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Mental Health Services
Oversight & Accountability Commission

Meeting Materials Packet

Commission Meeting
November 21, 2024
9:00 AM – 3:45 PM

COMMISSION MEETING NOTICE AND AGENDA

November 21, 2024

NOTICE IS HEREBY GIVEN that the Commission will conduct a meeting on November 21, 2024, at 9:00 a.m.

This meeting will be conducted via teleconference pursuant to the Bagley-Keene Open Meeting Act according to Government Code sections 11123, 11123.5, and 11133. The location(s) from which the public may participate are listed below. All members of the public shall have the right to offer comment at this public meeting as described in this Notice.

DATE	November 21, 2024
TIME	9:00 a.m.
LOCATION	1812 9th Street, Sacramento, CA 95811 and Virtual

COMMISSION MEMBERS:
Mara Madrigal-Weiss, *Chair*
Mayra E. Alvarez, *Vice Chair*
Mark Bontrager
Bill Brown, *Sheriff*
Keyondria D Bunch, Ph.D.
Wendy Carrillo, *Assemblymember*
Steve Carnevale
Rayshell Chambers
Shuonan Chen
Dave Cortese, *Senator*
Dave Gordon
Gladys Mitchell
James L. Robinson III, Psy.D., MBA
Alfred Rowlett
Gary Tsai, MD

INTERIM EXECUTIVE DIRECTOR
Will Lightbourne

ZOOM ACCESS
Zoom meeting link and dial-in number will be provided upon registration.
Free registration link: https://mhsoac-ca-gov.zoom.us/meeting/register/tZIkf-6grToiG9frxRPTlyOJIioTcAkL7q_c

Public participation is critical to the success of our work and deeply valued by the Commission. Please see the detailed explanation of how to participate in public comment after the meeting agenda.

Our Commitment to Excellence

The Commission's 2024-2027 Strategic Plan articulates four strategic goals:

Champion vision into action to increase public understanding of services that address unmet mental health needs.

Catalyze best practice networks to ensure access, improve outcomes, and reduce disparities.

Inspire innovation and learning to close the gap between what can be done and what must be done.

Relentlessly drive expectations in ways that reduce stigma, build empathy, and empower the public.

Meeting Agenda

It is anticipated that all items listed as “Action” on this agenda will be acted upon, although the Commission may decline or postpone action at its discretion. Items may be considered in any order at the discretion of the Chair. Public comment is taken on each agenda item. Unlisted items will not be considered.

9:00 a.m. **1. Call to Order and Roll Call**
Information

Vice Chair Mayra Alvarez will convene the Commission meeting and a roll call of Commissioners will be taken.

9:05 a.m. **2. Announcements and Updates**
Information

Vice Chair Mayra Alvarez, Commissioners, and staff will make announcements and give updates.

9:15 a.m. **3. General Public Comment**
Information

General Public Comment is reserved for items not listed on the agenda. No discussion or action will take place.

9:30 a.m. **4. October 24, 2024 and November 4, 2024 Meeting Minutes**
Action

The Commission will consider approval of the minutes from the October 24, 2024 and November 4, 2024 Commission meetings.

- Public Comment
- Vote

9:35 a.m. **5. Consent Calendar**
Action

All matters listed on the Consent Calendar are routine or noncontroversial and can be acted upon in one motion. There will be no separate discussion of these items prior to the time that the Commission votes on the motion unless a Commissioner requests a specific item to be removed from the Consent Calendar for individual action.

1. BHSA Implementation Planning: Nevada
2. Level Up – Community Driven Practices for Health Equity: Shasta
3. Psychiatric Advanced Directives (PADs) Phase 2: Alameda & Tri-Cities
4. Information Technology Contract Update
5. Reallocation of unencumbered MHWA funds - EmPATH
6. Rules of Procedure Update

- Public Comment
- Vote

9:45 a.m.

6. Grant Opportunities: Mental Health Wellness Act: Strategies to Address the Needs of Children 0-5, Advocacy for K-12 and Immigrant/Refugee Populations

Action

The Commission will hear a presentation on grant opportunities for the mental health and wellness needs of pregnant people and children ages 0-5 as well as advocacy opportunities for K-12 and Immigrant/Refugee populations. The Commission will be presented with strategies for the allocation of Mental Health Wellness Act and Advocacy funds to support these populations; *presented by Riann Kopchak, Chief, Community Engagement and Grants and Tom Orrock, Deputy Director, Operations.*

- Public Comment
- Vote

11:00 a.m.

7. Chair and Vice-Chair Elections

Action

Nominations for Chair and Vice-Chair for 2025 will be entertained. The Commission will elect the next the Commission Chair and Vice-Chair; *led by Sandra Gallardo, Chief Counsel*

- Public Comment
- Vote

11:45 p.m.

8. Lunch

12:30 p.m.

9. Proposition 1 Implementation Update

Action

The Commission will hear an update on the implementation of Proposition 1 related to the 2025 meeting structure, the potential formation of additional subcommittees, and branding strategies; *presented by Kendra Zoller, Deputy Director of Legislation, Andrea Anderson, Chief of Communications, and Jigna Shah, Chief of Innovation and Program Operations.*

- Public Comment
- Vote

1:00 p.m.

10. Planning for County Transitions to BHSA: P.I.V.O.T.

Action

The Commission will hear a proposal from Orange County to utilize Innovation dollars to plan for the Behavioral Health Transformation. Representatives from Orange County will cover five proposed areas of reform to plan for the transition to the BHSA.

- Public Comment
- Vote

1:40 p.m. **11. Full Service Partnership Report**

Action

The Commission will receive and consider adoption of a legislative report on the status of Full Service Partnerships as mandated in the Welfare and Institutions Code Section 5845.8 of Senate Bill 465; presented *by Kallie Clark, PhD, MSW, Research Scientist Supervisor I*

- Public Comment
- Vote

2:15 p.m. **12. Mental Health Student Services Act Report**

Action

The Commission will consider approval of the draft biennial progress report to the legislature on the Mental Health Student Services Act and a contract up to $4 million for phase 2 of the MHSSA evaluation; *presented by Melissa Martin- Mollard, PhD., Chief of Research and Evaluation*

- Public Comment
- Vote

3:00 p.m. **13. School-Based Universal Mental Health Screening Legislative Report**

Action

The Commission will receive and consider adoption of a draft policy report and recommendations on school-based universal mental health screenings (SUMHS) for children and youth. Per a 2023-24 Budget Act request, this report presents findings from a landscape analysis of statewide SUMHS policies and practices and a set of recommendations for implementing SUMHS in support of California's broader youth behavioral health initiatives; *presented by Kali Patterson, Research Scientist Supervisor I*

- Public Comment
- Vote

3:45 p.m. **14. Adjournment**

Our Commitment to Transparency

In accordance with the Bagley-Keene Open Meeting Act, public meeting notices and agenda are available on the internet at www.mhsoac.ca.gov at least 10 calendar days prior to the meeting. Further information regarding this meeting may be obtained by calling (916) 500-0577 or by emailing mhsoac@mhsoac.ca.gov

Our Commitment to Those with Disabilities

Pursuant to the Americans with Disabilities Act, individuals who, because of a disability need special assistance to participate in any Commission meeting or activities, may request assistance by calling (916) 500-0577 or by emailing mhsoac@mhsoac.ca.gov. Requests should be made one (1) week in advance, whenever possible.

Notes for Participation

For Public Comments: Prior to making your comments, please state your name for the record and identify any group or organization you represent.

Register to attend for free here:
https://mhsoac-ca-gov.zoom.us/meeting/register/tZIkf-6grToiG9frxRPTlyOJIioTcAkL7q_c

Email Us: You can also submit public comment to the Commission by emailing us at publiccomment@mhsoac.ca.gov. Emailed public comments submitted at least 72 hours prior to the Commission meeting will be shared with Commissioners at the upcoming meeting. Public comment submitted less than 72 hours prior to the Commission meeting will be shared with Commissioners at a future meeting. Please note that public comments submitted to this email address will not receive a written response from the Commission. **Emailing public comments is not intended to replace the public comment period held during each Commission Meeting and in no way precludes a person from also providing public comments during the meetings.**

Public Participation: The telephone lines of members of the public who dial into the meeting will initially be muted to prevent background noise from inadvertently disrupting the meeting. Phone lines will be unmuted during all portions of the meeting that are appropriate for public comment to allow members of the public to comment. Please see additional instructions below regarding public participation procedures.

The Commission is not responsible for unforeseen technical difficulties that may occur. The Commission will endeavor to provide reliable means for members of the public to participate remotely; however, in the unlikely event that the remote means fail, the meeting may continue in person. For this reason, members of the public are advised to consider attending the meeting in person to ensure their participation during the meeting.

Public participation procedures: All members of the public have a right to offer comment at the Commission's public meeting. The Chair will indicate when a portion of the meeting is open for public comment. Any member of the public wishing to comment during public comment periods must do the following:

→ If joining in person. Complete a public comment request card and submit to Commission staff. When it is time for public comment, staff will call your name and you will be invited to the podium to speak. Members of the public should be prepared to complete their comments within 3 minutes or less, unless a different time allotment is needed and announced by the Chair.

→ If joining by call-in, press *9 on the phone. Pressing *9 will notify the meeting host that you wish to comment. You will be placed in line to comment in the order in which requests are received by the host. When it is your turn to comment, the meeting host will unmute your line and announce the last three digits of your telephone number. The Chair reserves the right to limit the time for comment. Members of the public should be prepared to complete their comments within 3 minutes or less time if a different time allotment is needed and announced by the Chair.

→ If joining by computer, press the raise hand icon on the control bar. Pressing the raise hand will notify the meeting host that you wish to comment. You will be placed in line to comment in the

order in which requests are received by the host. When it is your turn to comment, the meeting host will unmute your line, announce your name, and ask if you'd like your video on. The Chair reserves the right to limit the time for comment. Members of the public should be prepared to complete their comments within 3 minutes or less time if a different time allotment is needed and announced by the Chair.

In accordance with California Government Code § 11125.7(c)(1), members of the public who utilize a translator or other translating technology will be given at least twice the allotted time to speak during a Public Comment period.

AGENDA ITEM 4

Action

November 21, 2024 Commission Meeting

October 24, 2024 Meeting Minutes
November 4, 2024 Meeting Minutes

Summary:
The Mental Health Services Oversight and Accountability Commission will review the minutes from the October 24, 2024 and November 4, 2024 Commission meetings. Any edits to the minutes will be made and the minutes will be amended to reflect the changes and posted to the Commission Web site after the meeting. If an amendment is not necessary, the Commission will approve the minutes as presented.

Enclosures (4): (1) October 24, 2024 Minutes; (2) October 24, 2024 Motions Summary (3) November 4, 2024 Minutes; (4) November 4, 2024 Motion Summary

Handouts: None

Proposed Motion: That the Commission approves the October 24th and November 4th meeting minutes.

State of California

MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

Commission Meeting Minutes

Date October 24, 2024

Time 9:00 a.m.

Location MHSOAC
1812 9th Street
Sacramento, California 95811

Members Participating:

Mara Madrigal-Weiss, M.Ed., Chair
Mayra Alvarez, MHA, Vice Chair
Mark Bontrager, J.D., M.S.W.
Sheriff Bill Brown, M.P.A.
Keyondria Bunch, Ph.D.
Steve Carnevale
Rayshell Chambers, M.P.A.
David Gordon, Ed.M.
Gladys Mitchell. M.S.W.
Jay Robinson, Psy.D., M.B.A.
Alfred Rowlett, M.B.A., M.S.W.

Members Absent:

Assembly Member Carrillo, M.A.
Shuo Chen, J.D.
Senator Dave Cortese, J.D.
Gary Tsai, M.D., DFAPA, FASAM

MHSOAC Meeting Staff Present:

Sandra Gallardo, Chief Counsel
Tom Orrock, Deputy Director, Program Operations
Norma Pate, Deputy Director, Administration and Performance Management
Amariani Martinez, Administrative Support
Lester Robancho, Health Program Specialist
Cody Scott, Meeting Logistics Technician

1: Call to Order and Roll Call

Chair Mara Madrigal-Weiss called the Meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at 9:03 a.m. and welcomed everyone. The meeting was on Zoom, via teleconference, and held at the MHSOAC headquarters, located at 1812 9th Street, Sacramento, California 95811.

Chair Madrigal-Weiss stated the Commission's Strategic Plan for 2024-27 was approved at the January 25, 2024, Commission meeting. She reviewed a slide about how today's agenda supports the Commission's Strategic Plan Goals and Objectives, and noted that the meeting agenda items are connected to those goals to help explain the work of the Commission and to provide transparency for the projects underway.

Sandra Gallardo, Chief Counsel, called the roll and confirmed the presence of a quorum. Attending in Person: Chair Madrigal-Weiss, Vice Chair Alvarez, and Commissioners Bontrager, Brown, Bunch, Carnevale, Chambers, Gordon, Mitchell, Robinson, and Rowlett. No Commissioners attended remotely.

Amariani Martinez, Commission staff, reviewed the meeting protocols.

2: Announcements and Updates

Chair Madrigal-Weiss gave the announcements as follows:

Mental Health Awareness Month

October is Mental Health Awareness Month, a month dedicated to raising awareness and understanding of mental health conditions with an aim to reduce stigma and promote public education around mental health.

World Mental Health Day

October 10th is World Mental Health Day. This year, the World Health Organization announced the theme for World Mental Health Day as Workplace Mental Health, focusing on the importance of mental health and wellbeing in professional settings.

Legislation

The 2024 legislative session concluded on September 30th. Governor Newsom signed three bills supported by the Commission:

- Senate Bill (SB) 1318 by Senator Wahab regarding crisis interventions in schools;
- Assembly Bill (AB) 2711 by Assembly Member Ramos regarding a public health approach to suspensions; and
- AB 1281 by Assembly Member Lowenthal, which will require the Commission to consult with the California Department of Public Health (CDPH) on a statewide strategy to address mental health risks associated with the use of social media by children and youth.

A presentation and discussion on legislative priorities for 2025 is anticipated at the January 2025 Commission meeting.

Innovation Partnership Fund

Proposition 1, the Behavioral Health Services Act (BHSA), establishes the Innovation Partnership Fund (IPF) and directs the Commission to administer that fund. The Commission has contracted with the University of the Pacific (UOP) to engage community partners and develop a strategic and operational plan for the IPF.

The first deliverable of this contract is a white paper outlining the opportunity, vision, potential roles, and challenges to be explored. A draft of the white paper was included in the meeting materials. A representative from the UOP has been invited to present at the January 2025 Commission meeting. Feedback on the white paper or the IPF can be emailed to staff at Innovation@mhsoac.ca.gov.

Cultural and Linguistic Competency Committee (CLCC) Update

Chair Madrigal-Weiss invited Vice Chair Alvarez to provide an update on CLCC activities.

Vice Chair Alvarez, Chair of the CLCC, provided a brief update on the work of the Committee since the last Commission meeting:

- The CLCC last met on October 16th and had a substantive open-format discussion about how the Commission can better reach marginalized communities and populations and, in particular, the role or roles the CLCC and other Committees can play in supporting the Commission's strategic plan around reaching diverse communities across the state.
- Conversations were focused on two overarching topics: Community-Defined Evidence Practices (CDEPs) and the definition of what good mental health looks like for various populations. The Committee referenced the comprehensive California Reducing Disparities Project (CRDP) Report that the Commission delved deeper into last year in Santa Barbara; both community members and the public commented that they would like to see the Commission lift up CDEPs and are excited to see that the Department of Health Care Services (DHCS) has been uplifting CDEPs as part of the Children and Youth Behavioral Health Initiative (CYBHI) and other efforts the DHCS is leading in promoting mental health.
- With the prominent inclusion of CDEPs as part of Proposition 1, the Committee discussed the opportunity for the Commission to serve as a champion for putting forward CDEPs that have demonstrated positive outcomes, such as contributing to the literature around CDEPs, continuing to change the narrative around the value of CDEPs, and highlighting lessons learned for counties to build on what works across the state.
- The Committee then transitioned to a presentation from Commission staff about upcoming Requests for Proposals (RFPs). This is another opportunity where the Committee sees direct influence and impact by the Committee in the work that the Commission does, in particular around the idea of informing and supporting those RFPs on the front end, informing the development of the RFPs, bringing

the lived experience of Committee Members to influence what goes into an RFP, and, on the back end, promoting the RFPs.

- In addition to discussing CDEPs, which was also part of the RFP conversation, the group delved deeper into the conversation around building trust between counties and community organizations, and how oftentimes these RFPs provide unique resources to community organizations to get connected to counties. It was a promising conversation about what can be done moving forward with Proposition 1 implementation and the Commission's strategic plan to think through the Committee structure and how to strengthen it for the future.
- The next CLCC meeting will take place on December 11th from 3:00 p.m. to 5:00 p.m. The time will be used to continue to identify effective programs that reach marginalized communities but will also include a discussion about adding new members to the CLCC in the coming months.

Vice Chair Alvarez stated the Centers for Medicare and Medicaid Services (CMS) released a commitment to reimburse traditional healers and natural helper services in Medicare and Medicaid programs. This is an incredible step forward in advancing health equity by valuing the wisdom and traditional practices of Indigenous communities. California is one of four states approved to reimburse these traditional health care practices through the Medi-Cal program. This is a testament to the many community organizations and tribal leaders who spoke to the power of these practices in promoting good health and serve as an incredible model for the mental health system in California to do the same.

Commissioner Comments & Questions

Commissioner Carnevale stated there was a news article that circulated yesterday that was inflammatory but was incomplete. He stated the article tried to tie together two issues: a contract with Kooth, a London-based digital mental health company the state hired to develop a virtual tool to help tackle its youth mental health crisis, and the information trip the Commission delegation took to London.

Commissioner Carnevale stated Kooth provides a digital solution, which was a contract that they received from the California Health and Human Services Agency (CalHHS). He noted that the Commission has nothing to do with that contract. The importance of it is that it is a digital solution that falls under the category of recommendations the Commission made several years ago for digital solutions to address teen suicide prevention and is a big part of the Governor's plan to lean into new technologies to cost-effectively reach youth. They are important programs.

Commissioner Carnevale stated, during the steep budget deficit issue, there were negotiations between the Legislature and the Governor and that solution became one of the debated items. As often happens, the Governor's Office reached out to the Commission to help them support the arguments, which is what the Commission did. The Commission explained its position on digital solutions provided generally without comment on any company or product in particular. The Governor's administration was set on keeping that in the budget. That was the nature of those conversations.

Commissioner Carnevale stated the allegations in the article that there was lobbying on behalf of that company are not true. A recent independent investigation cleared up that issue successfully.

Commissioner Carnevale stated the other thing is the trip to London. He stated he covered that extensively at a past Commission meeting. This was an opportunity that Kooth happened to organize. The event had nothing to do with Kooth. It was an organization of global mental health leaders. Kooth wanted the Commission at the table because it is recognized as one of the leaders in innovation. It was important to all of the leaders that the Commission be at the table. Because budgets were limited, Kooth offered to pay for some expenses for Commissioners to attend that convening. In addition to the convening, the Commission packed in week of other meetings. Commissioners took off a week of vacation time to spend morning to night on Commission business. It was a successful trip that had nothing to do with previous issues regarding the digital solutions that were debated in the budgets. The independent investigation cleared that.

Commissioner Carnevale stated this is the full story that was not captured in the article.

Chair Madrigal-Weiss stated she provided information to the reporter. She noted that the article did not mention that BrightLife Kids was also a digital application with rave reviews from parents. County offices across the state were promoting this as a resource. The Commission has long been supporting these kinds of resources.

Chair Madrigal-Weiss stated she also shared with the reporter that, as of May, the Commission learned that Soluna was not only designed with over 300 youth but 53 percent of the registrants who had used Soluna at that time were from underserved communities with good outcomes. This was also not put in the article.

Commissioner Chambers, Co-Founder and C-Executive Director of Painted Brain, stated she supports digital solutions. As a peer-run organization, Painted Brain has been a part of the digital Technology Suite Collaborative Innovation Project and applications. This conversation creates opportunities that Painted Brain would like to be involved in. Painted Brain has a track record of working with app companies. This creates an opportunity for peers and individuals with lived experience to be at the table, at the forefront, and to work because that is one of their strengths. Painted Brain is an organization that has been at the forefront advocating for that. She stated she is happy that the Commission is uplifting digital solutions in alignment with those apps. She stated Painted Brain will be working to support and ensure that individuals are being protected in those apps. She offered to provide insights into Painted Brain's experience in working with apps.

3: <u>General Public Comment</u>

Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), stated serious issues with Commission administration have been going on for years. The speaker questioned the fact that no former Commission staff who have shared their concerns about the administration were interviewed or contacted by the investigator. This has the appearance of a conflict of interest.

Stacie Hiramoto stated another appearance of a conflict of interest is that the Commissioners who were implicated in the news article are on the Human Resources Committee that will make a decision on these allegations.

Stacie Hiramoto provided another example of an appearance of a conflict of interest, which happened years ago. The Commission unexpectedly tried to give a contract of half a million dollars to an entity, when that entity did not provide a budget or a summary of how they planned to use the funding. Two Commissioners were on that Advisory Committee.

Stacie Hiramoto stated these companies that benefited may be good organizations that serve people, but if the process is not upfront, there is an appearance of a conflict of interest. The Commission cannot do this; it is a serious issue.

Josefina Alvarado Mena, Chief Executive Officer, Safe Passages, part of the CRDP, stated the news article was shocking and offensive to everyone in the state who is working tirelessly to serve the children, youth, and families in their communities.

Josefina Alvarado Mena stated the fact that former Commission staff have come forward with complaints should be a red flag that something is wrong with the Commission and its administration. The speaker implored the Commission to be guided by integrity, accountability, and transparency, and to be good stewards of the public trust. The speaker implored the Commission to do the right thing in response to the article.

Susan Gallagher, Executive Director, Cal Voices, echoed the comments of the previous speakers and stated things have been going on with the Commission for many years. The Commissioners who went on the London trip should recuse themselves from any vote about Executive Director Ewing in this investigation. The speaker asked Commissioners who have a conflict of interest to act with integrity.

Susan Gallagher stated the Commission stands before the state of California as an oversight body over counties to ensure that funding is spent properly. The Commission serves the people of California with mental health and substance use issues. Lobbying behind the scenes for entities to receive funding is not the Commission’s role.

Susan Gallagher stated concern that peers and stakeholder contractors cannot get on Commission agendas. Stakeholder contractors cannot get their reports published. The speaker stated concern that Commissioners took the trip to Europe when people are dying in the streets. Individuals have no mental health services and no housing in the state of California.

4: <u>August 22, 2024, September 11, 2024, and September 26, 2024, Meeting Minutes</u>

Chair Madrigal-Weiss stated the Commission will consider approval of the minutes from the August 22, 2024, September 11, 2024, and September 26, 2024, Commission meetings. She stated meeting minutes and recordings are posted on the Commission’s website.

Vice Chair Alvarez referred to the second bullet on page 3 of the August 22nd minutes and asked to change “the site visit included visiting For the Village” to “Commissioners electronically visited For the Village.”

Vice Chair Alvarez referred to page 15 of the August 22nd minutes and asked to change “noted that it starts at school” to “noted that it starts at school and early learning centers.”

Public Comment

There was no public comment.

Action: Chair Madrigal-Weiss asked for a motion to approve the August 22, 2024, minutes. Commissioner Brown made a motion, seconded by Commissioner Robinson, that:

- *The Commission approves the August 22, 2024, Meeting Minutes, as modified.*

Motion passed 8 yes, 0 no, and 1 abstain, per roll call vote as follows:

The following Commissioners voted “Yes”: Commissioners Brown, Carnevale, Chambers, Gordon, Robinson, and Rowlett, Vice Chair Alvarez, and Chair Madrigal-Weiss.

The following Commissioner abstained: Commissioner Bunch.

Action: Chair Madrigal-Weiss asked for a motion to approve the September 11, 2024, minutes. Commissioner Robinson made a motion, seconded by Commissioner Rowlett, that:

- *The Commission approves the September 11, 2024, Meeting Minutes, as presented.*

Motion passed 9 yes, 0 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted “Yes”: Commissioners Brown, Bunch, Carnevale, Chambers, Gordon, Robinson, and Rowlett, Vice Chair Alvarez, and Chair Madrigal-Weiss.

Action: Chair Madrigal-Weiss made a motion, seconded by Commissioner Bunch, that:

- *The Commission approves the September 26, 2024, Meeting Minutes, as presented.*

Motion passed 8 yes, 0 no, and 1 abstain, per roll call vote as follows:

The following Commissioners voted “Yes”: Commissioners Brown, Bunch, Carnevale, Gordon, Robinson, and Rowlett, Vice Chair Alvarez, and Chair Madrigal-Weiss.

The following Commissioner abstained: Commissioner Chambers.

5: Transformational Change in Behavioral Health: Early Intervention and Full-Service Partnerships

Chair Madrigal-Weiss stated the Commission will hear a presentation from the DHCS on the vision for early intervention services and Full-Service Partnerships (FSPs). Proposition 1 directs counties to identify early intervention approaches to address the negative outcomes of mental illness and sets aside 35 percent of BHSA county allocations for Behavioral Health Services and Supports (BHSS), which includes funding for early intervention and FSPs. This will be the first of several discussions the Commission will have with the DHCS on both topics while exploring opportunities and priorities.

Chair Madrigal-Weiss noted that written testimony from behavioral health partners on potential priority areas for early intervention is included in the meeting materials. The Commission hopes to bring subject matter experts, consumers, and representatives from community-based organizations together with state partners for further discussions on priority areas for early intervention in the coming months. She asked the representative from the DHCS to give her presentation.

Marlies Perez, Behavioral Health Transformation Project Executive and Division Chief, DHCS, provided an overview, with a slide presentation, of the background, early intervention funding requirements, required early intervention components, coordinated specialty care for first episode psychosis, and FSP levels of care. She stated early intervention is housed in WIC section 5840(a)(1), which defines early intervention as services to prevent mental illnesses and substance use disorders (SUDs) from becoming severe and disabling.

Ms. Perez noted that this does not mean that individuals who could be receiving early intervention services need a diagnosis. That is pre-diagnosis. This is about getting young people and adults before they need treatment services. This would include indicated prevention, case identification, and early treatment and supports. The statute requires early intervention programs for children and youth to be designed to meet their social, emotional, developmental, and behavioral health needs along the continuum of care.

Ms. Perez stated the legislation requires the DHCS to develop a non-exhaustive evidence-based practice and CDEPs list biennially for counties and communities to use as a reference tool. She noted that, if a county is demonstrating gaps in services or is struggling to meet performance measures, the DHCS may require the county to implement a particular evidence-based practice or CDEP from the biennial list.

Ms. Perez stated the FSP levels of care are Assertive Community Treatment (ACT), Forensic Assertive Community Treatment (FACT), Individual Placement and Support (IPS), and High Fidelity Wraparound (HFW). She stated FSP ACT programs must mirror the service components outlined in the Medi-Cal benefit and be made available to non-Medi-Cal members who receive FSPs and are clinically eligible for the highest level of care. FSP funding can be used to cover additional non-clinical supports that are not covered by Medi-Cal, as needed. The HFW level of care is a team-based and family-centered evidence-based practice that includes an “anything necessary” approach to care for children and youth living with the most intensive mental health or behavioral

challenges. HFW is regarded as an alternative to out-of-home placement for children with complex needs by providing intensive services in the family's home and community.

Commissioner Comments & Questions

In response to a Commissioner's question off mic, Ms. Perez stated the difference between clinical adult FSP levels of care is around the model used and the intensity of services. FSP programs are not standardized for all counties and models are not necessarily done to fidelity. The FSP levels of care bring standardization and a fidelity assessment.

Commissioner Bunch asked Ms. Perez to share the staffing patterns and the number of individuals who can be served under the models.

Commissioner Chambers thanked Ms. Perez for her presentation. She stated she looks forward to the clear guidelines and policy manual that will help with implementation of the models. She suggested encouraging counties to contract with community-based organizations and peer-run organizations, particularly with the IPS work, peers in employment, and overall substance use. An equity issue for the state to consider is discrimination of small community-based organizations in areas to operate.

Commissioner Chambers thanked the DHCS for including peers and stakeholders at the table. She encouraged the state to consider how to localize their population outreach.

Ms. Perez stated outreach for early intervention is still at the local level. There are other outreach efforts around housing and general outreach, which can be done under the BHSS bucket, but other outreach and engagement activities can be done at the local level.

Commissioner Bontrager stated this works great for Sacramento and Los Angeles but not for small counties. Although small counties can opt out, the impact is that, if they cannot participate in the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT), they will not be able to pull down federal dollars for institutions for mental disease (IMD) placements. The issue then becomes that the gap between the haves and have nots continues to grow. He stated concern about that because areas of misery in the state for overdose rates and other misery indexes are in rural areas. He asked what can be done to create regional efforts so the gap does not continue to grow.

Ms. Perez stated the BHSA is different in that it brings everything under one umbrella. The County Integrated Plans for Behavioral Health Services and Outcomes coordinates it, and the Behavioral Health Outcomes and Accountability Transparency Report (BHOATR) is a mirror of that. This puts accountability for transparency at the local level and also puts accountability and transparency at the state level for behavioral health in California. Performance measures will soon be rolling out.

Ms. Perez agreed that there are gaps in rural counties but also in larger counties with rural populations. There is a need to bring all this together. Individuals deserve accessible services, which is a big part of BH-CONNECT and of FSPs, but it will take time to help people get there. There are exemptions and assistance for smaller county

partners, but also more things will be streamlined and connected together with Medi-Cal, documentation reform, and other things to help county partners. The DHCS is looking at these pieces and working on streamlining. The BHSA provides the ability to do that, but it is a process that will not happen overnight. Regional models are being worked on with bond applications and provisions are being put in place to help small counties.

Commissioner Brown echoed Commissioner Bontrager's concerns and comments. He encouraged the DHCS to incentivize regionalization for small counties. He referred to the asterisk on Presentation Slide 13, BHSA Early Intervention Program Components, that states "DHCS may include additional components" and asked what else is being considered.

Ms. Perez stated there are provisions in the legislation that give the DHCS the authority to include other provisions; however, the DHCS is not considering anything at this time.

Commissioner Rowlett referred to Presentation Slide 11, Mental Health Services Act (MHSA) to BHSA: BHSS Early Intervention Aims, that talks about an individual-based strategy versus a population-based strategy for school suspension, expulsion, or referral to an alternative or community school. He referred to an article in the Los Angeles Times on October 14th that talked about a successful population-based strategy to enhance Black student achievement that was upended because it was population-based. He stated this issue continues because there is resistance to population-based strategies that work for children and youth that get at the goals listed on Slide 11.

Commissioner Rowlett stated the state is rethinking the way to strategize addressing the intersection between behavioral health and education because the current population-based strategies are not working – Black and brown kids are still being suspended at alarming rates. Local communities can identify strategies better than the state can, but as the state continues to consider individual-bases strategies, he stated the hope that those individual strategies will be aggressive.

Commissioner Gordon stated he is thankful for the CYBHI. It has been transformational but there is much further to go. For example, there are First 5 Commissions in all counties and they sponsor programs like HelpMeGrow, which is a cost-effective screening program currently in 30 counties that could easily be in all countries with a higher level of support. California also has a small district association, but the issue is if California can continue at the higher levels to bring the education and health systems more closely together, not only with the goal of prevention and early intervention, but streamlining systems so it is not so complicated to access services. It is important to bring groups and resources together in collaboration to find new and imaginative ways to deliver services.

Chair Madrigal-Weiss stated a lot of work has been done on the continuum of care in schools ranging from school mental health services, allcove® Youth Drop-In Center Programs, and early psychosis programs. There is a demand for these programs across the state. She asked how these models will be included in the thinking while developing the framework for future early intervention plans.

Ms. Perez agreed that the allcove® Model is incredible but it is only one example of what counties can utilize under the early Intervention bucket of funding, especially with the focus on youth. Another opportunity is how to bring mental health and SUDs together. It is important to ensure that the models reach young people with both of these potential issues.

Chair Madrigal-Weiss stated there has been a great push and advocacy around including student and youth voice. She stated the importance of keeping that at the top of mind and including them at the table and in the decision making.

Commissioner Bunch stated she is a supervisor at one of the largest clinics in Los Angeles County and stated there has been a lot of anxiety around what this will look like. She asked for more information on the next level.

Ms. Perez stated she will send additional slides to staff that will help with the clinical piece around FSPs. The next level will be the draft release of Modules 1 and 2, which outline the policy, by the end of 2024.

Commissioner Mitchell asked how to hold counties accountable to do everything they are mandated to do. She noted that, at the end of the day, consumers just want services.

Ms. Perez stated the BHSA brings a level of accountability in California it has never had before. The County Integrated Plans and the BHOATR tell what the counties are planning to do and what they did with their funding. Performance measures will be in place across these systems. Tools will be in place at the state level with lots of technical assistance. Enforcement ability can be a lever like never before. Although the BHSA focuses on the counties, there are other provisions in there as well. Commercial health services also are responsible for behavioral health services in California.

Vice Chair Alvarez stated appreciation for emphasizing the need to prevent crisis in young people and ensuring that funding is going toward that. There is great alignment with many historic reforms that the DHCS is doing with the California Advancing and Innovating Medi-Cal (CalAIM) Program and improving and strengthening Medi-Cal. That effort has emphasized the “without diagnosis” piece. To be hand-in-hand with this effort is important. At the same time, through CalAIM and other initiatives, it has been clear that there are challenges with building the capacity of community-based organizations to bill Medi-Cal or to understand how certification works. Thinking of the lessons learned from CalAIM and how they apply here is important.

Vice Chair Alvarez asked where the Commission can serve as a partner and be collaborative. She stated the need to consider opportunities to cross-post and cross-message so the community hears the same message from the MHSOAC and the DHCS. She noted that state agencies should be consistent.

Vice Chair Alvarez asked if the discussion around community-based organizations and CDEPs is centered around certain programs or approaches. It is important to consider approaches over specific programs. The Commission can be a partner to the DHCS in emphasizing that narrative around CDEPs.

Vice Chair Alvarez stated analysis shows that more than half of FSPs are focused on children and young people. As rules and approaches are changed, there is a risk that

FSPs will no longer emphasize young people. She stated the importance of ensuring that these changes do not have unintended consequences.

Commissioner Carnevale asked how to integrate data so results can be measured across the system.

Ms. Perez stated the DHCS is looking at current data systems to see what is necessary to get the level of data needed for the performance measures. An extensive amount of work is being done in this space.

Commissioner Carnevale stated this would be a great point of collaboration with the Commission.

Ms. Perez thanked Deputy Director Tom Orrock and his staff for their help the last few weeks in helping her and the DHCS give their presentation today.

Public Comment

Stacie Hiramoto stated it has been difficult for members of the public to follow what the DHCS has been doing with early intervention. The fact that there is room about whether a diagnosis is required is good because current regulations require a diagnosis in order to be considered early intervention. This is important because perhaps more than 50 percent of CDEPs do not require individuals to have a diagnosis and yet they serve individuals in this category alongside individuals in prevention. The speaker asked how this will be funded. Unlike the Commission's fabulous public comment process with a lot of open interaction, the public sessions at the DHCS are difficult to understand and the process to participate in meetings is difficult. The DHCS does not have a robust public engagement.

Dr. Merritt Schreiber, Clinical Child Psychologist, Harbor-UCLA Medical Center, Lundquist Institute, and David Geffen School of Medicine at UCLA, stated they were heartened to hear the presentation by the DHCS and the focus on early risk identification and even pre-diagnosis. The speaker stated there is a federal effort to improve the response in children in disasters and other kinds of acute trauma. The speaker stated their organization would like to be more engaged. The speaker stated the Stepped Triage to Care: Supporting Students in the Aftermath of Crisis/Disaster pilot in Sonoma County with the Sonoma County Office of Education was an early risk identification and rapid linkage program before clinical disorder or school impairment can set in. The speaker asked to partner further with the DHCS to ensure that the Stepped Triage to Care Model is one piece of this larger early risk intervention.

Dr. Merritt stated the California Department of Education and the Sonoma County Office of Education have a triage system that parents can access voluntarily indicating what is happening to their children via their schools. This is currently available at no cost to any school district in California but is not well-known.

Chair Madrigal-Weiss asked staff to contact Dr. Merritt offline for information on the free resource for parents.

Steve Leoni, consumer and advocate, stated concern that FSPs have been changing over the years and what is being done in many counties is not what was originally intended and is even contrary to the original model. FSPs were founded on The Village

in Long Beach that created evidence during its 10-year pilot, led by Dr. Mark Ragins and Dr. Dave Pilon, although that evidence is not considered evidence-based practices or CDEPs.

Steve Leoni referred to Presentation Slide 26, SB 326 on FSP Programs, that states “FSP programs shall have an established standard of care with levels based on an individual’s acuity and criteria for step-down into the least intensive level of care.” The speaker stated it is a damaging statement that the step-downs are based on acuity. In the original FSP, it was something called the Milestones of Recovery that did not step individuals down. They were self-sustaining to some extent with self-management. It used the Clubhouse and Discovery Models, which were active, community-based models as opposed to a state model, no matter how intense and elaborate. There is a lot being lost.

Steve Leoni stated they were listening with great interest when the presenter talked about the children’s intensive wraparound that does not define multiple levels of care and that the “service design enables flexibility to adjust the level of intensity according to an individual’s needs.” (Slide 41) He asked why that flexibility cannot be on the adult side as well. That flexibility is at the heart of the MHSA. The Village Model in Long Beach was recognized at the national level in the past but something will be lost that is precious unless care is taken to preserve it.

Jazmin Estevez-Rosas, Policy Associate, The Children's Partnership, thanked the DHCS for including children’s advocates in the dialogue on Proposition 1 implementation. The speaker stated the importance that state guidance makes explicit that county early intervention services are inclusive of but not limited to services that intervene early in the life course and not only early in the disease or illness course as a way to prevent mental illness from ever developing in children and youth.

Jazmin Estevez-Rosas thanked the presenter for noting in her presentation that diagnosis is not necessary for children and youth to receive early intervention services. Children of color and low-income children are the populations that are at most risk and have the least resources to access diagnostic tools and services. As such, The Children’s Partnership is grateful to the Governor for his inclusion of language in Proposition 1 that makes clear that children and youth who do not have a diagnosis but nevertheless have unmet mental health needs due to trauma of whose communities have experienced historic disparities in access and positive mental health outcomes are indeed eligible for early intervention services under the BHSA. The speaker stated The Children’s Partnership asks that the DHCS in its policy manual make this explicit to counties that in the past have had a much narrower understanding of who is eligible for early intervention services.

Jazmin Estevez-Rosas encouraged the Commission to collaborate closely with the DHCS in the development of its BHSA policy manual, given the Commission’s history in an oversight and accountability role and the challenges communities have had in participating in county MHSA decisions, accessing disaggregated service and outcome data, and holding the county leaders accountable to regulatory and statutory requirements for minimum spending on children and youth.

6: Closed Session – Personnel Matter

Closed Session – Government Code § 11126(a)(1) related to a personnel matter.

Chair Madrigal-Weiss asked for public comment prior to the Commission's entering into closed session.

Public Comment

Stacie Hiramoto stated members of the public have opinions on this agenda item and would like to speak but it was not noticed as part of the agenda so they are not prepared.

Andrea Margolis stated their full comment has been submitted to staff. The speaker stated there have been Commission staff who have been unhappy and feeling that they were working in a hostile environment and that that environment under Executive Director Ewing's leadership significantly affected their mental health. The speaker stated their brother, Geoff Margolis, was Chief Counsel at the Commission for a year and a half until his sudden death from a massive heart attack. Stress at work was one of several factors contributing to his death. The speaker stated the stress resulted from the fact that Executive Director Ewing did not like their brother's efforts to try to ensure that the executive director was operating completely within the law. Although fantastic work has been accomplished under Executive Director Ewing's leadership, the speaker stated he cannot be allowed to continue to hurt people in this role.

Susan Gallagher stated the importance for the public to learn the result of today's closed session for transparency. The speaker stated sole-source contracts, lobbying at the Capitol, and not listening to peer-run organizations about focus areas have been going on for a long time. The speaker stated the public testifies at meetings at risk. Staff and the community have been bullied by Executive Director Ewing. The speaker provided the example of Executive Director Ewing's telling them that, if they kept coming to meetings and testifying against his policies, he would take their funding – and he did.

Susan Gallagher stated the Commission and stakeholders work in the mental health system and are supposed to preserve mental health and create psychological safety. Commissioner leadership and staff are role models for the community and the system.

