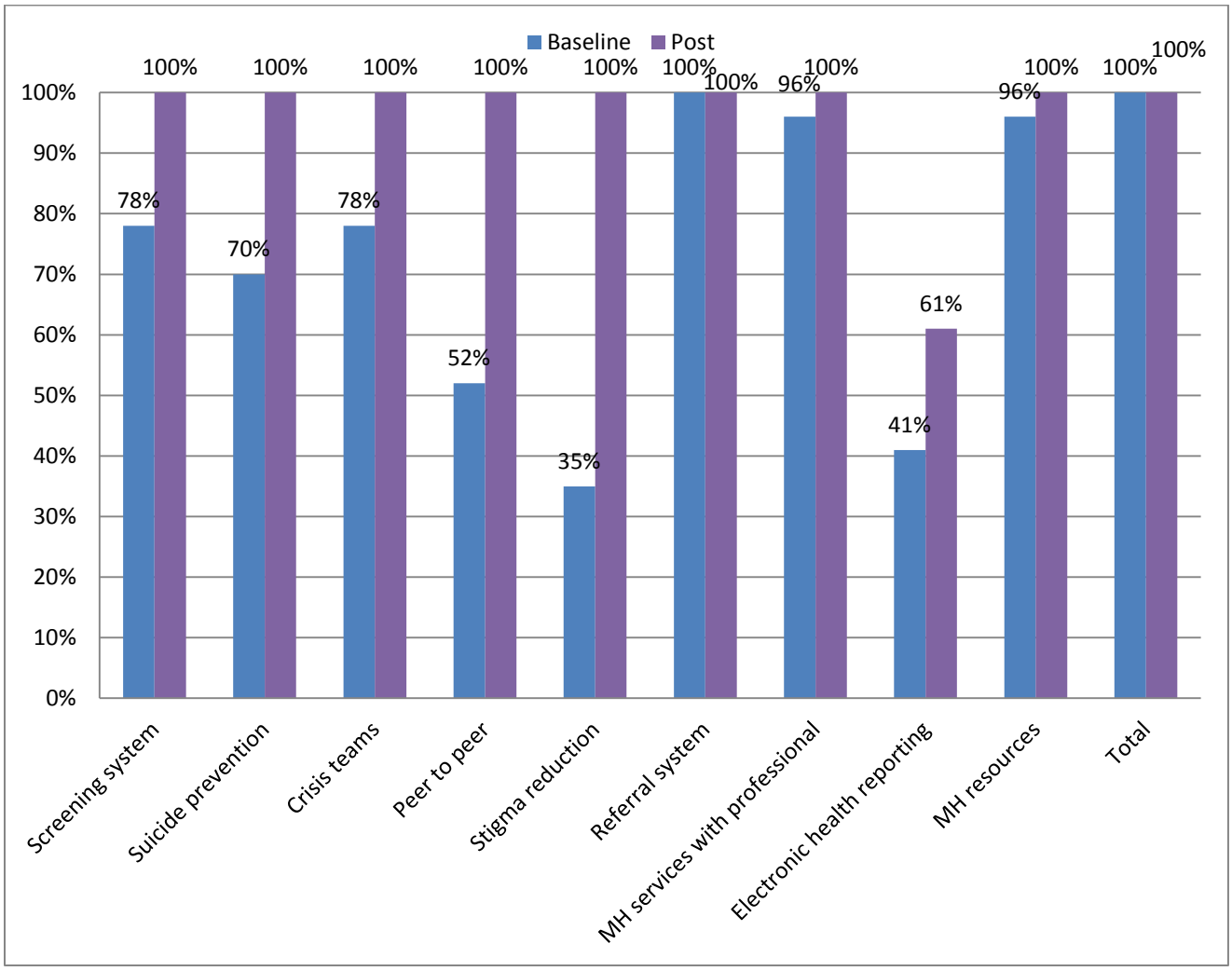


Figure 8. Capacity All CBG Campuses with Data at Each Time Period (Present at Baseline & Any Change After Baseline)



Tables 41a through 41c present results (for the campuses with data at all waves) showing the average number of capacity change areas in which they reported collaborating with each of four partners: (1) County mental health; (2) Other California community colleges; (3) Universities in the UC or CSU systems; and (4) Training or TA providers (CARS or Kognito) on the capacity change(s).

One obvious pattern is that having a grant on campus (i.e., a CBG) really did seem to boost collaboration across the board in comparison to the non-CBGs. This was perhaps most evident in the collaboration with UCs or CSUs, but can be seen in collaboration with County Mental Health partners and the TTA provider as well.

At Waves 2 and 3, the T/TA providers were the partners on which the campuses reported collaborating on the largest number of capacity areas that changed (the average numbers were 4.1 at Wave 2 and 4.0 at Wave 3).

It is also of interest in these results that the average number of capacity change areas on which the CBG campuses reported having collaborated with other California community colleges increased from 3.2 (at Wave 2) to 5.3 (at Wave 3).

Table 41a. Counts of Areas of Capacity Change on which Campuses Collaborated with Four Partners (N=57)

	Wave 1 Mean	Wave 2 Mean	Wave 3 Mean
Collaboration with County Mental Health	3.5	3.1	3.8
Collaboration with Other Community Colleges	3.1	2.7	3.8
Collaboration with UC or CSU Systems	1.6	1.5	1.9
Collaboration with Training or TA Provider(s)	3.2	4.1	4.0

Table 41b. Counts of Areas of Capacity Change on which CBG Campuses Collaborated with Four Partners (N=23)

	Wave 1 Mean	Wave 2 Mean	Wave 3 Mean
Collaboration with County Mental Health	4.0	5.0	5.6
Collaboration with Other Community Colleges	3.9	3.2	5.3
Collaboration with UC or CSU Systems	2.8	2.7	3.4
Collaboration with Training or TA Provider(s)	5.0	5.0	4.5

Table 41c. Counts of Areas of Capacity Change on which Non-CBG Campuses Collaborated with Four Partners (N=34)

	Wave 1 Mean	Wave 2 Mean	Wave 3 Mean
Collaboration with County Mental Health	3.2	1.8	2.6
Collaboration with Other Community Colleges	2.6	2.4	2.7
Collaboration with UC or CSU Systems	0.8	0.6	0.9
Collaboration with Training or TA Provider(s)	2.0	3.5	3.6

Since the role that the TTA (CARS) played in providing support to colleges was so prominent, we also asked more specifically about the degree of their involvement in capacity development.

Table 42 presents results showing overall change and differential change, comparing CBG and non-CBG, over time in reported collaboration with the TTA provider(s) in making capacity changes. The following statistically significant results were found:

- Overall positive change in collaboration for capacity change from Wave 1 to Wave 2 or 3 in three types of capacity (stigma reduction, referral system, and resources) as well as total capacity. Differential negative change in collaboration for capacity change by CBG campuses from Wave 1 to Wave 2 or 3 in the combined capacity measure and in the referral system was found (meaning there the change associated with collaboration was greater among the non-CBGs.)