Susan Gallagher stated disappointment that the Commission did not oppose SB 326 and Proposition 1. The speaker stated it is changing everything and shifting taxpayer money towards hedge funds because these treatment facilities are owned by places like that. Community-based organizations are going out of business and California will never get that back. The Commission has a responsibility. It is not some fun game about going on trips and rubbing elbows with people of stature. The speaker urged the Commission to do the right thing today.

Renay Bradley, Former Director of Research and Evaluation, stated they were hired in 2012 and left voluntarily three years later because they were routinely subjected to bullying, intimidation, harassment, and threats by Executive Director Ewing. The speaker stated they personally witnessed Executive Director Ewing attacking their research scientist staff and bullying them based on their mental health illnesses and

challenges. The speaker stated they reached out to every Commissioner at that time nine years ago and they turned a blind eye and did not do anything. It is sad to see nine years have passed and nothing has been done about this. The speaker encouraged the Commission to do the right thing and terminate Executive Director Ewing's employment. Executive Director Ewing does not behave in a manner that is appropriate for a state representative or the leader of the Mental Health Services Oversight and Accountability Commission.

Chair Madrigal-Weiss stated the Commission will meet in closed session to discuss confidential personnel matters as permitted by law. The Commission entered into closed session at 11:32 a.m.

7: **Report Out from Closed Session**

Chair Madrigal-Weiss reconvened the meeting at 3:23 p.m. and stated during closed session the Commission accepted Executive Director Ewing's resignation, effective November 22, 2024.

8: **Consent Calendar**

Chair Madrigal-Weiss tabled this agenda item to the next meeting.

9: **Chair and Vice Chair Elections**

Chair Madrigal-Weiss tabled this agenda item to the next meeting.

10: **Mental Health Student Services Act Report**

Chair Madrigal-Weiss tabled this agenda item to the next meeting.

11: **Adjournment**

Chair Madrigal-Weiss thanked everyone for their participation in today's meeting. The next Commission meeting will take place on November 21st. There being no further business, the meeting was adjourned at 3:24 p.m.

Motions Summary
Commission Meeting
October 24, 2024

Motion #: 1

Date: October 24, 2024

Proposed Motion:

That the Commission approves the August 22, 2024 Meeting Minutes, as modified.

Commissioner making motion: Commission Brown

Commissioner seconding motion: Commissioner Robinson

Motion carried 8 yes, 0 no, and 1 abstain, per roll call vote as follows:

Name	Yes	No	Abstain	Absent	On Leave
1. Bontrager	☐	☐	☐	☐	☐
2. Brown	☒	☐	☐	☐	☐
3. Bunch	☐	☐	☒	☐	☐
4. Carnevale	☒	☐	☐	☐	☐
5. Carrillo	☐	☐	☐	☒	☐
6. Chambers	☒	☐	☐	☐	☐
7. Chen	☐	☐	☐	☐	☒
8. Cortese	☐	☐	☐	☒	☐
9. Gordon	☒	☐	☐	☐	☐
10. Mitchell	☐	☐	☐	☐	☐
11. Robinson	☒	☐	☐	☐	☐
12. Rowlett	☒	☐	☐	☐	☐
13. Tsai	☐	☐	☐	☒	☐
14. VACANT	☐	☐	☐	☐	☐
15. Vice-Chair Alvarez	☒	☐	☐	☐	☐
16. Chair Madrigal-Weiss	☒	☐	☐	☐	☐
Totals:	8	0	1		

MHSOAC
Mental Health Services
Oversight & Accountability Commission

Motions Summary
Commission Meeting
October 24, 2024

Motion #: 2

Date: October 24, 2024

Proposed Motion:

That the Commission approves the September 11, 2024 Meeting Minutes, as presented.

Commissioner making motion: Commissioner Robinson

Commissioner seconding motion: Commissioner Rowlett

Motion carried 9 yes, 0 no, and 0 abstain, per roll call vote as follows:

Name	Yes	No	Abstain	Absent	On Leave
1. Bontrager	☐	☐	☐	☐	☐
2. Brown	☒	☐	☐	☐	☐
3. Bunch	☒	☐	☐	☐	☐
4. Carnevale	☒	☐	☐	☐	☐
5. Carrillo	☐	☐	☐	☒	☐
6. Chambers	☒	☐	☐	☐	☐
7. Chen	☐	☐	☐	☐	☒
8. Cortese	☐	☐	☐	☒	☐
9. Gordon	☒	☐	☐	☐	☐
10. Mitchell	☐	☐	☐	☐	☐
11. Robinson	☒	☐	☐	☐	☐
12. Rowlett	☒	☐	☐	☐	☐
13. Tsai	☐	☐	☐	☒	☐
14. VACANT	☐	☐	☐	☐	☐
15. Vice-Chair Alvarez	☒	☐	☐	☐	☐
16. Chair Madrigal-Weiss	☒	☐	☐	☐	☐
Totals:	**9**	**0**	**0**		

MHSOAC
Mental Health Services
Oversight & Accountability Commission

Motions Summary
Commission Meeting
October 24, 2024

Motion #: 3

Date: October 24, 2024

Proposed Motion:

That the Commission approves the September 26, 2024 Meeting Minutes, as presented.

Commissioner making motion: Chair Madrigal-Weiss

Commissioner seconding motion: Commissioner Bunch

Motion carried 8 yes, 0 no, and 1 abstain, per roll call vote as follows:

Name	Yes	No	Abstain	Absent	On Leave
1. Bontrager	☐	☐	☐	☐	☐
2. Brown	☒	☐	☐	☐	☐
3. Bunch	☐	☐	☐	☐	☐
4. Carnevale	☒	☐	☐	☐	☐
5. Carrillo	☐	☐	☐	☒	☐
6. Chambers	☐	☐	☒	☐	☐
7. Chen	☐	☐	☐	☐	☒
8. Cortese	☐	☐	☐	☒	☐
9. Gordon	☒	☐	☐	☐	☐
10. Mitchell	☐	☐	☐	☐	☐
11. Robinson	☒	☐	☐	☐	☐
12. Rowlett	☒	☐	☐	☐	☐
13. Tsai	☐	☐	☐	☒	☐
14. VACANT	☐	☐	☐	☐	☐
15. Vice-Chair Alvarez	☒	☐	☐	☐	☐
16. Chair Madrigal-Weiss	☒	☐	☐	☐	☐
Totals:	8	0	1		

State of California

MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

Commission Meeting Minutes

Date November 4, 2024

Time 4:00 p.m.

Location MHSOAC
1812 9th Street
Sacramento, California 95811

Additional Public Locations:

Substance Abuse Prevention and Control (SAPC) Bureau
1000 S Fremont Avenue
A9 East, 3rd Floor
North Wing – Executive Conference Room
Alhambra, California 91803

San Diego County Office of Education
6401 Linda Vista Road
Room 208
San Diego, California 92111

Santa Barbara County Sheriff's Office
4434 Calle Real
Santa Barbara, CA 93110

The Children's Partnership
700 S Flower Street, Suite 1000
Los Angeles, CA 90017

Members Participating:

Mara Madrigal-Weiss, M.Ed., Chair*
Mayra Alvarez, M.H.A., Vice Chair*
Mark Bontrager, J.D., M.S.W.
Sheriff Bill Brown, M.P.A.*
Steve Carnevale
Assembly Member Wendy Carrillo, M.A.*
Rayshell Chambers, M.P.A.
David Gordon, Ed.M.
Gladys Mitchell. M.S.W.
Alfred Rowlett, M.B.A., M.S.W.
Gary Tsai, M.D., DFAPA, FASAM*

*Participated remotely

Members Absent:

Keyondria Bunch, Ph.D.
Shuo Chen, J.D.
Senator Dave Cortese, J.D.
Jay Robinson, Psy.D., M.B.A.

MHSOAC Meeting Staff Present:

Sandra Gallardo, Chief Counsel
Tom Orrock, Deputy Director, Program Operations
Norma Pate, Deputy Director, Administration and Performance Management
Amariani Martinez, Administrative Support
Lester Robancho, Health Program Specialist
Cody Scott, Meeting Logistics Technician

1: Call to Order and Roll Call

Chair Mara Madrigal-Weiss called the Meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at approximately 4:00 p.m. and welcomed everyone. The meeting was held on Zoom, via teleconference, at multiple satellite locations across the state that were open to the public, and at the MHSOAC headquarters, located at 1812 9th Street, Sacramento, California 95811.

Chair Madrigal-Weiss noted for the record that the Commission is required by the Bagley-Keene Open Meeting Act to have a minimum of eight Commissioners in person to establish a quorum to conduct business today.

Sandra Gallardo, Chief Counsel, called the roll and confirmed the presence of a quorum. Attending in Person: Commissioners Bontrager, Carnevale, Chambers, Gordon, Mitchell, and Rowlett. Attending by Satellite: Chair Madrigal-Weiss, Vice Chair Alvarez, and Commissioners Brown, and Tsai.

Amariani Martinez, Commission staff, reviewed the meeting protocols.

2: General Public Comment

Clare Cortwright (attended in person at the Sacramento location), Policy Director, Cal Voices, asked that several Commissioners resign. Commissioners should avoid even the appearance of impartiality, misconduct, or public corruption. The speaker stated several Commissioners are not meeting that ethical bar. They should be held to that standard. The public's perception of the Commission is not good right now. It is important to state why.

Clare Cortright explained that they reviewed the links in the two KFF news articles that came out. Some of those links were emails from Executive Director Toby Ewing. In them, after he and several Commissioners returned from a Kooth-financed trip to London, he wrote the Chief Operating Officer of Kooth and said, "We are home and mostly recovered," except he notes that, "Commissioner Carnevale is still in London. We returned home with ambitious ideas and you have outlined several exciting propositions. We are also thinking through a number of follow-ups and I want to share with you what we understand to be the Legislature's follow-up coming out of budget negotiations on the digital platform. We expect you to be involved in whatever we dream up." The speaker stated they did not believe that Executive Director Ewing's "we" refers only to himself. There are other Commissioners involved in whatever the dealings are with Kooth and Executive Director Ewing is referencing that. Those Commissioners know who they are and should step down as a result.

Clare Cortright stated these emails contain lobbying and consulting on behalf of a hedge-fund-owned United Kingdom-based company that include such things as Executive Director Ewing telling Kooth that it should get money for its engagement and that it is required under its contract to have its number of users and meet payments from the state: "If there are concerns that there are no funds for that work, consider asking this Commission to dedicate some of the funding you provide us for the community advocacy to be used to support community advocacy for the digital platform."

Clare Cortright asked what is going on, why Kooth would be giving money to this Commission, and why this Commission would be giving money back to Kooth. This does not look good. The speaker stated what has come out to date will not be the end of it because it should not be. The Commissioners involved should resign. They are causing scrutiny on themselves and their appointing bodies.

Susan Gallagher (attended in person at the Sacramento location), Executive Director, Cal Voices, stated they were deeply concerned that Executive Director Ewing was seeking executive authority to execute sole-source contracts on his own outside of Commission work. The speaker stated their son, who is a lawyer, approached this Commission after doing legal research, saying that Executive Director Ewing did not have executive authority to do these sole-source contracts. There was an attorney general opinion on this matter but no one seems to care. The speaker stated concern that this issue was not shared with the public. This is a problem that continues. The speaker stated concern that the Commission will bring in a new Executive Director without cleaning this up.

Susan Gallagher stated it is egregious that the words "oversight" and "accountability" are part of the Commission's name. This is a problem. Clearly, Executive Director Ewing and other Commissioners have been engaging in serial communication in violation of the Bagley-Keene Open Meeting Act. There are many emails that can prove this. The speaker stated concern that the Commission has regularly engaged in conversations outside of the public process that is mandated in the state of California.

Susan Gallagher stated the Commission not only went to London, they went to New York for Kooth with Dr. Ghaly, Michele Baass, Autumn Boylan, the governor's wife, and others. The speaker asked who paid for the New York trip and what Kooth has done to get so much play. The public does not have this much access to government officials or this kind of funding broken off to peer-run organizations or client behavioral health services. The speaker stated they asked the Executive Director to put a peer-run program presentation on the agenda for years but it has never happened. The Commission has not published the reports put out by peer-run organizations.

Susan Gallagher stated concern that the Commission is allowing Executive Director Ewing to go to Rome tomorrow. This does not look good.

Susan Gallagher stated the focus has been shifted away from the grassroots community. Nothing was learned from the Technology Suite Collaborative Innovation Project. There were groomers in the Technology Suite Collaborative Innovation Project but the Commission buried it.

Stacie Hiramoto (attended remotely via Zoom), Director, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), thanked Cal Voices for their comment. The speaker stated they personally agree with much of Cal Voices' comment and have experienced that themselves when asking many times for this Commission to hear about certain projects or about other matters that were never allowed to be on the agenda.

Stacie Hiramoto stated the Commission will be discussing the hiring of a new Executive Director today. It would be beneficial to involve the behavioral health community, especially representatives of unserved, underserved, and inappropriately served communities as well as the client and family communities, in the recruitment and hiring of the next Executive Director. Involving community representatives in the hiring process would go a long way towards building and restoring trust between the Commission and the community.

Stacie Hiramoto stated community input might call attention to such things as whether the candidate has been a supportive supervisor in the past, since, in general, Commission staff have not been supervised in a supportive, collaborative manner that promoted teamwork for some time. Current staff deserve this and deserve a leader who will reward their hard work and dedication to the Commission and their commitment to the values of the Mental Health Services Act (MHSA).

Stacie Hiramoto stated community input might ensure that the candidate understands, promotes, and has a track record of bringing on and retaining staff from Black, Indigenous, and People of Color (BIPOC) communities, and also has a personal interest in reducing disparities, since this has not been a priority of the Commission in the past. The speaker stated the community would love the candidate to have knowledge regarding mental and behavioral health, housing, and other policy issues, but there have been areas that the Commission has not been leading on. This would be an opportunity to strengthen those areas now.

Kevin Dredge (attended remotely via Zoom), mental health advocate, stated they were surprised to hear such derogatory things said about such an important part of California's future in regards to the Commission. They stated they were not here to discuss that issue. The speaker suggested that the Commission support implementing May 18th as "National Kids Day" with the Lions Club. The Lions Club talks about the truth about drugs, socioemotional learning skills, the way to happiness, and human rights. The speaker asked to talk to staff offline about putting together a steering committee for National Kids Day.

Chair Madrigal-Weiss stated staff will contact them offline.

Craig Durfey (attended remotely via Zoom), Founder, Parents for the Rights of Developmentally Disabled Children (PRDDC), stated they have dealt with vision illness for the past six years that has not been identified. Assembly Bill (AB) 638: Mental Health Services Act: early intervention and prevention programs, was passed in 2021 but this has not yet been defined. The "anxious generation" is connected to vision illness. The speaker stated California does not have the awareness that Utah has to bring correction on this issue. Elected officials and legislative staff are inept. Federal laws in the state indicate that any socioemotional harm causes problems and the dots are not being

connected. The Commission should be reviewing this issue globally but no one wants to take the time to put a plan together under AB 638 to define prevention and early intervention and how to promote community awareness on this issue in order to decrease suicide risk.

3: Bagley-Keene Special Meeting Requirement

Chair Madrigal-Weiss stated the Commission will consider if circumstances exist to make a finding which requires the Commission to hold a special meeting pursuant to Government Code § 11125.4(c).

Commissioner Comments & Questions

Commissioners asked questions about the Bagley-Keene Open Meeting Act rules.

Public Comment

There was no public comment.

Action: Chair Madrigal-Weiss asked for a motion to approve meeting in closed session. Commissioner Rowlett made a motion, seconded by Commissioner Gordon, that:

- *The Commission approves moving forward with the special meeting to address the personnel matter in closed session pursuant to Government Code § 11125.4(c).*

Motion passed 10 yes, 0 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted “Yes”: Commissioners Bontrager, Brown, Carnevale, Chambers, Gordon, Mitchell, Rowlett, and Tsai, Vice Chair Alvarez, and Chair Madrigal-Weiss.

4: Closed Session – Personnel Matter

Closed Session – Government Code § 11126(a)(1) and § 11125.4(a)(9).

Public Comment

Stacie Hiramoto asked if Commissioner Carrillo was in attendance at the time.

Commissioner Carrillo stated she was.

Chief Counsel Gallardo stated Commissioner Carrillo was attending as a member of the public because she was not at one of the noticed satellite locations.

Kevin Dredge asked what will be discussed in closed session.

Chair Madrigal-Weiss stated the Commission will discuss a personnel matter.

The Commission met in closed session to discuss confidential matters as permitted by law.

5: Report Back from Closed Session

Chair Madrigal-Weiss reconvened the meeting and stated, during closed session, the Commission voted to appoint Will Lightbourne as the Interim Executive Director of the

Commission while the Commission undergoes a nationwide search for a new Executive Director.

6: Adjournment

Chair Madrigal-Weiss stated the next Commission meeting will take place on November 21st. There being no further business, the meeting was adjourned at approximately 6:00 p.m.

Motions Summary
Commission Meeting
November 4, 2024

Motion #: 1

Date: November 4, 2024

Proposed Motion:

> That the Commission approves moving forward with the special meeting to address the personnel matter in closed session pursuant to Government Code § 11125.4(c).

Commissioner making motion: Commissioner Rowlett

Commissioner seconding motion: Commissioner Gordon

Motion carried 10 yes, 0 no, and 0 abstain, per roll call vote as follows:

Name	Yes	No	Abstain	Absent	On Leave
1. Bontrager	☒	☐	☐	☐	☐
2. Brown	☒	☐	☐	☐	☐
3. Bunch	☐	☐	☐	☐	☐
4. Carnevale	☒	☐	☐	☐	☐
5. Carrillo	☐	☐	☐	☒	☐
6. Chambers	☒	☐	☐	☐	☐
7. Chen	☐	☐	☐	☐	☒
8. Cortese	☐	☐	☐	☒	☐
9. Gordon	☒	☐	☐	☐	☐
10. Mitchell	☒	☐	☐	☐	☐
11. Robinson	☐	☐	☐	☐	☐
12. Rowlett	☒	☐	☐	☐	☐
13. Tsai	☒	☐	☐	☒	☐
14. VACANT	☐	☐	☐	☐	☐
15. Vice-Chair Alvarez	☒	☐	☐	☐	☐
16. Chair Madrigal-Weiss	☒	☐	☐	☐	☐
Totals:	**10**	**0**	**0**		

AGENDA ITEM 5

Action

November 21, 2024 Commission Meeting

Consent Calendar

Summary:
The Commission will consider approval of the Consent Calendar which contains the following items:

1) BHSA Implementation Planning: Nevada County
2) Level Up – Community Driven Practices for Health Equity: Shasta County
3) Psychiatric Advance Directive (PADs) Phase 2: Alameda County & Tri-Cities
4) Information Technology Contract Update
5) Reallocation of unencumbered MHWA funds – EmPATH
6) Rules of Procedures Update

Items are placed on the Consent Calendar with the approval of the Chair and are deemed non-controversial. Consent Calendar items shall be considered after public comment, without presentation or discussion. Any item may be pulled from the Consent Calendar at the request of any Commissioner. Items removed from the Consent Calendar may be held for future consideration at the discretion of the Chair.

1) <u>BHSA Implementation Planning: Nevada County</u>

Nevada County is requesting up to $1,365,000 of Innovation spending authority to prepare MHSA-funded partners for implementation of Proposition 1, or the Behavioral Health Services Act (Prop 1/BHSA). Changes to the original MHSA include elimination of the Prevention and Early Intervention (PEI) fund and added fidelity requirements to Full Service Partnership programs (FSPs). This proposed project seeks to provide technical assistance to currently funded providers, with emphasis on community-based organizations (CBOs), to maximize Medi-Cal billing. It also seeks to prepare FSP providers for new BHSA FSP data and reporting requirements.

BHSA Alignment and Sustainability:
On July 1, 2026, the funding categorization under the MHSA will no longer be in effect, and existing programs currently supported by the MHSA's PEI fund will need to identify other sources of funding to maintain programs that provide vital services and supports to community members and to prevent lapses in care. Many providers in Nevada County are small grass roots organizations with limited capacity to shift administrative infrastructure in ways that maximize Medi-Cal billing, putting these CBOs at high risk of losing the financial support needed to continue serving the County's marginalized populations. Additionally, the BHSA directs FSP programs to

implement fidelity-based requirements, ensuring effective outcomes and performance measurements of its providers.

To assess how current programs fit into the modernized funding structure and ensure continuity of care, Nevada County will convene a Learning Collaborative that explores ways in which existing programs can be billable through revenue models such as Specialty Mental Health Services (SMHS) via the County Mental Health Plan (MHP), the county's Managed Care Plan Partnership, or Medi-Cal Administrative Activities (MAA). Contracted expert advisors will help local agencies determine how to bill services from a suite of options that may include: Drug Medi-Cal Organized Delivery Services (DMC-ODS), Enhanced Care Management (ECM), Community Supports, Community Health Worker (CHW) benefits, and the Children and Youth Behavioral Health Initiative (CYBHI).

The County will identify and select up to 20 local providers of PEI programs to join the Learning Collaborative. An expert consultant will offer training and guidance both in a group setting as well as through individual coaching. Content of the Learning Collaborative will include, but is not limited to, reviewing current systems and administrative policies, analyzing services, and exploring Electronic Health Record (EHR) and billing systems. To encourage participation in the Learning Collaboratives, Nevada County will be providing financial incentives to assist program providers with administrative and/or implementation costs associated with participating in this project. In addition to tailored support for current PEI program providers, Nevada County will also be preparing for fidelity-based FSP requirements and plans on implementing a performance-based contract management tool by implementing locally tailored "performance pack" outcome measurements and data collection to analyze contract performance and possible areas of improvement.

Community Planning Process:
Local Level
To identify priorities for future innovation projects, meetings were held on November 8, 2023, March 28, 2024, and August 27, 2024. Participants in the County's community planning process included providers, program participants, family advocates, peers, family members, County employees, and other members of the community. At these meetings, Nevada County shared information on Proposition 1 and the BHSA, leading way to concerns about program sustainability once MHSA funding allocations convert to the BHSA categories. PEI providers were most apprehensive about the changes, and ultimately, those primary concerns led to the drafting of this proposed innovation project. During the County's most recent community meeting in August 2024, 96% of respondents expressed their support for a project that would address these sustainability issues. Most attendees at that meeting were representatives of community-based organizations.

Nevada County's 30-day public comment period for this plan was September 4, 2024 through October 4, 2024. Within that time, the County received one letter from a currently incarcerated county resident. In the letter, the commenter did not comment on this innovation plan, specifically; rather, the individual shared their first-hand experiences with the criminal justice

system and homelessness, and reiterated the importance of mental health supports for people in their position.

Nevada County's local Mental Health and Substance Use Advisory Board approved the plan on October 4, 2024. It is scheduled for review by the local Board of Supervisors on November 12, 2024.

Commission Level
Commission staff shared this project's initial plan with its community partners and the Commission's listserv on September, 9, 2024, and comments were directed to County staff. An updated project plan was shared with the Commission's community partners and listserv on October 17, 2024.

2) <u>Level Up – Community Driven Practices for Health Equity: Shasta County</u>
Shasta County is requesting up to $999,977.52 of Innovation spending authority to partner with Level Up NorCal to provide case management and wrap-around supports for low income and underserved residents of the Hispanic/Latino and Asian communities that are traditionally difficult to reach. Level Up NorCal is a community-based organization whose mission is to improve and promote health and well-being of ethnic minorities through education, support, and advocacy. Level Up NorCal staff have a combined 30+ years of experience providing outreach and information to bicultural and bilingual community members and have built trust and rapport with individuals throughout Shasta County.

This proposed project will implement a community-driven and culturally based approaches to address Shasta County's underserved communities through methods previously proven effective in public health settings. This project will use the promotoras model to reach unserved and underserved communities, scaling these methods beyond the public health setting and into the behavioral health space. Case management services utilizing bilingual/bicultural staff will ensure culturally and linguistically responsive services through enhanced understanding and comprehension between providers and those seeking assistance, as well as increase awareness of and access to services.

Behavioral Health Services Act (BHSA) Alignment and Sustainability:
The BHSA aims to expand the behavioral health workforce to reflect and connect with California's diverse population by focusing on outcomes, accountability, and equity. Shasta County's proposed plan aligns with and furthers that purpose through its culturally and linguistically diverse approach at reaching its community members who have typically been unserved, underserved, and/or inappropriately served. By implementing promotoras, this project will foster supports and services from within its local community through a workforce that addresses specific behavioral health needs for its Hispanic/Latino and Asian community members. Since translation services and cultural and linguistic competency has been a major challenge for Shasta County's Hispanic/Latino and Asian communities, this project will provide translation services to promote shared understanding of vital behavioral health concepts between community members and providers through use of staff who speak the language of the individuals being served and

represent the community being served. The primary languages that will be utilized for provision of services will include Spanish, Mien, and Hmong.

Participants will also receive wrap-around case management with a whole-person approach to focus on the unique needs of those who require culturally and linguistically tailored assistance in areas such as housing, food, and economic insecurities. Addressing these basic immediate needs permits individuals to focus more on their behavioral health. If successful, the county plans on sustaining this project through BHSA funding allocated for early intervention efforts, such as outreach, case management support, referrals, and family and individual skill building.

Community Planning Process:
Local Level
During the County's community planning process, the main priority populations identified as being in most need of behavioral health services and supports were the Hispanic/Latino and Asian communities who face cultural and linguistic barriers that prevent them from receiving timely access to appropriate care. In April 2023, a community-wide survey was sent out to the public to identify ideas for potential innovation projects. Community members expressed the need for improvements in culturally appropriate services, and thus, this project was created.

Between August 7, 2023 and September 6, 2023, the plan underwent its 30-day public comment period. During that time, the proposed project received large support from community-based organizations and local community members, with the County receiving over a dozen letters of support. Some of the organizations who voiced their support of the plan included the Shasta Equal Justice Coalition, the National Alliance on Mental Illness (NAMI) Shasta branch, SEIU Local 2015, community members representing the target populations, and numerous other residents of Shasta County.

Many of the public comments centered around the pressing need for culturally and linguistically appropriate services for the Hispanic/Latino and Asian/Pacific Islander populations, who make up a large portion of the County's demographic but who often find it difficult to trust, access, and receive services that meet their specific needs. These comments also noted how beneficial the proposed services would be in promoting health equity and diversity within the behavioral healthcare space. Education and advocacy efforts that account for language barriers were called out as important strategies to advance the health and wellbeing of ethnic minorities, with some sharing their first-hand experiences witnessing the challenges and lack of supports available for the Hispanic/Latino and Asian communities.

An overwhelming portion of community comments vouched for the skills and efficacy of the Level Up NorCal organization, which has previously worked alongside other community-based organizations in Shasta County during the COVID-19 pandemic to promote vaccine awareness and education. Through their past efforts, Level Up NorCal increased vaccine equity among underserved communities by breaking down cultural and linguistic barriers. The trust in Level Up NorCal's ability to connect community members with much needed services is highly evident among the letters of support.

Shasta County's local mental health board approved the plan on September 6, 2023. Local Board of Supervisor approval is pending.

Commission Level
Commission staff shared this project's initial plan with its community partners and the Commission's listserv on August, 15, 2024, and comments were directed to Commission staff. An updated project plan was shared with the Commission's community partners and listserv on September 3, 2024.

3) <u>Psychiatric Advanced Directives (PADs) Phase 2: Alameda County & Tri-Cities</u>

Alameda and Tri-City are requesting approval to participate in Phase Two of the Psychiatric Advance Directives (PADs) multi-county collaborative, joining Fresno, Shasta, and Orange Counties who have received previous approvals. Alameda is requesting up to $3,070,005 and Tri-City is requesting up to $1,500,000 in Innovation funding.

The first cohort of the Psychiatric Advance Directive (PAD) project was approved by the Commission on June 24, 2021, for a total of four years and is set to conclude on June 25, 2024. Partnering counties consisted of Fresno, Contra Costa, Mariposa, Monterey, Orange, Shasta, and Tri-City.

Phase Two will focus heavily on the training and "live" use of PADs. At this time, Fresno and Shasta County are ready to pilot Phase Two; however, up to fifteen counties may join Phase Two by the end of the year.

Phase Two goals include engagement for new counties, collaboration amongst stakeholders, training and accessibility, testing in a live environment, evaluation, and transparency through www.padsCA.org.

Behavioral Health Services Act Alignment (BHSA) and Sustainability:
This project will focus on individuals with behavioral health needs who may be unhoused and need housing and supportive services, who receive services from Full-Service Partnerships, and other individuals who are in the behavioral health system of care including veterans, justice-involved, recently hospitalized in emergency room departments or inpatient units, and those with co-occurring substance use disorders.

The project also aligns with the Commission's Strategic Plan goals of advocacy for system improvement, supporting universal access to mental health services, participation in the change in statutes, and promoting access to care and recovery.

On April 23, 2024, The Commission was asked to support Assembly Bill 2352 (Irwin) which will seek to build out a legal framework for PADs in California that will work the Counties who are currently participating in Phase One of this project. Support of AB 2352 was granted with the stipulation that this bill continues to work with disability rights groups and ensures that the bill empowers peers and supports recovery. *PADs Phase Two has outlined efforts to collaborate and partner with*

Peer Support Specialists, Painted Brain, Disability Rights of California, NAMI California (for complete list of collaborating partners, see page 4-5).

Regarding sustainability, PADs has received support from current legislative action (AB2353, Irwin) for Phase One efforts. It is the hope that continued funding through legislation will support the work in Phase Two. Part of the goal within Phase Two is to show the need and the utility of PADs with the hope that it will secure ongoing funding from various agencies.

Discussion of County Specific Community Planning Process:

Alameda

In Phase Two, Alameda County is continuing to prioritize their focus on individuals who access crisis support services, individuals experiencing homelessness and those who are justice-involved.

Alameda County proposes to spend $3,070,005 in Innovation funding towards this multi-county collaborative.

Tri-City

In Phase Two, Tri-City has identified two priority populations: transitional aged youth (18-25) and individuals who are homeless/at risk of homelessness.

Tri-City reports that 24% of all crisis calls during Fiscal Year 2022/2023 involved transitional aged youth (TAY). Other data provided indicates the need for additional interventions specific for this population.

For individuals experiencing housing instability, PADs can help identify emergency contact information, treatment plans and tools to help in a time of crisis.

Tri-City Mental Health Authority proposes to spend up to $1,500,000 in Innovation funding towards this multi-county collaborative.

This final projects for Alameda and Tri-City to join the PADs Collaborative was shared with the Commission's community partners and listserv on September 25, 2024. No comments were received in response to this sharing.

4) Information Technology Contract Update

Requesting the approval of a contract in the amount of $215,550 to support updating the Commission's best practices in Information Technology security as mandated by the State of California Department of Justice (DOJ). The goals of this project are to ensure the Commission meets or exceeds the updated requirements as mandated by DOJ and follows appropriate best practices for data security.

Background
The Commission offers data transparency as part of a continuous commitment to support improved public access to and understanding of California's mental health services. Data for these analyses are obtained through data sharing agreements with other state entities. The DOJ requires the Commission as a non-law enforcement agency (NJCA) to demonstrate compliance with Federal Bureau of Investigation Criminal Justice Information Services Security Policy (FBI CJIS SP) to receive Criminal Justice Offense Record Information (CORI). DOJ and FBI CJIS regularly update their requirements, which requires the Commission to review and update our policies regularly.

The Commission was first required to document CJI Compliance in 2020. The Commission received 3 bids for assistance, and the vendor Flank, now Centris, was contracted for compliance assistance. This contract was approved by the Commission in 2020 and the Commission successfully completed FBI CJIS SP 5.9 compliance on 6/30/21. Cost $114,625.00 - 20MHSOAC018.

In 2022 the Commission moved their data center to a new environment and the DOJ updated their security policies to FBI CJIS SP 5.9.1. The Commission contracted with the same vendor for compliance assistance. The Commission successfully completed the second compliance effort for FBI CJIS SP 5.9.1on 10/1/22. Cost $98,625.00 - 22MHSOAC024.

The DOJ has now updated security requirements to FBI CJIS 5.9.3. There are significant updates to the requirements from the prior version the Commission completed. The Commission requested five bids and received four. Three of the bids were accepted. Centris was the most competitive bid and chosen as the vendor. The current effort is proposed to be completed by June 2025 for FBI CJIS SP 5.9.3 at a cost of $215,550.00.

The bids were:

Illumant, LLC	$96,000	Unacceptable: Could not provide support for all items required in our request for proposal.
Centris	$215,550	Acceptable
Arlington, LLC	$373,000	Acceptable
MorganHill Consulting Group, LLC	$454,000	Acceptable

5) <u>Reallocation of unencumbered MHWA funds – EmPATH</u>
The Community Engagement and Grants Team is seeking approval to reallocate a total of $3 million in Mental Health Wellness Act Funding to current EmPATH program grantees. Excess funds were made available as the result of a previous grantee contract refusal. Specifically, Riverside University Health System declined a $3 million EmPATH Grant due to implementation challenges. The applicant did not enter a contract, and these funds are available to be directed to current EmPATH grantees. The RFA includes language that permits the reallocation to other

grantees if additional funds become available. The additional funding would assist in program development and cover higher than anticipated building costs and program sustainability while licensing approvals and county behavioral health agreements are negotiated. It is recommended that the Sutter Coast Hospital contract amount be increased from $2 million to $3 million which will bring it up to the funding level of other grantees, and the remaining funds be offered to all other grantees. The funds will be distributed based on the needs of interested grantees.

Current grantees include:

Community Regional Medical Center - Fresno, CA
Henry Mayo Newhall Hospital- Valencia, CA
Loma Linda University Children's Hospital - Loma Linda, CA
Loma Linda University Medical Center - Loma Linda, CA
Sutter Coast Hospital - Crescent City, CA
Twin Cities Community Hospital - Templeton, CA
Pacifica Hospital of the Valley - Sun Valley, CA
Sharp Chula Vista Medical Center - San Diego, CA
College Medical Center - Long Beach, CA
Mercy Medical Center - Redding, CA

6) Rules of Procedure – Proposition 1 Statutory Changes

The passage of Proposition 1 in March of 2024 changed the name, membership and structure of the Commission. The proposed changes in this Consent Calendar Item are strictly statutory in nature and do not include any non-statutory changes and are thus non-controversial.

At the November Commission meeting, Commissioners will consider approval of the non-controversial, statutory changes to the Rules of Procedure.

Presenter(s): None

Enclosures (6): (1) Commission Community Engagement Process; (2) Nevada County Analysis: BHSA Implementation Planning; (3) Shasta County Analysis: Level Up-Supporting Community-Driven Practices for Health Equity; (4) Alameda and Tri-City Joint Analysis: Psychiatric Advance Directives (PADs) Multi-County Collaborative; (5) Reallocation Proposal for MHWA Funding; (6) Rules of Procedure Amendments;

Handouts: None

Additional Materials (3): Links to the final Innovation projects are available on the Commission's website at the following URLs:

Nevada County: BHSA Implementation Planning
https://mhsoac.ca.gov/wp-content/uploads/Nevada_INN-Project_BHSA-Implementation-Plan_Final.pdf

Shasta County: Supporting Community-Defined Practices for Health Equity
https://mhsoac.ca.gov/wp-content/uploads/Shasta_INN-Plan_Level-Up.pdf

Alameda and Tri-City: Psychiatric Advance Directive (PADs) Multi-County Collaborative
https://mhsoac.ca.gov/wp-content/uploads/Multi-County-Collab_PADS_Phase-2_Alameda-and-Tri-City_09132024_Final.pdf

Proposed Motion:
That the Commission approve the Consent Calendar that includes:

(1) Funding for Nevada County's BHSA Implementation Plan Innovation project for up to $1,356,000; and
(2) Funding for Shasta County's Supporting Community-Driven Practices for Health Equity Innovation Project for up to $999,977.52; and
(3) Funding for Alameda County to join the Psychiatric Advance Directive (PADs) Multi-County Collaborative Innovation Project for up to $3,070,005; and
(4) Funding for Tri-City to join the Psychiatric Advance Directive (PADs) Multi-County Collaborative Innovation Project for up to $1,500,000.
(5) Authorization for the Interim Executive Director or the Commission Chair to enter one or more contracts not to exceed $225,000 to support the Commission in updating its best practices in Information Technology security as mandated by the State of California, Department of Justice.
(6) Reallocation of $3 million in Mental Health Wellness Act funds to existing EmPATH grantees.
(7) Approval of the Proposition 1 statutory changes to the Commission's Rules of Procedure.

Commission Process for Community Engagement on Innovation Plans

To ensure transparency and that every community member both locally and statewide has an opportunity to review and comment on County submitted innovation projects, Commission staff follow the process below:

Sharing of Innovation Projects with Community Partners

- **Procedure – Initial Sharing of INN Projects**
  1. Innovation project is initially shared while County is in their public comment period
  2. County will submit a link to their plan to Commission staff
  3. **Commission staff will then share the link for innovation projects with the following recipients:**
     - **Listserv recipients**
     - **Commission contracted community partners**
     - **The Client and Family Leadership Committee (CFLC)**
     - **The Cultural and Linguistic Competency Committee (CLCC)**
  4. Comments received while County is in public comment period will go directly to the County
  5. Any substantive comments must be addressed by the County during public comment period
- **Procedure – Final Sharing of INN Projects**
  1. **When a final project has been received and County has met all regulatory requirements and is ready to present finalized project (via either Delegated Authority or Full Commission Presentation), this final project will be shared again with community partners:**
     - **Listserv recipients**
     - **Commission contracted community partners**
     - **The Client and Family Leadership Committee (CFLC)**
     - **The Cultural and Linguistic Competency Committee (CLCC)**
  2. The length of time the final sharing of the plan can vary; however, Commission tries to allow community partner feedback for a minimum of two weeks
- **Incorporating Received Comments**
  1. Comments received during the final sharing of the INN project will be incorporated into the Community Planning Process section of the Staff Analysis.
  2. Staff will contact community partners to determine if comments received wish to remain anonymous
  3. Received comments during the final sharing of INN project will be included in Commissioner packets
  4. Any comments received after final sharing cut-off date will be included as handouts

STAFF ANALYSIS—Nevada County

Innovation (INN) Project Name:	**BHSA Implementation Plan (Technical Assistance on Medi-Cal Billing and FSP)**
Total INN Funding Requested:	**$1,365,000**
Duration of INN Project:	**36 months (3 years)**
MHSOAC consideration of INN Project:	**November 21, 2024**

Review History:

Public Comment Period:	September 4, 2024 – October 4, 2024
Mental Health Board Hearing:	October 4, 2024
Approved by the County Board of Supervisors:	Pending (tentatively scheduled for November 12, 2024)
County submitted INN Project:	October 3, 2024
Dates Project Shared with Commission Community Partners:	September 9, 2024 and October 17, 2024

Project Introduction

Nevada County ("County") is requesting up to $1,365,000 of Innovation spending authority to prepare MHSA-funded partners for implementation of Proposition 1, or the Behavioral Health Services Act (Prop 1/BHSA). Changes to the original MHSA include elimination of the Prevention and Early Intervention (PEI) fund and added fidelity requirements to Full Service Partnership programs (FSPs). This proposed project seeks to provide technical assistance to currently funded providers, with emphasis on community-based organizations (CBOs), to maximize Medi-Cal billing. It also seeks to prepare FSP providers for new BHSA FSP data and reporting requirements.

What is the Problem?

The sunsetting Mental Health Services Act (MHSA) is originally composed of five (5) funding buckets, one of which is PEI. On July 1, 2026, the funding categorization under the MHSA will no longer be in effect. The BHSA significantly transforms the funding structure of county

behavioral health services into three (3) main categories: FSP, Behavioral Health Services and Supports (BHSS), and Housing Interventions. Nevada County has a population of approximately 102,000 residents, putting them in the category of a small county. This lends to their limited capacity to adjust swiftly to large shifts in statewide directives, such as those coming with the BHSA.

Existing programs currently supported by the MHSA's PEI fund will need to identify other sources of funding to maintain programs that provide vital services and supports to community members and to prevent lapses in care. Most of these organizations are overwhelmed by the restructuring of funding and are unsure of how to adapt to the upcoming changes. Many providers in Nevada County are small grass roots organizations with limited capacity to shift administrative infrastructure in ways that maximize Medi-Cal billing, putting these CBOs at high risk of losing the financial support needed to continue serving the County's marginalized populations. Additionally, the BHSA also directs FSP programs to implement fidelity-based requirements, ensuring effective outcomes and performance measurements of its providers.

In development of this project, Nevada County reviewed literature on effective approaches for implementing changes of this scale. Their findings pointed toward a Learning Collaborative model as a successful method for technical assistance. The County also researched available State programs in hopes of identifying other existing sources of support. One such avenue of technical assistance for providers is through the Department of Health Care Services' TA Marketplace Platform; however, accessing this information requires an MOU with managed care plans that in and of itself can be a barrier for small organizations with minimal administrative and quality assurance capacity. This project bypasses this burden by contracting directly with expert advisors who will provide direct and individualized educational and technical guidance for the County's PEI and FSP programs.

<u>How this Innovation project addresses this problem</u>

This project seeks to increase access to and quality of mental health services and promote interagency and community collaboration by introducing a new approach to the overall mental health system. This project also makes a change to an existing practice in the field of mental health, transitioning from the MHSA's funding structure to BHSA.

To assess how current programs fit into the modernized funding structure and ensure continuity of care, Nevada County will convene its local MHSA provider network by forming a Learning Collaborative that explores ways in which existing programs can be billable through revenue models such as Specialty Mental Health Services (SMHS) via the County Mental Health Plan (MHP), the county's Managed Care Plan Partnership, or Medi-Cal Administrative Activities (MAA). Contracted expert advisors will help local agencies determine how to bill services from a suite of options that may include: Drug Medi-Cal Organized Delivery Services (DMC-ODS), Enhanced Care Management (ECM), Community Supports, Community Health Worker (CHW) benefits, and the Children and Youth Behavioral Health Initiative (CYBHI).

The County will identify and select up to 20 local providers of PEI programs that serve an estimated 4,250 individuals annually to join the Learning Collaborative. Chosen providers will be limited to those that may be most appropriate to qualify for one of the above billable funding categories. An expert consultant will offer training and guidance both in a group setting as well as through individual coaching. Content of the Learning Collaborative will include, but is not limited to, reviewing current systems and administrative policies, analyzing services, and exploring Electronic Health Record (EHR) and billing systems. Furthermore, to encourage participation in the Learning Collaboratives, Nevada County will be providing financial incentives to assist program providers with administrative and/or implementation costs associated with participating in this project.

In addition to tailored support for current PEI program providers, Nevada County will also be preparing for fidelity-based FSP requirements and plans on implementing a performance-based contract management tool. In partnership with Healthy Brains Global Initiative (HGBI), the County will implement locally tailored "performance pack" outcome measurements and data collection to analyze contract performance and possible areas of improvement for continuing quality assurance.

Community Planning Process

Local Level

To identify priorities for future innovation projects, meetings were held on November 8, 2023, March 28, 2024, and August 27, 2024. Participants in the County's community planning process included providers, program participants, family advocates, peers, family members, County employees, and other members of the community. At these meetings, Nevada County shared information on Proposition 1 and the BHSA, leading way to concerns about program sustainability once MHSA funding allocations convert to the BHSA categories. PEI providers were most apprehensive about the changes, and ultimately, those primary concerns led to the drafting of this proposed innovation project. During the County's most recent community meeting in August 2024, 96% of respondents expressed their support for a project that would address these sustainability issues. Most attendees at that meeting were representatives of community-based organizations.

Nevada County's 30-day public comment period for this plan was September 4, 2024 through October 4, 2024. Within that time, the County received one letter from a currently incarcerated county resident. In the letter, the commenter did not comment on this innovation plan, specifically; rather, the individual shared their first-hand experiences with the criminal justice system and homelessness, and reiterated the importance of mental health supports for people in their position.

Nevada County's local Mental Health and Substance Use Advisory Board approved the plan on October 4, 2024. It is scheduled for review by the local Board of Supervisors on November 12, 2024.

Commission Level
Commission staff shared this project's initial plan with its community partners and the Commission's listserv on September, 9, 2024, and comments were directed to County staff. An updated project plan was shared with the Commission's community partners and listserv on October 17, 2024.

No comments were received in response to the Commission's final request for feedback.

Learning Objectives and Evaluation

The primary learning objectives of this proposed plan are to determine if MHSA-funded partners are able to effectively transition from PEI to a Medi-Cal fee-for-service model, as well as to meet fidelity-based FSP requirements through implementation of "performance pack" management tools. Through these efforts, the County aims to increase program self-sufficiency, adhere to BHSA directives, and prevent lapses in care during a time of immense change. Specific goals of this project include:

- Maximizing billable revenue
- Reducing dependency on MHSA PEI funding within the local network of providers
- Determining if a Learning Collaborative model will work in a small, rural county
- Enhance fidelity and quality of FSP programs

To measure these goals, the project will collect the following data:

- Number of provider participants in the Learning Collaborative, with a goal of up to 20 providers.
  - Provider appropriateness will be determined by set criteria that identifies PEI providers with the most potential to qualify for Medi-Cal billing.
- Number of providers who successfully bill Medi-Cal by the end of the project, broken down by funding source (i.e., ECM, SMHS, CHW benefits, etc.).
  - Baseline: 0 PEI providers are currently Medi-Cal certified; 2 community support providers are currently supported through CalAIM. Measure of success will be an increase in those numbers.
- Survey results to measure the qualitative benefits of participating in the Learning Collaborative.
  - Sample metrics may include measuring provider perception of future sustainability efforts and percent satisfaction with the Learning Collaborative.
- FSP "performance pack" outcomes, including staff vacancy rates, client contact rates, housing, client progress, and client voice survey.

Overall success will be determined based on the number of providers who are able to shift from PEI funding to Medi-Cal billing along with positive survey responses. Nevada County will

contract out for administrative support during the Learning Collaborative as well as for the technical assistance around Medi-Cal billing. The County also will share learnings from this plan with other counties through the County Behavioral Health Directors Association's All-County Steering Committee, since other counties are likely experiencing similar challenges with BHSA implementation.

The Budget and Budget Narrative

EXPENDITURES	Year 1 (FY 24-25)	Year 2 (FY 25-26)	Year 3 (FY 26-27)	TOTAL
Personnel Costs	$ 25,000.00	$ 25,000.00	$ 25,000.00	**$ 75,000.00**
Operating Costs	$ -	$ -	$ -	**$ -**
Non-Recurring Costs	$ -	$ -	$ -	**$ -**
Consulting/Contracts	$ 125,000.00	$ 175,000.00	$ 125,000.00	**$ 425,000.00**
Other (stipends)	$ 175,000.00	$325,000.00	$325,000.00	**$ 825,000.00**
Administration	$ 8,000.00	$ 13,000.00	$ 13,000.00	**$ 34,000.00**
Evaluation	$ 2,000.00	$ 2,000.00	$ 2,000.00	**$ 6,000.00**
TOTAL	**$ 335,000.00**	**$ 540,000.00**	**$ 490,000.00**	**$ 1,365,000.00**

FUNDING SOURCE	Year 1 (FY 24-25)	Year 2 (FY 25-26)	Year 3 (FY 26-27)	TOTAL
Innovation Funds	$ 335,000.00	$ 540,000.00	$ 490,000.00	**$ 1,365,000.00**
TOTAL	**$ 335,000.00**	**$ 540,000.00**	**$ 490,000.00**	**$ 1,365,000.00**

The County is requesting authorization to spend up to $1,365,000 in MHSA Innovation funding for this project over a period of 36 months (3 years). One-hundred percent (100%) of the project will be supported by Innovation funding.

Sixty percent of the budget ($825,000) is allocated for incentives for participating providers, which will motivate and reward achievement of benchmarks throughout the project. These benchmarks will be developed in consultation with contracted subject matter experts who will also provide expert advice, analysis, and training on Medi-Cal billing systems. These consultant contracts will make up about 31% ($425,000) of the plan's budget.

Additionally, approximately 5% of the total budget ($75,000) is allotted for Personnel costs that include salaries and benefits for the Nevada County ECM Homeless Outreach and Medical Engagement (HOME) Program Manager and Clinical Supervisor. These ECM HOME staff members will participate in the project's Learning Collaborative and will be responsible for analyzing potential sustainability solutions, including the potential transition to SMHS billing.

Two percent ($34,000) of the total budget is allotted for administrative needs, such as contract management, stakeholder engagement, and general project oversight; meanwhile, $6,000 of the total budget will go toward program evaluation for staff conducting the data collection, analyses, and evaluation reporting. These duties may be performed by the MHSA Coordinator and Senior Administrative Analyst.

The projected budget does not indicate any costs associated with operations, nor does it contain any non-recurring costs. The County provides additional budget details on pages 15-19 of their plan.

Conclusion

The proposed project, "BHSA Implementation Plan (Technical Assistance on Medi-Cal Billing and FSP)", appears to meet the minimum requirements listed under MHSA Innovation regulations; however, if this project is approved, the County must receive and inform the MHSOAC of certification of approval from the Nevada County Board of Supervisors before any Innovation Funds can be spent.

STAFF ANALYSIS—Shasta County

Innovation (INN) Project Name:	**Supporting Community-Driven Practices for Health Equity**
Total INN Funding Requested:	**$999,977.52**
Duration of INN Project:	**24 months (2 years)**
MHSOAC consideration of INN Project:	**November 21, 2024**

Review History:

Public Comment Period:	August 7, 2023 – September 6, 2023
Mental Health Board Hearing:	September 6, 2023
Approved by the County Board of Supervisors:	Pending Commission Approval
County submitted INN Project:	September 9, 2024
Dates Project Shared with Commission Community Partners:	August 15, 2024 and September 3, 2024

Project Introduction

Shasta County ("County") is requesting up to $999,977.52 of Innovation spending authority to partner with Level Up NorCal to provide case management and wrap-around supports for low income and underserved residents of the Hispanic/Latino and Asian communities that are often difficult to reach. Level Up NorCal is a community-based organization whose mission is to improve and promote health and well-being of ethnic minorities through education, support, and advocacy. Level Up NorCal staff have a combined 30+ years of experience providing outreach and information to bicultural and bilingual community members and have built trust and rapport with these communities throughout Shasta County.

In line with the California Reducing Disparities Project's Strategic Plan, originally developed for the California Department of Public Health, this proposed project will implement a community-driven and culturally based approaches to address Shasta County's underserved communities through methods previously proven effective in public health settings. This project will use the promotoras model to reach unserved and underserved communities, scaling these methods beyond the public health setting and into the behavioral health space.

Case management services utilizing bilingual/bicultural staff will ensure culturally and linguistically responsive services through enhanced understanding and comprehension between providers and those seeking assistance, as well as increase awareness of and access to services.

What is the Problem?

Shasta County is one of the most diverse communities in the Superior Region. According to the 2020 US Census, people of Hispanic or Latino, Asian, Pacific Islander, and bicultural ancestry make up nearly a quarter of the county's population; however, these groups are not being effectively reached. A lack of behavioral health education, cultural stigmas, linguistic barriers, and socioeconomic hardships have contributed to health disparities. To address these challenges, the County is proposing a plan with a heavy focus on outreach and engagement to connect with diverse populations, which directly aligns with the goals of the Behavioral Health Services Act (BHSA).

Research shows that people of color are less likely than their white counterparts to engage in behavioral health services due to stigma, distrust, and lack of culturally appropriate providers. In particular, the Hispanic/Latino and Asian communities in Shasta County have been historically underrepresented. Within these groups, there is a general lack of trust in government entities and limited access to linguistically appropriate lines of communication to effectively meet culturally specific needs.

Appropriate translation services are largely in demand. Current translation services sourced from outside the community are not well-received, with families preferring to use their own children as translators; however, children are often limited in their language skills and lack the behavioral health-related knowledge to serve as effective and appropriate translators. Comparatively, some staff who are appropriately trained in behavioral health may not have the background or understanding of cultural nuances to provide culturally competent services. It is more common for people to seek out and receive services from someone who comes from their own community and culture. This project plans to marry together the two skillsets of both cultural relatability and subject matter expertise through outreach that best reaches these traditionally hard-to-reach communities.

How this Innovation project addresses this problem

This project seeks to increase access to mental health programs and services to underserved groups by applying a promising community driven practice or approach that has been successful in a non-mental health context.

Proposition 1: BHSA aims to expand the behavioral health workforce to reflect and connect with California's diverse population by focusing on outcomes, accountability, and equity. Shasta County's proposed plan aligns with and furthers that purpose through its culturally and linguistically diverse approach at reaching its community members who have typically

been unserved, underserved, and/or inappropriately served. By implementing promotoras, this project will foster supports and services from within its local community through a workforce that addresses specific behavioral health needs for its Hispanic/Latino and Asian community members.

Language barriers can adversely affect access to appropriate behavioral health services and supports. Since translation services and cultural and linguistic competency has been a major challenge for Shasta County's Hispanic/Latino and Asian communities, this project will provide translation services to promote shared understanding of vital behavioral health concepts between community members and providers through use of staff who speak the language of the individuals being served and represent the community being served. The primary languages that will be utilized for provision of services will include Spanish, Mien, and Hmong.

Participants will also receive wrap-around case management with a whole-person approach to focus on the unique needs of those who require culturally and linguistically tailored assistance in areas such as housing, food, and economic insecurities. Addressing these basic immediate needs permits individuals to focus more on their behavioral health.

In development of this project, Shasta County researched other innovation plans from other counties. Contra Costa County implemented a project that focuses on a similar target population; however, that project uses external agencies to provide services, whereas this proposed project plans to utilize culturally and linguistically competent staff from Level Up NorCal, a direct part of their community, to provide client- and family-driven practices.

Modeling the Promotores de Salud program, this project will provide the following activities:

- Culturally appropriate outreach and education to target populations to increase awareness of behavioral health concepts and early identification of behavioral health challenges, leveraging Level Up NorCal's extensive network within immigrant communities
- Case management supports in a culturally and linguistically appropriate manner to increase access to services and available programming by removing language barriers
- Culturally appropriate services to families, addressing not only the needs of individuals seeking services, but also empowering and bolstering their familial support system across multiple generations through both written and verbal communication and translations

Additionally, this project also aligns with the Commission's strategic goal of advocacy and universal access to mental health services by elevating the perspectives of diverse communities.

Community Planning Process

Local Level

During the County's community planning process, the main priority populations identified as being in most need of behavioral health services and supports were the Hispanic/Latino and Asian communities who face cultural and linguistic barriers that prevent them from receiving timely access to appropriate care. In April 2023, a community-wide survey was sent out to the public to identify ideas for potential innovation projects. Community members expressed the need for improvements in culturally appropriate services, and thus, this project was created.

Between August 7, 2023 and September 6, 2023, the plan underwent its 30-day public comment period. During that time, the proposed project received large support from community-based organizations and local community members, with the County receiving over a dozen letters of support. Some of the organizations who voiced their support of the plan included the Shasta Equal Justice Coalition, the National Alliance on Mental Illness (NAMI) Shasta branch, SEIU Local 2015, community members representing the target populations, and numerous other residents of Shasta County.

Many of the public comments centered around the pressing need for culturally and linguistically appropriate services for the Hispanic/Latino and Asian/Pacific Islander populations, who make up a large portion of the County's demographic but who often find it difficult to trust, access, and receive services that meet their specific needs. These comments also noted how beneficial the proposed services would be in promoting health equity and diversity within the behavioral healthcare space. Education and advocacy efforts that account for language barriers were called out as important strategies to advance the health and wellbeing of ethnic minorities, with some sharing their first-hand experiences witnessing the challenges and lack of supports available for the Hispanic/Latino and Asian communities.

An overwhelming portion of community comments vouched for the skills and efficacy of the Level Up NorCal organization, which has previously worked alongside other community-based organizations in Shasta County during the COVID-19 pandemic to promote vaccine awareness and education. Through their past efforts, Level Up NorCal increased vaccine equity among underserved communities by breaking down cultural and linguistic barriers. The trust in Level Up NorCal's ability to connect community members with much needed services is highly evident among the letters of support.

Shasta County's local mental health board approved the plan on September 6, 2023. Local Board of Supervisor approval is pending.

Commission Level

Commission staff shared this project's initial plan with its community partners and the Commission's listserv on August, 15, 2024, and comments were directed to Commission staff. An updated project plan was shared with the Commission's community partners and listserv on September 3, 2024.

A total of three (3) comments were received in response to the Commission's final request for feedback.

One (1) commenter stated:

> *"After reviewing the INN for Shasta County, it appears to be lacking a 'training component' for CHW and/or Peer Support Specialists."*
>
> The commenter later added: *"As Californians continue to grow and expand on HEALTHCARE access and services, it's very important to keep sustainability in mind. With that said, this link: https://www.dhcs.ca.gov/community-health-workers addresses some of those areas. California has been working on establishing CHW and PSS [as] health care career pathways, I hope all Counties work toward this goal."*

In response, the County added the following information to their plan:

> *"While our program is modeled on the CHW/PSS model, it builds and expands it to focus on addressing cultural and linguistic barriers to health equity. Staff will be bicultural and bilingual with shared lived experiences with the communities of focus and will be trained on understanding the mental health and behavioral health resources available to community members and how to access those resources to better support and improve health equity for these underserved communities. The proposed program is a more expansive wraparound program that addresses the whole needs of the individual. Training will vary and depends on the program and service needs of each specific individual. Training will include working with providers to understand their programs so that we can effectively educate and communicate the services available to community members. We are not clinicians; we do not treat or provide care for any behavioral or mental health concerns. We help connect community members to the mental health and behavioral experts and clinicians so that appropriate services can be provided to those who would otherwise not receive the support they need. Our role is to connect them to services that will provide them this care by providing cultural and linguistic support for clients that will enable them to seek and receive such services. We are filling a gap in services that tele translators or providers without the cultural or linguistic capacity are not able to meet. With populations who have been historically underserved or unserved, the proposed program builds a bridge towards health equity by offering culturally and linguistically appropriate support for the communities of focus to understand and receive the services they need.*
>
> *Below are the trainings we currently provide to staff:*
> - *HIPAA*
> - *Mandated Reporter*
> - *Sexual Harassment*
> - *Cultural Competency*
> - *Translation/Interpretation For Services*

- *Working with Providers*
- *Person Centered Training*
- *Youth Mental Health First Aid*
- *Adult Mental Health First Aid*
- *Applied Suicide Intervention Skills*

We are also open to adding other trainings as needed."

In addition to this comment, two (2) other comments were received in support of the plan:

"I am writing to support Shasta County Health and Human Services (HHSA) and Level Up for the Innovation project entitled, Supporting Community Driven Practices for Health Equity. This is an important project that will increase access to mental health and substance use disorder treatment for members of marginalized communities in Shasta County, namely immigrant communities with limited English ability. Shasta County has a predominantly English speaking population of European descent, with small populations of immigrants with limited English ability. These mainly include Mien, Hmong, and Latin American populations. These individuals struggle to access behavioral health services due to the fact that most services are provided in English. Shasta County HHSA has some bilingual staff, but the number is not sufficient to adequately provide behavioral health services for everyone who needs then in languages other than English. For this reason, the department relies heavily on language line services, which is poorly received by the immigrant communities. This program would provide an innovative solution to this problem by providing translation and case management
services in native tongues, which is more effective and culturally competent. This program will directly affect existing disparities in behavioral health access."

"I want to comment that I happy to see Shasta County is finally help our people. We do not get help or assistance now. Glad to see them do this. I support for our Asian community."

Learning Objectives and Evaluation

The County has identified the following learning objectives for this project:

1. Will offering culturally and linguistically appropriate case management increase utilization of programs and services among the target population?
2. Will offering culturally and linguistically appropriate outreach and engagement opportunities increase knowledge of available resources among the target population?
3. Will offering culturally and linguistically appropriate wraparound services to participants and their families promote overall mental health and wellness?

To determine project success and evaluate the desired goals and objectives outlined above, the County will collect and measure both qualitative and quantitative data including, but not limited to, the following:

- Number of individuals served based on enrollment in the project
- Participant demographic information, including race, ethnicity, and primary/preferred language
- Select outcome measures from SAMHSA's National Outcome Measures (NOMs)
    - Overall mental health
    - Handling daily life
    - General wellbeing
    - Social connectedness
- Access to programs and services
    - Number of programs and services community members were connected with
    - Types of programs or services
    - Language assistance needs by program and service
- Satisfaction surveys collected upon entry/middle/exit of services
- Narratives from individuals and families participating in the program

Success will be shown through increased utilization and awareness of programs, services, and/or resources. Increased number of referrals from providers and follow through will also help determine whether the project goals have been met. Additionally, surveys collected upon entrance and exit of programs will gauge whether the project has resulted in improved mental health and wellness.

Shasta County will be contracting with Level Up NorCal to provide services and collect data for this project and will receive monthly reports covering the aforementioned measures and information. "After Action Reviews" (AARs) will also be conducted following program activities, such as outreach events, to identify potential areas of improvements as the project progresses.

The BHSA heavily emphasizes health equity and aims to advance effective planning, services, and data to meet the needs of the diversity of Californians' geographic and demographic communities. In direct alignment with those objectives, Shasta County's Supporting Community-Defined Practices for Health Equity project intends on reducing disparities in their unserved and underserved communities. This project also focuses on early intervention, outreach, and engagement, which are some of the primary elements of the BHSA. The above proposed measures and evaluation plan will determine the success of culturally and linguistically diverse outreach and early intervention strategies on the Hispanic/Latino and Asian communities in Shasta County.

Upon completion of the project, and if determined successful, the County plans to continue services for clients through the Behavioral Health Services and Supports (BHSS) funding category.

The Budget and Budget Narrative

EXPENDITURES	Year 1 (FY 25-26)	Year 2 (FY 26-27)	TOTAL
Personnel Costs	$ 410,126.32	$ 431,496.90	**$ 841,623.22**
Operating Costs	$ 42,343.40	$ 45,010.90	**$ 87,354.30**
Non-Recurring Costs	$ 15,000.00	$ -	**$ 15,000.00**
Other (stipends)	$ 28,000.00	$ 28,000.00	**$ 56,000.00**
TOTAL	**$ 495,469.72**	**$ 504,507.80**	**$ 999,977.52**

FUNDING SOURCE	Year 1 (FY 25-26)	Year 2 (FY 26-27)	TOTAL
Innovation Funds	$ 495,469.72	$ 504,507.80	**$ 999,977.52**
TOTAL	**$ 495,469.72**	**$ 504,507.80**	**$ 999,977.52**

The County is requesting authorization to spend up to $999,977.52 in MHSA Innovation funding for this project over a period of 24 months (2 years). One hundred percent (100%) of the project will be supported by Innovation funding.

The budget allocates $841,623 (approximately 84% of the total budget) for Personnel wages and benefits. Additionally, community conversations have highlighted the importance of a workforce representative of the community's bicultural and bilingual needs; in response, the wages and benefits for project staff are to include a bilingual differential. Personnel for this project will include the following:

- 0.5 FTE Program Manager
- 1.0 FTE Project Manager
- 1.0 FTE Promotora (Spanish)
- 1.0 FTE Promotora (Mien)
- 0.66 FTE Promotora (Hmong)

The Level Up NorCal Program Manager will be responsible for evaluation of the innovation project, with 5% of the total budget ($49,998.88) reserved for evaluation of the project.

Approximately $87,354 (about 9% of the total budget) has been allocated for operating costs. These costs include expenses related to day-to-day operational needs, such as administrative support, rent, supplies, travel for outreach and engagement, and software to support data collection and tracking.

Non-recurring costs total $15,000 (approximately 2% of the total budget) and will cover office and workstation equipment.

Other expenses totaling $56,000 (about 6% of the total budget) will provide $200 stipends for community participants to help pay for fees that might otherwise be a barrier to accessing a service or program (i.e., application fees). These stipends will comprise 6% of the requested budget.

The County provides additional budget details on pages 13-16 of their plan.

Conclusion

The proposed project, Supporting Community-Defined Practices for Health Equity, appears to meet the minimum requirements listed under MHSA Innovation regulations; however, if this project is approved, the County must receive and inform the MHSOAC of certification of approval from the Shasta County Board of Supervisors before any Innovation Funds can be spent.

Additionally, this project is in alignment with the Behavioral Health Services Act and has provided information regarding sustainability.

STAFF ANALYSIS – ALAMEDA & TRI-CITY

Psychiatric Advance Directive Multi-County Collaborative

Innovation (INN) Project Name: **Psychiatric Advance Directives (PADs) – Phase 2**

MHSOAC consideration of INN Project: **November 21, 2024**

Review History

New Counties Joining PADs Phase 2:

County	Total INN Funding Requested	Duration of INN Project	30-day Public Comment	MH Board Hearing	BOS Approval (or calendared date to appear)
Alameda	$3,070,005	3 Years	4/1/2024-5/15/2024	3/20/2024	9/17/2024
Tri-City	$1,500,000	4 Years	9/6/2024-10/6/2024	10/8/2024	10/16/2024
TOTAL:	**$4,570,005**				

Previously Approved Counties:

County	Total INN Funding Requested	Duration of INN Project	30-day Public Comment	MH Board Hearing	Commission Approval Date
Fresno	$5,915,000	4 Years	2/16/2024-3/16/2024	3/20/2024	5/23/2024
Shasta	$1,000,000	4 Years	4/19/2024-5/19/2024	5/22/2024	5/23/2024
Orange	$4,980,470	4 Years	3/11/2024-4/15/2024	4/24/2024	8/22/2024
TOTAL:	**$ 11,895, 470**				

Statutory Requirements (WIC 5830(a)(1)-(4) and 5830(b)(2)(A)-(D)):

The primary purpose of this project is to *increase access to mental health services to underserved groups, promote interagency and community collaboration related to Mental Health Services, supports for outcomes, and increases the quality of mental health services, including measured outcomes.*

This Proposed Project meets INN criteria by *introducing a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention.*

Project Introduction:

Psychiatric Advance Directives (PADs) are used to support treatment decisions for individuals who may not be able to consent to or participate in treatment decisions because of a mental health condition. They generally are used to support individuals at risk of a mental health crisis where decision-making capacity can be impaired. PADs allow an individual's wishes and priorities to inform mental health treatment. Like their general health care counterpart, a PAD can also allow an individual to designate proxy decision-makers to act on their behalf in the event the individual loses capacity to make informed decisions.

Both Alameda and Tri-Cities are seeking approval to use innovation funds to join Fresno, Shasta, and Orange Counties in Phase Two of the Psychiatric Advance Directive (PADs) Multi-County Collaborative. This project will perform live testing and evaluation of the use of a digital Psychiatric Advance Directive utilizing the web-based platform. The overall goals of Phase Two will focus on engagement, collaboration, training, testing, evaluation, and transparency.

PADs Phase One Background:

The first cohort of the Psychiatric Advance Directive (PAD) project was approved by the Commission on June 24, 2021, for a total of four years and is set to conclude on June 25, 2024. Partnering counties consisted of Fresno, Contra Costa, Mariposa, Monterey, Orange, Shasta, and Tri-City.

The overarching goal of Phase One was for participating Counties to work in partnership with various contractors, stakeholders, peers with lived experience, consumers, and advocacy groups to provide resources relative to PADs training, a toolkit, as well as the creation of a standardized PAD template and a PADs technology-based platform to be utilized voluntarily by participating Counties.

Phase One will culminate with the following goals being achieved:

- Standardized PAD template language for incorporation into an online and interactive cloud-based webpage, created in partnership with Peers and first responders
- Creation of a PADs facilitator training curriculum that will utilize a training-the trainer model for facilitation
- Creation of easily reproducible technology that can be used across California while maintaining sustainability
- Legislative and policy advocacy to create a legal structure to recognize PADs
- Evaluation of the development and adoption of PADs, the understanding of PADs, and the user-friendliness of PADs with measured outcomes

The goals for Phase Two are to take achievements from Phase One and test them in a live environment following training on the use and completion of PADs.

Behavioral Health Services Act Alignment and Sustainability:

This project will focus on individuals with behavioral health needs who may be unhoused and need housing and supportive services, who receive services from Full-Service Partnerships, and other individuals who are in the behavioral health system of care, including but not limited to: Veterans, justice-involved, recently hospitalized in emergency room departments or inpatient units, and those with co-occurring substance use disorders.

The project also aligns with the current Commission Strategic Plan goals of advocacy for system improvement, supporting universal access to mental health services, participation in the change in statutes, and promoting access to care and recovery (see Appendices for Alameda and Tri-City, pages 56-69, for detailed information).

On April 23, 2024, the Commission was asked to support Assembly Bill 2352 (Irwin) which will seek to build out a legal framework for PADs in California that will work the Counties who are currently participating in Phase One of this project. Support of AB 2352 was granted with the stipulation that this bill continues to work with disability rights groups and ensures that the bill empowers peers and supports recovery. *PADs Phase Two has outlined efforts to collaborate and partner with Peer Support Specialists, Painted Brain, Disability Rights of California, NAMI California (for complete list of collaborating partners, see pages 18-22).*

Regarding sustainability, PADs has received support from current legislative action (AB 2353, Irwin) for Phase One efforts. It is the hope that continued funding through legislation will support the work in Phase Two. Part of the goal within Phase Two is to show the need and the utility of PADs with the overarching goal of securing ongoing funding from various agencies.

What is the Problem:

As outlined in Phase One of the PADs project, there is widespread support for the use of PADs to empower people to participate in their care, even during times of limited decision-making capacity. PADs can improve the quality of the caregiver-client relationship and improve health care outcomes. The Joint Commission on the Accreditation of Healthcare Organizations recognizes the value of psychiatric advance directives for treatment decisions when an individual is unable to make decisions for themselves (JCAHO, Revised Standard CTS.01.04.01).

While psychiatric advance directives were first put utilized in the United States in the 1990s, and have widespread support, research suggests their use is limited by lack of awareness, and challenges with implementation.

Although 27 states have passed laws recognizing PADs, most PADs are incorporated with the main emphasis on physical health. Adding to this is that there is not a standardized template for individuals, or their support systems, to access it when they might need it the most.

With the increasing rates of mental illness and high rates of recidivism, steps need to be taken so that directives are in in place in the event a person experiences a psychiatric episode.

Phase One explored the utility of PADs as a strategy to improve the effectiveness of community-based care for persons at risk of involuntary care, hospitalization, and criminal justice involvement. Phase Two will focus on the effectiveness of a PAD with training and live testing.

Innovation project overview:

Given the goals of Phase One have been achieved, Phase Two will focus heavily on the training and "live" use of PADs. At this time, Alameda and Tri-Cities are joining Fresno, Shasta, and Orange Counties.

Phase Two goals include the following (see pages 5-6 for details):

1. Engagement for new counties joining the project. Counties will work with first responders, behavioral health departments, courts, local NAMI chapter and peer organizations to better understand PADs and how to successfully utilize a PAD.
2. Collaboration amongst stakeholders will continue surrounding legislative efforts and to inform and enhance the use and access of a standalone PAD when tested in a "live" environment. Some of the groups that will partner include but are not limited to county staff, peer support specialists, Painted Brain, Cal Voices, Disability Rights of California, local NAMI chapters, California Professional Firefighters, California Sheriff's Association, California Hospital Association, Department of Justice, Patient Right's attorneys to name a few.
3. Training will be the main component within this project and the use and accessibility of a PAD will be closely monitored throughout the project. Training modules will be provided for first responders, crisis intervention teams, CARE Courts for judicial staff, Peer training for Peer Support Specialists and peer supports within the court system, and counties who have identified their own priority population.
4. Testing will occur after training has been provided. The testing phase will occur in a live environment to determine the ease of use, number of PADs that have been completed, and the disposition of law enforcement and hospitals to assess if there was a reduction in the number of 5150s requiring hospitalization due to the availability and use of a PAD.
5. Evaluation of Phase Two will continue from Phase One; however, emphasis will be on the intersectionality of the use of a PAD combined with the technology platform. Evaluation will include data obtained through interviews and observation and will meet all Institutional Review Board (IRB) requirements.

6. Transparency will be made available as Phase Two progresses on the project's website: www.padsCA.org.

The purpose of Phase Two will be to perform in-depth training, testing and evaluation of the tasks completed during Phase One.

Discussion of County Specific Regulatory Requirements

Alameda County (see Appendix, page 56)

In Phase Two, Alameda County is continuing to prioritize their focus on individuals who access crisis support services, individuals experiencing homelessness and those who are justice-involved.

The County believes this project will assist individuals by doing the following:

- Improve outcomes for individuals in crisis who are unable to advocate for themselves in a time of need
- Provide appropriate resources for first responders for the needs of the individual in crisis
- Will bring the County closer to compliance with Care Court legislation
- Will hopefully reduce recidivism within the criminal justice system and reduce visits to the emergency rooms during crisis
- Empower individuals with their own recovery and resilience by having a voice

The need for PADs was originally identified during the County's previous innovation project (Community Assessment Treatment Team – CATT). Local community efforts (23 listening sessions, 12 key informant interviews, and community surveys) held between October and December 2023 revealed the continued need for PADs. Strong community support led Alameda County Behavioral Health to join Phase 2 of this Multi-County Collaborative.

The County shared their intent to participate in this collaborative during their FY 2024/2025 Annual Update. The County's 30-day public comment period began on April 1, 2024 and held their public health board hearing on April 20, 2024. The County is calendared to appear before their Board of Supervisors on September 17, 2024.

Alameda County proposes to spend $3,070,005 in Innovation funding towards this multi-county collaborative.

Tri-City Mental Health Authority (see Appendix, page 61)

In Phase Two, Tri-City has identified two priority populations: transitional aged youth (18-25) and individuals who are homeless/at risk of homelessness.

Tri-City reports that 24% of all crisis calls during Fiscal Year 2022/2023 involved transitional aged youth (TAY). Other data provided indicates the need for additional interventions specific for this population.

For individuals experiencing housing instability, PADs can help identify emergency contact information, treatment plans and tools to help in a time of crisis.

Tri-City believes this project will assist individuals by doing the following:

- Empower individuals in crisis to select their preferred method of treatment
- Provide support for those in crisis by informing first responders and emergency room staff with resources, information, and options
- Allow individuals to take control and ownership of their own resiliency and recovery
- Enable peers to engage and build trust with consumers through outreach and promotion of PADs

Tri-City began their 30-day public comment period on September 6, 2024, followed by their local Mental Health Board hearing on October 8, 2024. Tri-Cities is expected to appear before their Board of Supervisors on October 16, 2024.

Tri-City Mental Health Authority proposes to spend up to $1,500,000 in Innovation funding towards this multi-county collaborative.

Commission Level

This final project for Alameda and Tri-City to join the PADs Collaborative was shared with the Commission's community partners and listserv on September 25, 2024. No comments were received in response to this sharing.

Learning Objectives and Evaluation (see pages 22-26):

Burton Blatt Institute will continue their work on this project and be the primary subcontractor, working in collaboration with other subcontractors, to perform the evaluation based on the established learning questions during this testing and implementation phase.

The following **individual and service-level** questions have been identified as follows:

(1) In the opinion of PADs county managers, did Phase 2 counties achieve the outcomes they specified in their work plans to test and implement the PADs web-based platform with their priority peer populations and community-based stakeholders?

(2) In the opinion of mental health legislative advocates, did PADs and its web-based platform address the county's goals for mental health treatment and recovery and for reducing the frequency of involuntary hospitalizations?

(3) In the opinion of peers, did accessing and using the PADs web-based platform positively affect their lives over the three-year evaluation period?

a. Did they experience increased feelings of empowerment, self-direction, and hope for the future by creating a web-based PAD?
b. Did they have better experiences with law enforcement, first responders, hospitals, and others when their web-based PAD was accessed and used when they were in crisis?
c. Did using a web-based PAD decrease the length of time when they were in crises and could not make their own decisions?
d. Did the use of a web-based PAD decrease the frequency of involuntary psychiatric commitments?
e. Did they feel that having a web-based PAD improved the quality of crisis response services they receive from their mental health, homelessness, criminal justice, and other agencies who work with them?
f. Was their crisis support system, including peers, family members, and stakeholder agency staff, strengthened by their use of a web-based PAD?

(4) In the opinion of community agency stakeholders, how did access and use of the PADs web-based platform positively affect how law enforcement, first responders, hospitals, and others serve peers when they are in crises over the three-year evaluation period?

a. Did orientation and training on PADs and its web-based platform improve their understanding, acceptance, and capacity to access and use web-based PADs on behalf of peers when they are in crisis situations?
b. Did they feel that accessing and using a peer's web-based platform improved their de-escalation, treatment, and support experiences when peers are in crisis situations?
c. Was the PADs web-based platform sufficiently customized to address the capacity and technology infrastructure of law enforcement, first responders, medical and mental health care providers, and other stakeholders including Care Courts in accessing and using a peer's PAD?
d. Did the PADs web-based platform affect the ways that Care Courts, law enforcement, first responders, medical and mental health care providers, and other stakeholders interact with and support peers in mental health crisis situations?
e. Was access and use of the PADs web-based platform integrated into the services that mental health agencies, including Full Services Partnerships, and community stakeholders provide to peers in crisis situations?
f. Were there indicators that access, and use of the PADs web-based platform could be sustainable and under what conditions?

The following **systems level** questions have been identified as follows:

1) Were Phase 2 counties successful in aligning services, partnerships, funding, and systems in testing and demonstrating the effectiveness of the PADs web-based platform, including its acceptance and use by Care Courts?

2) Did the knowledge and experiences of implementing the PADs web-based platform in Phase 1 counties inform and improve the design, marketing, and use of the PADs web-based platform among Phase 2 counties?
3) Were precepts of peer inclusion and methods of incorporating peer perspectives established during Phase 1 relevant and effective in accessing and using the PADs web-based platform by Phase 2 counties' priority populations?
4) Were Phase 2 counties able to establish a process and plan for sustaining and replicating the access and use of the PADs web-based platform by their priority populations, and community stakeholders?

For specific evaluation methods, please see page 22 and pages 24-26.

The Budget (see Appendices, pages 57-60 and pages 67-69):

Alameda County is seeking to contribute $3,070,005 of innovation dollars to fund the Psychiatric Advance Directives Phase Two project for three years:

- Personnel costs total $1,764,003 (57% of total budget) to cover staffing costs for this project, including benefits and salaries
- A total of $1,166,001 (38% of total budget) will cover consultant and evaluation costs
- Other costs total $140,001 (5% of total budget) to cover promotional materials for outreach and engagement, meeting/travel costs, and equipment/technology costs.

Tri-City is seeking to contribute a total of $1,500,000 of innovation dollars to fund the Psychiatric Advance Directives Phase Two project for four years:

- Personnel costs total $758,569 (51% of total budget) to cover staffing costs for this project, including benefits and salaries
- A total of $500,000 (33% of total budget) will cover consultant and evaluation costs
- Other costs total $241,431 (16% of total budget) to cover promotional materials for outreach and engagement, meeting/travel costs, equipment/technology costs and county administrative costs.

This project will partner with the following contractors for the implementation, training, testing and evaluation of this project (see pages 18-22 for listed Contractors in this project):

- Concepts Forward Consulting – will be the assigned Lead Project Manager and will provide case management, full project oversight, financial oversight of sub-contractors and will work closely with Commission staff
- Alpha Omega Translation – will over translation and interpretation services
- Burton Blatt Institute will perform the evaluation of this phase of the project
- Idea Engineering – will offer strategic consultation and creative direction as a full-service marketing agency (i.e. video direction and production, graphic design, translation, art production and coordination)

- Painted Brain - Peer Organization selected by counties who participated in Phase One to by providing input at stakeholder meetings representing the peer voice. Painted Brain will be instrumental in utilizing peers for this project, including outreach, education, peer representation, legislative advocacy, and training in the use of PADs platform.
- Chorus Innovations, Inc - this consultant will continue from building the secure, private, and voluntary platform where individuals can store their PADs to now testing the live platform

Conclusion

The proposed project appears to meet the minimum requirements listed under current MHSA Innovation regulations; **however**, if Innovation Project is approved, both Alameda and Tri-City must receive Board of Supervisor/Mental Health Authority (Tri-City) approval before any Innovation Funds can be spent. Additionally, this project is in alignment with the Behavioral Health Services Act and has provided information regarding sustainability (see pages 43-45).

The Community Engagement and Grants Team is seeking approval to reallocate a total of $3 million in Mental Health Wellness Act Funding to current Emergency Psychiatric Assessment Treatment and Healing unit (EmPATH) grantees. Excess funds were made available as the result of a previous EmPATH grantee refusing the award. Riverside University Health System received a $3 million grant through the Commission's EmPATH program. The applicant did not enter a contract and these funds are available to be directed to other EmPATH grantees. The RFA includes language that permits the reallocation of funds to other programs if additional funds become available.