Table 42. Change in Reported Collaboration with TTA Provider(s) - (Wave 1 to Wave 2 or 3)

	Overall Change (*t*)	Diff. Change by CBG (*t*)
Screen	.80	-.75
Suicide	1.05	-.52
Teams	.32	.38
Peer2peer	1.32	-.98
Stigma	2.03*	1.30
capacity	3.63**	-2.20*
RefSys	3.20**	-2.04*
MHsvcs	1.73	-1.15
E-Report	.00	-.38
Resources	2.69**	-.43
Total	2.94**	-1.39

*p<.05; ** p<.01

One has to be careful in interpreting the results in Table 42. It would be incorrect to conclude either that TTA did not matter with the CBGs (no significant positive differential scores) or, even stranger, that the significant negative differential change for the CBGs meant that TTA was actually inhibiting development! Instead, a more likely interpretation is that the TTA had a greater impact for the non-CBGs, who otherwise had presumably fewer resources to develop capacity than the colleges receiving the supplemental grant funding.

b. Impact of Training on Faculty, Staff and Students

As described earlier, six versions of interactive training were made available to all California community colleges, and were a required component for any of the colleges receiving CBGs. At-Risk for Faculty & Staff (for Faculty/Staff/ Administration), At-Risk for Student Leaders (for students), and Veterans on Campus (for Faculty/Staff/Administration) were later joined by Veterans on Campus Peer-to-Peer (for students); LGBTQ on Campus (for Faculty/Staff/Administration), and LGBTQ on Campus (for students). All trainings were designed to increase referral services to mental health providers, with the latter four trainings including added material to enhance support for veteran and LGBTQ populations more generally. Brief surveys were administered before the training (Pretest), after the training (Posttest), and 3 months later (Follow-Up) (see also Appendix A).

We examined the extent to which more students were referred to support services as a function of type of training. These data were obtained from the Pretest assessment and the (3-month) follow-up assessment. The results must be treated with caution, not only because those participating in the trainings were self-selected, but also because only a small proportion of trainees responded to the request to provide follow-up responses.

Table 43. Increases in Referral Rates

Training	Pre-Mean	Follow-Up Mean	Change in Mean	Increase	%[1]	n	p
At Risk FSA	1.475	1.487	.01	none	8.3%	255	.93
VOC FSA[2]	0.897	0.952	.06	6%	9.1%	145	.73
LGBTQOC:FSA	1.92	2.00	.08	none	3.1%	49	.70
At Risk (Stndt)	0.70	1.23	.53	76%	1.8%	154	< .001

Note: FSA = Faculty/Staff/Administrators, VOC = Veterans On Campus, P2P = Peer to Peer
[1] Percentage of those completing the training that also completed the optional 3-month follow-up assessment.
[2]For VOC FSA, pre referral rates were collected at the immediate Posttest not the Pretest (to reduce participant burden at the Pretest).

Table 44 shows the change in referral rates for all the trainings that had at least 40 participants. It would appear that the student trainings are more effective in increasing referral rates than those for faculty and staff. However, this may be misleading since the findings are based on the small number of students who responded to the request for follow up data. Note that a much larger proportion of faculty and staff completed the 3-month follow-up assessment. We also note that baseline referral rates are lower for Veterans than At-Risk / LGBTQ students, so training for these groups may provide greater effect within those populations than for students in general.

These results encouraged us to estimate what the effects might translate to in terms of the full number of faculty, staff, and students who took the training. While referral rates increase in general for students that take the trainings, increases were also apparent for faculty, staff, and administrators if they were making fewer than 2 referrals in the past month before being trained. Thus, the training seems to have the greatest impact on those who were the least likely to make referrals in the first place.

As seen in Table 44 below, an estimated 6,794 CCC students were referred to services, just as a function of the Kognito trainings. This does not account for other initiatives present at the colleges.

As we calculated an estimate of the increase in referrals across the CCC system, we also calculated an estimate of the increase in referrals for each college in the CCC system. The increase in referral rate (Δ M) was multiplied by the relevant number of trainings, and summed across the six trainings to compute an estimate of the increase in the number of referrals per college.

With the college-level data, the mean was 57, with a median of 3 and a range from zero to 687. The distribution was highly skewed, with the most common estimate of zero increase. Note that this estimate may be an overestimate in some cases. For instance, more than one person may have referred the same student to support services. Using this estimate, CBGs outperformed non-CBGs referring an additional estimated 156 (SD = 208) students to services per college, compared to 20 (SD = 53) for non-CBGs.

Table 44. Estimated Increases in Referrals

Trainings Completed across CCCs	No. of Trainings	Δ M	Estimated Increases in Referrals
At Risk FSA	3,074	0.01	31
VOC FSA	1,597	0.06	96
LGBTQOC FSA	704	0.08	56
At Risk Student	8,543	0.53	4,528
VOC P2P	1,169	1.27	1,485
LGBTQOC Student	1,495	0.40	598
Across Faculty/Staff/Administrators			183
Across Students			6,611
Across All Trainers			6,794

Note: Ratio of referrals by Students to FSA = 36 to 1

Since letting students know about trainings may be a pragmatic challenge, and may also interact with the number of referrals made, we examined how students found out about the At Risk trainings, and whether this predicted the increase in referral rates. Again, small numbers make conclusions difficult, but most students heard about the training from an email, though those hearing from the counseling center (or a flyer) seemed to generate more referrals.

Table 45. "How did you hear about this course?" and Referral Rate Increase

	n	M
Administrator/Faculty Email	77	0.47
Counseling Center	22	0.91
Poster	5	0.20
Friend (word of mouth)	7	0.29
Flyer	12	1.08
Other	53	0.55

There was slight evidence that student role was related to an increase in referral rates:

Table 46. "Are you a Peer Counselor or Student Leader?"

	n	M
Yes	37	1.11
No	116	0.35

Whether or not students were required to take the training was not associated with the increase in referral rates, suggesting that requiring students to take the training may be an effective strategy (i.e., there seemed to be no "backlash" to the requirement). Other variables (e.g., gender, full-time versus part-time staff) were not associated with referral rate increases among trainees, suggesting that the trainings generalize across different groups.

As indicated above, across the CCC system, the greatest increases in number of referrals were seen through the At-Risk trainings (4528), than the Veteran trainings (1485) and the LGBTQ trainings (598). At the college level, the maximum increase in referrals for any college for these three specific trainings was 512, 294, and 102, respectively. These findings may be for a number of reasons. All colleges have LGBTQ support services in place. Student veterans can be referred to a number of places, depending on the issue. For example, some students may prefer to receive services at the local Vet Center, or the VA Medical Center. Other resources available to student veterans include a college Point-Of-Contact for Student Veterans, and the college Student Veterans of America chapter. Focusing on the increase in referrals through At-Risk trainings, there were 15 colleges with an increase of 100 or more referrals across the two years of the project. Thirteen of these colleges were CBGs and the other two were non CBGs. For the ten of these 15 colleges that completed the capacity survey at Wave 1 and Wave 2, dramatic increases in mental health staffing were apparent [$M_{Wave1} = 12.6$, $SD_{Wave1} = 17.0$ compared to $M_{Wave2} = 20.4$, $SD_{Wave2} = 3.7$, (or an increase of 62%) though not significant given an outlier at Wave 1, note SD_{Wave1}, $t(10) = 1.33$, $p = .22$]. Similarly for the 13 colleges with valid data for at least one wave, the minimum level of staffing was 1 MH staff person at Wave 1 and 12 MH staff persons at Wave 2. These results suggest that those colleges that increased referrals through the Kognito trainings also increased capacity to serve these students.