EmPATH

In 2022, five awards were announced for the EmPATH program to create Behavioral Health Emergency units adjacent to existing hospital emergency rooms. Riverside University Health System was awarded $3 million to build an EmPATH unit but refused the award prior to execution. They cited complications with their construction and permitting process that will delay their project to Fiscal Year 2028/29, which is past this grant term. There were three other EmPATH applicants, but their applications were not substantive enough to receive an award. As a result, this $3 million is available for reallocation.

There are a total of 10 EmPATH grantees, nine of which were awarded $3 million contracts and one which received a $2 million contract (Sutter Coast Hospital). With the $3 million available, staff proposes to increase the contract for Sutter Coast Hospital by $1 million, bringing this contract to $3 million, a level commensurate with the other grantees. The remaining $2 million will be made available to the grantees. Commission staff will solicit interest from grantees to determine their need for additional funding. These additional funds would allow the EmPATH units to reach a level of implementation that would support long term sustainability. The Commission's EmPATH technical assistance provider, Dr. Scott Zeller, has recommended the allocation approach outlined above.

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RULES OF PROCEDURE

As of ~~February 2021~~January 1, 2025

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MISSION

The ~~Mental~~ Behavioral Health Services Oversight and Accountability Commission works through partnerships to catalyze transformational change across systems and ensure everyone who needs ~~mental~~ behavioral health care has access to and receives effective and culturally competent care.

GOVERNANCE PHILOSOPHY

Integrity and sound stewardship in adherence to the Commission's Mission, Vision, and Core Principles are paramount in the governance of all Commission activities. The Commission will govern itself with an emphasis on the following:

a. Collaborating with clients, their families, and underserved communities
b. Advancing health equity and strategies to eliminate disparities
c. Promoting mental wellness and supporting recovery and resiliency
d. Advancing an objective understanding and incorporating diverse viewpoints
e. Making decisions in a transparent, responsive, and timely manner
f. Striving to improve results and outcomes
g. Elevating transformative vision and strategic leadership
h. Working collaboratively to drive system-scale improvements
i. Being proactive

COMMISSIONERS

1.1 Terms of Commissioners

A. The Commission consists of ~~16~~ 27 voting members

1. ;*The Attorney General or the Attorney General's designee.*

2. *The Superintendent of Public Instruction or the Superintendent's designee.*

3. *The Chairperson of the Senate Committee on Health, the Chairperson of the Senate Committee on Human Services, or another member of the Senate selected by the President pro Tempore of the Senate, or their designee.*

4. *The Chairperson of the Assembly Committee on Health, the Chairperson of the Assembly Committee on Human Services, or another Member of the Assembly selected by the Speaker of the Assembly, or their designee.*

5. *The following individuals, all appointed by the Governor:*

   a. *Two persons who have or have had a mental health disorder.*

   b. *Two persons who have or have had a substance use disorder.*

   c. *A family member of an adult or older adult who has or has had a mental health disorder.*

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d. One person who is 25 years of age or younger and has or has had a mental health disorder, substance use disorder, or cooccurring disorder.

e. A family member of an adult or older adult who has or has had a substance use disorder.

f. A family member of a child or youth who has or has had a mental health disorder.

g. A family member of a child or youth who has or has had a substance use disorder.

6. A current or former county behavioral health director.

7. A physician specializing in substance use disorder treatment, including the provision of medications for addiction treatment.

8. A mental health professional.

9. A professional with expertise in housing and homelessness.

10. A county sheriff.

11. A superintendent of a school district.

12. A representative of a labor organization.

13. A representative of an employer with less than 500 employees.

14. A representative of an employer with more than 500 employees.

15. A representative of a health care service plan or insurer.

16. A representative of an aging or disability organization.

17. A person with knowledge and experience in community-defined evidence practices and reducing behavioral health disparities.

18. A representative of a children and youth organization.

19. A veteran or a representative of a veteran's organization.

(Welfare and Institutions Code Section 5845)

~~the Attorney General or designee; the Superintendent of Public Instructions or designee; the Chairperson of the Senate Committee on Health, the Chairperson of the Senate Committee on Human Services, or another member of the Senate selected by the President pro Tempore of the Senate; the Chairperson of the Assembly Committee on Health or another member of the Assembly selected by the Speaker of the Assembly; and twelve members appointed by the Governor to specified seats: two individuals with lived experiences, two family members, a physician specializing in alcohol and drug treatment, a mental health professional, a county sheriff, a superintendent of a school district, a representative of a labor organization, a representative of an employer with less than 500 employees, a representative of an employer with more than 500 employees, and a representative of a health care services plan or insurer. (Welfare and Institutions Code Section 5845)~~

B. The term of each Commissioner is three years, to be staggered so that approximately one-third of the appointments expire in each year. A Commissioner may resign prior to the end of the Commissioner's term by submitting written notification to the appointing authority and sending a copy of the resignation to the Commission Chair and the Executive Director. A Commissioner who desires to serve after their term has expired shall notify the Commission Chair and the Executive Director in writing of their intention to serve until reappointed or replaced by a new appointee. Commissioners serve without compensation but are reimbursed in accordance with the policy of the State of California for all actual and necessary expenses incurred in the performance of their duties. (Welfare and Institutions Code Section 5845)

1.2 The Role of Commissioners

A. Commissioners are expected to work collectively to accomplish the Commission's goals as adopted by the Commission and to attend Commission meetings in person or via teleconference.

B. At the request of the Chair, Commissioners are expected to serve as a member of a committee, subcommittee, or other Commission body.

C. At the request of the Chair, Commissioners are expected to represent the Commission in meetings, conferences, testimony in public hearings, and other speaking engagements.

D. The Commissioner with the most seniority and present at the meeting is expected to preside at the Commission meeting when neither the Chair nor Vice Chair is available to run all or part of the meeting.

E. The best decisions come out of unpressured collegial deliberations and the Commission seeks to maintain an atmosphere where the Commissioners can speak freely, explore ideas before becoming committed to positions and seek information from staff and other members. To the extent possible the Commission encourages members to come to meetings without having fixed or committed their positions in advance.

1.3 Chair

A. Election of the Chair

A.1. The Commission shall elect a Chair at a Commission meeting preferably held in September but no later than during the last quarter of the calendar year. The Chair shall be elected by a majority of the Commissioners present and voting consistent with the Rule 4.11A and shall assume all duties starting January 1, following the election. The Chair is elected to a one-year term. A Commissioner may be elected to serve more than one term as Chair.

A.2. In the event more than two candidates are nominated for Chair and no candidate receives a majority of the votes cast, the balloting shall continue, and another vote taken between the two candidates receiving the highest number of votes.

B. Duties of the Chair

B.1. The Chair, with input from Commissioners and staff, sets the Commission's meeting agenda, prioritizing and scheduling agenda items as appropriate, and conducts the meetings.

B.2. The Chair appoints Commissioners to Commission subcommittees, committees, or other bodies as necessary to conduct the Commission's business.

B.3. The Chair provides guidance and direction to the Executive Director on Commission business, including but not limited to: (a) advocating on legislation consistent with Commission Rule 2.5; (b) approving Innovation projects consistent with Commission Rule 2.6; and (c) placing items on the Commission agenda consistent with Commission Rule 4.5.

B.4. In the event the Chair is unable to continue with the Chair's duties due to resignation, death, incapacity, or no longer being a member of the Commission, the Vice Chair shall assume all of the responsibilities of the Chair until a successor is elected. The election shall be held within 60 days of the vacancy.

1.4 Vice Chair

A. Election of the Vice Chair

A.1. The Commission shall elect the Vice Chair at a Commission meeting preferably held in September but no later than during the last quarter of the calendar year. The Vice Chair shall be elected by a majority of the Commissioners present and voting consistent with the Rule 4.11A and shall assume all duties starting January 1, following the election. The Vice Chair is elected to a one-year term. A Commissioner may be elected to serve more than one term as Vice Chair.

A.2. In the event more than two candidates are nominated for Vice Chair, and no candidate receives a majority of the votes cast, the balloting shall continue, and

another vote taken between the two candidates receiving the highest number of votes.

B. Duties of the Vice Chair

B.1. The Vice Chair fulfills the role of Chair and presides at meetings in the absence of the Chair.

B.2. In the event the Vice Chair is unable to continue with the Vice Chair's duties due to resignation, death, incapacity, or no longer being a member of the Commission, an election for a successor shall be held within 60 days of the vacancy.

B.3. When neither the Chair nor Vice Chair is available to run all or part of the meeting, e.g., both officers may be absent, need to leave the room, or are disqualified from discussion and action on an item due to conflict of interest, the Commissioner with the most seniority on the Commission who is present shall preside at the meeting.

1.5 Commission Member Vacancy

When a vacancy occurs on the Commission, a successor is selected by the appointing authority.

1.6 Compensation and Expenses

Commissioners will be reimbursed in accordance with State per diem laws. Also, any reasonable business expenses incurred will be reimbursed as authorized by law.

1.7 Training and Orientation

A. New Commissioners shall within 30 days of being appointed receive orientation in: (1) Commission governance, policies and procedures, including the Commission's Strategic Plan, Mission Statement, Vision Statement, Core Principles, and governance philosophy; (2) Commission strategic directives; (3) ~~Mental~~ Behavioral Health Services Act (~~MHSA~~BHSA) programs and issues, including the principles of recovery, consumer and family-driven decision making, community collaboration, meaningful stakeholder outreach and engagement, cultural competence and the imperative to reduce disparities; and (4) relevant laws and statutes.

B. At or before the orientation session, the new Commissioner will receive the following documents:

1) The Bagley-Keene Open Meeting Act

2) ~~Information on the~~The Political Reform Act and how it affects Commissioners

3) The Commission's Conflict of Interest Code

4) The Commission's Rules of Procedure

5) List of Commission meeting dates and locations

6) Any other documents that may be helpful to the Commissioner to fulfill the Commissioner's responsibilities on the Commission

C. As required by Government Code Sections 11146 through 11146.4 and 12950.1, within six months of beginning service as a Commissioner and at least every two years thereafter, Commissioners shall receive training on laws related to ethics, conflict of interest requirements, governmental transparency, open government, fair government processes, and sexual harassment and abusive conduct prevention.

1.8 Statement of Economic Interest – Form 700

Each Commissioner is required by the California Political Reform Act and the corresponding regulations to file a Statement of Economic Interests, Form 700: (1) within 30 days of being appointed; (2) on a yearly basis as prescribed by law; and (3) within 30 days of ending Commission membership.

1.9 Conflict of Interest

A. Presence of a conflict of interest prohibits Commissioners as public officials from participating in discussion about or taking action on an item. Provisions in California statutes, regulations, and case law define and provide guidelines related to conflict of interest. A Commissioner shall not make, participate in making, or in any way attempt to use the Commissioner's official position to influence a Commission decision in which the Commissioner knows or has reason to know the Commissioner has a financial interest (Government Code Section 87100). Additionally, Commissioners must be guided solely by the public interest, rather than by personal interest, when dealing with contracting in an official capacity (Government Code Section 1090 et seq.).

B. A Commissioner who has a financial conflict of interest shall do the following:

1) Notify the Executive Director as soon as possible if any agenda item presents a potential conflict of interest. This will prepare the Chair to announce the Commissioner's nonparticipation in any discussion, deliberation or vote when the item comes up.

2) Publicly identify, in enough detail to be understood by the public, the financial interest that causes the conflict of interest or potential conflict of interest.

3) Recuse themselves from discussing or voting on the matter or from attempting to use their position to influence the decision.

1.10 Commission Representation

A. Every Commissioner retains the right to express their opinion on any subject whenever the Commissioner is acting as an individual and not on behalf of the Commission.

B. Commissioners who agree to represent the Commission and do so at the request of the Commission, agree to represent only the officially approved positions of the Commission or a complete and accurate presentation of issues under consideration by the Commission. Commissioners whose personal positions are in conflict with the Commission's official positions must represent either the Commission's positions only or decline the request to represent the Commission.

C. A Commissioner is considered to be acting officially on behalf of the Commission whenever the Commissioner states or implies that they are acting as a representative or member of the Commission, whenever the Commissioner is authorized by the Commission to represent it, or the activity of the Commissioner results in an expense to the Commission.

D. Nothing shall prevent Commissioners from expressing their views as individuals in Commission meetings or activities when these views bear directly upon policy issues under discussion.

EXECUTIVE DIRECTOR

2.1 Duties of the Executive Director

A. The Executive Director is appointed and discharged by the Commission. The Executive Director acts under the authority of, and in accordance with direction from the Commission.

B. The Executive Director represents the Commission and advances its goals by working with California's constitutional officers, federal, state and local agencies, national and international organizations, private sector leaders, and other stakeholders, including but not limited to, consumers, families, and representatives of diverse communities.

C. The Executive Director presents to the Commission the annual budget and expenditures at the beginning of the fiscal year for Commission adoption, a mid-year expenditure report, and a close-of-year expenditure report.

D. The Executive Director fulfills the responsibilities set forth in the Executive Director's duty statement and implements the delegated authority specified in the Rules of Procedure.

2.2 Designation of Acting Executive Director

When the Executive Director is absent or otherwise unavailable to perform the duties set forth in these Rules of Procedure, the Executive Director may designate in writing another person to act on the Executive Director's behalf. Within 24 hours of such delegation the Executive Director shall notify the Chair and Vice Chair of the delegation including the scope and duration of the delegation.

2.3 Evaluation of Executive Director

The Commission shall in closed session evaluate the Executive Director's performance on an annual basis. Prior to the closed session evaluation, the Chair and Vice Chair will provide the Executive Director with a performance review to be discussed in the closed session evaluation. The evaluation will be based on the performance goals and professional development objectives adopted by the Commission and the Executive Director's duty statement.

2.4 Contract Authority

Pursuant to the MHSOAC Resolution adopted on March 24, 2011, the Executive Director has the authority to take all actions necessary to enter into contracts on the Commission's behalf in the amount of $100,000 or less and to enter into Interagency Agreements in the amount of $200,000 or less.

2.5 Authority to Advocate on Legislation

A. The Commission is authorized to advise the Governor and Legislature regarding actions the State may take to improve the ~~mental~~behavioral health care and services of Californians. As part of this authority, the Commission may advocate on legislation.

B. The Executive Director, or the Executive Director's designee, is authorized on behalf of the Commission to advocate on legislation: (1) when the legislation advances a formally established position of the Commission; (2) at the direction of the Chair and when the legislation furthers the interest of the Commission; or (3) after full discussion with and at the direction from the full Commission.

C. The Executive Director shall give an update of all advocacy efforts, except confidential budget proposals, taken on behalf of the Commission at the next Commission meeting following the advocacy efforts.

2.6. Authority to Approve Innovation Projects

A. The Executive Director, with the consent of the Commission Chair, is authorized to approve a county Innovation plan that meets any of the following conditions:

1) The county Innovation plan, plan extension or modification does not raise significant concerns or issues and includes total B~~M~~HSA Innovation spending authority of $1,000,000 or less.
2) The county Innovation plan is substantially similar to a county Innovation proposal that has been approved by the Commission within the past three years, if in the judgement of the Executive Director,
    a) differences in the county Innovation proposal and a previously approved plan are not material to concerns raised by the Commission in its previous review and are non-substantive, and

b) the new project furthers the ability of the previously approved Innovation plan to support statewide transformational change.

B. The Executive Director shall publicly report to the Commission, at the next Commission meeting any county Innovation plan approved by the Executive Director on behalf of the Commission under this delegated authority.

LEGAL COUNSEL

3.1 Duties of Chief Legal Counsel

A. Chief Counsel provides legal advice to the Commission and reports both to the Commission and to the Executive Director.

B. Chief Counsel is responsible for, among other things, advising staff regarding all relevant legal matters and supporting the legal inquiries and meeting activities of the Commission.

C. In situations where the Chief Counsel may have a conflict of interest, or where legal expertise outside the practice of Chief Counsel is imperative, the Commission may consult with the office of the Attorney General or another state department.

D. Counsel shall not provide legal counsel to members of the Commission except in their role as members of the Commission.

3.2 Hiring Chief Counsel

A. The Executive Director is responsible for hiring and discharging the Chief Counsel.

B. The Executive Director is responsible for evaluating the Chief Counsel's performance with input from the Commission and staff.

COMMISSION MEETINGS

4.1 Frequency of Meetings

A. Commission meetings are to be held as often as is necessary to enable the Commission to fully and adequately perform its duties, but not less than once each quarter. All meetings shall be open to the public pursuant to the Bagley-Keene Open Meeting Act.

B. The Commission meeting schedule for the calendar year is approved in January of that calendar year.

4.2 Robert's Rules of Order

Robert's Rules of Order will be used as a guide at Commission meetings.

4.3 Open Meetings

A. Commission meetings are subject to the Bagley-Keene Open Meeting Act set forth in Government Code Sections 11120 et seq.

B. The Bagley-Keene Open Meeting Act prohibits Commissioners from using direct communication, personal intermediaries, or technological devices to discuss, deliberate, or take action outside of an open meeting (Government Code Section 11122.5 (b)). Serial meetings are also prohibited. A serial meeting is a series of communications, each of which involves less than a quorum of the Commission, but which taken as a whole involves a majority of the Commission's members. (Government Code Section 11122.5)

4.4 Agenda Items

A. A Commission meeting agenda may include action or information items.

B. Action items that are non-controversial or *pro forma* may be placed on the consent calendar. All items on the consent calendar are voted upon as one unit and are not voted upon as an individual item. At the meeting any Commissioner may ask that a matter be removed from the consent agenda and that request shall be effective without further action. If a matter is removed from the consent agenda it may be discussed at the same meeting or at a different Commission meeting as deemed appropriate by the Commission. There shall be no discussion or presentations made concerning items that remain on the consent agenda.

Staff prepares briefing materials on each agenda item and provides Commissioners with those materials in advance of the meeting. These materials provide Commissioners with a detailed description of a proposed course of action, background information, fiscal impact, the pros and cons of taking the action, and similar information for alternative actions.

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4.5 Request for Item to be Placed on the Agenda

A. Agenda items are placed on the Commission's meeting agenda with the approval of the Chair and Executive Director. The final meeting agenda is approved by the Chair and the Executive Director after consultation with the Chief Counsel.

B. Individual Commissioners wishing to place items on the agenda should contact the Chair or the Executive Director.

C. Members of the public wishing to place items on the agenda should contact Commission staff.

4.6 Exhibits and Handouts

A. Agendized presenters who are not associated with the Commission may provide exhibits and handouts related to their presentation for distribution at the Commission meeting and are encouraged to submit them to the Commission at least two weeks before the meeting.

Additionally, they are encouraged to provide the materials in an electronic format that meets federal and state accessibility standards.

B. The Commission will make the above-mentioned materials available to the public by publishing them on the Commission website in a format that meets federal and state accessibility standards. The Commission will also send a notice to the Commission's list-serve that the materials have been published on the website.

C. If the above-mentioned materials were received by the Commission within a reasonable time before the meeting date, the Commission will also make those materials available in printed format for public inspection on the day of the meeting.

4.7 Public Agenda Notice

A. A public agenda notice of any Commission meeting must be made available on the Commission's website at ~~www.MHSOAC.ca.gov~~INSERT NEW URL, at least 10 calendar days before the meeting. The public agenda notice will also be emailed to the Commission's list-serve. A copy of the public agenda notice will also be sent to any person who requests one in writing. (Government Code Section 11125).

B. The public agenda notice of a Commission meeting must include the name, address, and telephone number of the individual who can provide additional information prior to the meeting and the address of the internet site where notices are posted. (Government Code Section 11125)

C. The public agenda notice of a Commission meeting must also include a specific agenda for the meeting containing a brief description of the items of business to be transacted or discussed in either open or closed session. No agenda items may be added after the ten-day period begins, unless permitted by specific exceptions set forth in the Bagley-Keene Open Meeting Act. (Government Code Section 11125)

D. The public agenda notice of a Commission meeting shall also be made available in appropriate alternative formats as required by Section 202 of the American with Disabilities Act of 1990 and the federal rules and regulations adopted in implementation thereof. The public agenda notice shall include information regarding how, to whom, and by when a request for any disability-related modification or accommodation including auxiliary aids or services may be made by a person with a disability who requires these aids or services in order to participate in the public meeting. (Government Code Section 11125)

4.8 Availability of Commission Meeting Materials

A. The public agenda notice and all other materials distributed to the Commissioners prior to or at a Commission meeting are public records and as such are subject to disclosure, unless a recognized exemption applies under California Public Records Act, set forth in Government Code Sections 6250 et seq. or the Bagley-Keene Open Meeting Act set forth in Government Code Sections 11120 et seq. Commission meeting materials are available to the public at INSERT NEW URL~~www.MHSOAC.ca.gov~~. The Commission will also

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make meeting materials available for public inspection in printed format on the day of the meeting.

B. The Bagley-Keene Open Meeting Act provides that unless a specific exemption applies, materials pertaining to agenda items distributed to the Commission by the staff or individual Commissioners prior to or during the meeting must be made available for public inspection at the meeting. Materials pertaining to agenda items prepared by a person other than staff or a Commissioner shall be made available after the meeting. In addition, the materials shall be distributed to all persons who request or have requested copies of the materials and will be available on the Commission's website.

4.9 Closed Sessions

A. Any closed session must be noted on the meeting agenda and properly noticed, citing the statutory authority or provision of the Bagley-Keene Open Meeting Act that authorizes the closed session. The Commission may only hold closed sessions for the reasons set forth in the Bagley-Keene Open Meeting Act.

B. Prior to convening a closed session, the Chair must publicly announce those issues that will be considered in closed session (Government Code Section 11126.3). This can be done by a reference to the item as properly listed on the agenda. After the closed session has been completed, the Commission must reconvene in public prior to adjournment (Government Code Section 11126.3). If the closed session involved a decision to hire or fire an individual the Chair is required to report the action taken, and any roll call vote taken.

C. Chief Counsel will attend each closed session and keep and enter in a minute book a record of topics discussed and decisions made at the meeting. These minutes are confidential, maintained by Chief Counsel, and are discoverable only to the Commission itself or to a reviewing court. The minutes may, but need not, consist of a recording of the closed session. (Government Code Section 11126.1)

4.10 Teleconference Meetings

Pursuant to the Bagley-Keene Open Meeting Act the Commission may hold a meeting by audio or audio-visual teleconference for the benefit of the public and the Commission. (Government Code Section 11123) All public agenda notice requirements apply.

4.11 Quorum

A. A simple majority of the Commission's statutory membership shall constitute a quorum for the transaction of business. The Commission's statutory membership is ~~16~~ 27 members making ~~nine~~ 14 members a quorum. When a quorum is present, a simple majority of those present and voting may act to bind the Commission.

B. A meeting at which a quorum is initially present may continue, notwithstanding the withdrawal of Commissioners and the absence of a quorum. The only action that may be

taken in the absence of a quorum is to fix the time to adjourn, recess, or take measures to obtain a quorum.

4.12 Voting

A. After a motion is made, seconded, and public comment has been heard, the Commission may vote. A Commissioner must be present to vote.

B. A Commissioner who is disqualified in a matter because of financial contributions, financial interest, or another conflict is not entitled to vote. The Commissioner is required to announce at the meeting that the Commissioner will not participate and disclose the reasons for the disqualification on the record. This information is noted in the meeting minutes.

C. A Commissioner may "abstain" from voting, if the Commissioner is entitled to participate but chooses not to. The reason for abstaining need not be disclosed on the record.

D. Prior to voting on a policy project report, the Commission shall consider the report in at least one meeting prior to the meeting at which the motion to approve is considered.

E. Approval of a policy project report by a subcommittee of the Commission constitutes the "first reading" of a policy project report.

F. The Commission may determine that the timely release of a policy project report is in the public interest and may vote to suspend this rule in order to approve a policy project report in a single meeting.

4.13 Public Comment

A. Opportunity is provided for the public to address the Commission on agenda items. The Commission may adopt reasonable procedures so that members of the public have an opportunity to directly address the Commission on each agenda item before the Commission. These procedures may include limiting the total amount of time allocated for public comment on a specific agenda item and for each individual speaker. (Government Code Section 11125.7)

B. If the agenda item has already been considered by a multi-member body composed exclusively of members of the Commission at a public meeting where interested members of the public were afforded the opportunity to address the multi-member body on the item, additional public comment opportunity at the Commission meeting need not be provided unless the item has been substantially changed since the multi-member body heard the item. (Government Code Section 11125.7)

C. Members of the public who wish to provide public comment at a meeting are encouraged to complete a public comment card but are not required to do so.

4.14 Access to Commission Meeting Sites

Commission meeting sites are accessible to people with disabilities and should also be accessible by public transportation. Those who need special assistance may contact the meeting coordinator listed on the public agenda notice of the meeting.

4.15 Minutes and Motion Summaries

Minutes and motion summaries of each open session meeting are included in the meeting materials and posted on the Commission website at: INSERT NEW URL.

PUBLIC OUTREACH AND ENGAGEMENT

5.1 The Commission is committed to ensure the perspective and participation of diverse community members – those with lived experiences and their family members, community advocacy organizations, county behavioral health agencies - are a significant factor in the Commission's understanding, actions, decisions, and recommendations. The Commission ensures broad and inclusive community outreach and engagement through the following actions and other opportunities that may be identified going forward:

- Public meetings with open, informed, and transparent deliberation.
- Committee and subcommittee meetings that hear from community members and other subject matter experts to develop a shared understanding of the challenges and opportunities of topics specified by the Commission.
- Community forums that are organized to highlight and understand topics specified by the Commission and of concern to the community.
- Small group listening sessions to hear from individuals with lived experience on sensitive topics.
- Site visits that are organized to acquire first-hand knowledge and understanding of the challenges of specific topics and the existing efforts to address those challenges.
- Convening advisory bodies with expertise on topics specified by the Commission.
- Meetings with community-based organizations and local leaders.
- Use of surveys.

COMMITTEES/SUBCOMMITTEES/OTHER MULTI-MEMBER BODIES

6.1 Structure

A. The Commission may establish one or more committees as necessary to provide technical and professional expertise pursuant to Welfare and Institutions Code Section 5845 (d)(3). Such committees provide guidance, review materials, and make recommendations to the Commission.

A.1. The Commission Chair shall appoint a Chair and Vice Chair for each committee from among the Commission's membership who will assume their duties immediately upon appointment.

A.2. Ideally each standing committee shall have a maximum of 15 members and shall include public membership. Of this public membership, at least two shall be consumers, at least two shall be family members or care givers of consumers, and at least two shall be members of underserved ethnic and cultural communities. Public membership of each committee shall be selected by the committee Chair and Vice Chair. In their recruitment and appointment committee Chair and Vice Chair shall pay special attention to issues related to cultural diversity and competency. Commission staff and/or consultants will staff each committee.

A.3. The committee Chair may establish one or more multi-member body consisting of committee members in order to further the work of the committee.

A.4. If a committee member cannot attend a committee meeting the member shall notify the committee Chair and the committee staff member of such absence in advance of the committee meeting. If a committee member misses more than one committee meeting without notice or three committee meetings in a calendar year with notice, the committee Chair has discretion to decide whether it is in the best interest of the committee to have that committee member replaced.

The membership of each Committee will be confirmed every other year in odd numbered years at the January Commission meeting. In the intervening time each Committee Chair has discretion to modify the Committee membership based upon the needs of the Committee.

B. The Commission may establish any multi-member body (e.g. committee, subcommittee, taskforce) consisting of Commissioners appointed by the Chair as necessary to support the work of the Commission.

6.2 Bagley-Keene Open Meeting Act

A. Meetings of a committee, subcommittee, and multi-member body are subject to the Bagley-Keene Open Meeting Act set forth in Government Code Sections 11120 *et seq*.

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B. A public agenda notice of a committee, subcommittee, or multi-member body meeting must be given and made available on the Commission website at INSERT NEW URL~~www.MHSOAC.ca.gov~~, at least 10 calendar days before the meeting. The public agenda notice will also be emailed to the Commission's list-serve. A copy of the public agenda notice will be sent to any person who requests it in writing.

C. The public agenda notice of a committee, subcommittee, or multi-member body meeting must include the name, address, and telephone number of the individual who can provide additional information prior to the meeting and the address of the internet site where notices are posted.

D. The public agenda notice of a committee, subcommittee, or multi-member body meeting must also include a specific agenda for the meeting containing a brief description of the items of business to be transacted or discussed. No agenda items may be added after the ten-day period begins, unless permitted by specific exceptions set forth in the Bagley-Keene Open Meeting Act. (Government Code Section 11125)

E. The public agenda notice of a committee, subcommittee, or multi-member body meeting shall also be made available in appropriate alternative formats as required by Section 202 of the American with Disabilities Act of 1990 and the federal rules and regulations adopted in implementation thereof. The public agenda notice shall include information regarding how, to whom, and by when a request for any disability-related modification or accommodation including auxiliary aids or services may be made by a person with a disability who requires these aids or services in order to participate in the public meeting.

F. A committee, subcommittee, or other multi-member body may hold a meeting by audio or audio-visual teleconference (Government Code Sections 11123 and 11123.5). All public agenda notice requirements apply.

6.3 Compensation and Expenses

Active members of committees, subcommittees or any other multi-member body and agendized presenters are eligible to be reimbursed in accordance with State per diem laws.

AGENDA ITEM 6

Action

November 21, 2024, Commission Meeting

Grant Opportunities: Mental Health Wellness Act and Advocacy Funds

Summary
The Commission will consider the approval of three grant opportunities in two categories. The first category is a Request for Proposal for Mental Health Wellness Act funds of $21 million to develop partnerships between community-based organizations, behavioral health departments, child welfare agencies, and other local organizations to provide support services relative to maternal mental health and the 0-5 population, as well as conduct a landscape analysis, evaluation, and provide technical assistance to grantees. This effort will seek to expand best practices delivered through organizations within the community to meet the goal of providing support services to pregnant people during pregnancy and the family through infancy.

The second category is relative to two (2) Request for Proposals (RFP) designed to award grant funds to promote advocacy, training and education, and outreach and engagement on behalf of two populations: K-12 Students and Immigrants and Refugees. This effort will award advocacy funds to community-based organizations to support the mental health needs of underserved populations through advocacy, training, education, outreach, and engagement activities.

MHWA- 0-5 and Maternal Mental Health Systems of Care Initiative

Background

In 2021, the Commission released a report on prevention and early intervention entitled "WELL AND THRIVING Advancing Prevention and Early Intervention in Mental Health." The report provided a vision and framework to guide prevention and early intervention in mental health via the benefit of a whole community, public-health approach. It is recognized that early detection and intervention is key to improving health across the lifespan, and the earliest intervention involves creating healthy, safe environments for families even before a baby is born. Under the direction of Senate Bill 1004, the Commission established priorities for local prevention and early intervention that included, in pertinent part, programs that target children who are at risk of trauma; strategies to reach underserved populations and address barriers related to racial, ethnic, cultural, language, gender, age, economic, or other disparities; and the use of evidence-based and community and culturally-defined approaches to increase early detection of mental health symptoms.

The Commission's 2024-2027 Strategic Plan goals serve as a decision-making framework to guide Commission initiatives aimed at improving behavioral health systems and outcomes. Through this framework, the Commission works to achieve its strategic goal of *closing the gap between what is being done and what can be done* by incentivizing and scaling best practices and promising solutions. Toward this goal, the Commission is working to accelerate the adoption of effective programs targeting 0-5 populations using MHWA incentive funding.

With consideration given to the community engagement, the proposed initiative allows all community-based organizations to apply as long as they meet the goal of providing support services to birthing people during pregnancy and the family through infancy. This approach offers a wide range of opportunities informed by organizations who understand the nuanced needs of their specific communities and requires the formation of partnerships to implement a multi-faceted approach to supporting this population. The initiative will provide the opportunity for community-based organizations to form local partnerships to provide wrap-around services to birthing people and their children through age five in an effort to create safe, healthy environments to reduce out of home placement and promote social emotional and academic readiness.

Eligibility

All eligible bidders must meet the following minimum qualifications:

1. Be an established statewide organization which has been in operation for 2 years and has experience providing services that reduce out of home placement or other negative outcomes of mental illness for pregnant people and children ages 0-5.
2. Be a non-profit organization, registered to do business in California.

The grant awards will be limited to one per county, and two different counties in each category (small, medium and large) to serve six counties in total.

RFA Target Release Date- January 2024

Motion:

That the Commission authorizes staff to release an RFP to award $21 million in Mental Health Wellness Act funding through a competitive bid process designed to support partnerships serving maternal mental health and the 0-5 population, conduct landscape analysis and evaluation, and provide technical assistance to grantees awarded through the competitive bid process.

Advocacy

K-12 Student Advocacy

Background

Beginning in fiscal year 2022/23, the annual state budget allocates $670,000 to the Commission to support K-12 student advocacy. The Commission has conducted two (2) rounds of procurement. The first was focused on awarding multiple micro-grants to increase statewide youth participation in conversations about school-based mental health and to learn about the

most effective strategies for future K-12 student advocacy. The second procurement focused on conducting Statewide Student Advocacy Conferences and establishing Student Advisory Planning Teams with the purpose of informing the Statewide Conferences.

Engagement

The Commission has used polls, virtual meetings, and in-person convenings to solicit input from grantees, students, educators, community-based organizations, and county agencies relative to future funding focus. From August to December 2023, the Commission held five (5) virtual meetings in partnership with grantee Pro Youth & Families. The meetings engaged two hundred seventy-two (272) youth throughout fourteen (14) counties in California, and youth attendees were polled during the meetings. Poll results showed that youth in attendance identified themselves as strong advocates for mental health services, but also had low confidence in mental health knowledge and resource accessibility. The Commission carefully considered this feedback and used the responses to prepare for future youth convenings.

From January – February 2024, the Commission conducted a series of four (4) youth-led conferences throughout California in partnership with Pro Youth & Families to gather input from students on the most pressing mental health needs of the K-12 student population. During the conferences, Commission staff held interviews with student attendees asking questions related to youth mental health. The robust conversations revealed key points of interest for the students, as well as barriers to success. Thoughts and issues presented by youth participants focused on their desire to shape mental health policy decisions and ideas for improvement in mental health service accessibility.

As a result of the feedback received from students and their adult allies, this proposal seeks to award a grant to a statewide contractor who will subcontract with local partners in eight regions of the state to develop youth-led teams working toward engagement and empowerment. Additionally, the contractor will hold two conferences in each of the grant years to bring regional teams together with state-level decisionmakers and inform state policy makers.

Eligibility

All eligible bidders must meet the following minimum qualifications:

1. Be an established statewide organization which has been in operation for 2 years and has experience with coordinating statewide advocacy activities and planning and holding large-scale conferences relative to the unique mental health needs of K-12 students.
2. Have experience connecting with State legislators, County Boards of Supervisors, and state and local level decisionmakers.
3. Have experience and familiarity working with and/or advocating for student mental and behavioral health needs.
4. Be a non-profit organization, registered to do business in California for at least two years.

RFA Target Release Date- January 2025

Motion:
That the Commission authorizes staff to release an RFP for K-12 Advocacy in the amount of $2,010,000 to support advocacy, training and education, and outreach and engagement efforts in the K-12 student population.

Immigrant/Refugee Advocacy
Background
The Governor's 2018 Budget provided $670,000 annually to the Commission to fund advocacy contracts on behalf of immigrant and refugee populations. In April 2019, the Commission awarded three-year contracts in the amount of $402,500 to five local level community-based organizations (CBO). A Budget Change Proposal provided an additional $670,000 annually for expanded advocacy efforts in this population resulting in the current funding availability of $1,340,000 per year for a three-year total of $4,020,000. These CBOs conducted advocacy, training, and outreach activities in the Superior, Bay Area, Central, Los Angeles, and Southern regions and engaged immigrants and refugees from South America, Asia, Africa, and the Middle East.

In June 2022, the Commission awarded three-year contracts to one statewide organization and four local organizations to create a network of CBOs advocating for and engaging immigrant and refugee populations. In March 2023, the Commission awarded four more local contracts after receiving additional funding for immigrant and refugee advocacy. This cohort of eight advocacy partners worked independently and collaboratively to strengthen the voice of immigrant and refugee communities in mental health policy and program development. Their work was encapsulated in a statewide policy report that shared findings and recommendations.

Engagement
Commission staff conducted a series of community engagement activities between August-November 2024 consisting of a site visit, review of the Immigrant and Refugee state policy report, listening sessions with the current Immigrant and Refugee contractors, and input from the Cultural and Linguistic Competency Committee. These activities provided valuable information about current mental health needs of immigrant and refugee populations and feedback on how to address these needs to inform the next round of advocacy funding. During these engagements, members of the community revealed three primary areas to focus advocacy efforts including cultural responsiveness and linguistic competency, access to culturally relevant mental health professionals, and the use of community-based organizations to build trust and reduce stigma within those communities.

As a result of the feedback received during engagement, this proposal will encourage advocacy efforts in these areas and promote cross community collaboration to strategize ways to advocate for the needs of this population. There will be two RFPs, one for a statewide advocate

and one for seven (7) local advocacy groups across the state. Each grantee will be awarded $502,500 over a period of three years for advocacy efforts within their respective areas of expertise.

Eligibility
All eligible bidders must meet the following minimum qualifications:

Local Program Contractors
All eligible bidders must meet the following minimum qualifications:

1. Be an established community-based organization which has been in operation for two (2) years and has experience with providing direct outreach and engagement for immigrants and/or refugees;
2. Have capacity to advocate in and engage with communities at the regional level; and
3. Be a non-profit organization, registered to do business in California.

State-Level Advocacy Contractor
All eligible bidders must meet the following minimum qualifications:

1. Be an established state-level organization with at least two (2) years' experience conducting advocacy campaigns statewide at both the state, regional, and local levels;
2. Have demonstrated experience addressing the critical needs of immigrant and refugee populations; and
3. Be a non-profit organization, registered to do business in California for at least two years.

RFA Target Release Date- February 2025

Motion:
That the Commission authorizes staff to release two RFPs totaling $4,020,000 to support the state and local level advocacy, training and education, and outreach and engagement needs in immigrant and refugee populations.

Presenter: Tom Orrock, Deputy Director of Program Operations and Riann Kopchak, Chief of Community Engagement and Grants

Enclosures (7): (1) Proposed Outline for Maternal Mental Health/0-5 Initiative, (2) Proposed Outline for K-12 Student Advocacy, (3) K-12 Region Map (4) K-12 Community Engagement Summary (5) Proposed Outline for Immigrant and Refugee Advocacy, (6) Immigrant and Refugee Community Engagement Summary, and (7) CPEHN State Report

Handouts: A copy of the PowerPoint for each presentation will be provided at the meeting.

0-5 and Maternal Mental Health Systems of Care Initiative

Overview

In August 2023, the Commission prioritized opportunities to advance the care and treatment of children ages 0-5. Through robust engagement and analytic processes, Commission staff have identified strategic opportunities to allocate $21 million in Mental Health Wellness Act (MHWA) funding to support the 0-5 population and their parents/caregivers .

Background and Strategic Alignment

In 2021, the Commission released a report on prevention and early intervention entitled "WELL AND THRIVING Advancing Prevention and Early Intervention in Mental Health." The report provided a vision and framework to guide prevention and early intervention in mental health via the benefit of a whole community, public-health approach. It is recognized that early detection and intervention is key to improving health across the lifespan, and the earliest intervention involves creating healthy, safe environments for families even before a baby is born. Under the direction of Senate Bill 1004, the Commission established priorities for local prevention and early intervention that included, in pertinent part, programs that target children who are at risk of trauma; strategies to reach underserved populations and address barriers related to racial, ethnic, cultural, language, gender, age, economic, or other disparities; and the use of evidence-based and community and culturally-defined approaches to increase early detection of mental health symptoms.

The Commission's 2024-2027 Strategic Plan goals serve as a decision-making framework to guide Commission initiatives aimed at improving behavioral health systems and outcomes. Through this framework, the Commission works to achieve its strategic goal of *closing the gap between what is being done and what can be done* by incentivizing and scaling best practices and promising solutions. Toward this goal, the Commission is working to accelerate the adoption of effective programs targeting 0-5 populations using MHWA incentive funding.

Process

When selecting grant projects, the Commission considers three factors for each strategic initiative: the components of each initiative, strategic initiative criteria, and barriers to successful implementation of the initiative.

1) **Components:** The Commission has identified three components common to each initiative; incentive funding to drive change, technical assistance to ensure quality, and evaluation to measure results. Within each funding opportunity, resources are allocated to support each of the three components.