Campus Climate

Working with Kognito to develop Pretest and Posttest trainee questionnaires, PIRE researchers adapted the "Climate for Diverse Group" items from the Hutchinson, Raymond, and Black (2008) campus climate measure. More specifically, the group "students with disabilities" was divided into "students with physical disabilities" and "students with mental health issues." The group "Student Veterans" was also added as another student group of interest. This resulted in seven student groups to be rated: students with physical disabilities, students with mental health issues, women students, racial/ethnic minority students, LGBTQ students, students with different religious beliefs and backgrounds, and student veterans.

The campus climate data from the Pretest Kognito survey was used since this had the largest N, and would not be subject to reactivity[9] from completing the Kognito training. Time was split into four categories: July 1 through 12/31/2012, 01/01/2013 through 06/30/2013, 7/1/2013 through 12/31/2013, and 01/01/2014 through 05/31/2014.

Since the CCC SMHP program focused primarily on students with mental health issues, and to a lesser extent student veterans, and LGBTQ students as groups that were also prioritized within the broader scope of mental health, we focus primarily on these three campus climate measure items. The

[9] Reactivity is a term used to describe the effect respondents may have after completing the training; respondents may be inclined to provide answers that they think the trainer wants.

Fall of 2012 was compared to the Fall of 2013, and the Spring of 2013 was compared to the Spring of 2014 to control for seasonal effects. Across the CCC system, improvements were seen from Spring 2013 to Spring 2014, in the campus climate for students with mental health issues. CBG status did not predict campus climate.

Table 47. Campus Climate Over Time

	M (SD)	M (SD)	Statistics
	Fall 2012	**Fall 2013**	
Students with mental health issues	4.07 (1.04)	4.10 (1.01)	t(3176) = 0.59, p = .56
LGBTQ students	4.30 (0.93)	4.28 (0.97)	t(3176) = 0.47, p = .64
Student Veterans	4.47 (0.85)	4.47 (0.85)	t(3168) = 0.07, p = .94
	Spring 2012	**Spring 2013**	
Students with mental health issues	**4.04 (1.02)**	**4.11 (0.99)**	**t(5127) = 2.30, p = .02**
LGBTQ students	4.29 (0.95)	4.32 (0.93)	t(5125) = 1.25, p = .21
Student Veterans	4.45 (0.87)	4.47 (0.84)	t(5108) = 1.03, p = .30

Where 1=hostile, 2=somewhat hostile, 3=neutral, 4=somewhat welcoming, 5=welcoming

The following analyses highlight the need to ask reference group members what *they* think the campus climate is like, and what the frequency of insensitive or negative comments may be, since these factors may be more salient to them. Using the Student At-Risk Pretest ratings (which by far had the largest number of trainees 8543 versus 1169 and 1495), we found that campus climate ratings for some groups were indeed lower, if rated by the reference group, rather than by students that were not in the reference group. For instance, racial/ethnic minority students rated the campus climate for racial/ethnic minority students lower than did White students for the same subgroup.

Table 48. Reference Group Analyses on Campus Climate

Campus Climate Ratings	Reference Group M (SD)	Other Group M (SD)	(df)	*t*	p
Racial/ethnic minority students [Reference Group (RG) n = 1391]	4.43 (0.88)	4.51 (0.81)	(3123)	2.91	.004
LGBTQ students (RG n = 136)	4.18 (1.03)	4.32 (0.92)	(2564)	1.73	.08
Primary language other than English (RG n = 661)	4.29 (0.94)	4.36 (0.92)	(3783)	1.65	.10
Student Veterans (RG n = 79)	4.47 (0.84)	4.49 (0.83)	(2694)	0.21	.83

Where 1=hostile, 2=somewhat hostile, 3=neutral, 4=somewhat welcoming, 5=welcoming

Similarly, reference group members rated the frequency of insensitive comments as greater than did non- reference group members. Racial/ethnic minority students rated the frequency of insensitive or negative comments towards racial/ethnic minority students greater than did White students rate the frequency of insensitive or negative comments towards racial/ethnic minority students. LGBTQ students rated the frequency of insensitive or negative comments towards LGBTQ students greater than did non-LGBTQ students. Students with a primary language other than English rated the frequency of

insensitive or negative comments towards students with different religious beliefs and backgrounds greater than did students with English as a primary language.

Table 49. Reference Group Analyses on Frequency of Insensitive or Negative Comments

Campus Climate Ratings	Reference Group M (SD)	Other Group M (SD)	(df)	*t*	p
Racial/ethnic minority students	1.73 (0.94)	1.57 (0.84)	(3174)	5.27	< .001
LGBTQ students	2.07 (1.03)	1.69 (0.90)	(146.2)	4.21	< .001
Primary language other than English	1.75 (0.95)	1.61 (0.85)	(906.5)	3.32	.001
Student Veterans	1.51 (0.73)	1.35 (0.70)	(82.4)	1.91	.06

Where 1=never, 2=rarely, 3=sometimes, 4=often

c. Changes in Student Mental Health Status

Data from the Kognito follow-ups seem to show an increase in students referring their peers to mental health and/or support services. This generates a cautious optimism that the CCC SMHP is indeed having a positive and measureable effect one of its major objectives—identifying students in need of those services and increasing the likelihood that they will receive those services.

The reason our optimism must be cautious stems from the fact that "real world" evaluations, such as this one, do not have the resources to conduct a "gold standard" randomized experimental trial of the SMHP, as doing so would require a much greater budget and extensive agreements among the community colleges to collaborate in such a design. In addition, data collection usually involved voluntary participation from individuals and colleges, with expected lower response rates and smaller sample sizes.

One way to compensate for these understandable limitations is to look for consistent trends or findings across multiple data sources. Thus, we make use of reports from key informants for the capacity surveys, pre/post training data from participants in the Kognito trainings, quarterly reports from the recipients of campus-based grants (CBGs) and the PIRE/RAND pre/post online surveys of students across the CCC system. It is to this last source of data that we now turn our attention.

Only 9 colleges participated in both the Pretest and Posttest surveys, and of those, 7 were CBGs and 2 were not. This means that any results taken in isolation, and especially any comparison of CBG and non-CBG, must be considered provisional and treated cautiously.

Students were asked (Q6) "Have you ever been referred for or used counseling or mental health services on campus from your current college/university's counseling or health service?" For the entire sample, the percent saying "yes" increased from 10.4% to 12%, a 15% increase in use/referral (Figure 9).

Many students are not candidates for such services, of course, so perhaps more important, when we limited our comparison to those students who scored positive for "probable psychological distress" (13 or more points on scale of items scoring 1-4 points each) we find referral/use went from 15.4% at

baseline to 17.8% at Posttest, an increase of 15.6%. The corresponding numbers for those scoring lower on the "probable psychological distress" was 9% at baseline and 10.1% on follow up (Figure 10).

Figure 9. Overall Rate of Referrals for Student Mental Health Services – Baseline vs. Post-SMHP

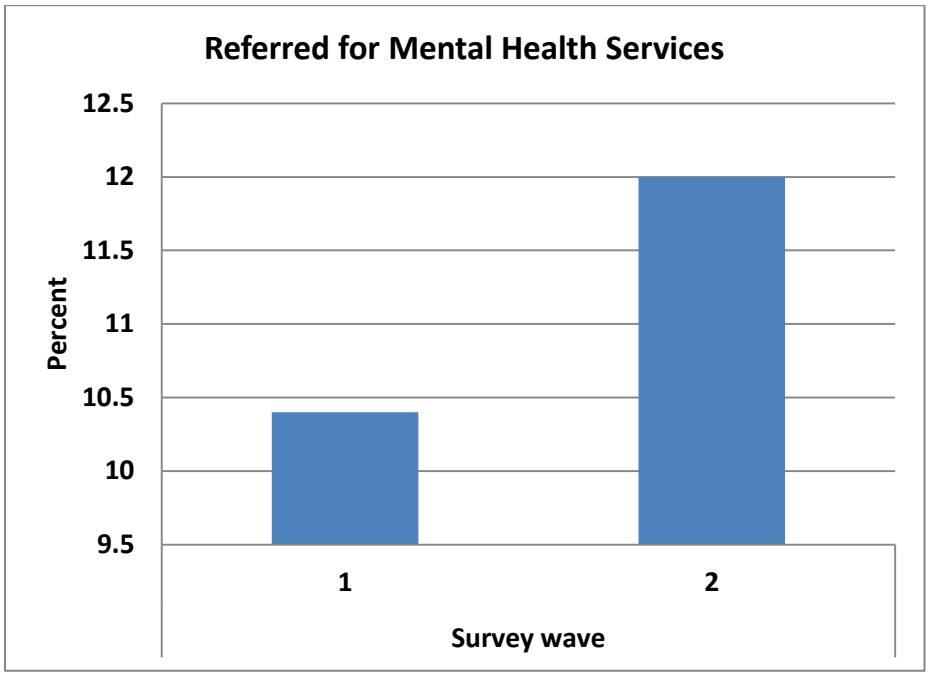
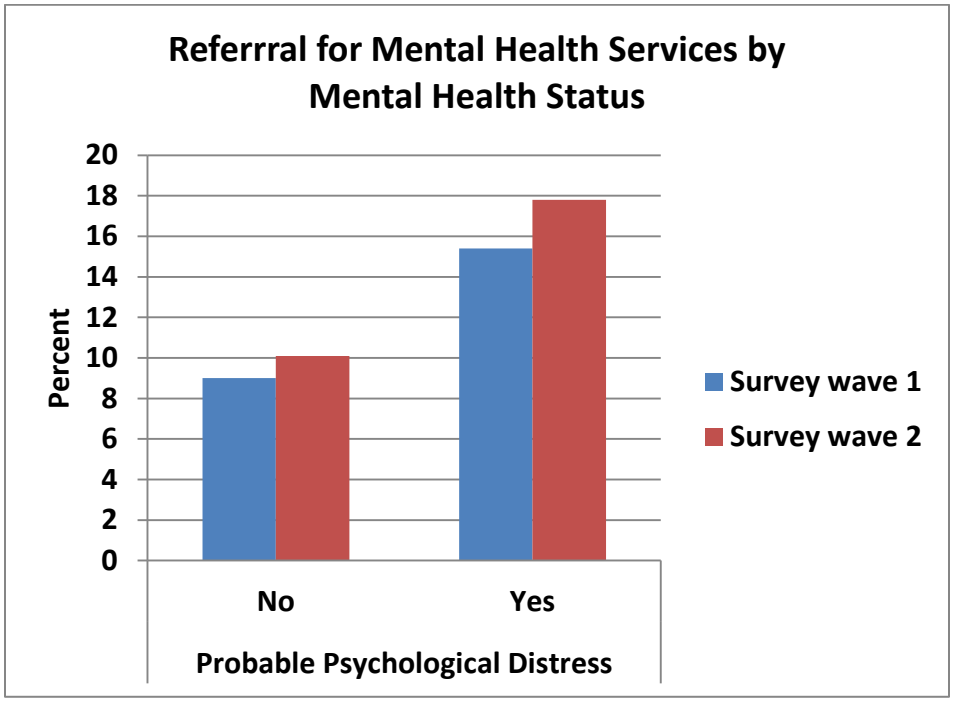
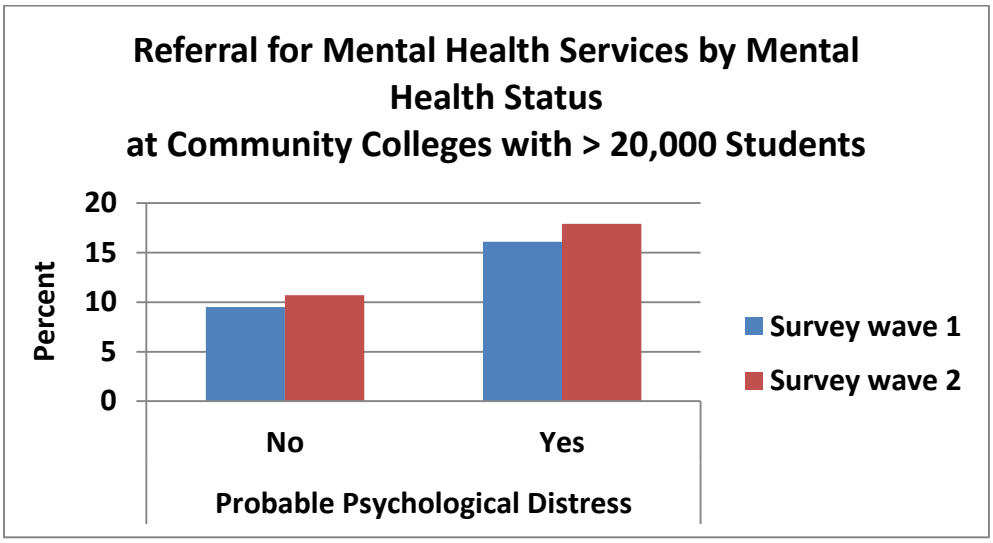


Figure 10. Rate of Referrals for Student Mental Health Services by Probable Psychological Distress – Baseline vs. Post-SMHP