2) **Criteria for prioritization**: Commission staff have assessed opportunities to scale a best practice or pilot a promising practice that catalyzes improvements in accessing quality care. A program identified as a strategic initiative is assessed using the following criteria:
    - No Overlap- Does not overlap with other funding from the Commission, other agencies, or funding sources?
    - Immediate Impact- Is there an immediate impact on systems of care?
    - Sustainable- Can this be sustained through existing funding streams, including the BHSA?
    - Scalable- Can this be scaled by leveraging MHWA funding?
    - Population- Does this reach an age group or issue the Commission has not previously supported?
    - Address Negative Outcome- Does this address one of the identified negative outcomes of mental illness?
    - Strategic Plan- Does the initiative align with the Strategic Plan?
3) **Barries to implementation**: When selecting potential grant projects, Commission staff work with technical assistance providers and evaluators to identify barriers and assess how each project can serve to address those barriers to successful implementation. Common barriers assessed through previous grant projects typically fall into one of the following areas: vision, public awareness, expanding access, quality, workforce development/training, sustainable funding, technical assistance, equity, outcomes, and engagement of other state and federal agencies.

Engagement

Commission staff reached out to key partners to identify their perspective on the current programs to support this population as well as glean their thoughts on opportunities for funding. Each engagement is synopsized below along with the opportunity as identified by the program or agency. The conversations highlight several opportunities for the Commission to meet an overarching strategic plan goal to *close the gap between what is being done and what can be done*. The Commission will work to accelerate the adoption of effective programs to reduce geographic, demographic, cultural, and socio-economic disparities in services, supports and outcomes. The information used from these meetings was considered when designing this grant proposal.

UCSF - Dyadic Care

Opportunity*- Additional funding would be focused on technical assistance to scale Medi-Cal billing statewide.* California's new Dyadic Care benefit aims to make family-centered behavioral health promotion and prevention a sustainable standard in early childhood pediatric healthcare. According to the UCSF team, dyadic care programs need technical assistance to learn the Medi-Cal billing processes which would help to grow and sustain dyadic care programs. This program is going to be funded by DHCS in order to scale Medi-Cal billing outside of San Francsico County. Those systems will require significant time and coordination for an impact on services to be realized.

UCLA - Early Development Instrument (EDI)

Opportunity*- Funding would be used to scale the use of the assessment tool to economically disadvantaged communities across the state.* The EDI is a population-level teacher assessment tool

developed by UCLA that measures physical health, social-emotional maturity, confidence, and communication skills for children in kindergarten. Funding this project would help to scale the best approach for assessing kindergarten students in lower socio-economic areas where there are high levels of toxic stress for young children and allow for early interventions leading to improved behavioral health. The EDI is intended for use in children ages 3.5-6.5 during the second half of their kindergarten school year. The assessment consists of 103 questions to be answered by teachers based on their observations of the child's behavior over the school year. The questions focus on five areas including physical health and wellbeing; emotional maturity; social competence; language and cognitive development; and communication skills and general knowledge. There are concerns about the time needed by educators to screen each child.

Opportunity: *Funding would be used to provide services with well child visits, reading readiness programs and access to preschools.* In a subsequent meeting, UCLA discussed their national data set revealing that black and Latinx children have much lower scores in social emotional and academic readiness. Wrap-around service providers and collaborative partnerships between Community Based Organizations appear to be a direct access point to remedy these identified issues.

Kidango

Opportunity*- Funding would be used to establish a career ladder for Early Childhood Mental Health Consultation.* Kidango operates 54 childcare centers in Alameda, Contra Costa, and Santa Clara County, providing subsidized childcare programs for families in need. Kidango staff identified the need for a statewide technical assistance center for Early Childhood Mental Health Consultation and the development of career pathways toward ECMH Consultation. The centers are fully funded by existing grants from different state agencies and operate in the Bay Area Region of California. The technical assistance center would take significant time and effort to become operational, so immediate impact is unlikely. The program is not ready to scale statewide as there is no existing model branding or implementation tool kit.

State Board of Education (Expanded After School Care)

Opportunity*- Funding would be used to establish a training module for program staff relative to behavioral health.* The Board of Education is implementing CYBHI and community school models, including state preschool for 3 and 4-year-olds. Rate reform is being discussed to increase access to preschool, and there is a need for additional teacher training. The statewide initiative for Expanded After School Program receives $4 billion annually, however, future funding opportunities may support training and education to EAS staff. Expanded after-school programs would not immediately impact on a system of care but would provide resources for working parents of school-aged children which does not necessarily include this population.

Department of Health Care Services (ECHMHC & IECMHC)

Opportunity*- Funding would be used to conduct a landscape analysis that would identify service gaps and unresolved areas within this population, as well as establish a technical assistance hub for this area.* The Department of Health Care Services provided information relative to two rounds of funding for children ages 0-5 focusing on Community Defined Evidence Practices, with another three rounds of funding that will focus on home visits and Early Childhood Mental Health consultation. DHCS emphasized the importance of conducting a landscape analysis to identify service gaps, underserved

areas, and where CYBHI Round 1 and 2 programs and other 0-5 services are provided around the state. Currently, there is an existing technical assistance hub through DSS.

Department of Social Services (Community Pathways & Bridge Program)

The Department of Social Services identified the opportunity to fund grants to prevent child welfare involvement for children 0-5. These grants would provide community pathways to prevent and reduce child welfare involvement, involving family resource centers, local childcare centers, and referral programs.

Opportunity*: Funding would support new programs that meet the Community Pathways criteria in strategic areas of the state.* Community Pathways criteria provide resources and guidance to prevent involvement from the child welfare system. Primary focuses include promotion of intervention rather than mandated reporting. The program is partially funded via DSS, but future focus includes scaling of resources via CBOs or Family Resource Centers.

Opportunity*: Funding could be used to scale to the counties not currently using the program.* Emergency Bridge Childcare Program for Foster Children provides vouchers for childcare to the relatives of children who accept placement but may not be able to afford or provide childcare. The program also provides assistance in navigating through providers and provides Trauma-Informed Care and coaching to childcare staff. This program is funded through DHCS and is present in 51 counties, limiting scalability.

For the Village/Urban Restoration

Meetings with the Doula network and therapy center identified a model of wrap-around services for birthing parents and their children that promoted well-being, connections to resources, and identified opportunities to fill gaps and remove barriers to these services.

Opportunity: *Funding for partnerships to provide wrap-around services.* Establish support to fund partnerships between county behavioral health and social service agencies in collaboration with Community Based Organizations that offer services to reduce school failure, prevent out of home placement, and serve birthing parents and their children prior to birth and through infancy.

The following chart is intended to demonstrate the level to which each program meets the criteria.

Opportunities	Dyadic Care TA	Early Development Instrument	Kidango IECMHC Career Ladder	Expanded After School Care Program	IECMHC TA Hub	Community Pathways	Bridge Programs	For the Village/ Urban Restoration
No Overlap	-	-	+	-	-	=	=	+
Immediate Impact	-	-	-	-	-	+	+	+
Sustainable	+	+	-	+	-	+	+	+
Scalable	+	+	=	+	-	+	=	+
Population	+	+	+	+	+	+	+	+
Address Negative Outcome	+	+	-	+	-	+	+	+
Strategic Plan	Capacity Building	Data Collection	Capacity Building	Professional Development	Capacity Building	System Improvement	System Improvement	System Improvement

Proposed Initiative

With consideration given to all engagement efforts, the proposed initiative incentivizes the enhancement of 0-5 systems of care and will allow all community-based organizations to apply as long as they meet the goal of providing support services to birthing people during pregnancy and to the family through infancy and early childhood. This approach offers a wide range of opportunities informed by organizations who understand the nuanced needs of their specific communities and requires the formation of partnerships to implement a multi-faceted approach to supporting this population.

1. Three million dollars set aside for Landscape Analysis, Evaluation, and Technical Assistance. The contractor or contractors would conduct a landscape analysis of current systems, identify gaps and barriers, and provide an evaluation of this initiative to inform future work. They would also focus on providing technical assistance to the 0-5 partnership enhancement grantees with a focus on coordinating the partnership organizations and sustaining the services identified by the grantees. The TA will also provide consultation services in

partnership development, best practices in 0-5 services, human centered design, and identification of challenges/barriers to success. Focus areas could include access to dyadic care models, design of 0-5 wrap around services, increased access to pre-school, improved coordination between schools and 0-5 children identified as vulnerable, or identification of future opportunities for sustainable funding.

2. Six (6) Grants ($18 million)

   Two Grants (2) for partnerships involving a lead CBO and 3 support CBOs in large counties ($4 million each)

   Two Grants (2) for partnerships involving lead CBO and 2 support CBOs in medium counties ($3 million each)

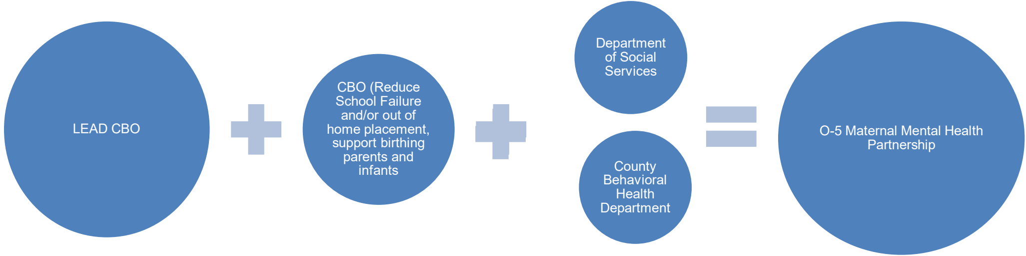
   Two Grants (2) for partnerships involving lead CBO and 1 support CBO in small counties ($2 million each)

   This opportunity would require a lead Community Based Organization to form partnerships with County Behavioral Health Departments, Social Service Agencies, regional centers, school districts, pre-K programs, and other child serving programs to develop wrap-around service-oriented teams for pregnant people and their families, including prenatal care through infancy. Grant awards will be limited to one per county. Lead CBOs must provide services to prevent out-of-home placement, reduce school failure, and/or serve birthing people and families prior to birthing through infancy. This could include Doula’s, midwives, home visit networks, or other wrap-around services.

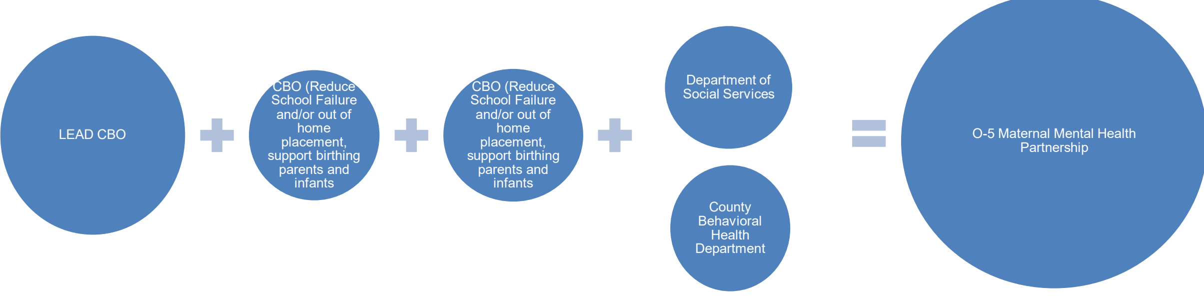
Planning Time and Funding

The 0-5 grantees may spend up to $200,000 in the first six months for planning efforts to assemble the partnership and create a project plan to accomplish the goals of the project: reduction of out of home placement and reduction of school failure. The project plans would be presented to the Commission for approval prior to starting the work. The plans will include a detailed description of the expectations for organizations included in the partnership. The remainder of funds would be released upon approval of the project plan.

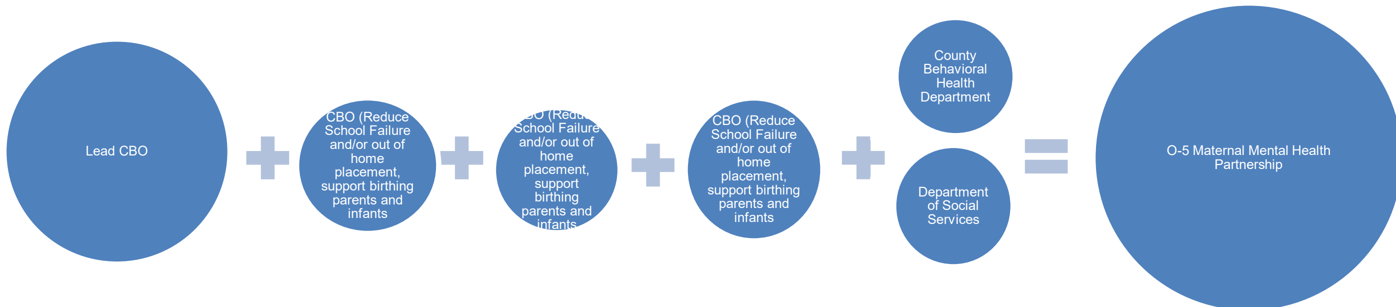
Small County



Medium County



Large County



K-12 Student Advocacy Proposal
November 21, 2024

The Commission is proposing to release one (1) Request for Proposal (RFP) to select a statewide organization to conduct state and local level advocacy, training and education, and outreach and engagement activities on behalf of K-12 student populations. The statewide organization will subcontract with eight local level organizations. The full contract term will be three years (36 months). The total amount available for the statewide advocacy organization is $670,000 per year for a three-year total of $2,010,000.

Background of K-12 Student Advocacy

In 2022, the Commission sought legislative approval and additional funding to support the advocacy needs of K-12 students. This action was in response to California's historic levels of funding provided for student behavioral health. Beginning in fiscal year 2022/23, the annual state budget allocates $670,000 to the Commission to support K-12 student advocacy. The Commission has conducted two (2) rounds of funding. The first was focused on awarding multiple micro-grants to increase statewide youth participation in conversations about school-based mental health and to learn about the most effective strategies for future K-12 student advocacy. The second procurement focused on conducting Statewide Student Advocacy Conferences and establishing Student Advisory Planning Teams with the purpose of informing the Statewide Conferences.

Contracts awarded are as follows:

Awardee	Population	Contract Terms
Micro-Grant Awardees: • Twenty-Six (26) Micro Grant Awardees • PRO Youth and Families • Event Planning Support	K-12 Students	Start: 6/27/2023 End: 6/30/2024 $670,000 total
Jakara Movement	K-12 Students	Start: 6/27/2024 End: 5/15/2026 $970,000 total*

*An additional $300,000 was added to this procurement from one-time funding for a youth convening.

Each statewide organization formed partnerships with local level entities including community-based organizations, county behavioral health departments, county office of educations, and school districts to assist in holding local mental health advocacy events. The statewide organization and their local partners organized in-person and virtual convenings, facilitated advocacy events, and interacted with local and state-level decision-makers. As of November 2024, approximately four hundred (400) youth community members and twenty-six (26) local level entities engaged in advocacy across eight (8) counties. An additional estimated one thousand (1000) youth are to engage in upcoming statewide

conferences scheduled for 2025. Other notable accomplishments from each procurement are outlined below:

Micro-Grant Awardees & Pro Youth & Families

- The Commission awarded micro-grants to twenty (20) community-based organizations and six (6) county offices of education to increase the reach and diversity of its K-12 student advocacy funding.
- PRO Youth & Families worked closely with the micro-grant awardees to organize the youth advocacy work which aimed to develop a network of youth across California.
- The advocacy initiative engaged approximately four hundred (400) young people through virtual meetings and in-person convenings held in Humboldt, Sacramento, Fresno, and San Bernardino counties.

Jakara Movement

- Jakara Movement staff is currently organizing and recruiting youth to serve on two (2) regional youth advisory boards in the northern and southern regions of the state.
- The first of four (4) statewide student conferences is scheduled to take place in February 2025 at Yuba College, and conference topics will be informed by youth advisory board members.
- Jakara Movement staff is collaborating with school districts across the state to recruit students for the youth advisory boards and conferences that represent underserved and low-income student populations.

Request for Proposal Outline: State and Local Advocacy

Interested organizations will be asked to create a workplan consisting of statewide and local level activities that meet the critical mental and behavioral health needs of the K-12 student populations. The workplan will include a budget and tentative timelines for all activities, as well as the methods used to evaluate the impact of their state and local advocacy efforts.

Local Level Partnerships

The statewide advocacy contractor will be required to enter into partnership with one (1) local partner (may be a County Office of Education or a Community-Based Organization) from each of the seven (7) geographic lead regions defined by CA Department of Education (CDE), and Los Angeles County as its own region for a total of eight (8) regions (see Regions Map attachment), to assist in conducting local advocacy, training, and outreach activities. The Contractor will recommend the appropriate funding amount (minimum of $20,000 per year) to each local partner. The Commission and statewide contractor will negotiate the final amounts of the local partner subcontracts.

Contractor Responsibilities

One contract will be awarded to the highest scoring statewide organization to conduct advocacy, training, and outreach activities on behalf of the K-12 student population. The contracted statewide organization will propose a workplan that meets the following goals:

Local Level

- Establish youth education, advocacy and engagement teams in collaboration with local partners in each of the eight (8) defined regions to support emerging and ongoing youth advocacy in that region.
- Enter into partnership with one (1) local partner in each of the eight (8) defined regions to strengthen the capacity of each local partner and the regional youth team that they oversee and leverage ongoing regional and local advocacy efforts.
- Facilitate training, outreach and engagement activities and events in collaboration with local partners to create opportunities for team members to connect with other youth and their communities, increase knowledge of mental health topics and services, and develop the capacity for self-advocacy.
- Represent the needs of the K-12 student population at the regional and local levels by utilizing strategies that target local decision-making entities including county behavioral health departments, school boards, community program planning processes, behavioral health advisory boards, and local mental health boards.
- Collaborate with the local partners from each defined region to ensure equitable distribution of resources, and to avoid duplication of advocacy efforts taking place within the regions.

Engage local K-12 student populations in education and outreach about Proposition 1, focusing on its impact on behavioral health services for children and youth and encouraging active participation in the planning process to ensure that the unique needs of K-12 students are represented.*Statewide*

- Elevate the mental and behavioral health needs of the K-12 student population to state level decisionmakers and uplift youth voice and stories to the State Legislature.
- Gather feedback from the regional advocacy teams and advocate for statewide policy initiatives and legislation that will have the most impact and bring positive outcomes for the K-12 student population.
- Increase K-12 student advocacy in rural and underserved populations.
- Hold one (1) statewide conference per year for a total of three (3) throughout the duration of the grant with the purpose of bringing together the regional advocacy teams to exchange their local level advocacy approaches, advise and engage with state-level decisionmakers, and gain statewide insights to inform their local level work. Conferences should be held in the Northern, Central/Bay Area, and Southern Regions.
- The contractor will publish one (1) Final Report at the end of the grant period that is designed to highlight K-12 student voices and inform state policy makers and will be created in a medium or format that is most relevant and accessible for the K-12 student population.
- Create a framework for ongoing K-12 student advocacy.
- Lead statewide efforts to educate K-12 students and their families about Proposition 1, highlighting its potential to improve behavioral health services for children and youth, and gather feedback from local advocacy teams to shape state-level policies that prioritize the behavioral health needs of K-12 students.

Minimum Qualifications

All eligible bidders must meet the following minimum qualifications:

1. Be an established statewide organization which has been in operation for 2 years and has experience with coordinating statewide advocacy activities and planning and holding large-scale conferences relative to the unique mental health needs of K-12 students.
2. Have experience connecting with State legislators, County Boards of Supervisors, and state and local level decisionmakers.
3. Have experience and familiarity working with and/or advocating for student mental and behavioral health needs.
4. Be a non-profit organization, registered to do business in California for at least two years.

Desired Qualifications

1. Have experience and capacity to subcontract with, provide technical assistance to, and support local community-based organizations.
2. Have experience and familiarity forming and maintaining partnerships with local partners.

Timeline

RFP key action dates are as follows:

- RFPs released to the public:
    - January 2025
- Deadline to submit proposals:
    - February 2025
- Commission issues Notice of Intent to Award:
    - April 2025

K-12 Student Advocacy Proposal

Regions Map
November 21, 2024

Regions:

Orange: Far North Partnership
Teal: North Bay/North Coast Collaborative
Lavender: Capital Central Foothill Areas
Yellow: Bay Area Geographic Leads Consortium
Red: Mid-State Collaborative
Green: Valley to Coast Collaborative
Light Blue: Southern California System of Support
Purple: Los Angeles County

K-12 Student Advocacy
Community Engagement Feedback Summary

The Commission has used polls, virtual meetings, and in-person convenings to solicit input from grantees, students, educators, community-based organizations, and county agencies relative to future funding focus. From August to December 2023, the Commission held five (5) virtual meetings in partnership with grantee Pro Youth & Families. The meetings engaged two hundred seventy-two (272) youth throughout fourteen (14) counties in California, and youth attendees were polled during the meetings. Poll results showed that youth in attendance identified themselves as strong advocates for mental health services, but also had low confidence in mental health knowledge and resource accessibility. The Commission carefully considered this feedback and used the responses to prepare for future youth convenings.

From January – February 2024, the Commission conducted a series of four (4) youth-led conferences throughout California in partnership with Pro Youth & Families to gather input from students on the most pressing mental health needs of the K-12 student population. During the conferences, Commission staff held interviews with student attendees asking questions relative to youth mental health. The robust conversations revealed key points of interest for the students, as well as barriers to success. Thoughts and issues presented by youth participants focused on youth's desire to contribute to mental health policy decisions, room for improvement in mental health service accessibility, and additional suggestions for change. The list below provides insight on the common themes and ideas shared during the conferences.

1. While youth feel that they are more accepting toward addressing mental health topics than previous generations, they also feel disconnected from decision-making regarding mental and behavioral health policies. Youth believe that they hold insight that can help decisionmakers to be "creative" when addressing policies that directly impact youth and hold a desire to be advocates in their communities and on a state level.

2. Youth from rural areas voiced that it is difficult to access mental health resources due to cost and proximity to services. To improve access in rural and urban areas alike, youth expressed a desire for integrated mental health services in schools and increased Telehealth options.

3. Many youth expressed that they do not feel comfortable talking to their families about mental health, and that their families do not support them engaging in mental health services despite their open-mindedness to the services. Youth speculate this is for a

number of reasons, including generational differences, cultural trends, gender stereotypes and stigma.

4. Youth often prefer to talk to other youth in times of crisis since they tend to feel more connected with their peers. Specifically, youth prefer to talk to someone who shares their culture and background as this allows for a more meaningful connection and thus an increased benefit from discussing shared struggles. Consequentially, youth believe that peer advocacy programs on their school campuses would improve youth mental health metrics and sense of belonging at school.

5. Following the COVID-19 pandemic and with the emergence of social media, youth feel increasingly isolated. Youth believe that social media can play a negative effect on their mental health, introduce individuals to suicidal ideas, and create a false reality which makes youth feel insecure. As a result, youth believe that there should be more regulations around social media, particularly those focused on combatting harmful algorithms.

On October 31st, 2024, the Commission met with educators and county office of education staff involved with the El Dorado County Youth Commission to gather input regarding best practices for conducting and guiding K-12 student advocacy. Meeting attendees shared methodology on how to carry out youth advocacy work in the form of a local youth advisory board and showed enthusiasm toward the potential for statewide youth advocacy efforts. Adult allies shared that community leaders want to hear youth insight on mental health topics, and that the Youth Commission's input has directly resulted in positive outcomes in youth mental health services across El Dorado County. Additionally, many of the youth on the local level board have expressed interest in conducting statewide advocacy. In the context of statewide advocacy, it was advised that a regional approach that leverages already existing infrastructure, such as already formed local youth advisory boards, be utilized to unify youth advocacy efforts across the state.

As a result of input from the described engagement events, the Commission seeks to prioritize youth voices while providing resources to increase youth's knowledge of mental health, and opportunities for unified statewide advocacy work. Based on insight from adult allies highlighting the importance of already existing and newly emerging local youth efforts, the awardee will work closely with local partners from eight (8) defined regions throughout the state to develop further capacity for youth advocacy efforts and educational opportunities in each region. Recognizing that youth value in-person collaboration and show a desire to address varying mental health concerns, the awardee will conduct annual youth-led conferences to provide opportunities for collaboration among the regional youth teams, connections with statewide decisionmakers, and further learning. The responses and feedback were used to determine the noted priority areas to inform the next round of K-12 Student Advocacy funding as detailed in the outline.

Immigrant and Refugee Advocacy Proposal
November 21, 2024

The Commission is proposing to release Request for Proposals (RFP) to award contracts to seven (7) Local Organizations and one (1) Statewide Organization to conduct advocacy, training and education, and outreach and engagement activities on behalf of Immigrant and Refugee populations. The full term for each contract will be three years (36 months). The amount available for each of the eight contracts is $502,500. The total amount available for this funding opportunity is $4,020,000.

Background of Immigrant and Refugee Advocacy

The Governor's 2018 Budget provided $670,000 annually to the Commission to fund advocacy contracts on behalf of immigrant and refugee populations. In April 2019, the Commission awarded three-year contracts in the amount of $402,500 to five local level community-based organizations (CBO). A Budget Change Proposal provided an additional $670,000 annually for expanded advocacy efforts on behalf of the immigrant and refugee populations resulting in the current funding availability of $1,340,000 per year for a three-year total of $4,020,000. These CBOs conducted advocacy, training, and outreach activities in the Superior, Bay Area, Central, Los Angeles, and Southern regions and engaged immigrants and refugees from South America, Asia, Africa, and the Middle East.

In June 2022, the Commission awarded three-year contracts to one statewide organization and four local organizations to create a network of CBOs advocating for and engaging immigrant and refugee populations. In March 2023, the Commission awarded four more local contracts after receiving additional funding for immigrant and refugee advocacy. This cohort of eight advocacy partners worked independently and collaboratively to strengthen the voice of immigrant and refugee communities in mental health policy and program development. Their work was encapsulated in a statewide policy report that shared findings and recommendations.

Between August- November 2024, Commission staff conducted community engagement activities to gather information on current needs of immigrant and refugee populations and feedback on how to address these needs to inform the next round of advocacy RFPs.

Request for Proposal Outline: Statewide Organization and Local Organizations

Interested organizations will respond to the Local Organizations or Statewide Organization RFP and create a workplan consisting of activities that address the mental and behavioral health needs of immigrant and refugee populations.

One (1) contract will be awarded to a Statewide Organization with capacity to conduct advocacy at the state level as well as organize convenings for the local advocacy partners.

Seven (7) contracts will be awarded for Local Organizations to conduct activities in each of the five mental health regions. The number of awards designated to each region are as follows: Superior – one (1); Central- two (2); Bay Area- two (2); Southern/Los Angeles- two (2).

Statewide Organization

The Statewide Organization will create a workplan consisting of statewide activities that accomplish overarching goals:

- Advocate at the state level and address statewide issues that contribute to negative mental and behavioral health outcomes
- Leverage and support existing state and local programs relating to language access, Community Defined Evidence Practices (CDEP), culturally responsive services, and workforce development
- Organize convenings between the seven (7) Local Organizations to gain insight on current needs and elevate findings to the state level, as an opportunity to collaborate and strategize ways to best advocate for the needs of the population
- Share policy recommendations with behavioral health providers, community members and leaders, and government entities
- Educate communities about Proposition 1's impact on behavioral health services, advocate for their inclusion in the county integrated planning process, and gather feedback to inform state-level policy and resource allocation

Local Organization

Local Organizations will create a workplan consisting of local level activities that accomplish overarching goals:

- Conduct outreach and engagement activities directly with communities to address specific mental and behavioral health needs
- Provide training and education on addressing mental health through cultural responsiveness, CDEP models, and cultural practices
- Partner with community health workers, Promotores, representatives, and interpreters to increase effectiveness and reach of engagement
- Share knowledge with Local Organizations and the Statewide Organization to extend reach, inform state level advocacy, and impact within and across regions
- Educate local communities about Proposition 1's impact on behavioral health access, engage in outreach to gather feedback, and advocate for the needs of underserved populations in the county integrated planning process

Scope of Work

The Statewide Organization and Local Organizations will independently and collaboratively work to complete objectives that address critical mental health needs of immigrant and refugee populations. Contract Scope of Work will consist of objectives that include the following:

Advocate for the needs of impacted communities

- Represent the mental health needs of immigrant and refugee populations with decision-making entities
- Advocate for the needs of immigrants and refugees in rural communities
- Uplift the stories and experiences of immigrant and refugee populations
- Advocate for increased language access, trauma-informed care, and culturally responsive health interventions
- Advocate for the inclusion of community voices in the county integrated planning process under Proposition 1, ensuring that impacted communities have a direct role in shaping Proposition 1 strategies

Outreach to and directly engage with communities

- Educate communities about mental health and emotional wellness, behavioral health services, CDEP programs, and public programs and benefits
- Connect families to existing mental health services and local resources, such as childcare and transportation
- Gather data on outcomes from engagement to help inform state policies
- Educate communities about Proposition 1 and its impact and gather feedback to identify concerns, needs, and opportunities for improvement that can be shared with state and local partners for future planning

Promote cultural responsiveness, CDEP behavioral health models, and traditional practices

- Provide education and training on cultural responsiveness, CDEP models, and traditional practices for health providers, community leaders, and educators
- Promote the use of cultural responsiveness in mental health services and CDEP models to decision-making entities
- Support and promote culturally responsive programs and practices within communities

Advance development of interpreters, community health workers, Promotores, and community representatives (CHW/P/R)

- Partner with Community Health Workers/Promotores/Representatives (CHW/P/Rs) to build trust with communities and families and increase reach of education and outreach activities
- Connect CHW/P/Rs with families to more effectively address mental health needs and engage impacted communities

- Promote interpreter, community health, peer-based, and mental health careers among high school, college, and post-graduate students
- Support initiatives that build a workforce pipeline for diverse and culturally responsive mental health and behavioral health workers and interpreters

Minimum Qualifications

Local Program Contractors

All eligible bidders must meet the following minimum qualifications:

1. Be an established community-based organization which has been in operation for two (2) years and has experience with providing direct outreach and engagement for immigrants and/or refugees;
2. Have capacity to advocate in and engage with communities at the regional level; and
3. Be a non-profit organization, registered to do business in California.

State-Level Advocacy Contractor

All eligible bidders must meet the following minimum qualifications:

1. Be an established state-level organization with at least two (2) years' experience conducting advocacy campaigns statewide at both the state, regional, and local levels;
2. Have demonstrated experience addressing the critical needs of immigrant and refugee populations; and
3. Be a non-profit organization, registered to do business in California for at least two years.

Timeline

RFPs key action dates are as follows:

- RFPs released to the public:
    - February 2025
- Deadline to submit proposals:
    - March 2025
- Commission issues Notice of Intent to Award:
    - May 2025

Immigrant and Refugee Advocacy Community Engagement
August - November 2024

Commission staff conducted a series of community engagement activities between August-November 2024, consisting of site visits, review of the Immigrant and Refugee state policy report, listening sessions with the current Immigrant and Refugee contractors, and input from the Cultural and Linguistic Competency Committee. These activities provided valuable information about current mental health needs of immigrant and refugee populations, as well as feedback on how to address these needs to inform the next round of advocacy funding. Findings from the community engagement we produced three overarching themes.

1. Cultural responsiveness and linguistic competency were the primary needs identified during engagement efforts. These are important factors in building trust with the immigrant and refugee communities in an effort to promote health and wellbeing. Strategies include increasing access to trained interpreters, providers, and law enforcement who specialize in cultural history and context, have the ability to speak different dialects, effectively communicate certain traumas, and specialize in translating mental health care terminology within cultural contexts.
2. Discussions also centered on disparities in the mental health system. Specifically, difficulties faced when navigating health care systems, concerns about costs, and transportation challenges. The community also mentioned stigma within specific cultures and skepticism towards Western health beliefs/treatments stemming from cultural and intergenerational differences regarding mental health. Strategies to mitigate these barriers include promoting culturally responsive mental health providers and outreach to immigrant and refugee communities with goals of educating families about public benefits and mental health resources.
3. Focus groups encouraged the use of grassroots community-based organizations (CBO) as subject matter experts who can provide access to immigrants and refugee communities. Through direct engagement, CBOs can cultivate close relationships with the immigrant and refugee population, receive information about communal crisis and basic needs, and build trust with the community. CBOs can address mental health problems at the systemic level by advocating at the local and state levels, providing an opportunity to be a voice for those who need it. CBOs aim to advance the growth of a more diverse mental and behavioral workforce by partnering with local universities and schools to create a workforce pipeline that prepares young professionals for work in CBOs. CBOs can help promote and increase the use of community defined evidence-based practices, traditional healing practices, and community health worker/promotores/representatives among immigrant and refugee communities. Finally, CBOs can partner with faith-based programs and practices, and can record sessions to use for future training, and hold informative sessions.

The engagements revealed that organizations, community members, and the public are concerned about the lack of cultural responsiveness and linguistic competency, disparities in the mental health system, and inadequate use of community-based organizations. These key issues were considered in developing the proposal for the next round of advocacy funding in an effort to promote cultural responsiveness, linguistic competency, and access to culturally responsive service providers. There will also be opportunities for the grantees to meet and strategize ways to improve their advocacy efforts to reduce stigma surrounding mental health.

August 2024

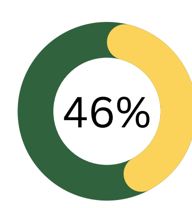
IMPROVING MENTAL HEALTH CARE FOR CALIFORNIA'S IMMIGRANTS AND REFUGEES

RECOMMENDATIONS SUPPORTED BY COMMUNITY VOICES

Motivation

California has a vibrant immigrant and refugee community that spans generations.

More than 1 in 4 Californians (27%) are immigrants.



Nearly half (46%) of all California children have at least one parent born outside the U.S.[1]

Method & Objective

Immigrants and refugees face unique challenges when it comes to maintaining their mental health and fulfilling their aspirations in their new home country. The Mental Health Services Oversight and Accountability Commission (MHSOAC) contracted with nine community-based organizations to bring forth barriers and solutions to improve access to culturally and linguistically appropriate mental health services for immigrants and refugees.

These discussions formed the basis of the following **recommendations in three areas:**

Workforce Development	**Investment in Community-Based Organizations (CBOs) and Services**	**Advancing Trauma-Informed Care**

Workforce Development

Building and retention of a culturally and linguistically responsive mental health workforce requires a dedicated pipeline. To advance this pipeline, greater support and incentives are needed to attract and retain youth from communities of color into the field of mental health (e.g., not limited to psychiatrists and therapists, but more inclusive of a broader scope of practice such as community health workers, promotoras, and doulas).[2]

Certified interpreters and translators who have experience working with their respective ethnic communities are an immediate necessity for enabling communication and navigation of the current insurance and health care system.

Investment in Community-Based Organizations (CBOs) and Services

Community-based services are a non-traditional workforce pathway and a near-term solution to reducing the multiple barriers faced by immigrant and refugee communities. Greater investment in CBOs to bridge the gap in mental health services, while becoming an integral part of service delivery, is a mechanism to increase the availability of culturally and linguistically competent care. CBOs, embedded within their communities, are situated to address cultural stigma, language barriers and navigation of a complex insurance and health care system. Community-based provider training programs support mid-term strengthening of the workforce pipeline.

Sources:

1. Perez, Mejia and Johnson, Immigrants in California, January 2023, PPIC
2. Community Health Workers, Promotoras, and Representatives Coalition

Advancing Trauma-Informed Care

While trauma may not be unique to immigrants and refugees, it is often front and center to their current life. Being displaced due to war, persecution for religious, political or social beliefs and identities are often the reasons for immigration and define refugee status within the U.S.[3]

Current providers as well as county workers who assist with health insurance enrollment and connection to health and social services require support and training to adequately address the needs of this population. The same CBOs identified to the right can serve as an invaluable resource.

This report was created in collaboration with the community-based organizations and partners listed here:

ocapica

Visión y Compromiso™

Discussions revealed barriers to care are numerous and fall under four categories. These are listed below and support the three recommendations previously presented.

Mental Health Stigma

In general, mental health is stigmatized, presenting a significant barrier to seeking help. In some cultures, the stigma runs deep, where expression of feelings or care-seeking behavior is viewed as a sign of weakness or failure (e.g., Mexican "machismo"). In addition, traditional healing practices may be preferred, but only Western care is offered and acknowledged.

Lack of Culturally and Linguistically Competent Services

Understanding, empathy and compassion are foundational to quality care. Without the support of culturally and linguistically competent health navigators, providers and services, immigrants and refugees are challenged to access care that brings hesitation to begin with.

Time and Cost: Off Work, Away from Children Who Need Care, Transportation, Waiting

Immigrants and refugees may have few resources due to the harrowing journey they took to the U.S. Missing work, paying for childcare and transportation are additional costs they are unable to manage. Once appointments are scheduled long wait times add to the cost.

Health Insurance Coverage

Health insurance is a significant barrier to accessing medical care due to high cost and provider networks that are linked to insurance. Cost-sharing provisions or restrictive benefits may pose a further barrier for those who do have coverage. A recent consumer survey found 74% of persons seeking mental health care reported a problem with their coverage (e.g., denials, confusion, red tape).[4] Importantly, this survey includes a majority who do not have the added difficulties of language, culture and trauma related to immigrant and refugee experiences.

Policies that improve Medi-Cal, Covered California and health insurance in general are a first step to improving access to mental health care for all Californians.

For the full report findings, visit www.cpehn.org

Sources:
3. U.S. Citizenship and Immigration Services
4. KFF Survey of Consumer Experiences with Health Insurance

August 2024

AGENDA ITEM 7

Action

November 21, 2024 Commission Meeting

Election of the Chair and Vice-Chair for 2025

Summary: Elections for the Mental Health Services Oversight and Accountability Commission Chair and Vice-Chair for 2024 will be conducted at the October 24, 2024 Commission meeting. The Commission's Rules of Procedure state that the Chair and the Vice-Chair shall be elected at a meeting held during the last quarter of the calendar year by a majority of the voting members of the Commission. The term for Commission Chair and Vice Chair is for one year and begins January 2025.

This agenda item will be facilitated by Chief Counsel, Sandra Gallardo.

Enclosures (1): Commissioner Biographies

Handout: None

Mental Health Services
Oversight & Accountability Commission

Commissioner Biographies
November 2024

Mayra Alvarez, Los Angeles

Current MHSOAC Vice Chair

Joined the Commission: December 2017

Mayra Alvarez is the President of the Children's Partnership, a nonprofit children's advocacy organization.

She also serves as a First 5 California Commissioner, appointed by Governor Newsom. Previously, she served in the U.S. Department of Health and Human Services (HHS), most recently as Director of the State Exchange Group for the Center for Consumer Information and Insurance Oversight at the Centers for Medicare and Medicaid Services.

She also served as the Associate Director for the HHS Office of Minority Health and was Director of Public Health Policy in the Office of Health Reform at HHS. Alvarez received her graduate degree from the University of North Carolina at Chapel Hill and her undergraduate degree from University of California, Berkeley. Commissioner Alvarez fills the seat of the Attorney General designee.

Mark Bontrager, Napa

Joined the Commission: November 2021

Mark Bontrager has been Behavioral Health Administrator for the Partnership HealthPlan of California since 2021. He was Director of Regulatory Affairs and Program Development for the Partnership HealthPlan of California from 2018 to 2021 and Executive Director of Aldea Children and Family Services from 2007 to 2018, where he was Deputy Director from 2005 to 2007. Commissioner Bontrager was an attorney in private practice from 2002 to 2006 and held multiple positions at the Villages of Indiana Inc. from 1996 to 2003, including Program Manager, Therapist and Social Worker. Commissioner Bontrager is vice chair of the Napa County Workforce Investment Board. He earned a Juris Doctor degree from the Indiana University School of Law and a Master of Social Work degree from the Indiana University School of Social Work. Commissioner Mark Bontrager fills the seat of representative of a health care service plan or insurer.

Sheriff Bill Brown, Lompoc

Joined the Commission: December 2010

Bill Brown was first elected as sheriff and coroner for Santa Barbara County in 2006, and reelected in 2010, 2014 and 2018. He had previously served as chief of police for the city of Lompoc from 1995-2007, and chief of police for the city of Moscow, Idaho from 1992-1995. He was a police officer, supervisor, and manager for the city of Inglewood Police Department from 1980-1992, and a police officer for the city of Pacifica from 1977-1980.

Prior to his law enforcement career, Sheriff Brown served as a paramedic and emergency medical technician in the Los Angeles area from 1974-1977. Sheriff Brown holds a master's degree in public administration from the University of Southern California and is a graduate of the FBI National Academy, the Delinquency Control Institute, the Northwest Command College, and the FBI National Executive Institute. Commissioner Brown fills the seat of a county sheriff.