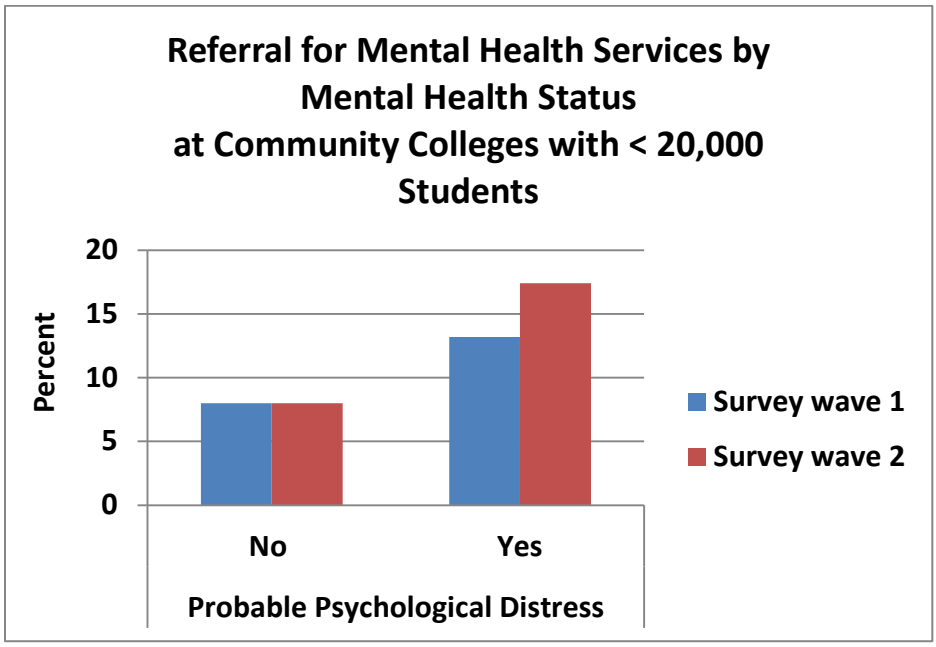
It's likely that larger colleges have greater resources to direct to mental health services. Comparing Figure 11 with 12 shows that larger colleges (over 20,000 student population) did indeed have a higher rate of referrals at baseline than smaller colleges, but smaller colleges had a higher increase in rate of referrals/service. Larger colleges' rate changed from 16.1% to 17.8% for those scoring high on the probable psychological distress scale.

Figure 11. Rate of Referrals for Student Health Services for Larger Colleges – Baseline vs. Post-SMHP



In Figure 12, we see that for smaller colleges, the rate changed from 13.2% to 17.4% for those scoring high on the probable psychological distress scale.

Figure 12. Rate of Referrals for Student Mental Health Services for Smaller Colleges – Baseline vs. Post-SMHP



CBGs vs. Non-CBGs

We would expect that those colleges who applied for and received CBGs would have started with more referrals/services for mental health than those campuses that did not apply for or receive CBGs. This turned out to be the case, although with only 2 Non-CBG colleges participating in the surveys, we must regard the findings as provisional at best. CBGs saw an increase in referrals or service, from 15.6% to 18.4% among those with probable psychological distress (Figure 13).

Figure 13. Rate of Referrals for Student Mental Health Services for CBGs – Baseline vs. Post-CCC SMHP

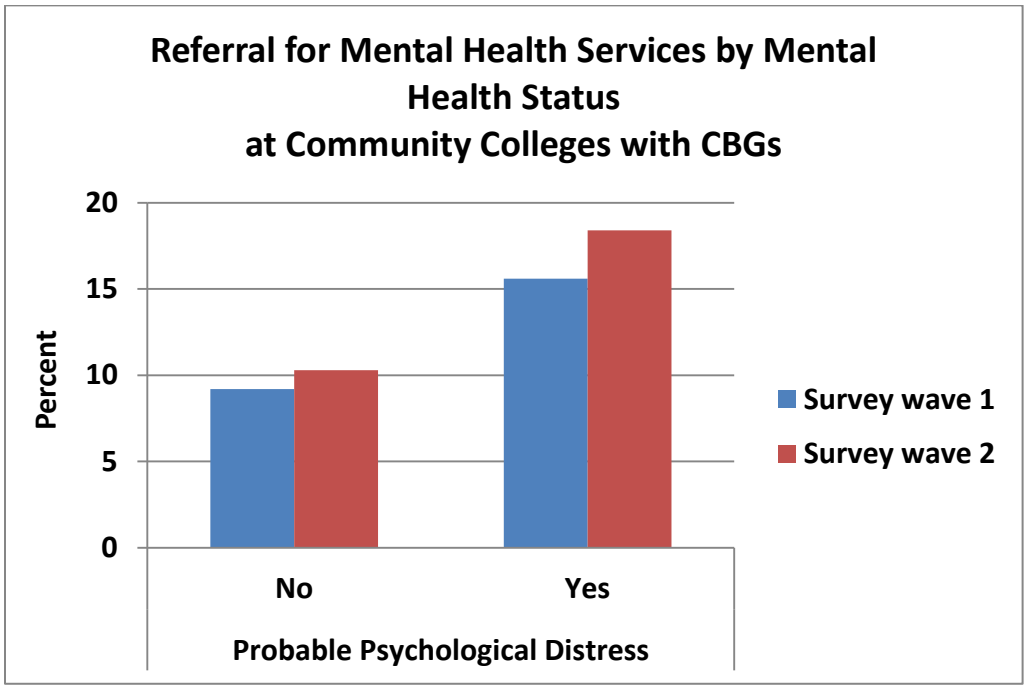
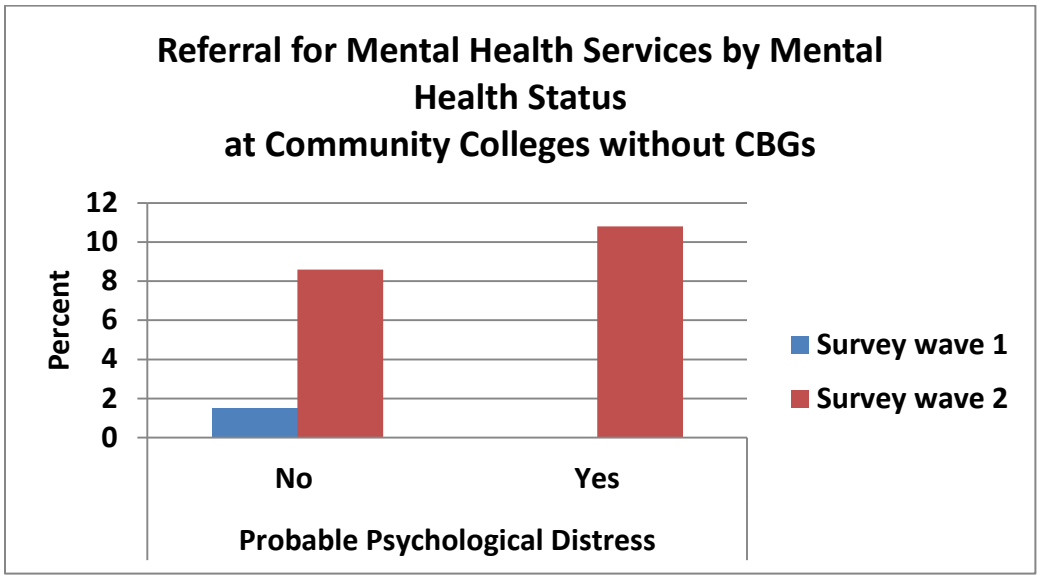


Figure 14 shows that, for Non-CBGs, the referral/services rate for those with probable psychological distress increased much more, from essentially 0 referrals at baseline to 10.8% at the second wave. Though somewhat speculative, these results suggest that, when multiplied by the number of colleges that were not CBGs, the CCC Student Mental Health Program may have had its greatest impact on the larger number of colleges who were likely less resourced than the CBG colleges were at the beginning of the CCC SMHP.