Keyondria Bunch, Ph.D., Los Angeles

Joined the Commission: August 2017

Keyondria Bunch, Ph.D., is Supervising Psychologist for Los Angeles County Department of Mental Health. Dr. Bunch has been with Los Angeles County since 2008 and has worked in several positions including clinical psychologist and supervisor for the Emergency Outreach Bureau, clinical psychologist for the Specialized Foster Care Program, clinical psychologist for juvenile justice mental health quality assurance, and a clinical psychologist for Valley Coordinated Children's Services.

She has been an adjunct lecturer at Antioch University as well as worked within the mental health court system around issues of competency. Dr. Bunch is currently a supervising psychologist at West Valley Mental Health outpatient program. Commissioner Bunch fills the seat of a labor representative.

Assemblymember Wendy Carrillo, Los Angeles

Joined the Commission: February 2018

Wendy Carrillo was elected to represent California's 51st Assembly District in December 2017, which encompasses East Los Angeles, Northeast Los Angeles, and the neighborhoods of El Sereno, Echo Park, Lincoln Heights, Chinatown, and parts of Silver Lake.

She is a member of the Health, Appropriations, Utilities & Energy, Labor Privacy and Consumer Protections, and Rules Committees. Assemblymember Carrillo has advocated for educational opportunities, access to quality healthcare, living wage jobs, and social justice. She was host and executive producer of the community-based radio program "Knowledge is Power" in Los Angeles.

Her previous work with Service Employees International Union (SEIU) Local 2015 included better working conditions for caregivers. She arrived in the United States as an undocumented immigrant from El Salvador and became a U.S. citizen in her early 20s. Assemblymember Carrillo represents the member of the Assembly selected by the Speaker of the Assembly.

Steve Carnevale, San Francisco

Joined the Commission: April 2021

Steve Carnevale is the executive chairman of Sawgrass, a developer of digital industrial inkjet technologies and cloud-based mass customization software. He runs a family-owned wine business in the Napa Valley called Blue Oak and is the founder and chair of the advisory board for the UCSF Dyslexia Center which is translating cutting edge neuroscience to enable precision learning. In addition to other education non-profit board service, Carnevale is a founder and co-chairs Breaking-Barriers-by-8, where he works with other non-profits, schools, corporations, and foundations toward achieving 100 percent literacy for all by age 8. He is also an advisor to ESO Ventures, a social venture fund in Oakland for community workforce development of unrepresented populations and is the former President and Emeritus Chair of The Olympic Club Foundation, whose mission is to support disadvantaged youth sports programs that develop future community leaders. Commissioner Carnevale represents an employer with fewer than 500 employees.

Rayshell Chambers, Los Angeles

Joined the Commission: May 2022

Rayshell Chambers has been Co-Executive Director and Chief Operations Officer at Painted Brain since 2016. She was Program Analyst III at Special Service for Groups from 2011 to 2018. Chambers held several positions at the City of Los Angeles Human Services Department and Commission on the Status of Women from 2006 to 2010, including Legislative Coordinator and Community Outreach Coordinator. She earned a Master of Public Administration degree in public policy and administration from California State University, Long Beach. Commissioner Chambers represents clients and consumers.

Shuo Chen, Berkeley

Joined the Commission: April 2021

Shuo Chen is General Partner at IOVC, an early-stage venture capital fund based in Silicon Valley focused on enterprise and SaaS, where she has invested in dozens of startups now unicorns or acquired by Fortune 50 companies. She is a Lecturer at the University of California, Berkeley, and Faculty at Singularity University, where she teaches entrepreneurship and emerging technologies. Chen is a co-author to one of the leading books on financial regulations published by Cambridge University Press. In addition to her investing and teaching roles, Chen is the CEO of Shinect, a Silicon Valley-based non-profit community of 5,000+ engineers passionate about entrepreneurship. She is also a Board Member of Decode, the largest tech and entrepreneurship community co-hosted with UC Berkeley and Stanford student organizations, alumni networks, and entrepreneurship centers, as well as an Advisory Board Member of Yale School of Medicine's Center for Digital Health and Innovation. Commissioner Chen fills the seat of a family member.

Senator Dave Cortese, Santa Clara

Joined the Commission: September 2021

California Senator Dave Cortese represents District 15 in the California State Senate which encompasses much of Santa Clara County in the heart of Silicon Valley. Along with his accomplished career as an attorney and business owner, the Senator previously served on the Santa Clara County Board of Supervisors, the San Jose City Council, and the East Side Union High School District Board. Senator Cortese was a major architect of School Linked Services, a program that connects students and families to behavioral health services and counseling in Santa Clara County. Commissioner Cortese fills the seat of a member of the Senate selected by the President pro Tempore of the Senate.

David Gordon, Sacramento

Joined the Commission: January 2013

David W. Gordon is the Superintendent of the Sacramento (CA) County Office of Education. He holds a B.A. from Brandeis University and an Ed.M. and Certificate of Advanced Study in Educational Administration from Harvard University.

David has dedicated his career to education with a focus on Special Education. He has served on the President’s Commission on Excellence in Special Education, the Governor’s Advisory Committee on Education Excellence, and a visiting scholar at Stanford University. Commissioner Gordon fills the seat of a superintendent of a school district.

Mara Madrigal-Weiss, San Diego

Current MHSOAC Chair

Joined the Commission: September 2017

Mara Madrigal-Weiss is the Executive Director of Student Wellness and School Culture, Student Services and Programs Division, San Diego County Office of Education.

Her experience includes working with school communities as a Family Case Manager, Protective Services Worker and Family Resource Center Director.

Madrigal-Weiss received her M.A. in Human Behavior from National University, a M.Ed in School Counseling, and a M.Ed in Educational Leadership from Point Loma Nazarene University. Madrigal-Weiss has been dedicated to promoting student mental health and wellness for over 19 years. She is a past president of the International Bullying Prevention Association (IBPA) the only international association dedicated to eradicating bullying worldwide.

Madrigal-Weiss is a member of the California Department of Education’s Student Mental Health Policy Workgroup. Commissioner Madrigal-Weiss fills the seat of the State Superintendent of Public Instruction designee.

Gladys Mitchell, Sacramento

Joined the Commission: January 2016

Gladys Mitchell served as a staff services manager at the California Department of Health Care Services from 2013-2014 and at the California Department of Alcohol and Drug Programs from 2010-2013 and from 2007-2009.

She was a health program specialist at California Correctional Health Care Services from 2009-2010 and a staff mental health specialist at the California Department of Mental Health from 2006-2007. She was interim executive officer at the California Board of Occupational Therapy in 2005 and an enforcement coordinator at the California Board of Registered Nursing from 1996-1998 and at the Board of Behavioral Science Examiners from 1989-1993.

She is a member of the St. Hope Public School Board of Directors. Mitchell earned a Master of Social Work degree from California State University, Sacramento. Commissioner Mitchell fills the seat of a family member of a child who has or has had a severe mental illness.

James (Jay) Robinson, Sacramento

Joined the Commission: May 2023

James L. (Jay) Robinson III, PsyD, MBA is the hospital administrator for Kaiser Permanente (KP) hospital Sunnyside and Westside Medical Centers and leads operations for the three ambulatory surgery centers for Kaiser Permanente Northwest.

In 2018, Jay was recognized as one of the 100 great leaders in health care by Becker's Healthcare. He holds bachelor and doctorate degrees in clinical psychology and has MBA from Concordia University Chicago. Jay has served as a Baldrige examiner for the State of Tennessee and is trained in Lean Six Sigma. He is an Adjunct Professor at the University of Tennessee Health Sciences Center in the school of Preventative Medicine and lecturer for the Kaiser Permanente Bernard J Tyson School of Medicine.

Jay brings 27 years of experience as a leader in hospital administration and clinical operations. Trained as a clinical psychologist, Jay focuses on employee engagement — teamwork and collaboration — to build community, drive quality, improve the patient care experience, and achieve high employee satisfaction. Jay's background includes serving as president of AMITA Saint Joseph Hospital, a 321-bed teaching hospital in Chicago; serving as CEO of Methodist South Hospital, a 145-bed community hospital in Memphis; and 20 years working within the Department of Veterans Affairs, where he worked at 5 different medical centers in roles of progressive complexity.

Al Rowlett, Sacramento

Joined the Commission: November 2021

Al Rowlett was named Turning Point Community Programs' Chief Executive Officer in 2014. Commissioner Rowlett has been with the agency since 1981 and today provides leadership and guidance to over 40 programs in several Northern and Central California counties. He holds a Bachelor of Arts degree from Ottawa University, a Master's in Business Administration in Health Services Management from Golden Gate University and in Social Work from California State University, Sacramento (CSUS). He is also a Licensed Clinical Social Worker.

Rowlett was appointed as a trustee to the Elk Grove Unified School District in 2009 serving through 2012. He is currently a Volunteer Clinical Professor at the University of California Davis Department of Psychiatry co-directing the Community Psychiatry seminar for residents and formerly served as an adjunct professor for the CSUS Mental Health Services Act cohort. In 2020, Assembly Speaker Anthony Rendon re-appointed Al to the California Institute for Regenerative Medicine Board. Commissioner Rowlett fills the seat of a mental health professional.

Gary Tsai, M.D., Los Angeles

Joined the Commission: August 2024

Dr. Gary Tsai is the Director of the Substance Abuse Prevention and Control, a bureau of the Los Angeles County Department of Public Health. In this role, he oversees a full spectrum of substance use prevention, harm reduction, and treatment services for the residents of Los Angeles County. Tsai is physician board-certified in both general psychiatry and addiction medicine.

Tsai serves on the Board of Directors of NAMI California, and the California Health and Human Services Agency's Behavioral Health Task Force. Tsai completed his medical training at the University of California, Davis School of Medicine and his residency training at the San Mateo County Psychiatry Residency Training Program. Commissioner Tsai fills the seat of a physician specializing in substance use disorder treatment, including the provision of medications for addiction treatment.

AGENDA ITEM 9

Action

November 21, 2024 Commission Meeting

Proposition 1 Implementation Update

Summary:
The passage of Proposition 1 in March of 2024 presents numerous opportunities to improve the Commission's processes and strengthen its commitment to the goals of the Behavioral Health Services Act. Proposition 1 also broadens the Commission's scope, duties, and roles, offering a unique opportunity to support the implementation of these reforms over the next few years. Navigating this transformative period will require strategic planning, innovation, and a steadfast commitment to improving behavioral health outcomes for all Californians.

At the November Commission meeting, Commissioners will receive an update on the implementation of Proposition 1 including the 2025 commission meeting calendar, potential formation of additional committees and subcommittees, and branding strategies.

Presenters:
Kendra Zoller, Deputy Director of Legislation
Jigna Shah, Chief of Innovation and Program Operations
Andrea Anderson, Chief of Communications

Enclosures (1): MHSOAC Brand Evolution Workshop

Handout (1): PowerPoint Slide Deck

Proposed Motion: To be Determined if there is a Vote for this Agenda Item

MHSOAC Brand Evolution

Workshop 1
Brand Audit &
Audience Segment Refinement

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Today's discussion and what comes next

07 **Interviews + key takeaways**
Themes and verbatims from our team talks

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33 **Naming Study**
Four approaches to evolving the Commission's name

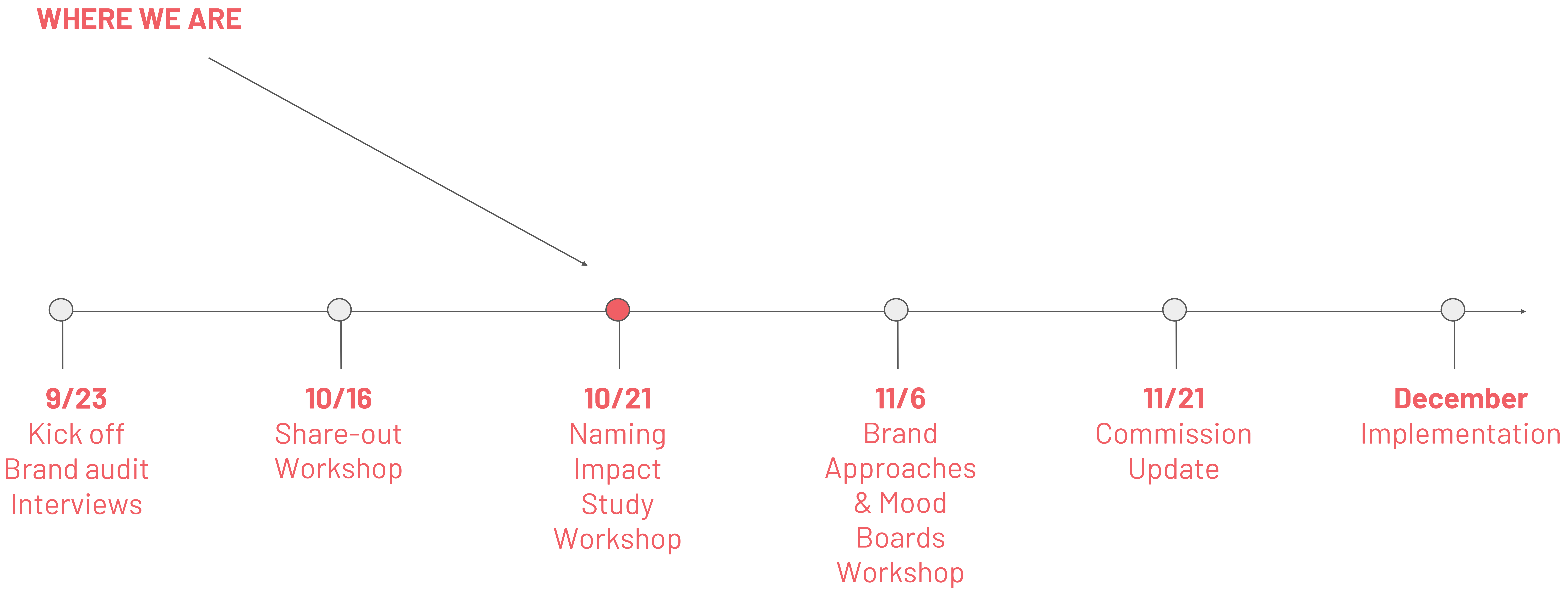
Where we are

This brand evolution effort is being driven by the upcoming January 1 statutory date, and also by a desire to better communicate the important work we are doing to our various constituents.

WHERE WE ARE

Between now and the end of the year, our top focus is this: name, nickname, visuals, and key assets. But from this work other brand opportunities are also being revealed. Namely, how we can continue to best communicate with each of our audiences.

WHERE WE ARE



Interviews + key takeaways

We interviewed key players who could add insight to where we've been and where we're going. How do we wish to be perceived? Who are our audiences and what do we want them to know?

01 Inclusivity should be our commitment and our calling card

Across interviews, there's a call for direct, consumer-friendly language that resonates with all Californians, including underrepresented BIPOC communities and those in need of behavioral health services.

02 Trust and transparency are paramount

Establishing the Commission as a trustworthy and transparent body is critical. Interviewees want the commission to be seen as an open, reliable partner that welcomes public input and clearly explains its decision-making process. Public input is an important thread that connects the past and the future.

03 Shifting our brand from “oversight” to “support” may help us more clearly communicate

There’s a clear interest in redefining the Commission’s role beyond “oversight” to include support and partnership. Multiple interviews highlighted a need to balance regulatory authority with a public-focused, supportive approach that emphasizes empowerment rather than control.

04 Clarifying the Commission's role as "catalyst" – not service provider or enforcer – should be considered

Multiple interviewees brought up the fact that people think the Commission directly provides or delivers "services" thanks to the word in the name. One interviewee told us he receives calls from people reporting on perceived bad actors because of the word "accountability" in the name.

05 Driving home the connection between equity and systemic change is important

Many interviewees emphasized their commitment to improving mental health by addressing the systemic factors that lead to inequities in care. They want the Commission's brand to reflect this equity-focused approach, highlighting its role in tackling root causes and promoting inclusive wellness.

06 Behavioral health = mental health, emotional wellbeing, and SUD.

We must recognize that brain health is central to understanding behaviors and that both mental and substance use disorders are interrelated. Services focusing on prevention, early intervention, and wellness across the lifespan must also address root causes like poverty, trauma, and systemic inequities.

07 Behavioral health, including SUD, must be reframed from punishment toward care

The Commission has an opportunity to shift the narrative around SUD, particularly in how it is communicated and addressed in educational settings. The emphasis should come across in our messaging of support and early intervention rather than discipline or shame.

08 We need to reach our youth populations

Youth populations should be actively spoken to and invited to the table as the brand evolves. We all benefit when youth become even more involved in shaping the behavioral health system.

09

Humanize our messaging

There's consistent support for a name change that's more consumer-friendly and easier to remember, reflecting both mental health and substance use.

There's also ongoing support for creating narrative stories and communications that resonate on an emotional level, creating a sense of safety, hope, and relief for audiences, especially for individuals and families in need of mental health services.

Our audiences

While the Commission serves and engages all Californians, we often speak to the policymakers and partners to affect change. We have multiple audiences, and must consider our key messages for each of them.

Audience #1: Policymakers

Policymakers emerge as a primary audience for the Commission because they are the key drivers of legislative change and resource allocation.

Multiple interviewees highlighted the role of policymakers in shaping mental health systems, making decisions about funding, and influencing how programs are implemented at the state and local levels.

Audience #2: Partners and Providers

Program partners, service providers, and local and county leaders are also identified as a critical audience for the Commission, as they are the ones who implement and manage mental health and substance use services at the community level.

These stakeholders are vital in translating policies into real-world impacts and ensuring that services reach the populations that need them most.

Audience #3: The Informed Public

The informed and impacted public were cited as the third crucial audience for the Commission because they are both the recipients of the services and an essential voice in shaping how those services are designed and delivered.

Engaging the public helps ensure that the Commission remains transparent, accessible, and responsive to the needs of the communities it serves.

Naming study

OUR APPROACH

With the new statutory name in place, we have focused on the development of an evolved Commission name, nickname, tagline, and boilerplate. We are considering our naming study in light of the entire brand ecosystem.

STUDY SUMMARY: OPTION 1

Commission for Behavioral Health

Transforming change for all Californians

Nickname: *The CBH*

Boilerplate: The CBH champions wellbeing for all Californians through behavioral health prevention and intervention, including mental health, substance use disorders, and trauma-related disorders. By working with the community, experts, and civic partners, we help to increase public understanding, catalyze best practices, and inspire innovation. Our goal: accelerating transformational change.

Why It Works*: It's simple, memorable, and offers a more purposeful combination of commission and behavioral health thanks to the "for." It's powerful to be* ***for*** *something, in this case behavioral health for all Californians.*

STUDY SUMMARY: OPTION 2

California Behavioral Health Commission

Catalysts for transformational change

Nickname: *The CBHC*

Boilerplate: *The CBHC* champions wellbeing for all Californians through behavioral health prevention and intervention, including mental health, substance use disorders, and trauma-related disorders. By working with the community, experts, and civic partners, we help to increase public understanding, cultivate best practices, and inspire innovation.

Why It Works: *Our desk research turned up Behavioral Health Commissions for both San Francisco and Riverside County. Whether or not there is any connection, with "California" at the front this name positions MHSOAC at the top – as a leader.*

Behavioral Health Innovation Commission

Fueling change for all Californians

Nickname: *BHIC*

Boilerplate: *BHIC* champions wellbeing for all Californians through behavioral health prevention and intervention, including mental health, substance use disorders, and trauma-related disorders. By working with the community, experts, and civic partners, we help to increase public understanding, catalyze best practices, and inspire innovation. Our goal: accelerating transformational change.

Why It Works: *Driving and inspiring innovation is at the heart of the Commission. By including "innovation" in the name, we elevate its gravity as an agency of thinkers and catalysts, driving transformational change.*

STUDY SUMMARY: OPTION 4

Commission for Transformational Change

Championing behavioral health for all Californians

Nickname: *The CTC*

Boilerplate: *The CTC* catalyzes better health for all California through behavioral health prevention and intervention, including mental health, substance use disorders, and trauma-related disorders. By working with the community, experts, and civic partners, we help to increase public understanding, catalyze best practices, and inspire innovation.

Why It Works: *This name is more about Commission's vision and role as a change agent. Paired with a grounding tagline that calls out behavioral health, it feels big, bold, and full of catalytic energy.*

APPENDIX

ADDITIONAL NAMES & TAGLINES

Names (Word Variations)

- Behavioral Health Commission
- Commission for Behavioral Health Innovation
- California Commission for Transformational Change

Taglines (w/o "behavioral health")

  - Catalyzing innovation in mental wellness for all Californians
  - Championing mental wellness for all Californians
  - Transforming change for all Californians
  - Catalyzing change for all Californians
  - California's catalyst for transformational change
  - California's think tank for transformational change
  - Championing mental health and wellbeing for all Californians
  - Championing wellbeing for all Californians

ADDITIONAL NAMES & TAGLINES

Taglines (w/ "behavioral health")

- Championing behavioral health for all Californians
- Supporting behavioral health for all Californians
- Catalyzing behavioral health for all Californians
- Behavioral health for all Californians

PARKING LOT IDEAS

- Create separate messaging frameworks tailored for each audience segment, once these are defined and prioritized.
- Educate our audiences about the link between brain health and behavioral health, similar to how heart health has been promoted over the years.
- Expand mechanisms for public input, leveraging new methodologies including different technologies and platforms to increase representation beyond current in-person or traditional methods.
- Transition from a business-to-business (B2B) model (focused on counties, legislators, etc.) to a more consumer-facing (B2C) approach to engage individuals and families directly.
    - Develop more user-friendly content (e.g. guides, explainer videos, storytelling, and visual content) to break down complex topics and increase accessibility.
    - Use social media to address key topics like mental health stigma, substance use, and behavioral health awareness in real time.

AGENDA ITEM 10

Action

November 21, 2024 Commission Meeting

Orange County Innovation Project

Summary:
The Mental Health Services Oversight and Accountability Commission will consider the approval of Orange County's request to fund the following project:

Program Improvements for Valued Outpatient Treatment -up to $34,950,000 in Innovation funds over five years.

Orange County requests authorization to use up to $34,950,000 of existing Innovation funding to redesign their system of care to meet local needs while aligning with the new requirements under the Behavioral Health Services Act (BHSA) to ensure sustainability. The BHSA redirects a portion of Mental Health Service Act (MHSA) funding to pay for housing and substance use disorders while also shifting funding from local use, to state-directed use, for prevention and workforce initiatives. As a result, Orange County must modify or eliminate existing MHSA funded programs and is anticipating a loss of $150 million from currently funded programs.

To identify successful strategies and administrative changes needed to prepare for the transition to the BHSA, including solutions to support individuals who will no longer qualify for services under the BHSA, Orange County will launch the Program Improvements for Valued Outpatient Treatment (PIVOT) Innovation Project. PIVOT proposes to create and test service models where the delivery, care coordination, systemwide collaborations and payment for care is aligned to make a seamless and integrated experience for behavioral health clients, resulting in improved client outcomes.

PIVOT has five distinct components, each with its own activities, subject matter experts, learning objectives and evaluation, that support alignment with the BHSA. These five components include:

1. <u>Full Service Partnership Reboot</u>
   To align with FSP guidelines in the BHSA, the County will leverage learnings from prior investments, and other FSP initiatives to address their system's readiness to support the required changes. To support this FSP Reboot, the County will focus on activities under two categories: Technical Data and Infrastructure, and Administrative Processes.

2. <u>Integrated Complex Care Management for Older Adults</u>
   To address the growing population of older adults in Orange County living with complex challenges of managing neurocognitive disorders, mental health issues, and who may also be at risk of, or experiencing homelessness, the County will engage a team of community identified experts, who serve older adults across the continuum of care to inform the development of a holistic and comprehensive system of care.

3. <u>Developing Capacity for Specialty MH Plan Services with Diverse Communities</u>
   Under this component, the County seeks to identify the minimum capacity of a community-based organization (CBO) to be able to become a specialty mental health plan or a drug Medi-Cal contracted provider. Considering that CBOs also integrate community-defined evidence practices into their services and serve the populations identified as underserved by county-based specialty mental health services, the County wants to develop capacity within these programs to be sustainable under the BHSA.

4. <u>Innovating Countywide Workforce Initiatives</u>
   Under this component, the County will uplift successful strategies from both internship and apprenticeship programs utilizing a third-party vendor and create a pathway from paid internship to employment of diverse professionals and paraprofessionals in regular county positions.

5. <u>Innovative Approaches to Delivery of Care</u>
   Orange County proposes to leverage learnings from prior investments and facilitate ongoing workgroups to understand consumer and family members' experience of receiving services and use their feedback to improve the delivery of care.

Behavioral Health Services Act Alignment and Sustainability:
The purpose of this project is to support Orange County, and other counties, to prepare for the changes required under the BHSA. Each of the five identified project components includes sustainability as an intended outcome that will be accomplished through administrative changes, collaboration between programs to streamline and create new funding structures, strategies to increase capacity of partners to become eligible to bill for Medi-Cal services, and development of needed infrastructure to ensure that the County can leverage grants and other funding opportunities that support the behavioral health system.

Additional Counties have expressed interest in joining Orange County to launch versions of PIVOT and create a larger learning collaborative. It is anticipated that additional counties will bring projects forward beginning January 2025.

The Community Program Planning Process:
Orange County posted PIVOT for review and public comment as part of their MHSA Annual Plan update for FY 2024-25 beginning March 11, 2024 and concluding April 15, 2024. A behavioral health board hearing was conducted on April 24, 2024, followed by an additional community planning meeting where stakeholders provided feedback on specific PIVOT components. The plan was subsequently approved by their Board of Supervisors on June 4, 2024.

Commission staff shared this project with community partners and the listserv on September 20, 2024, and again on November 4, 2024. No comments were received.

Enclosures (3): (1) Commission Community Engagement Process; (2) Biography for Orange County Presenter; (3) Orange County Staff Analysis: PIVOT

Additional Materials (1): A link to Orange County's PIVOT Innovation Project is available on the Commission website at the following URL: Orange_INN-Plan_PIVOT_1108024.pdf

Handout (1): PIVOT PowerPoint Presentation

Proposed Motion:
That the Commission approve Orange County's Program Improvements for Valued Outpatient Treatment (PIVOT) Innovation Project for up to $34,950,000 over five (5) years.

Commission Process for Community Engagement on Innovation Plans

To ensure transparency and that every community member both locally and statewide has an opportunity to review and comment on County submitted innovation projects, Commission staff follow the process below:

Sharing of Innovation Projects with Community Partners

- **Procedure – Initial Sharing of INN Projects**
  1. Innovation project is initially shared while County is in their public comment period
  2. County will submit a link to their plan to Commission staff
  3. **Commission staff will then share the link for innovation projects with the following recipients:**
     - **Listserv recipients**
     - **Commission contracted community partners**
     - **The Client and Family Leadership Committee (CFLC)**
     - **The Cultural and Linguistic Competency Committee (CLCC)**
  4. Comments received while County is in public comment period will go directly to the County
  5. Any substantive comments must be addressed by the County during public comment period
- **Procedure – Final Sharing of INN Projects**
  1. **When a final project has been received and County has met all regulatory requirements and is ready to present finalized project (via either Delegated Authority or Full Commission Presentation), this final project will be shared again with community partners:**
     - **Listserv recipients**
     - **Commission contracted community partners**
     - **The Client and Family Leadership Committee (CFLC)**
     - **The Cultural and Linguistic Competency Committee (CLCC)**
  2. The length of time the final sharing of the plan can vary; however, Commission tries to allow community partner feedback for a minimum of two weeks
- **Incorporating Received Comments**
  1. Comments received during the final sharing of the INN project will be incorporated into the Community Planning Process section of the Staff Analysis.
  2. Staff will contact community partners to determine if comments received wish to remain anonymous
  3. Received comments during the final sharing of INN project will be included in Commissioner packets
  4. Any comments received after final sharing cut-off date will be included as handouts

Orange County Innovation Projects
Presenter Bio

Flor Yousefian Tehrani, Psy.D., LMFT
Orange County Innovation Projects Program Manager

Flor Yousefian Tehrani is the Program Manager over MHSA Innovation Projects in Orange County. Dr. Tehrani has been involved in the development, implementation, and evaluation of Orange County Innovation projects since 2011. She is also a licensed marriage and family therapist and remains connected to the community by providing direct services and support to clients and their families.

STAFF ANALYSIS—Orange County

Innovation (INN) Project Name:	**Program Improvements for Valued Outpatient Treatment (PIVOT)**
Total INN Funding Requested:	**Up to $34,950,000**
Duration of INN Project:	**Five (5) years**
MHSOAC consideration of INN Project:	**November 21, 2024**

Review History:

Public Comment Period:	March 11, 2024 through April 15, 2024
Mental Health Board Hearing:	April 24, 2024
Approved by the County Board of Supervisors:	June 4, 2024
County submitted INN Project:	October 31, 2024
Date Project Shared with Stakeholders:	September 20, 2024 and November 4, 2024

Project Introduction:

Orange County requests authorization to use up to $34,950,000 of existing Innovation funding to redesign their system of care to align with the new requirements under the Behavioral Health Services Act (BHSA). The BHSA redirects a portion of Mental Health Service Act (MHSA) funding to pay for housing and substance use disorders while also shifting local funding for prevention and workforce initiatives to state-directed use. In addition to preparing the County for these updated regulatory obligations, this innovation project also aims to ensure sustainability of existing programs and supports that are at risk of discontinuation due to these modifications in funding categories. Orange County anticipates a loss of $150 million from currently funded programs.

To identify successful strategies and administrative changes needed to prepare for the transition to the BHSA, including solutions to support individuals who will no longer qualify for services under the BHSA, Orange County will launch the Program Improvements for Valued Outpatient Treatment (PIVOT) Innovation Project. PIVOT proposes to create and test service models that align the delivery, care coordination, systemwide collaborations, and payment for care to make a seamless and integrated experience for behavioral health clients, resulting in improved client outcomes.

PIVOT has five distinct components, each with its own activities, subject matter experts, learning objectives and evaluation:

1. Full Service Partnership Reboot
2. Integrated Complex Care Management for Older Adults
3. Developing Capacity for Specialty Mental Health Plan Services with Diverse Communities
4. Innovating Countywide Workforce Initiatives
5. Innovative Approaches to Delivery of Care

Behavioral Health Services Act Alignment and Sustainability (See pages 31-33; 44-45):
The purpose of this project is to support Orange County, and other counties, to prepare for the changes required under the BHSA. Each of the five identified project components includes sustainability as an intended outcome that will be accomplished through administrative changes, collaboration between programs to streamline and create new funding structures, strategies to increase capacity of partners to become eligible to bill for Medi-Cal services, and development of needed infrastructure to ensure that the County can leverage grants and other funding opportunities that support the behavioral health system.

What is the Problem (pages 6-7):
Orange County reports that the BHSA will have several significant impacts to their behavioral health system of care. Specifically, the BHSA redirects a portion of current MHSA funding to pay for housing and substance use disorder (SUD) services. The BHSA's expansion of priority populations, including individuals living with SUD, requires the County to change the way it conducts business and delivers services. Currently, mental health and SUD services operate independently and will need to be integrated under the BHSA.

The BHSA also removes county funding for prevention and innovation programs, and combines early intervention, general system development, workforce development, and capital facilities and technology needs into one funding bucket under Behavioral Health Services and Supports. Of particular concern are existing programs that are currently funded under the MHSA Prevention and Early Intervention (PEI) component. These programs provide vital services to communities who are underserved in the larger system of care. Many of these existing programs are not currently structured to bill Medi-Cal and have limited capacity to make the swift changes needed to align with the BHSA. As a result of this funding restructuring, individuals served by PEI programs may face lapses in care.

In total, Orange County anticipates a loss of $150 million from currently funded programs. This dramatic funding shift requires a redesign of their behavioral health system to align with the BHSA while also ensuring that their community continues to receive the services and supports needed to promote wellness.

How this Innovation project addresses this problem (pages 8-27):
PIVOT is presented as a comprehensive proposal with five components, each with its own activities and learning objectives, intended to result in an overall system redesign while simultaneously addressing key areas of need in the current behavioral health system of care. Each component was identified as a need through ongoing community and stakeholder feedback, and each component supports the county's transition to BHSA:

1. Full Service Partnership (FSP) Reboot
   To align with FSP guidelines in the BHSA, the County will leverage learnings from prior investments and other FSP initiatives to address their system's readiness to support the required changes. To support this FSP Reboot, the County will focus on two areas: Technical Data and Infrastructure, and Administrative Processes.

2. Integrated Complex Care Management for Older Adults
   To address the growing population of older adults in Orange County living with complex challenges of managing neurocognitive disorders and mental health issues, as well as support those who may also be at risk of, or experiencing homelessness, the County will engage a team of community identified experts who serve older adults across the continuum of care to inform the development of a holistic and comprehensive system of care.

3. Developing Capacity for Specialty Mental Health Plan Services with Diverse Communities
   Under this component, the County seeks to identify the minimum capacity of a community-based organization (CBO) to be able to become a specialty mental health plan or a drug Medi-Cal contracted provider. The elimination of the MHSA PEI funding component in the BHSA directly affects that ability of trusted CBOs, who are currently providing non- Medi-Cal based behavioral health services, to operate. Considering that CBOs also integrate community-defined evidence practices into their services and serve the populations identified as underserved by county-based specialty mental health services, the County must support capacity development within these programs for them to be sustainable under the BHSA.

4. Innovating Countywide Workforce Initiatives
   Under this component, the County will uplift successful strategies from both internship and apprenticeship programs utilizing a third-party vendor and create a pathway from paid internship to employment of diverse professionals and paraprofessionals in regular county positions.

5. Innovative Approaches to Delivery of Care
   Orange County proposes to leverage learnings from prior investments and facilitate ongoing workgroups to understand consumer and family members' experience of receiving services and use their feedback to improve the delivery of care.

Each PIVOT component will be guided by county staff and supported by a project manager, subject matter experts with experience and knowledge in that specific area of behavioral health, and an evaluator. Each component will also be staffed with five peer specialists to integrate the perspective of consumers and family members with lived experience in mental health and recovery.

Orange County is requesting the Commission's approval to make PIVOT a multi-county project, which would allow other counties the opportunity to join components that best align with their local needs and support their transition to BHSA.

<u>Community Planning Process</u> (Pages 36-37):

Local Level

Orange County posted PIVOT for review and public comment as part of their MHSA Annual Plan update for FY 2024-25 beginning March 11, 2024 and concluding April 15, 2024. A behavioral health board hearing was conducted on April 24, 2024, followed by an additional community planning meeting where stakeholders provided feedback on specific PIVOT components. The plan was subsequently approved by their Board of Supervisors on June 4, 2024.

Commission Level

Commission staff shared a draft of this project with community partners and email listserv on September 20, 2024. An updated plan, incorporating community input and MHSOAC technical advice, was shared with the Commission's community partners and listserv on November 4, 2024.

No comments were received in response to Commission staff sharing the project for feedback.

<u>Learning Objectives and Evaluation</u> (Pages 28-30):

The primary learning objective connecting all components of PIVOT is to prepare for and successfully transition to the BHSA through a redesign of the behavioral health system of care in Orange County and beyond. Orange County has identified general learning objectives and explains that each component will require its own evaluation plan and research team to track lessons learned.

Upon approval, the following preliminary learning questions will be further refined by contracted evaluators:

1. <u>Full Service Partnership Reboot</u>

- How can the different FSP levels be operationalized to support timely and appropriate transitions in level of care?
- What administrative processes and program operations ensure that members experience seamless continuity of care during transitions between FSP levels?

- For contracted programs, what changes are needed in the contract language to incorporate the different levels of care?
- What are the standards for fidelity monitoring?
- What Quality Assurance and Quality Improvement practices need to be implemented to ensure fidelity?

2. Integrated Complex Care Management for Older Adults

- What are the most successful strategies for identifying this target population?
- What are the most effective assessments and interventions for this target population?
- What are the viable funding structures that can support this integrated model of care?
- What housing models would best support the needs of this target population?

3. Developing Capacity for Specialty Mental Health Plan Services with Diverse Communities

- What are the minimum requirements for a CBO to become a Medi-Cal/DMC-ODS provider?
- What type and level of technical assistance is needed to support CBOs?
- In what ways does a hub and spoke model effectively support capacity building?
- Does embedding culturally based approaches for specialty mental health care improve penetration rates and client outcomes?
- Which CDEPs are most effective?
- How can CDEPs be utilized to generate revenue?

4. Innovative Countywide Workforce Initiatives

- Did the use of an alternative pathway, such as an apprenticeship program model, lead to increased employment engagement and/or retention?
- Which incentives contributed most to increased likelihood of employment engagement and retention?
- Does the development of a countywide initiative place the County in a better position to apply and qualify for grants to sustain/expand workforce initiatives?

5. Innovative approaches to delivery of care

- What clinic design or set-up elements are most impactful in supporting quality care and/or client engagement?
- Is there an optimal flow to the delivery of care?
- How does utilizing a user experience design impact client outcomes?

If additional counties are approved to join, the overall objectives and evaluation plan will remain consistent among participating counties while also allowing for additional learning questions to address local needs.

The Budget (See pages 46-49):

PERSONNEL COSTS	FY 24-25	FY 25-26	FY 26-27	FY 27-28	FY 28-29	TOTAL
Salaries	$965,000	$965,000	$965,000	$965,000	$965,000	$4,825,000
Total Personnel Costs	$965,000	$965,000	$965,000	$965,000	$965,000	$4,825,000
OPERATING COSTS	**FY 24-25**	**FY 25-26**	**FY 26-27**	**FY 27-28**	**FY 28-29**	**TOTAL**
Supplies	$275,000	$275,000	$275,000	$275,000	$275,000	$1,375,000
Translation	$100,000	$100,000	$100,000	$100,000	$100,000	$500,000
Travel	$125,000	$125,000	$125,000	$125,000	$125,000	$625,000
Indirect Costs (5% Admin)	$25,000	$25,000	$25,000	$25,000	$25,000	$125,000
Total Operating Costs	$525,000	$525,000	$525,000	$525,000	$525,000	$2,625,000
CONSULTANT/CONTRACTS	**FY 24-25**	**FY 25-26**	**FY 26-27**	**FY 27-28**	**FY 28-29**	**TOTAL**
Project Managers	$750,000	$750,000	$750,000	$750,000	$750,000	$3,750,000
Subject Matter Experts	$3,750,000	$3,750,000	$3,750,000	$3,750,000	$3,750,000	$18,750,000
Evaluators	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$5,000,000
Total Consultant Costs	$5,500,000	$5,500,000	$5,500,000	$5,500,000	$5,500,000	$27,500,000
EXPENDITURE TOTALS	**FY 24-25**	**FY 25-26**	**FY 26-27**	**FY 27-28**	**FY 28-29**	**TOTAL**
Personnel	$965,000	$965,000	$965,000	$965,000	$965,000	$4,825,000
Direct Costs	$6,000,000	$6,000,000	$6,000,000	$6,000,000	$6,000,000	$30,000,000
Indirect Costs	$25,000	$25,000	$25,000	$25,000	$25,000	$125,000
TOTAL INN BUDGET	**$6,990,000**	**$6,990,000**	**$6,990,000**	**$6,990,000**	**$6,990,000**	**$34,950,000**

Orange County is requesting authorization to spend up to $34,950,000 in MHSA Innovation funding, over a period of five (5) years, to launch and test the PIVOT Project. If the project is approved by the Commission, the County will refine the budget for each component through ongoing planning meetings.

The table represents a total budget for all five components. Each individual component will be supported locally by county staff, county champions, and peer support specialists. In addition, contracted project managers, subject matters experts, and evaluators will be hired to support activities under each component.

Local Personnel costs total $4,825,000 (13.8% of total budget) and include the following positions:

- 5 FTE County Innovation Staff, one per component for a total of $375,000 over five years;
- 10 FTE Peer Support Specialists, two per component for a total of $4,200,000 over five years; and
- County Champion Program Support Staff for a total of $250,000 over five years.

Consultant and contractor costs in the amount of $27,500,000 (78.6% of total budget) include the following positions:

- 5 FTE Project Managers, one per component;
- 25 FTE Subject Matter Experts, five per component; and
- 5 FTE evaluators, one per component.

Operating costs total $2,625,000 (7.5% of total budget) and include supplies, translation services and travel costs associated with each component.

The proposed project appears to meet the minimum requirements listed under MHSA Innovation regulations.