Figure 14. Rate of Referrals for Student Mental Health Services for non-CBGs – Baseline vs. Post-SMHP



These results lead us to be curious about whether the sources of referral may have changed over the life of the SMHP. Figure 15 suggests that there was an increase in the proportion of referrals from faculty/TAs, with a concomitant decrease in all the other sources of referrals.

Figure 15. Sources of Referrals for Student Counseling Services – Baseline vs. Post-SMHP

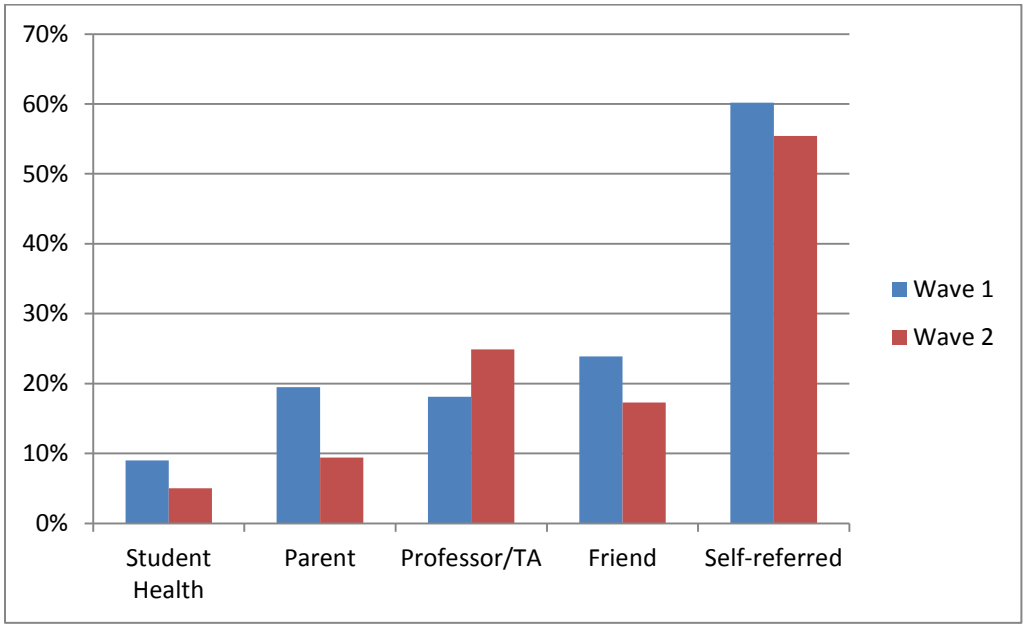
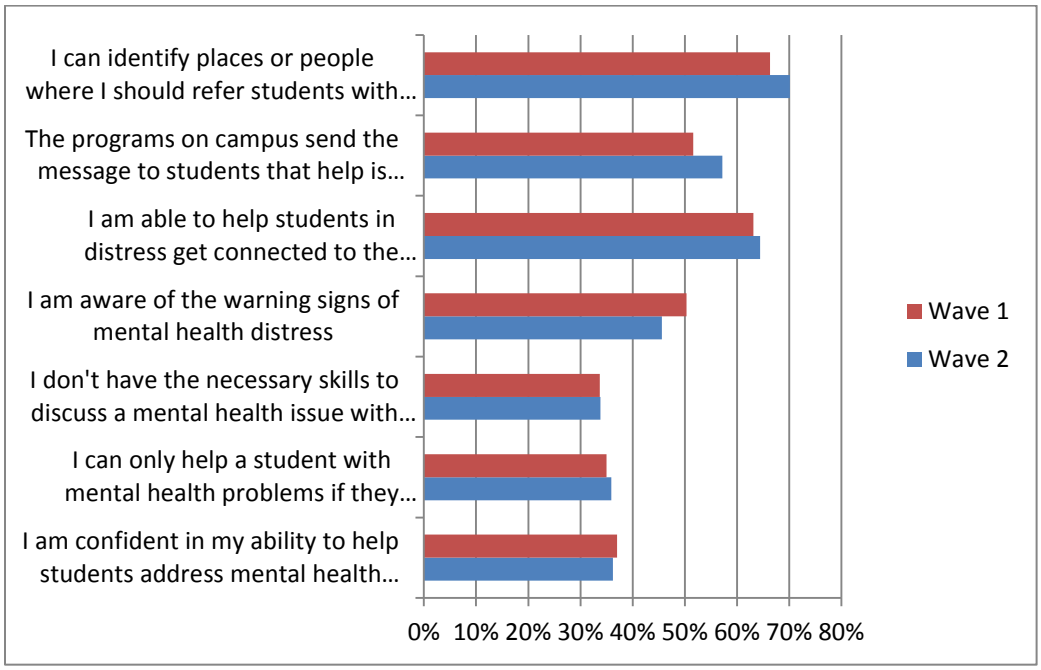


Figure 16, comparing results from the faculty/staff survey seems to show some evidence of improved knowledge and self-efficacy with regard to mental health issues, with the unexpected, if slight drop in their being aware of "warning signs of mental health distress."

Figure 16. Faculty/Staff Preparedness to Address Student Mental Health Issues – Baseline vs. Post-SMHP



Long-term Outcomes

The apparent increase in referrals gives some reason to hope that these short-term effects would translate into long-term improvements in students' mental health. Realistically, however, the one-year time span between the two waves of student surveys is very likely too short to be able to detect ultimate outcomes. As expected, then, there is basically no difference in the prevalence of impaired academic performance across the several possible sources of psychological problems (Figure 17), nor in the prevalence of probably psychological distress (Figure 18).