AGENDA ITEM 11

Action

November 21, 2024 Commission Meeting

Full-Service Partnership Legislative Report

Summary: Full Service Partnerships (FSPs) represent California's comprehensive and intensive efforts to serve individuals with serious mental illness in their communities and connect them to the resources they need to gain stability and maintain independence. On the continuum of care, FSPs are the last upstream effort to divert individuals away from the most devastating impacts of serious mental illness, including homelessness, incarceration, and hospitalization. This is the second biennial report to the Senate and Assembly Committees on Health and Human Services, and Assembly Budget Subcommittee on Health and Human Services, in compliance with Senate Bill (SB) 465.

Part 1 provides an overview of FSPs, and examines the data collection, reporting, and monitoring done by FSP and county staff to meet the needs of clients and comply with existing mandates. A key component to this evaluation is examining the role of the Data Collection Reporting (DCR) system managed by the Department of Health Care Services and providing possible solutions to improve data accuracy and transparency, while reducing administrative burden.

Part 2 provide a comprehensive overview of clients served by FSPs including age, race/ethnicity, gender, place of birth, and experiences of homelessness. It also examines service usage and outcomes, such as crisis service utilization, inpatient psychiatric hospitalization, and emergency department visits. We are not able to provide information on clients' incarceration, probation, or recidivism prior, during, or after FSP partnership due to data sharing lags with the Department of Justice (DOJ).

Background:

Senate Bill (SB) 465 directed the Commission to provide biennial reports to the Legislature on the operations of FSPs and recommendations on improving outcomes for FSP clients. Specifically, the Commission must report on:

- Criminal justice involvement; housing status or homelessness; hospitalization, emergency room utilization, and crisis service utilization for those eligible for an FSP.
- Analyses of separation from a FSP and the housing, criminal justice, and hospitalization outcomes for the 12-months following separation.
- An assessment of whether those individuals most in need are accessing and maintaining participation in a FSP or similar programs.
- Identification of barriers to receiving the data relevant to the report requirements and recommendations to strengthen California's use of FSPs to reduce incarceration, hospitalization, and homelessness.

Over the past two years, the Commission has undertaken extensive community engagement and evaluation efforts to better understand how FSPs can increase service quality and client outcomes. These efforts include targeted outreach, community forums, a statewide survey, and research.

The findings and recommendations are detailed in the report by the following categories:

1) **Statewide Data Infrastructure:** The existing DCR system is not sufficient for capturing accurate, high-quality data necessary for statewide accountability and transparency of FSPs. The Commission recommends that the existing DCR system be replaced or overhauled to have the following features at its core: functionality, customization, brevity, and interoperability.

2) **Performance Management:** Most counties are not currently engaged in substantive performance management practices. The Commission recommends launching a statewide learning community where county behavioral health staff and providers can gain greater knowledge of the potential benefits of performance management for their teams and better understand the resources necessary to undertake performance management with fidelity.

3) **Outcomes-Based Contracting:** The current contracting practices between counties and providers does not place a strong enough focus on outcomes. The Commission's recommendation is for counties to include performance metrics into their future contracts with service providers, specifying what success looks like and provide more substantial financial incentives for improved client outcomes.

4) **Funding:** Contracted providers shared their confusion around how to maximize FSP dollars, including what services were billable and to whom. The Commission suggests strong technical assistance and training for counties and service providers on maximizing FSP dollars under new Prop 1 changes.

5) **Service Delivery Models**: Most service providers would benefit from increased structure in both process and approach to service provision. Guidance on what service delivery models are best suited to particular populations, and best-practices within these models, could go far. It is our recommendation that the state develop and disseminate clear service model guidelines for FSP programs statewide.

6) **Staffing and Resources:** FSP providers repeatedly called for solutions to address persistent staff shortages and guidance on how to better leverage current staff resources. Training and capacity building alone will not be sufficient to alleviate the current strain on FSP providers or alleviate the resulting turnover. The Commission suggests the state invest significant resources in identifying scalable solutions that can widen the workforce pipeline, incentivize retention of current providers, and increase use of peers in the workforce.

Presenter(s): Kallie Clark,

Enclosure (1): (1) DRAFT- 2024 Full Service Partnerships Legislative Report

Handout (1): (1) Overview of report (presentation slides)

Proposed Motion: That the Commission approve for adoption the 2024 Full Service Partnership Report to the Legislature

Full Service Partnerships 2024 Legislative Report

by the Mental Health Services Oversight and Accountability Commission

Submitted to the Fiscal and Policy Committees of the Legislature

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PART 1

"They always see the bad things, but we never really highlight some of the amazing success stories that we have and that we have done working with FSPs […] They have got amazing success stories with clients. That to me [means] we're on the right path, that we're doing the right thing. There's no such thing as a perfect system. There's always room for improvement. And we have to work collaboratively with other departments [to get there]."

– FSP PROGRAMS DIRECTOR

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Acknowledgements

The Commission would like to acknowledge the hundreds of service providers, supervisors, county behavioral health staff, content experts, clients, peers and family members who shared their thoughts, experiences, and value time with us over the last two years. Without their contributions this report would not be possible. We would also like to thank our partners at Third Sector Capital Partners and Healthy Brains Global Initiative whose collaboration was essential to our engagement and learning efforts.

Lastly, we'd like to thank our colleagues at the California Department of Health Care Services and the California Health and Human Services Agency who have consistently offered their collaboration to better the behavioral health and wellbeing of Californians.

CHAPTER 1: WHATEVER IT TAKES

"Some of the best [parts] of FSP are related to our ability to join with the client wherever they may be. We make great connections with humans in need." – County Behavioral Health Agency

About This Report

Full Service Partnerships (FSPs) represent California's comprehensive and intensive efforts to serve individuals with serious mental illness in their communities and connect them to the resources they need to gain stability and maintain independence. On the continuum of care, FSPs are the last effort to divert individuals away from the most devastating impacts of serious mental illness, including homelessness, incarceration, and hospitalization.

This is the second biennial report to the Senate and Assembly Committees on Health and Human Services, and Assembly Budget Subcommittee on Health and Human Services, in compliance with Senate Bill 465.

Part 1 provides an overview of FSPs and examines the data collection, reporting, and monitoring done by FSP and county staff to meet the needs of clients and comply with existing mandates. A key component to this evaluation is examining the role of the Data Collection Reporting system managed by the Department of Health Care Services and providing possible solutions to improve data accuracy and transparency, while reducing administrative burden.

Part 2 provides a comprehensive overview of clients served by FSPs since their inception more than two decades ago. This includes age, race/ethnicity, gender, place of birth, and experiences of homelessness. It also examines service usage and outcomes, such as crisis service utilization, inpatient psychiatric hospitalization, and emergency department visits.

There are limitations to the information included in this report. Due to a lack of data, the Commission is not able to provide information on clients' incarceration, probation, or recidivism prior to, during, or after FSP participation. Some of the estimates may be inaccurate at the county level due to missing data or errors in reporting. Despite these limitations, this report outlines the potential for FSPs to deliver invaluable resources to individuals with severe mental illness and/or substance use disorders and identifies several roadblocks currently limiting their impact. The report includes specific recommendations for California to ensure FSPs meet their full potential and the expectations of Proposition 1 and the Behavioral Health Services Act.

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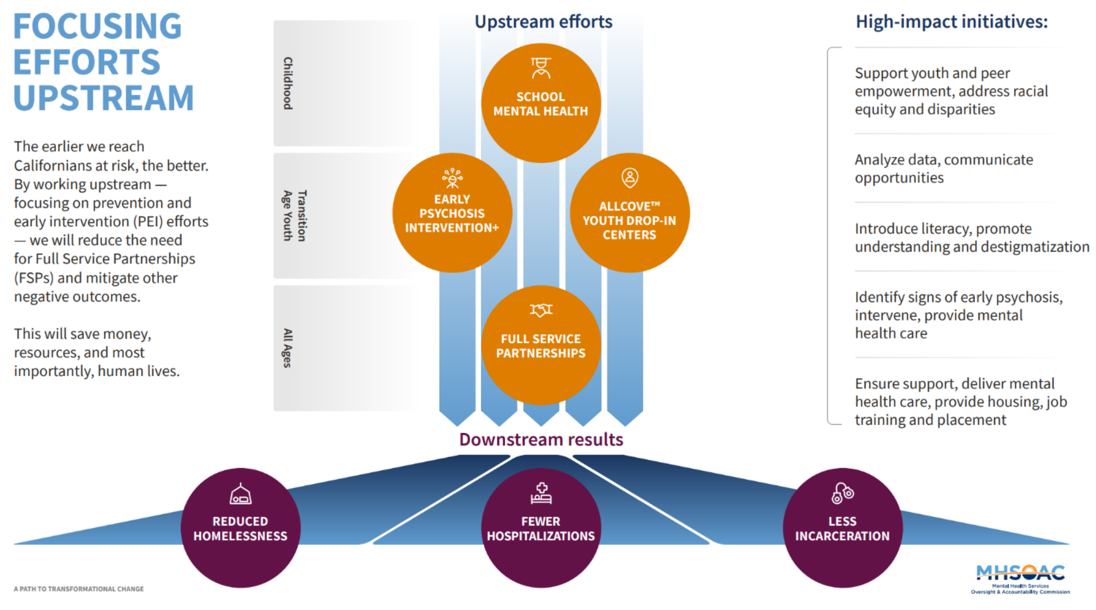
"[FSPs] create conditions to live with more dignity, be housed, … to transgress barriers, to have a soft landing and abundance of resources … [They give people their] own voice and connection back to families." – Participant from Community Forum 1

History and Role of Full-Service Partnerships

California's Full Service Partnership (FSP) programs are recovery-oriented, comprehensive services targeted to individuals who are unhoused or are at risk of becoming unhoused, and who have a severe mental illness, often with a history of criminal justice involvement and repeat hospitalizations. FSP programs were designed to serve people in the community rather than in locked state hospitals. FSPs provide services across the lifespan including children, transition aged youth[1], adults, and older adults. A unique component to FSPs is that services are available 24/7 and can include therapy, assistance planning transportation to medical appointments, housing assistance, and more.

Figure 1: FSPs are the Last Stop in the Upstream Efforts to Reduce Homelessness, Incarceration and Hospitalization



By engaging mental health consumers in their care and providing services tailored to individual needs, FSPs can reduce costs, improve the quality and consistency of care, enhance outcomes, and, most importantly, save lives. The name – Full Service Partnership – reflects the goal of developing a partnership between the person being served and the service

[1] Youth ages 16-25

provider, and offering a full array of services through a "whatever it takes" approach to meeting the consumer's needs. FSPs are core investments of the Mental Health Services Act (MHSA)and a key element of California's continuum of care, intended to be the bulwark against the most devastating impacts of untreated mental illness.

California's investment in FSPs evolved from advocacy efforts in the 1990s to reduce the number of people sent to locked state mental hospitals who could be better served in the community. In 1999, the state passed legislation to establish pilot projects across California, funding comprehensive, integrated care for people with high risk for homelessness, justice involvement, and hospitalization. After signs of success, the program was expanded to more sites across the state. Follow-up evaluations confirmed early findings: housing is a critical component of recovery, and people with serious mental illness *can* achieve housing stability with adequate support.

In the more than two decades since the birth of FSPs, numerous factors have led to advances and changes in how FSPs serve the community and who they serve.

In September 2022, Governor Newsom signed the Community Assistance, Recovery and Empowerment (CARE) Act. The goal of the CARE Act is to improve access to mental health services for people experiencing schizophrenia or other psychotic disorders and who are either not receiving adequate treatment or who do not have stable housing. Under the CARE Act, mental health consumers and counties negotiate individualized service plans called CARE Plans. CARE Courts oversee these plans and have the authority to compel counties to participate in those plans when necessary. Most CARE Courts were set to roll out in 2024. As more and more counties enact CARE Courts, it is expected that demand on FSPs will increase.

The most recent, and probably most prominent, changes to FSPs come from mandates enacted by Proposition 1. In March 2024, California voters approved Proposition 1, transforming the Mental Health Services Act into the Behavioral Health Services Act (BHSA). With this shift, several fundamental changes through the Welfare and Institutions Code Section 5887 were set in motion that will have substantial impacts on FSPs, including:

- The expansion of services to individuals with substance use disorders (SUD), including assertive, field-based treatment
- The development of standardized, evidence-based practices for models of treatment including Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT), Individual Placement and Support model of Supported Employment, high fidelity wraparound, or other evidence-based services and treatment models, as specified by the State Department of Health Care Services (DHCS).

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- The establishment of levels of care and criteria for stepping down to the least intensive level of care per the guidance of DHCS in consultation with the Commission.

These changes are set to go into effect in July of 2026. The State Department of Health Care Services (DHCS) has provided an overview of the new Behavioral Health Services Act and how it impacts FSPs here.

Lastly, Proposition 1 mandates the allocation of 30 percent of BHSA funds towards housing for eligible individuals, shifts FSP funding to 35 percent of BHSA revenue, and places a heightened focus on transparency and accountability for financial, performance, and outcomes data.

Report to the Legislature

Senate Bill 465 directs the Commission to provide biennial reports to the Legislature on the operations of FSPs and recommendations on improving outcomes for FSP clients. In these reports the Commission is charged with reporting on:

- Individuals eligible for FSPs, including information on incarceration or criminal justice involvement; housing status or homelessness; hospitalization, emergency room use, and crisis service use.
- Analyses of separation from an FSP and the housing, criminal justice, and hospitalization outcomes for the 12 months following separation.
- An assessment of whether those individuals most in need are accessing and maintaining participation in a FSP or similar programs.
- Identification of barriers to receiving the data relevant to the report requirements and recommendations to strengthen California's use of FSPs to reduce incarceration, hospitalization, and homelessness.

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The Commission's previous report to the Legislature in January 2023 identified three primary concerns. First, the report noted that missing and inaccurate data limit the Commission's ability to fully understand how effective FSPs are in preventing homelessness, justice involvement, and hospitalization. Second, despite regulatory requirements, county behavioral health departments did not appear to be allocating the mandatory minimum funding levels for FSP as specified by the law. Third, as of the time of the report, California had not established sufficient technical assistance and support for counties and providers to ensure that FSP programs are meeting the goals of reducing homelessness, hospitalizations, and justice involvement.

Since the Commission's initial report, the need for high quality FSPs has only grown. An increasing number of unhoused residents, long waiting lists to enter state hospitals, and

ongoing reliance on local law enforcement and community hospital care suggest the need for high-quality FSP programs is greater than ever.

- In 2020, approximately 37,000 unhoused Californians were living with mental illness and a similar number were living with chronic substance use disorder.
- Nearly 80 percent of unhoused individuals in California have a previous incarceration, and approximately 30 percent had been detained during their most recent experience of homelessness. This suggests a strong relationship between living unhoused and being involved in the criminal justice system.
- Approximately 30 percent of individuals incarcerated at the state and county level were either in need of mental health services or actively receiving psychotropic medication.
- In 2022, more than 1,700 individuals who were found incompetent to stand trial were being held in jail while on the waitlist for treatment at a state hospital. The cost of treating individuals in jails to restore them to competency was about $172 million.
- Those who are moved off the waitlist, are sent to one of five state hospitals that serve more than 6,200 individuals. The cost to run these five hospitals exceeds $2 billion annually.

Since our initial report, The Commission has done extensive work to better understand what needs to be done to improve FSPs and move the needle on hospitalization, homelessness, and incarceration for Californians with severe mental illness. This includes conducting targeted outreach, community forums, and a statewide survey reaching participants from 45 counties (77 percent of counties).

In addition to the efforts above, the Commission:

- Conducted deep dives with Nevada, San Francisco and Orange counties to review current FSP contract practices.
  Conducted case studies in two counties to better understand data collection and reporting practices, and the use of outcome and performance metrics by counties and providers.
- Are conducting performance management technical assistance and capacity building pilots in Sacramento and Nevada counties.

Lastly, the Commission hosted two public panels on FSPs including representatives from the Department of Health Care Services, a county behavioral health director, and leading researchers in the field of behavioral health.

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Figure 2: Learning Efforts, 2023-2024

Targeted Outreach	Community Forums	Statewide Survey	Research
• **87** participants • **40** organizations • **22** counties • **28%** identified as people of color • **24%** shared they had personal or family experience of behavioral health challenges	• **145** participants • **76** organizations • **29** counties • **43%** identified as people of color • **44%** shared they had personal or family experience of behavioral health challenges	• **228** participants • **35** counties • **57%** identified as people of color • **46%** shared they had personal or family experience of behavioral health challenges • Average of **10 years** of experience in FSPs	• **3** deep dives on county contract practices. • **2** case studies on data collection and reporting • **2** pilot projects on performance management • **4** site visits (3 adult and 1 child/TAY)

Notes: Learning efforts were carried out by Commission staff in collaboration with Third Sector Capital Partners and Healthy Brains Global Initiative

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This current report has two priorities. The most essential of these is to present the required information to the Legislature as directed by Senate Bill 465, and as outlined at the beginning of this section. The Commission is prepared to meet this directive in all areas except reporting on client' criminal justice involvement, both before and after FSP participation. Despite existing memoranda of understanding between the Department of Justice (DOJ) and the Commission, the Commission has not received updated criminal justice involvement data since 2016. Despite the lack of current DOJ data, this report will cover trends in the characteristics of clients including race and ethnic composition, diagnoses, service utilization, and housing status. The report will look at these issues, both as they are now and as trends over time. The report will also examine how clients have fared prior to and immediately after joining an FSP. Even with the lack of current criminal justice data the Commission believes this report presents a compelling narrative on the effectiveness, strengths, and areas of opportunity for California's FSPs.

The report's second priority is to examine FSPs as systems of care and illuminate how system-level issues, such as State-mandated data collection and reporting policies and practices, impact quality of care and client outcomes.

The information in this report is presented in the context of the rapidly approaching implementation of Proposition 1's mandates, including changes to eligibility criteria, target populations, and funding structure. At its core, Proposition 1 promises to improve accountability and quality of service by:

- Creating standards and guidelines for service delivery models, including ACT and FACT
- Developing recommendations around levels of care, including step-up and step-down criteria and services
- Improving fiscal and service quality accountability through developing performance metrics and increasing data transparency
- Expanding eligibility criteria to include individuals with SUD
- Requiring mobile, street-based treatment for SUD
- Maintaining the expectation of both clinical and non-clinical services for eligible clients
- Coordinating housing and providing supports for clients to maintain stable housing

The goals of Proposition 1 are ambitious and could have a transformational impact on FSP service delivery and outcomes, but its success will be determined by the intentionality and thoughtfulness of its implementation. In the next few chapters, the report examines some of the challenges faced by FSP service providers and county behavioral health staff and lays out potential solutions to overcome these challenges.

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CHAPTER 2: DATA COLLECTION AND REPORTING

"We have to double enter or triple enter our data." – FSP program lead

Terms Used in this Chapter

The DCR

Currently, State data on FSP program services and outcomes are housed in the Data Collection and Reporting system that is maintained by the Department of Health Care Services (DHCS). The system was developed in 2005, and all counties that have an FSP program submit information to DHCS through the Data Collection and Reporting system.

Three forms are used to collect all the necessary information, which include: the Partnership Assessment Form that gathers baseline information about the partner, such as demographics; the Key Event Tracking that gathers and updates information on events related to health and other milestones, such as graduating high school or obtaining employment; and the Quarterly Assessment form that gathers follow up information to the PAF.

There are four age groups that receive services through FSP: child/youth (ages 0-15), transition age youth (ages 16-25), adult (ages 26-60), and older adult (60+). Each age group has its own unique form that varies slightly from others, resulting in a total of 12 different forms.

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Term	Meaning
3M	Quarterly Assessment
County M	Participating county in a large/metropolitan region of California
County S	Participating county in a small/rural region of California
DCR	Data Collection and Reporting
DHCS	Department of Health Care Services
FSP	Full Service Partnership
KET	Key Event Tracking
OAC	Mental Health Services Oversight and Accountability Commission
PAF	Partnership Assessment Form
Partner	A Client of the Full Service Partnership
Provider A	Adult FSP program in County S
Provider C	Provider of child/ TAY FSP program in County S

How Does Client Data Get to the Commission?

INDIVIDUAL

Individuals get referred to FSPs through various sources. Regardless of where the referral originates, the referral must go through the county where the individual is screened for eligibility.

PROVIDER

Once an individual meets eligibility the provider can complete the Partnership Assessment Form. The client's information is collected by the service provider and entered into a data collection system. Some providers enter data directly into the DCR, and some send the data to the county.

COUNTY

Counties which receive data from providers review the data, look for missing or incorrect data, and then submit the reviewed data to DHCS through the DCR.

STATE

DHCS receives data from the counties and then shares these data with the Commission twice a year. These data include new client intake forms called Partnership Assessment Forms, Key Event Trackers, and quarterly updates.

DHCS

MHSOAC

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What Data Does the State Collect?

PAF The Partner Assessment Form (PAF) collects client data at intake, including housing status, education, employment, financial support and other relevant information.

! KET The Key Event Tracking (KET) captures when a client has a change in their residence, employment, health, justice involvement etc. or exits the program.

3M A 3M is a quarterly report (filled out every three months) that tracks a client's progress over time and updates information provided on the PAF.

The Impacts of Bad Data

The BHSA promises to put into place greater accountability for FSP spending and outcomes, but the current data collection and reporting procedures make this task nearly impossible. Data quality challenges not only threaten the State's ability to make the case for continued investment in FSPs – they undermine the efforts of service providers on the ground and invalidate the experiences of clients and their families.

This chapter details the findings from the Commission's research on the current processes and procedures for data collection and reporting in FSPs and identifies how and where the current system fails to meet the standards necessary to protect California's investment in FSPs.

Getting Data into the System

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Once an individual has been screened and deemed eligible for FSP services, the individual can seek a partnership with an FSP. An individual becomes a client when they complete the intake process, which includes filling out the Partnership Assessment Form (PAF). Many providers have their clinical staff complete the PAF, others have dedicated intake staff complete it. In each setting, the PAF is primarily completed on paper and then information is entered into whatever electronic system(s) providers use. Counties use a range of different electronic health records systems (EHRs). In some cases, there may even be multiple EHRs used in the same county, since contracted providers may use different EHRs than the county does. These EHRs are generally stand alone, and do not handshake well with other EHRs or with the state Data Collection and Reporting (DCR) system. This means that **FSP staff often have to enter duplicate data across two or three systems, a process that is cumbersome, time-consuming, and demoralizing**.

Regardless of how many data systems a county uses, all counties must eventually submit their data through the DCR. In some counties this is done directly by the provider. In other counties providers enter their data into a separate EHR and then the county compiles and submits those data to the DCR. Either way, at some point data must go through the DCR to get to DHCS and any other state agency who seeks to use them.

The usability of the DCR is key to understanding a major sticking point in the data collection and entry process. Many FSP staff and experts recognize the DCR as a potentially strong tool for demonstrating the effectiveness of FSP programs since it can help show reductions in incarcerations, psychiatric hospitalizations, and interactions with law enforcement. Nonetheless, the Commission's research shows that FSP staff and experts universally dislike the DCR system, and find it difficult to enter, access, or use the data. Stakeholders reported that the format and language of the system are challenging, and that there are some glaring

issues in the logic used to create data fields. For example, one staff person noted that employment data was required for children and that users were prompted to indicate whether adults without children had any adopted children.

Many counties still use paper forms or use digital forms that must be sent back and forth over email for completion and approval (e.g., fillable PDFs). These forms must then be individually uploaded or manually entered into the EHR. In counties with digital forms, many staff are still unable to enter data in real time when they are with a client, either because the client's needs do not allow for concurrent documentation or because limited Wi-Fi or cell service – or restrictions about how the EHR can be used – prevent them from accessing the digital forms while meeting with clients in the field. Staff must then do data entry after the fact. All of these formats also add time to the data collection and entry process; time that is typically not billable if it is not done while the staff member is with the client.

Staff turnover also affects service providers' ability to enter data factually. Multiple programs' staff mentioned having **multi-year gaps in data entry while they waited to fill a data-related position**. Another noted that in an effort to address this problem, newly hired staff were sometimes asked to enter data for which they did not have sufficient knowledge or context to do so accurately. The multiple systems and staff turnover can also lead to accidental duplicate entries, further muddying data.

> *"When staff leave or quit and they leave 10 FSP clients and there's not a single KET or 3M [quarterly update] entered, the new person looks at it and they can't fill that out. – FSP service provider*

Data quality is a major barrier to understanding FSP effectiveness. To a large degree, unreliable data quality is a product of the systems challenges combined with the limited staff capacity. The Commission surveyed providers about their staff roles, and of the 79 providers who responded, under half (48 percent) reported having a Data or Evaluation Specialist on staff. Staff who are already stretched thin often struggle to see the value in entering similar data into multiple systems and so enter data belatedly (especially into DCR) and sometimes simply do not enter all data into all systems. Additionally, there can be a disincentive to enter some data, particularly Key Event Tracking forms (KETs). KETs are supposed to track both positive and negative changes in a client's life. But service providers are often focused on preventing or triaging negative events as they happen, and positive events can fall to the wayside. As a result, KETs more often track negative life events, and so the fewer KETs a client has, the better they appear to be doing.

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> *"[The] biggest barrier to data entry is the **disconnect between what is valuable to the State and what is valuable to person in care and what is valuable to the staff.** … If you do it in way that is relevant to people in care, it should be relevant to [the] State as well. If you create system solely focused on needs of State and not the people in care and staff providing [care], it will only result in very low quality of care." – FSP service provider*

Given all these factors and the key role individual providers play in gathering and entering data, data quality varies not just from county to county, but from program to program. A lot of data cleanup is needed for meaningful analysis, and it remains difficult to identify strong practices by comparing across programs, or even to track outcomes longitudinally within a single program.

Getting Data Out of the System

"[It] feels like an act of God to get someone access to DCR"

– County behavioral health data lead

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More than half (53 percent) of the 95 providers we surveyed said they would like additional technical assistance and support around using the DCR and more than 70 percent wanted support in determining and tracking client outcomes.

Service providers and county staff spend countless hours collecting and entering data into the DCR. It would only make sense that the data they put in would be available to take out and use to track client progress and service utilization. But this is not the case. The DCR was created as a mechanism to help the State hold counties accountable; it was not set up to make it easy for counties to access and use the data they input. However, among the county staff the Commission spoke with, **there was a clear sense that counties should be receiving DCR data reports, and a mixture of frustration and resignation that they were not receiving the reports with the desired frequency**, or at all. Although some counties receive quarterly reports with DCR data, the supplied data is individual-level and needs further synthesis (including grouping individuals by FSP program) before most counties find it useful for program planning.

Even when counties use duplicate systems for data collection and analysis, different EHRs require different processes for inputting data and pulling it into reports, meaning that it can be difficult (sometimes impossible) and labor-intensive to create reports across multiple systems. Even systems that use the exact same progress or outcomes metrics. The **difficulty of making "apples to apples" comparisons across programs and counties makes it hard,**

in turn, to identify discrepancies (positive or negative) and understand when a county is doing a particularly good or bad job at serving a particular population. Without that information, it is challenging to identify best practices among peer counties or to use data to make clinical decisions or program changes with any certainty.

Counties and providers are capturing an array of information through a litany of tools, none of which align with the DCR. Even still this information is critical to providers ensuring clients are getting the highest quality of care possible and tracking client experiences and outcomes. Table 1 below outlines some of the most common tools used by survey respondents (n=104) to measure client outcomes. The Child and Adolescent Needs and Strengths assessment was easily the most common at 64 percent.

Table 1: Most Commonly Used Tools for Measuring Outcomes

	%	N	This tool assesses:
CANS	64	67	Strengths and needs in children and youth
PSC-35	48	50	Emotional and physical health
PHQ-9	38	39	Depression in adults
Service utilization data	28	29	Frequency and type of services used
Other	27	28	
Inpatient hospitalization	25	26	Number and days of hospitalization
Gad-7	22	23	Anxiety in adults and youth
Mors	16	17	Recovery in adults
Ansa	14	15	Strengths and needs in adults
	0 Total	294*	

Notes: A total of 104 respondents answered the question above and indicated a total of 294 tools. Respondents could select more than one tool.

Many counties expressed a strong desire for a **data system that could serve the dual function of reporting county data to the state *and* allowing counties to pull data to examine trends within their county and across the state**. However, many noted how challenging it is to switch data systems and expressed hesitancy to institute sweeping changes in how they gathered data or tracked outcomes until they had some confidence that the changes would be valuable. As one participant in a community forum on data and outcomes said, **"Instead of investing resources in improving the DCR and DCR response**

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rates, I think it might be better to invest in figuring out what you actually want to be measuring in FSPs." In fact, given the DCR's limitations, multiple leaders and experts in the field suggested that it would be best to get rid of it. One county behavioral health lead shared: "We certainly utilize the DCR, but if you have any leverage I would do away with that time consuming exercise. … I haven't seen a report from DCR in over five years."

Sharing data across agencies and systems remains a challenge in most counties, and as a result, **FSP programs often do not know about significant events** – such as hospitalization or release from jail – that might be included in outcomes measures or inform future client care. Information of this type is gathered piecemeal, if at all, and is usually labor-intensive. One county reported searching the county criminal justice system's website for information about people who had been arrested. Another assigned a specialist to track in-patient hospital admissions and flag for their team when KETs needed to be added.

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CHAPTER 3: A CASE STUDY OF DATA REPORTING AND MONITORING

County S may be considered small by a population standards, but they are big in their regard for providing the most effective services possible to their partners in the community. County S consists of two providers, one for adult clients and one for child/TAY clients. Staff for both providers were welcoming, smart, highly capable, and committed to developing better solutions to meet the needs of their clients.

County S works hard to cultivate collaborative and supportive relationships with their providers. In turn, providers voiced a deep respect for their county leadership and felt the county worked hard to ensure they had the necessary tools and training to provide the highest quality service possible. In the Commission's time with County S, Commission staff were impressed by their desire to continuously learn and grow.

County M may be a large county by population, but staff in County M approach their work with a level of collaboration and camaraderie one might expect from a small county.

County M has numerous contracted providers, and must balance meeting the needs of the state and the very real challenges faced by their many providers. One of County M's primary responsibilities is providing technical assistance to FSP providers and supporting them in navigating a daunting data collection and reporting process. County M has one of the most knowledgeable and highly experienced staff in the state. They bring to this study an invaluable insight into the opportunities and challenges large counties face regarding data collection and reporting for FSPs.

Current Study

The Commission presents the collective findings from two case studies consisting of qualitative information gathered from service providers, program staff, and county staff working directly with Full Service Partnerships (FSPs) and the Data Collecting and Reporting (DCR) system. The case studies are based on interviews conducted with 16 program staff and eight county staff in two counties. The findings represent common themes that emerged during interviews and illustrate the challenges faced by program and county staff with data collection, reporting, and monitoring.

In order to establish open and honest communication with selected counties, the names of those interviewed, as well as the service providers, and county names are kept confidential and where needed, pseudonyms of individuals, providers, and counties are used.

Selection of Counties

To gather information that would help illustrate the complexities experienced by both providers and counties in collecting data and reporting on programs, Commission staff sought to engage with counties with unique experiences. The selection for county participation in the case studies were based on diversity of geographic location and population size. It was the goal of the Commission to include a county that represented a small/rural region of California and a county that represented a large/metropolitan region of California.

Staff reached out to potential counties and spoke with them about their general experiences with data collection and reporting. Based on their responsiveness and openness to share their practices, two counties were selected to participate. County S is representative of a small county in a rural region of California, and County M is representative of a large county in a metropolitan region of California.

Methodology

During the studies, Commission staff visited service providers and county staff in each selected county. Staff were selected on their ability to speak directly to the data collection, reporting and monitoring processes within their organization, as well as their experiences with the DCR. Each of these topics are quite different, and individuals may have spoken to one or all topics depending on their role and responsibilities. Participants consisted of administrative and managerial staff, those involved in the collection of FSP data, and those who use the data submitted to the DCR for various program, county, or State reporting requirements.

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To guide the conversation, staff utilized a case study protocol consisting of learning goals for the project, as well as questions on experiences with data collection, data reporting, and data monitoring (see interview protocol here).

Learning Goals

1) What are the current processes for collecting, inputting, and extracting client data?
2) What challenges exist in this process?
3) What solutions have counties developed to address these challenges?
4) How is data currently being used by providers to measure client progress?
    a. What data would be helpful to providers to better serve clients?
5) How is data currently being used by counties to measure provider success?
    a. What data would be helpful to counties to better measure provider progress?

The interviews were transcribed, and Commission staff conducted a content analysis, coding key words, phrases, and quotes from the interview. Challenges and experiences were organized according to the data collection, data reporting, and data monitoring process within each county. What emerged were themes that represent the most frequently occurring comments and feedback. These domains and categories are presented in Table 2.

Table 2: Case Study Themes

Domain	Category	Subcategory
Data Collection and Entry	Lack of Clarity	• Not all staff versed in data systems • Lack of guidance on forms
	Inefficiency	• Paper forms, paper trail • Inflexibility of the DCR system
	Redundancy Administrative Burden	• Same information entered into multiple systems • Validation impedes submissions
Data Reporting and Monitoring	Inability to Pull Data	Providers cannot pull their own data for reporting
	Lack of Good Data	• No reciprocation • No collective understanding
Aspirations	Make it Useable	• Make the system user friendly • Involve providers in creation
	IT Solutions to Data System	• Connect to EHRs • Automation

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THEMES

Data Collection and Entry

The journey that individual client data take to get to the DCR begins at the program level. Access to the DCR is strictly controlled, therefore, most clinical and managerial staff are not able to enter data directly into the DCR. Instead, clinical staff or case managers collect data directly from clients and either keep paper records or enter them into a secondary software program. The reliability of the data collected depends on staff having a high level of training and skill. However, as William, Programs Director in County M explained, “there’s staff attrition and turnover, and that’s a problem.” Frequent turnover means more program staff lack the experience or training necessary for proper data collection and entry procedures. Many counties provide training and education to their own staff, who in turn provide technical assistance to providers. Even still, it is difficult to ensure that all provider staff have the same training and skills. This means errors in the data may be introduced before the data ever make it into the DCR.

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How client information gets from clinician to the DCR differs substantially across providers and counties. In County M, providers enter data into a county specific program. These data are reviewed and validated by County M’s data personnel and then submitted in batch to the DCR. It is a process that has its benefits and its challenges, born out of early issues with submitting data directly into the DCR. Overhauling or replacing such large, legacy systems is not an easy process.

Contrast this with the data collection and reporting processes of County S. Although small, County S has multiple providers, with a single provider for adult clients (Provider A) and another for child/TAY (Provider C) clients. Even though these providers are within the same county, they have vastly different data collection and reporting processes. Provider access to the DCR is typically limited to one or a few individuals within an organization. This is the case with Provider C, who has an in-house data team that check and validate data in real-time with staff located in the same office.

With the exception of the Partner Agreement Form (PAF), Provider C’s data collection is primarily done by case managers who gather information on clients during weekly check-ins where clinical staff provide updates to case managers on their clients and any changes or events worth noting. Case managers then fill out paper versions of the quarterly assessment (3M) or Key Event Tracking (KET) and submit these to their in-house data team. Provider C was candid with the Commission that although they try to complete 3Ms and KETs in a timely manner, 3Ms in particular, can fall to the wayside. If there is no issue or event that prompts a KET, it can be difficult to prioritize the time to complete mandatory 3Ms on seemingly

unchanged information. Additionally, because these documents are completed on paper and not in a system that allows for iteration, all 3Ms completed must be done from scratch, regardless of whether any information on a client has changed in the last 90 days. This adds immense administrative burden to an already burdensome process.

"I pull data from our EHR [electronic health record system], another unit pulls data mainly from our [other internal system] only because as it stands currently [our EHR] doesn't have as much data that we would need for the reporting purposes. And so that is why although it is cumbersome, and I do understand that, multiple entries have to occur for our sake." – Phillip, Analyst for Provider C

Lack of Clarity

Entering data into the DCR is a finicky and convoluted process. The nuances of the system take time to learn and become a critical skill for providers. Some staff become so well versed that they hold what Tanya from County S referred to as their entire *"institutional knowledge about the DCR and how it works."* Tanya recounted how a former employee Sabrina held *"all of the knowledge around the DCR."* This posed substantial challenges for County S when Sabrina retired.

With that institutional knowledge gone, the opportunity for cross-training and providing current employees with that knowledge, is also lost. Understanding how and why data is submitted and stored in the DCR also plays a key role into the clarity of how information should be collected.

"It is challenging on the side of collecting the data, obviously, because [it's] confusing for staff to fill out the forms." – Tiffany, County S

Depending on the length that a client remains in services, there are a lot of forms and thus a lot of information that providers must collect over time. Staff expressed frustration in the current state of some forms. For example, providers are required to collect school attendance and grades data for children ages 0-5, and ask clients questions that relate to obsolete programs.

"*I can understand why it is challenging to make changes to the forms and DCR, but without changes, it makes providers collect unnecessary and irrelevant information*." – Tabatha, Manager in County M.

Staff identified the KET as being the most challenging to complete due to the different forms by age group. As Tiffany in County S proposed, *"I think [the KET] is the one that gets the most questions because there are so many [age] variations."* For example, the form doesn't differentiate between *who* a child lives with and *where* a child lives. A child may live with their

parents who are homeless, but because residential status is mutually exclusive for children, that child would either be counted as "living with one or more biological parents" or as "homeless", but not both. This dilutes California's ability to capture the full dimensions of the child's living situation and threatens to artificially reduce counts of homelessness for these children. Because the forms may be unclear, the KET is handed over to other staff more familiar with the DCR validation rules who will look it over, make judgements, and then hand the form over to their data team who enter the data into the system. The multiple exchanges and differing interpretations of the information can change from staff member to staff member, calling into question the validity of the data and how it was originally expressed by the client to staff.

This sentiment was expressed by both providers in County S, particularly when needing to update a record or fill in missing gaps in a client's partnership timeline. Issues with inflexibility arise often when filling out a PAF form, which requires accounting for where a client has lived for the last 365 days. If a client states they lived in a shelter and in their car on and off, the provider must enter the exact number of days spent in each housing category and those categories must add up to 365 days. This process is daunting for all involved, and if a client is having or had issues with clarity of thought, the process can be impossible. Further, there are no reference materials or standardized definitions to help guide providers and counties when collecting these data. Even still, the provider must enter data that equates to 365 days. Requiring data that may not be accurate simply to comply with mandates undermines the validity of the data submitted through the DCR, the same data the State uses to assess the impact and functionality of FSPs.

"There is no database that we can access to [say], okay, where were you? We have to piece it together. And that is probably one of the more frustrating parts that we have to say, okay, we know today, because we're sitting with you, but even yesterday may not be clear."

– Thalia, Analyst in County S

Data is gathered for each partner and updated as their placement changes or when a milestone or key event occurs. The chronological way in which the DCR system was developed does not always align with the placement of a partner and their movements within the system. For instance, Mark in County M shared that *"one of the major hiccups for our providers is when another [provider] doesn't enter their data in a timely manner. So, that is a roadblock for [the other provider] to enter their data."*

This can happen when, for example, Provider A fails to submit a completed PAF because they were waiting on the status of a client, and Provider B is unable to submit any additional forms

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until the previous form has been submitted. This can cause issues if a long period of time has lapsed since the client was seen by Partner A or if Partner A lost documentation for that client.

> *"I think the issue with FSP is just the data builds on each other as the client transfers from provider to provider."*
>
> *– Tabatha, Manager in County M*

County M experienced challenges with the DCR system from its inception due to the amount of data that was being submitted into the system. Staff shared that when the DCR was launched, large counties, including County M, were unable to submit data directly through the DCR. County M was forced to create their own system to maintain the data until the state's DCR could accept such a large transfer of data, Tabatha recounts:

> *"The State wants the data in order, right? […] sometimes, things don't happen like [that]. And we struggle with this too, right? Do we build for the exceptions, or do we build for how things are supposed to go?"*

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The process of validating these data before they are submitted to the DCR is extensive. County M's staff must examine the data submitted by providers for completeness and accuracy. Because County M's staff are not *"on the ground"* with individual providers, it can be a difficult and labor-intensive process to validate these data, including reaching out to providers, requesting they submit missing data, or fixing identified errors and resubmitting the data. In a large county with numerous providers serving many clients, this process takes an extensive amount of time. Thus, there can be a lag between when providers originally submit their data and when County M is able to successfully submit the data through the DCR.

As a result, data such as client counts for previous years may change over time. This is not ideal. Changing counts can cause the public to question the accuracy of the data shared by the Commission through its online Transparency Suite. County M is not the only county who experiences this kind of lag due to the extended data validation process. However, this is an issue more common to large counties. The process for data collection and reporting for small counties is such that data lag is not as pressing of an issue. That does not mean that small counties do not face other challenges.