Figure 17. Reported Impairment to Academic Performance – Baseline vs. Post-SMHP

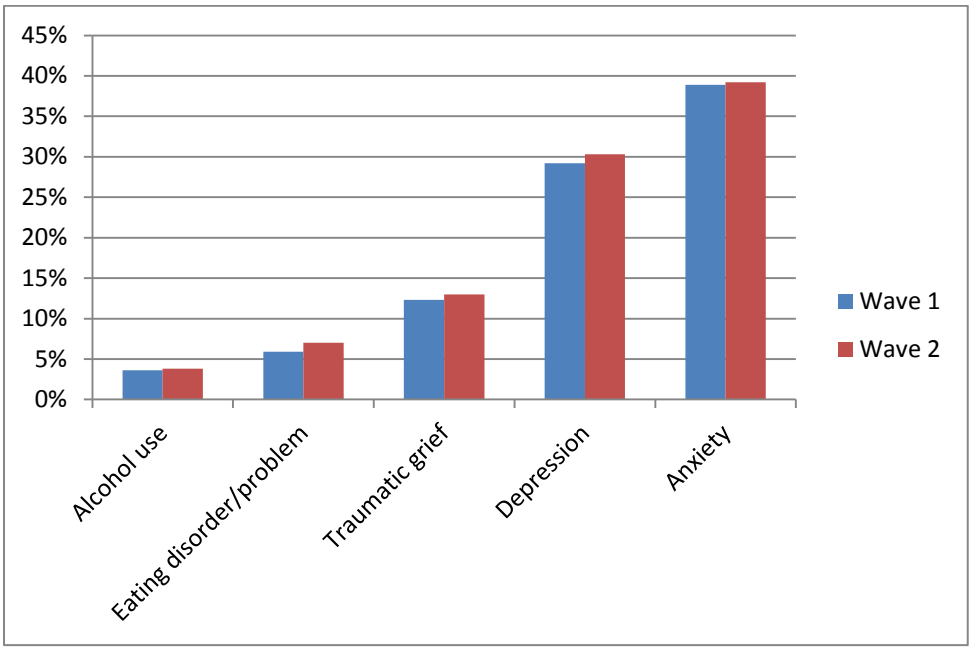
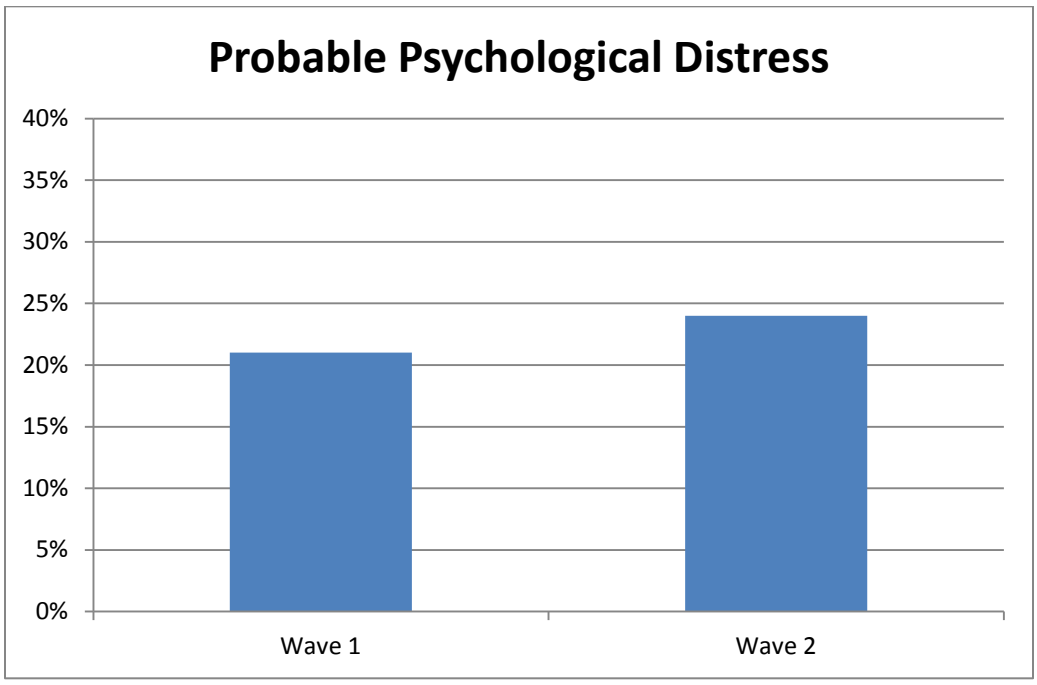


Figure 18. Probable Psychological Distress Baseline vs. Post-SMHP



V. Summary and Recommendations

Demonstrated need for Student Mental health Support: In the fall of 2013, RAND, the Statewide Prevention and Early Intervention (PEI) evaluator for CalMHSA, partnered with PIRE to conduct a baseline survey of students attending California community colleges. RAND also conducted similar student surveys across the University of California (UC) and the California State Universities (CSU) systems. Results of these surveys suggested a number of things:

- The 19% rate of psychological distress found for California community college students (and equivalent to students at UC and CSU) was substantially higher than the 3.5% rate commonly reported for the general population (Ward, Schiller, & Freeman, 2013), but comparable to rates reported in other studies of higher education populations (Hunt & Eisenberg, 2010);
- Rates of psychological distress varied across subgroups of students. Higher rates were reported by biracial students (22.9%), students with disabilities (36.2%), and LGBTQ students (29.1%);
- Despite similar rates of psychological distress, students from the CCC system reported consistently higher rates of impaired academic performance due to mental health issues than their counterparts in the other systems of higher education (CSU and UC);
- Despite experiencing comparable levels of psychological distress, students in the CCCs were half as likely to receive referrals for counseling or mental health services as their peers in the other state systems;
- CCC students who were referred for services (other than self-referral) were substantially more likely to report being referred for mental health services by a professor or teaching assistant (TA) than were UC or CSU students, consistent with higher rates of CCC faculty and staff reporting talking with a student about their mental health problems than UC and CSU faculty and staff;
- At baseline, fewer than half of the faculty and staff in all three systems reported being aware of the warning signs of psychological distress, or felt they had the necessary skills to discuss mental health issues with students or confident in their ability to help students address mental health issues;
- UC and CSU students reported much higher rates of receiving services on campus compared to the rates reported by CCC students. The lower rates of service among CCC students do not appear to be compensated by use of services off-campus.

All together, these findings support the case for addressing the mental health needs of students in California's community colleges, consistent with the original intent of the funding received from CalMHSA to develop and implement the CCC SMHP.

Capacity to Support Student Mental Health Services: In an effort to track possible changes in college capacity to support mental health services, a key priority specific to the CCC SMHP, PIRE conducted a Capacity Survey of CCC campus mental health administrator. We found that at baseline:

- 85% of CCCs collected a student health fee;
- An estimated average 23% of those fees supported mental health services;
- 64% of colleges provided mental health services within their health centers, with an additional 15% providing services in a separate mental health center;

- Across a range of 9 broad types of capacity to address the mental health needs of students (e.g., screening system, peer-to-peer programs, referral system), a majority of colleges (over 50%) reported some level of capacity, with the exception of peer-to-peer activities (49% of colleges) and electronic health reporting system (27% of colleges).

Reach of the CCC SMHP Initiative: The main body of the report documents the extensive range, types, and reach of the various components of the CCC SMHP from April, 2013 through June, 2014. (Note: Some CBG campuses received additional funding to continue the program beyond June 2104, and thus these numbers will have increased as a result). Among the highlights are:

- Over 11,000 students completed the on-line training provided by Kognito Solutions;
- Over 5,000 faculty and staff also participated in the on-line trainings;
- 96% of all California community colleges participated in a TTA readiness call;
- Nearly 30 webinars were developed and delivered by the TTA provider, CARS;
- 89 colleges participated in one or more of those webinars;
- There were 42 regional trainings completed by CARS, reaching 1,700 college faculty, staff, and students who reported extremely high satisfaction (4.8 on a 5-point scale) with the training;
- In addition, CARS delivered 56 tailored, on-site trainings to nearly 3,000 participants;
- The TTA providers engaged in 35 one-on-one TA sessions with 138 participants from about 30% of all the community colleges;
- CARS also developed and continuously updated a comprehensive website for CCC SMHP that drew over 40,000 unique visitors viewing over 300,000 web pages;
- CARS produced 34 publications and products including training videos, online courses, and other resources and tools;
- Finally, this report documents the excellent progress the Campus-Based Grantees (CBGs) made on the enhanced activities they were able to undertake in addition to the system-wide training and TTA that was available to all community colleges in California.

Impact of the CCC SMHP Initiative: Measures of the CCC SMHP's impact must necessarily be treated with caution, but there does appear to be evidence of some immediate effects, even in the short span of time covered by the program:

- The capacity surveys, completed by CCC campuses, showed increased efforts to improve capacity across a number of categories, with particular attention given to peer-to-peer program activities (86% of the colleges) and stigma reduction (96%);
- Participation in various CCC SMHP activities was, as expected, higher among the campus-based grantees (CBGs) and was reflected in increased capacity, but greater changes in capacity were found, relative to baseline, among the non-CBGs;
- CBGs reported greater levels of collaboration with both the TTA provider and with their county departments of mental health;
- Greater collaboration with the TTA provider was associated with increased capacity overall, and especially among non-CBGs;

- Students who completed the Kognito on-line training and participated in pre and post-training follow-up reported an increased number of peers who they referred to mental health services.
- Similarly, pre and post course surveys of CARS trainings participants indicated significant shifts in self-efficacy and intentions to engage with students in distress;
- Increased referrals were also found among those faculty and staff who had not previously reported referring students to services at the Pretest;
- Measures of campus climate for students with mental health issues started out with good scores, but still showed an improvement over the period of the CCC SMHP;
- Using student surveys conducted at the beginning and end of the CCC SMHP, we found an increase in the prevalence of students who were themselves referred to mental health services, and this was especially pronounced among those who were "probable for suffering psychological distress;"
- The results suggest that while non-CBGs had a lower rate of self-reported student referrals compared to CBGs, they showed a relative greater improvement at the end of the CCC SMHP.

Recommendations

The recommendations that are provided in this section should be considered in a broader context. While they may seem clear and simple, each implies many unknown assumptions and details that may be contained within the scope of program implementation. Our process started with identifying resources and then understanding how well the recommendation "fits" within existing practices.

Nevertheless, we feel the data presented in this report and the evaluation team's experience with the CCC SMHP and the key collaborators allow us to proceed with several recommendations that could be considered for future enhancements to support all California community college students and those who are at risk of psychological distress. From the baseline data from the faculty/staff and student survey(s), we have seen that students with mental health needs in community colleges are half as likely to get services as their peers in the University of California or California State University systems. We also learned that this shortfall was not due to one or more structural barriers (e.g., lack of money or time) but rather a lack of knowledge about how to get those services, whether they were eligible for services, or just a simple ignorance of the existence of those services. The CCC SMHP certainly marshalled effort to provide this information to students, so our recommendation is to:

Recommendation 1: Using a variety of channels of communication and outreach, continue to provide new and continuing CCC students with information about the availability of services for mental health problems, how they may be accessed and whether there are any eligibility requirements to obtain those services.

This should help boost the most common form of referrals, the self-referrals. We found that the CCC SMHP did appear to boost other sources of referrals via students and also faculty and staff. For CCC students in particular, staff and faculty referrals were a major source of referrals, with friends being the next most likely source. Our recommendation, then, is to

Recommendation 2: Continue using on-line training for faculty/staff as well as for students, given that both appear to be key sources of referrals and can be trained to improve the rate of such referrals.

Although we saw that training can boost referrals, participation rates for the on-line training were generally low, although not in absolute numbers. Several colleges used some form of incentive to boost participation rates, but in order to universally increase the likelihood that students needing mental health services will be encouraged to do so, we recommend that

Recommendation 3: Some form of incentive be further developed to increase participation in on-line training for faculty, staff, and students. The incentive might be tied to course credit for students, recognition during performance reviews for faculty and staff, financial incentives (including a lottery) or perhaps requiring participation as part of suitable courses (e.g., in psychology or health sciences). Some CBG colleges that offered incentives showed greater participation in online training by faculty, staff and students.

It is one thing to boost referrals and thereby encourage students to seek help, but to increase the likelihood that they actually get those services, there should be some way of following up with students who self-refer or are referred by others. This, of course, is not a trivial challenge, but we would still recommend that

Recommendation 4: Some type of tracking infrastructure be developed that would enable health services staff or mental health providers to contact students who are referred to services or have participated in services, so that colleges can determine how many such students actually receive services (on campus or elsewhere) and how many fall through the cracks in the system or otherwise fail to get needed services.

While developing these various sources of referrals, we wish to point out that a more active form of screening or "case finding" could be adopted. We would recommend

Recommendation 5: Colleges explore the possibility of using a system of universal screening each fall semester to identify students in need. This could be done either on-line, during visits to health services, or as part of the orientation process.

Of course, an increase in referrals is likely to require an increase in the capacity of colleges to meet greater demands for service. While the increase in that demand is an excellent rationale for adding staff to those that provide mental health services, other strategies for coping with demand for services would be likely. We would recommend

Recommendation 6: Continued collaboration with county behavioral health departments, regional service providers and nearby UC or CSU health or counseling centers so that new capacity might be found to provide students with more easily-accessible mental health services.

A comprehensive system for identifying students in need of mental health services, and developing the capacity to respond to those needs would be a major undertaking for any college. It may well be that a coordinating office could seek out and find pieces of such a system (e.g., software, materials) that could be shared across many colleges that individually may not be able to pay for or develop them on their own. Therefore, we would recommend that

Recommendation 7: The California Community Colleges Chancellor's Office work with the directors and staff of community college health services to identify resources that could be shared across participating colleges. This could be done in conjunction with the existing Health Services Association of the CCCs (HSACCC), and the online searchable database already developed and available on the CCC SMHP website.

Finally, the evaluation team would be remiss is we did not also encourage evaluation as a tool to guide any of these possible activities. We would therefore recommend that:

Recommendation 8: The CCC system and participating colleges continue to adopt and refine data collection methods and tools that were developed for this project as part of the evaluation to help guide future development of a system to address their students' mental health needs, and to better demonstrate the value of those efforts to the students, the California community colleges, and the State of California as a whole.

VI. References

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