Inefficiency and Redundancy

It can be a long and complex journey for client data between the clinician who records the data to the moment it reaches the DCR. Both County M and County S use multiple systems for data tracking. This is partly because the DCR was never intended to be a performance management software, a quality improvement software, or even an outcome tracking software. The DCR is a one-way transmission of information. Providers who seek to track their

client's progress have little choice but to employ a second or even a third data collection program.

County M records and tracks their data universally with all the providers inputting their data directly into a county specific program, which, eventually – for the most part – handshakes with the DCR. County S has multiple methods for submitting data, with Provider C submitting data directly to the DCR, and Provider A submitting data to a provider specific program and *then* entering the information again into the DCR. Provider A, much like County M, reaps many benefits through their internal data collection, tracking and monitoring software, such as being able to catch errors through the reports their systems create, which allows them to work with providers to fill in missing information *before* submitting to the DCR. But this does not erase the administrative burden of having to enter duplicate data into the DCR or guarantee that their submissions will be accepted by the DCR system.

Administrative Burden

As previously mentioned, there is often little to no training on how data is entered and stored into the DCR, what validation rules are necessary to successfully submit data, and more importantly, where the data goes and how it is used. Once the information is submitted, the submitter is either notified that the submission was successful, or if unsuccessful, the DCR will generate a validation report. This might sound helpful and valuable, but validation reports from the DCR system do not provide clarification into what caused the error. Users simply get a flag that the file is not able to be successfully submitted due to an error. Users can locate additional information on individual errors, but the process is not intuitive and must be done for every flag.

"If they have some really clear, simple directions for it, it would probably be easier, but it is a lot of clicking around and figuring out what you are doing."

– Tiffany, County S.

Instead, staff find themselves spending a considerable amount of time self-learning and identifying errors and then navigating multiple systems to correct the errors. Often, providers have to re-enter the information and/or start the entire form all over again due to the inflexibility of the system posed by its validation rules.

"I have never seen [a training manual]. And honestly, the information and the processes that I've learned is by trial and error. It is just going into the system and oh, that didn't work. Getting these validation errors. It is just trial and error, there is no real training regimen. It is here is the DCR, we need this information, it is in your contract, do it."

- Bethenny, County S.

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Commission researchers did locate a 2020 version of the DCR training manual, but multiple service providers we spoke to were unaware of its existence. In addition to the training manual, DHCS also offered a webinar in 2021 on the latest version of the manual. Despite these efforts there remains a gap in knowledge regarding the DCR.

Similarly in County M, despite having had the resources to build their own internal system that could incorporate data validation and formatting that aligns with DCR requirements, there are still errors that stall the submission process. Jose laments, *"the State system needs to be rebuilt or something. But they put, I don't know why they put so many checks on our data."*

Data Reporting and Monitoring

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As data ongoingly gets collected and entered, FSP data gets used for reporting and monitoring purposes. The Mental Health Services Act requires that counties submit a 3-year plan for all programs, as well as annual updates. Both require counties to report aggregated data on program demographics and outcomes. Determining what to include in these reports is, often, at the mercy of the data that counties have in their possession and/or what they can obtain from their own systems or in collaboration with individual providers.

Having already entered these data into the DCR, the reporting process would seem simple and intrinsic. However, this is simply not the case due to a few reasons: not all essential staff have access to the DCR, not all of the required report information is located in the DCR, and it is either impossible or staff have not received the proper training on how to extract data from the DCR. These reasons create substantial administrative burden upon an already limited staff.

As mentioned, extracting the data and writing the reports require a great deal of staff resources. Sonia, the director for Provider A in County S, wrote, *"We can answer these questions if we want to, and the tools that we have to do it just don't meet the need, and it's painful. It takes a lot of brains to sit down and go, this is the question, how are we going to answer it? And who is going to analyze it? Who is going to clean it? Where are we going to pull it? Can we piece this together? It takes a lot of effort."*

Similar sentiments were shared by Tabatha in County M whose team she prides in being able to collaborate and problem-solve. *"[Our department] here is just so understaffed. It's just really hard. I think just the fact that we get our submission out is a miracle."*

Before reports can even be written, providers find themselves first contemplating where exactly they are going to get the necessary data to highlight the phenomenal work that is being done, especially when those data are not readily accessible.

Inability to Pull Data

"[The] DCR is kind of like a black hole. You put stuff in, but I don't ever get anything out."

– Victoria, County S

If there was one overarching theme common among both providers and counties, it would be the inability to access the data they spent numerous hours collecting, cleaning, validating, and correcting. Due to systematic requirements, access to the DCR is extremely limited. County officials designate who can access the system, but increasing access to the DCR wouldn't change these frustrations. Pulling data – raw data, to be exact – is not possible for providers. This lack of reciprocity raises frustrations, as service providers do not have access to their own data.

The DCR is not the only data system failing to meet the needs of providers. Provider A, who pays to have their own systems in addition to the DCR, still experiences roadblocks to getting the data they need. Provider A was promised a system that would not only be user friendly for clinicians and providers but would also make accessing the data they needed possible.

"But a lot of things we had in the past from other systems, they are not built or ready yet. And that' s the reporting aspects of data in, we can't get it out. So, that's probably my biggest frustration with all the systems. Data is in. We know we are putting the data in the system. There is not an easy way to pull the data out."

– Thalia, Provider A, County S

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Lack of Good Data

The FSP data that is submitted to the DCR is the same data used to tell a statewide story of the impact of FSPs. Unfortunately, there are numerous ways the system works against collecting quality data. FSP forms (PAF, KET, and 3M) are not the most user friendly and, at times, unclear. For example, the KET, which collect life events both positive and negative is vitally important in determining changes in levels of care and tracking when a crisis occurs in an individual's life. However, providers who are inundated with entering data into multiple systems or keeping paper forms for client records, can be discouraged from completing KETs as often as they should.

Provider C in County S shared that, unfortunately, they do not track the positive events of a client's life, such as obtaining a job or graduating. This is because key events cannot be accessed through the DCR and Provider C must keep paper forms of their KETs, creating stacks of key events and counting by hand to provide the county with unduplicated numbers of the negative outcomes. Keeping paper forms for positive outcomes would double the

stacks of papers they must manually count. Thus, many of the positive life changes Provider C's clients may be experiencing go undocumented. Collectively, what is left is what both providers and counties agree on: a lack of good data. Incomplete data can mask positive outcomes, presenting a distorted picture that shows the opposite of what is happening.

Point-in-time counts are another way data can distort what's happening on the ground. These counts do not always capture the full picture of a client's journey in a program. Instead, Provider A of County S must rely on describing the nuances of their client's experiences in narrative form and hope their data team can translate these nuances into outcomes that are tracked. Thalia recounts, *"we look at the data and like, okay, you're not accounting for this many people that we know came in unhoused and we housed in the course of a few days. Sometimes they come in and we house them immediately and that doesn't get captured. So, it just looks like poor performance."*

The only "good data" is data that is being used. But because providers are not able to directly access and use the data from the DCR, it seemingly becomes a useless system that collects information for compliance purposes only.

"We pretty much collect the DCR data, because it is in our contract, and we have to. We don't do much of anything with it, to be honest. … Capturing it in this external system that doesn't have much to do with our client record or really influence the course of our services or anything like that, it really, it feels like paperwork to staff more than anything." – Phyllis, Provider C Manager

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Aspirations

Despite the challenges that the DCR system presents, staff members understand the goal around its creation and have an overall positive attitude toward the potential that the system – or *a* system – can have in improving the services they provide. From direct service providers to county administrators, everyone shared aspirations for a data system that could make data collection and reporting efficient and useful. They want a system that not only tracks client outcomes and illustrates the impact of FSPs but shares information between counties to encourage collaboration and innovation. These aspirations can be highlighted in two different themes: making the system useable and finding IT solutions to make it more dynamic.

Make it Useable

Providers from County S expressed that one of the most vital ways to make the DCR system useable is by having clinicians and those using the system on a day-to-day basis included in the development of the data system. *"I think really having the providers at the table when this is being built out and speaking to what a day looks like and where things fit within the system of their day would make a huge difference – it doesn't make sense [to have] PAFs in one area and a*

million miles away from a KET or something. It has to be all in one place where it makes logical sense to go and access things."

Making a system useable also means what is being inputted into the system needs to be user-friendly and intrinsic in daily work. Making forms – PAF, KET, 3M – less burdensome and as universal as possible across all clients would be a good start. Currently, for example, a PAF can be between 10 to 12 pages long, and some providers have noted that not all the information included is utilized. More importantly, this it is a lot of information to gather from families and clients during their first meeting.

Finally, the system should be accessible to all staff and track not only the outcomes mandated by the State but also additional outcomes meaningful to individual providers. A key component to access is having access to the raw data needed to conduct different types of analyses. For example, Carrie mentioned that County S would *"want to be able to slice and dice the data however we want. So, if it's by tenure, if it's by age group, if it's by some sort of other demographic … raw data is essential at that point."*

IT Solutions to Data Systems

To make a system useable, providers, and counties understand that it will require IT solutions, such as ensuring that local data systems are compatible with the state system. Rey from County S suggests, *"if we do build a new system, it would be nice [if] it can talk to EHRs. It is my understanding that DCR has no capability right now to talk to any of the systems."*

Within this system, providers aspire for a tracking function that would notify them when forms are missing for a client. This would help lessen the backlog that is created when new providers are unable to enter information due to outstanding forms.

Probably the most agreed upon solution to many of the challenges experienced in working with FSP data and the DCR would be automation. Providers, particularly, aspire for a system in which data entered by a clinician would make its way into the DCR, and in turn, reduce the need to double and triple enter information. *"[Automation] would be incredibly helpful because that is one less thing that we would have to [do]." – Sonia, Provider A Director*

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CHAPTER 4: BEYOND THE DATA

"The thing with the travel time, since this is an intensive outpatient program, is that we need to have people out in their cars. And we aren't able to bill for that. There's just not as much money." – FSP provider

A Multi-layered Analysis

OUR PROCESS: Chapters 1 through 4 used client data from various sources to describe who receives Full Service Partnership (FSP) services, and the service usage of those individuals prior to and after joining an FSP. Chapters 5 and 6 highlighted the challenges of the current data collection and reporting system for service providers through a combination of quantitative analysis of administrative data, case study analysis, and key informant interviews. This chapter brings together findings from a multi-county deep-dive into FSP service delivery and contracting, a statewide survey of service providers and county behavioral health directors, and key informant interviews with a wide variety of stakeholders. To learn mor about who participated in each of these phases of analysis, please see Appendix X.

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FSP Service Delivery and Models

FSPs can be very effective at supporting individuals with serious mental illness, and reducing the negative outcomes often associated with such challenges. How FSPs achieve these outcomes varies by provider. FSPs differ not only in their client population, but in the suite of services offered to those clients.

For example, one young man enrolled in a child/Transitional Age Youth FSP the Commission visited voiced how important the social aspect of his FSP was for him, as he was otherwise isolated and confined at home due to his extensive health challenges. For him, the only time he was able to leave the house was with his FSP caseworker. Like any other aspect of FSP service delivery, there is variability in how FSPs engage clients socially. Not all FSPs have community building activities, but some host support groups, recreational activities, field trips or social outings for clients.

Balancing Flexibility and Structure

Providers, clients, and other experts consistently cited the importance of FSP's flexible "whatever it takes" approach in driving positive outcomes for clients and communities. Providers, clients, county staff, and others particularly valued that FSP programs can provide a wide range of resources, including support for basic needs, (e.g., sleeping bags, tents, subsidized housing), socialization support, medication assistance, and variety of behavioral health interventions. The "whatever-it-takes" nature of the FSP model enables providers to meet people where they are: physically, circumstantially, and clinically. Outreach in the community, "house calls," or other in-the-field services reduce barriers to care and make it more likely clients will attend their clinical appointments. Particularly in rural counties, resources to support in-the-field care are a crucial element of program success.

Even as they highlighted the importance of flexibility in shaping their approach to FSP, interviewees across the FSP ecosystem expressed a need for a common definition of FSP that would enable providers to offer consistent and evidence-based care in support of improved outcomes, share best practices across the state, and provide consistent quality assurance and training to provider staff. Since FSPs are locally operated and controlled, they differ significantly in structure across counties, which makes it difficult to ensure high-quality care statewide and to compare outcomes or practices. Some FSP programs adhere closely to a single evidence-based treatment framework (e.g., Assertive Community Treatment [ACT]), while others take a more eclectic approach to care delivery.

Many of those with whom the Commission spoke felt that FSP programs would benefit from more structure in both process and approach to service provision. Some policy and data experts recommended that the State should select specific service models to underpin the functions of FSPs and take steps – including offering additional guidance, support, and funding – to encourage fidelity to whatever model is chosen. Providers and experts also called for better-defined eligibility criteria for FSPs. Clarified criteria would ensure the correct individuals are being served through FSPs and create a shared understanding of the role of FSPs in the broader behavioral health ecosystem.

Interviewees emphasized that any State guidance around FSPs must balance standardization with retaining the flexibility and adaptability that enables FSP programs to serve a range of individuals with significant and varying needs.

Assertive Community Treatment

Many individuals we spoke with suggested ACT as a common treatment model. Interviewees recommended ACT for its diversity of included services, team approach, and ability to adapt to client needs. Even though ACT was popular among service providers, there are some

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aspects of ACT that require consideration. ACT tends to have higher costs, mostly due to the caseload ratio of 1:10 required by the model. ACT also requires multidisciplinary teams, meaning any staff vacancies can affect the fidelity of the model.

While ACT may be well suited to many clients, it may not be appropriate for all clients. Some clients may not require the intensity of ACT and could be effectively served by lower-cost models, and other clients may not want to work with a large group or receive the full suite of services that ACT provides.

Collaboration

Providers consistently noted that collaborating with clients on their care and adapting service plans to address individualized wellness goals were essential to a high-quality FSP. A behavioral health director shared the importance of this approach in fostering engagement and person-centered progress: *"What is the goal of the person in care? It doesn't have to be the goal of the State. What do they want out of [FSP] and are we meeting their goals? If you don't start with that, I don't know how you are going to get anyone to engage. One of the person's goals was to have teeth so they could smile. That was their whole goal from the FSP. Then they could go for a job and show up and be present. If you don't focus on that, celebrate it, and work on it, you'll never get to the downstream goals [like housing stability]."*

Staffing and Resources

Vacancies and Recruitment

Both the Commission's statewide survey and conversations with providers and county staff confirmed that FSP programs are operating with high numbers of staff vacancies, and staff and programs are being further strained by broader shifts in community needs, including more individuals seeking behavioral health services, and higher levels of complexity and acuity among those seeking services. It was reported that the vacancy rates are highest on the most intensive services, with up to 50 percent of positions unfilled on stabilization services (i.e. short-term assistance for people leaving the hospital). Some providers reported extended times for vacancies, reaching up to 250 days.

Some interviewees and survey respondents pointed to the extra challenges of rurality, and others to the very high costs of city living. However, the biggest variance appears to be between providers, reflecting different organizational cultures and employment practices. The service providers with the lowest turnover use several different strategies. They try and over-recruit throughout the year. They may use an external recruitment company or increase their use of accredited peers or paid interns (many of whom progress to permanent positions).

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Contributing Factors

One major factor contributing to staff vacancies is pay and benefits, which are typically low when compared to the cost of living. Private practice, other social work employers, and even other county FSP programs are outcompeting some FSP programs for staff by offering better salaries. In addition, FSP programs typically do not provide workplace perks that align with those offered elsewhere in the workforce, particularly the option to work from home. There has been a general labor market shift towards wanting the option to work remotely, but telehealth is not suitable to the needs of many FSP clients and many FSP programs have not implemented strategies for offering remote work.

FSP work can be particularly grueling compared to other behavioral health care roles, as it requires engaging directly with individuals experiencing significant challenges and experiencing symptoms that may be difficult for both provider and client to manage. Peers and other FSP staff spoke to the need to process the challenging emotions that came up as part of their jobs.

FSP work can lead to significant burnout and secondary trauma among providers. In addition, ongoing staff vacancies contribute to pervasive staff burnout by straining the remaining staff members. Providers also mentioned the inability to bill for non-direct services, overwhelming amounts of paperwork, the high rate of homelessness in California (and its attendant challenges for FSP care), and frustrations caused by recent policy changes as contributing to burnout.

When FSPs are able to fill vacant positions, it is often with staff who are newer to the field. Many only stay long enough to gain the experience necessary to be secure positions that offer a better salary, better hours, or are less emotionally demanding. High turnover compromises continuity of care and reduces institutional knowledge. We spoke with one client who very clearly stated that low staff turnover was the single greatest indicator of a successful FSP.

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Resources

Many interviewees identified the need for better and more frequent staff training to help keep teams aligned during this period of high turnover. Topics that were commonly requested include billing, data collection and reporting, acquiring and securing housing, and best practices for treatment of individuals with substance use disorders. These are also areas where Proposition 1 has an increased focus.

To bolster the workforce overall, several interviewees mentioned their desire to see stronger connections with local universities resulting in more intentional training and internship programs. Training programs could include courses on frequently requested areas like data

collection and reporting, and internships could help students understand the value of FSP programs while also preparing them for careers as service providers. In addition to traditional university programs, interviewees suggested investing more heavily in peer certification programs, allowing providers and counties to recruit peers to the FSP workforce, where those peers' lived experiences can help build connections between clients and clinical staff.

The use of peers appears to be growing, and models such as Club House appear to deliver strong outcomes. This may be because peers are more likely to match their client demographic, and as such, may have better engagement.

Funding

Given the substantial financial investment California has made in FSPs, it might seem counter intuitive that FSPs would struggle with securing sustainable funding, but a consistent sentiment from providers was the need for clarity and technical assistance on who to bill for services and how to bill for services. Most FSP providers we spoke with were successfully braiding funds to support service provision. For example, of the 121 survey respondents who answered questions related to braiding funding, the vast majority (88 percent) stated they were leveraging Medi-Cal reimbursement as part of their funding strategy. However, 11 percent of respondents were not braiding additional funding and were only using Community Services and Support funds to support FSP service.

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Providers were also vocal about the need for support navigating the numerous recent changes to funding brought about through CalAIM payment reform and Proposition 1. Almost unanimously, FSP providers expressed significant anxiety about how these changes were affecting FSP programs' abilities to provide quality care. While DHCS has provided clarification to counties around CalAIM payment reform (letter can be read here), FSP providers indicate that more support and guidance is needed to understand its complexity and nuance.

Counties also shared that FSP funding shortages are limiting the type of services they can offer. One county reported that a general lack of funding was preventing them from establishing program models like Intensive Outpatient Care. They also noted that a lack of funding is preventing other programs in the region from reaching the 1-to-10 staff-to-client ratio considered ideal under the ACT model. Other interviewees predicted that payment reform would incentivize a shift to clinic-based services, as opposed to the field-based engagement model that is part of ACT and that most FSP providers consider best practice, which could have a disproportionately negative impact on rural services and outreach.

There was general uncertainty among program staff about how to approach billing after recent reforms. Some interviewees speculated that there might be "less obvious" ways to bill

for activities like transportation and documentation, but did not feel programs were prepared to do so. Additionally, interviewees expressed uncertainty about what activities were, and were not, included within the new Proposition 1 statutes. This is especially essential information for smaller and rural counties, which experts and FSP staff agree are likely to be most heavily impacted by the Proposition 1 guidance. In the past, smaller, rural counties have typically spent less of their BHSA funding on housing than larger, urban counties, and so smaller counties will need to shift a larger proportion of their funding from FSPs to housing. FSP providers – both contracted and county-run – indicated a clear and immediate need for additional guidance and technical assistance around how to use new fundings structures to ensure FSP services remain "whatever it takes".

Relatedly, interviewees reported that it was extremely challenging to identify which funds should be used for which FSP clients, since many funding streams have highly specific eligibility criteria. The complexity of the eligibility requirements and vast recent changes to the billing systems are creating significant administrative burdens that FSP providers feel are preventing them from maximizing the use of their staff time and funding to provide care to clients.

This section has outlined the confusion on the part of service providers and counties around how best to structure payment to maximize service quality in the wake of payment reform and in anticipation of BHSA statutes. DHCS is preparing to release initial guidance on BHSA statutes for public comment by the end of 2024. Feedback and public comment will be incorporated into the guidelines and released to counties in early 2025, well in advance of when changes under the BHSA are set to go into effect.

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Performance Management and Outcome-Based Contracting

To better understand how contracting practices influence client outcomes, the Commission conducted a series of "deep dives" on county contract practices with service providers. The "deep dives" discovered that current contracting practices do not prioritize client outcomes and do not provide a substantial enough incentive to encourage providers to meet client goals. What we found instead, was a strong focus on billable services and the rate of reimbursement for those services.

Much of what is deemed important to measure for performance is influenced – if not directly determined – by the structure of service delivery contracts. Currently, contracts for service providers are highly complex documents including up to 13 pages of "look up tables" describing the billable activities and their codes. These billable codes set a tone for what is valued by the county and the state. If providers cannot be reimbursed for certain activities it is difficult for providers to prioritize those activities or offer them at all.

Payment to service providers is currently a “pay for service” type model, not a pay for performance model. However, some counties have piloted the use of incentive payments to providers for process-or compliance-oriented outcomes, such as time taken from referral to program start, level of interaction with service users and maintenance of the required documentation. These supplementary payments can amount to 2 percent to 10 percent over and above the contract value. In one county, a provider can earn an additional $1,500 for each person they step down from the program; however, it is difficult to meet all the necessary criteria, and most incentives go unpaid.

When performance metrics were included, they often focused on activities and not outcomes.

For instance, the principal performance measures used by most counties and providers on a day-to-day basis were:

- Total number of clients
- The total number of staff and their caseload
- Amount of staff time, and dollars, billable to Medi-Cal.

Many counties measure additional activities and outputs, such as the time to process referrals, and timely completion of mandated documentation, but these measures vary vastly across counties.

Provider performance is also shaped by the extent to which provider leadership engages in performance management. When done well, performance management is about setting clear goals and objectives and working with staff to identify their strengths and available resources to meet these goals. It gives staff clarity about how and where to focus their energy, and recognizes the fruits of their efforts, thus increasing motivation.

Despite its potential positive impact on performance and morale, the use of performance management varies between counties in frequency, detail, and result. In some cases, an annual report is produced by an external unit, one entirely separate from the county’s FSP contract management team. In one county the Commission visited, this report was based on a combination of aggregate data from their data collection system and data self-reported by providers. However, the reports were not used to set goals or track provider performance in an ongoing manner.

In another county, staff conducted monthly performance reviews with all providers. This is a large county with the resources to manage such an undertaking. Each month, staff reviewed data, looking at client outcomes for incarceration and hospitalization, and tried to understand any changes or trends. They also administered regular client satisfaction surveys. While no direct causal affect should be implied, it should be noted that this county does appear to have higher performing FSPs and falling rates of homelessness.

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The level of engagement and active performance management mentioned for the large county above appears to be the exception rather than standard practice. This may be partially due to budget and staff constraints. For example, a small county the Commission visited had to rely on a trust-based relationship as they were stretched too thin for systematic performance management.

Funding is just one reason counties may shy away from consistent, in-depth performance management. Other reasons include:

- A lack of positive outcomes to measure. Exclusively measuring performance against negative outcomes such as hospital admissions can be demoralizing for staff.
- Concern that staff may perceive performance management as a negative experience and thus increase staff turnover.
- A lack of confidence or experience in engaging in performance management,
- A work culture that is resistant to performance management.

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CHAPTER 5: RECOMMENDATIONS

"I just wonder what the ultimate goal of FSP is? We should have measures that capture the goal of getting people better." - MHSA Coordinator

Proposition 1 creates pathways for Full Service Partnerships (FSPs) to meet the rising needs of Californians with serious behavioral health challenges. If implemented effectively and with fidelity, FSPs can be a keystone in reducing homelessness, incarcerations, and repeat hospitalizations in California. The recommendations and next steps outlined in this chapter are informed by the Commission's extensive engagement with service providers, county behavioral health staff, content experts, clients, families, and peers. These findings stem from a robust, mixed methods approach including: key informant interviews, case studies, site visits, focus groups, and a statewide survey. The Commission is confident that these recommendations consider a wide range of perspectives and experiences, and include diverse voices across age, gender, race and ethnicity, region, and lived experience. For more information on the Commission's engagement efforts please visit the Commission's website.

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Statewide Data Infrastructure

A substantial portion of this report is dedicated to the challenges that current data collection and reporting processes pose for FSP providers and counties. Providers are swimming in the administrative burden that results from redundant data entry with no practical purpose or benefit to clients. Providers are left to either keep secondary paper copies of forms and hand calculate client outcomes or pay for supplementary software to track their client's progress.

Proposition 1 makes clear that accountability and transparency are foundational to behavioral health transformation. It is the Commission's goal to highlight the implications of the current data system and elevate solutions for the Department of Health Care Services to consider as they shape the future of data collection and reporting for FSPs.

Recommendation

The Commission's findings suggest the existing DCR system is not sufficient for capturing accurate, high-quality data necessary for statewide accountability and transparency of FSPs. The Commission recommends that the existing DCR system be replaced with a more flexible, adaptive, provider-centered system or be overhauled to have the following features at its core:

- Functionality
  - Allows providers to edit previous submissions to correct errors in client information.
  - Provides flags for information that does not meet submission standards before data is submitted, instead of having files rejected after submission.
  - At a minimum, programs need to allow raw data to be extractable, and preferably, software needs to have performance and outcome analytics built in, as well as the ability to generate customizable reports at the provider level.
- Brevity
  - A small set of key client outcomes should be identified, and forms should be streamlined to focus on these key items. Forms should only collect what is essential for tracking client progress and eligibility and remove all unessential content.
  - Forms should be customized by client age group and have separate, clearly labeled sections of forms for questions that pertain to children versus parents/guardians. This would reduce confusion and increase the accuracy of client data.
- Customizable
  - Allow providers to add additional customized outcomes for each client. This would maintain the standardization necessary for tracking across the state while supporting the unique needs and goals of each client.
- Interoperability
  - Counties have core electronic health record (EHR) systems, including the semi-statewide EHR that CalMHSA facilitated for 25 counties. Counties often use supplementary data warehouse and visualization tools and participate in their county health information exchanges. Any statewide system should consider interoperability with existing data and reporting systems, allowing batch uploads or real-time linking of data to streamline the submission process.

While the Commission is aware that this suggestion is not one that can be implemented easily, or quickly, it also recognizes it is essential to reducing administrative burden on service providers and counties alike and improving the quality of data necessary for accurate accountability and transparency under Proposition 1.

Performance Management

Performance management focuses efforts on getting clients to their goals in a timely and efficient manner. It prioritizes client outcomes over all else and creates an avenue of accountability for providers. Performance management is key to ensuring inputs produce

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results, but performance management does more than improve client outcomes. When executed with care and fidelity performance management can reduce provider stress by concentrating energies where they will have the greatest impact on target goals. It can offer clarity and direction in an industry where providers often feel overwhelmed with a seemingly endless cycle of work. Performance management should be viewed as a tool with equal benefit to clients, supervisors and staff.

Recommendation

This report's findings suggest most counties are not currently engaged in substantive performance management practices. Lack of funding and resources is partially responsible but equally so is the hesitation of many providers to engage in performance management. The Commission recommends California launch a statewide learning community where county behavioral health staff and providers can gain greater knowledge of the potential benefits of performance management for their teams and better understand the resources necessary to undertake performance management with fidelity. Furthermore, the Commission suggests an evaluation of the plausible impact and resources needed to create scalable performance management statewide.

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The Commission suggests any performance management efforts incorporate the following:

- Accurate Data Collection and Analysis
    - Providers need substantial technical assistance and capacity building around data collection and analysis, including how to keep accurate and thorough records on all services clients receive, key events in clients' lives (both positive and negative), client outcomes, and engagement activities. Such records are necessary to set helpful goals for clients and providers.
- Consistent and Thorough Review
    - Providers must have access to user friendly data collection tools, and supervisors must frequently review trends and progress towards goals. Frequent (e.g. monthly or quarterly) performance reviews should be completed by a performance advisory group, and include representation from the county, clients, family members and peers. The advisory group should review and set goals at all levels (individual staff member, team, provider level). The goal of these reviews is to identify successes, while also continuously adjusting goals to drive improvement. Aggregate (program or provider level) results should be shared with the public.

- Engaged Leadership
    - Service providers can only be successful if they have the right resources, and the right support. Proper training and capacity building opportunities must be provided and encouraged by the State and counties. An annual statewide survey of supervisors and service providers should be administered to identify where additional resources are needed and who should be targeted for such resources.

Outcomes Contracts

The current contracting practices between counties and providers does not place a strong enough focus on outcomes. The Commission recommends counties include performance metrics into their future contracts with service providers, thus incentivizing improved client outcomes. Outcome based contracting should be thoroughly vetted and an evaluation should be conducted to identify:

1. Impacts on providers, both immediate and long term
2. Disproportionate impacts on certain demographic groups and regions
3. Impacts on both state-specified and client-specified outcomes
4. Impacts on retention, step down, and service utilization
5. Sustainability and scalability of such models statewide

When designing outcome-based contracting models, the following should be addressed:

- What defines success
    - Contracts should clearly define what success is and how it will be measured. County behavioral health leadership, service providers, clients, family members and peers should all participate in the development of these measures.
- Specifics of compensation
    - Compensation metrics should be verifiable, easy to understand, limited in number, assessed at the individual service user level, and should focus on outcomes as much as appropriate. Selected metrics should support a culture of high-quality service that drives frontline behavior and can serve as the basis for performance management with staff.
    - Compensation should incentivize performance and drive efficiencies. The goal of this work is to obtain the best outcomes possible for the money available.
- Roles and involvement
    - Contracts should designate advisory roles for clients, peers, and families throughout the program design and performance review process. Clients

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should be central to deciding the performance metrics from which providers are measured and compensated.

- Specify target population
  - Contracts should clearly state how the target population for each contract will be determined and ensure enough flexibility, so these parameters can be reviewed regularly to ensure they meet the needs of the county.
- Ensuring accountability
  - Providers need to have in place a robust, systematic process to verify the deliverables/outcomes that are claimed including the quality of the service received by each client. Counties should undertake periodical auditing to ensure accuracy and quality.

Funding

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Contracted providers shared their confusion around how to maximize FSP dollars, including what services were billable and to whom. The Commission was surprised to learn that about one in 10 providers were funding FSP services strictly through CSS funds and not billing to Medi-Cal. Even providers who were successfully braiding funding were overwhelmed with changes to billing through CalAIM and the potential funding changes through Proposition 1.

Recommendation

The Commission suggests strong technical assistance and training for counties and service providers on:

- Braiding funding and sustainability
- Clarity around Medi-Cal billable services
- Impacts of CalAIM: Developing new county-to-provider payment models that support FSP service delivery and account for technical changes that occurred as part of CalAIM payment reform.
- Impacts of Proposition 1

FSP Service Delivery Models

Perhaps the most prominent characteristic of FSPs, and potentially their key to success, is their flexible nature, allowing providers to customize a “whatever it takes” approach to meet client needs. But flexibility without parameters can leave providers and clients uncertain about whether they are meeting goals in a timely manner. Our extensive conversations and information gathering suggests most service providers would benefit from increased structure in both process and approach to service provision. Guidance on what service delivery models are best suited to particular populations, and best practices within these models, could go far

in providing the kinds of supports service providers have requested. Under the new BHSA, each county will be required to implement the following models through their FSPs: Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT), Individual Placement and Support model of Supported Employment, and High Fidelity Wraparound. As currently written, counties with under 200,000 residents may be granted an exemption from this requirement by DHCS.

Although not specific to FSPs, DHCS is establishing Centers of Excellence (COEs) as part of their expansion of evidence-based practices under Medi-Cal through BH-CONNECT. This is reflective of DHCS' efforts to support training, guidance, and fidelity monitoring for service delivery through BH-CONNECT.

The Commission will supplement these efforts by providing a toolkit specifically for FSP service providers, with concrete and actionable tools they can use to improve service delivery. Additional information on these efforts will be discussed later in this chapter.

Recommendation

The Commission recommends California develop and disseminate clear service model guidelines for FSP programs statewide, including:

- A clear definition of what an FSP is, and what the shared goals of FSPs are.
- Clear and specific eligibility requirements for FSP clients to reduce wait times and ensure individuals are connected to the correct resources from day one.
- Recommended evidence-based practices for treatment models specified in BHSA
- Guidance on selecting an appropriate treatment model.

Staffing and Resources

The ongoing workforce crisis significantly affects all aspects of FSP programs. FSP providers repeatedly called for solutions to address persistent staff shortages and guidance on how to better leverage current staff resources. Training and capacity building alone will not be sufficient to alleviate the current strain on FSP providers or alleviate the resulting turnover.

Recommendation

The Commission suggests the State invest significant resources in identifying scalable solutions that can:

- Widen the Pipeline

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    - Create a stronger behavioral health workforce pipeline by building relationships with local universities and developing internship programs specifically tailored to prepare future clinicians to succeed in FSP settings.
- Increase Incentives /Benefits
    - Provide financial resources for counties to raise wages in areas most struggling to fill positions or offer workforce incentives like subsidized housing, loan repayments or paid internships.
- Reduce Provider Stress
    - Support counties in developing trainings on specific high-stress and high-priority topics, including billing, documentation and data entry, housing, and serving individuals with SUDs.
- Utilize Peers
    - Invest in expanding peer certification and placement programs, including licensing, training, and post placement supports. Peers are more than a workforce shortage solution; they are key to increasing client retention and ultimately improving client outcomes.

Next Steps

This report has laid out, as clearly and practically as possible, the Commission's recommendations for bringing transformational change to FSPs. Below, the report detail the Commission's current and forthcoming efforts to make these recommendations a reality.

In February of 2024, the Commission allocated $20 million in Mental Health Wellness Act funds towards a technical assistance and capacity building strategy to:

- Advance sustainable funding solutions through the restructuring of current funding models to increase efficiency and impact.
- Strengthen the workforce by identifying innovative, scalable workforce development solutions to increase capacity and reduce turnover.
- Improve accountability by developing metrics of success, identifying key client outcomes, and improving data collection and reporting practices.
- Fortify current infrastructure by strengthening service delivery models connected to the broader continuum of care.

The Commission is currently developing a request for proposals, not to exceed $10 million, for technical assistance and capacity building focused on:

- Value-based contracting and performance management

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- Improved service delivery

This substantial investment in technical assistance and capacity building is in direct response to the feedback we received from service providers and county staff. Interviewees were clear in their need for technical assistance and capacity building to strengthen their FSP programs, meet increasingly complex consumer needs, and navigate the changing regulatory landscape. They were equally clear that any technical assistance needed to consider their limited time and capacity. As such, the Commission recommends all technical assistance and capacity building efforts supported with public funds adhere to the following:

- Be concrete
    - Generalized trainings are time-consuming and difficult to translate into immediate action. Trainings should provide immediate tools and answers to specific challenges providers face.
- Leverage what works
    - County departments and providers frequently expressed a desire to learn from one another. Creating facilitated and intentional spaces for discussion can bring common concerns to the forefront and highlight field-tested solutions that were developed locally.
- Reflect reality
    - Consider the every-day constraints and challenges FSP service providers face and provide reasonable and practical solutions that incorporate FSP provider voice.
- Be manageable
    - FSP providers are often doing the jobs of more than one person due to staff vacancies. As much as counties want support, technical assistance will only be as useful to them as their capacity to genuinely engage with the content. Trainings and supports should be compact, clear, and have an immediate benefit.

Supplementing the substantial investment of $20 million mentioned above, the Commission has several additional projects underway aimed at improving FSPs. The first is a best practices toolkit for service providers, currently in development in collaboration with Third Sector Capital Partners. This toolkit will bring together recommendations and best practices identified by FSP service providers and county behavioral health staff into a single resource that will be widely available for public use.

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The toolkit will focus on the following five topics and is expected to be available in summer of 2025:

- Peer and paraprofessional supports in the workforce
- Services and treatment for individuals with substance use disorders
- Collaboration with community and cultural partners
- Step down-levels of support
- Outreach and engagement

Simultaneously, the Commission launched two pilot projects with Healthy Brains Global Initiative to provide performance management capacity building and technical assistance to FSP service providers in Sacramento and Nevada counties. In these pilots, counties and service providers work together to identify performance goals and develop performance monitoring tools to track progress towards these goals. Results from these pilots will also be available in the summer of 2025.

It is important to note that the kind of transformational change the Commission is advancing cannot be implemented or catalyzed by any single entity or organization. California will only achieve these efforts through a statewide collaboration and coordinated effort of DHCS, HCAI, the Commission, county behavioral health departments and the numerous advocacy organizations that seek to support change for Californians with unmet behavioral health needs. The Commission is committed to meeting the challenge ahead and recognizes the commitment of its partners at every level.

Currently, DHCS is undertaking extensive steps to meet the needs of counties and service providers. An example of such is the establishment of Centers of Excellence (COEs) aimed at improving service delivery across the continuum of care. These COEs will provide training and technical assistance to county behavioral health programs and Medi-Cal specialty behavioral health providers. While these COEs are not specific to FSPs, they certainly encompass them and will undoubtedly be a valuable resource as providers navigate the transition to the BHSA.

> *They always see the bad things, but we never really highlight some of the amazing success stories that we have and that we have done working with FSPs […] They have got amazing success stories with clients. That to me [means] we're on the right path, that we're doing the right thing. There's no such thing as a perfect system. There's always room for improvement. And we have to work collaboratively with other departments [to get there]"*
>
> *– FSP Programs Director*

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PART 2

THE STATE OF FULL SERVICE PARTNERSHIPS: CLIENT CHARACTERISTICS, SERVICE USE, AND OUTCOMES

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CHAPTER 6: THE STATE OF FULL SERVICE PARTNERSHIPS

"For every 10 people we are housing, 16 more are going homeless. … No matter what we do we are always getting further behind." – County behavioral health leader

Who is included in this chapter?

PARTNERSHIPS: The information presented in this chapter is for partnerships not clients. This is because an individual may participate in more than one Full Service Partnership (FSP) program in their lifetime. They may move counties and partner with a new provider, or they may simply exit and FSP and then re-enter an FSP down the road. If an individual is separated from an FSP for more than a year and returns, they are assigned a new identification number and are established as a new partnership. In total there have been 244,179 partnerships for 222,145 FSP clients through December 31, 2022, meaning 22,034 partnerships were held by clients who had previously been enrolled in an FSP. The Commission's data stop at 2022 as many counties have substantial lag in the Data Collection and Reporting (DCR) data they report and newer data is unreliable.

LAST FIVE YEARS: When the Commission examines a more recent state of FSP clients, it presents data on partnerships in the last five years, between 2018 and 2022. This gives the Commission enough data to tell an accurate story (especially for underrepresented groups that may not have high enough numbers to be included within a single year) but is recent enough to capture current trends including the COVID-19 pandemic. Commission analysts do their best to examine and report any shifts in client demographics and outcomes that clearly differ post the onset of the pandemic. If you want to see detailed information about differences over time, click the corresponding hyperlink in the text and you can examine these data in more depth.

EVER CLIENTS: When the Commission wants to speak about the experiences or characteristics of *all clients ever served* in FSP partnerships (up to 2022) you will see it use the term "Ever Clients." Ever Clients includes data on all partnerships ever established since the onset of FSP.

AGE: FSP clients are divided into four age groups, and the services they receive differ largely by age. Client's age is determined at time of entry into the FSP. See Chapter 4 for more information about types of FSPs.

- Child: Below 16 years old
- Transition Aged Youth (TAY): 16 to 25 years old
- Adult: 26 to 64 years old
- Older Adult: over 65 years old

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Statewide Snapshot

One of the central directives of our mandated reporting to the Legislature is to provide an overview of who is being served by FSPs, and the experiences of those individuals. This chapter provides a statewide snapshot of FSP clients and their experiences with homelessness, emergency department visits, and psychiatric holds.

There are numerous ways to describe who is being served. The Commission approached this task by balancing comprehensiveness and clarity, electing to focus on key characteristics like age, race and ethnicity, gender, psychiatric diagnoses, primary language spoken and place of birth. You will see statewide averages for all FSP clients ever served, recent trends in characteristics, and regional and county differences that are worth noting. A full description of methodology for each characteristic and figure can be found in the corresponding hyperlinks.

Overview of FSP Partnerships

To date, FSPs have served more than 222,145 clients, averaging tens of thousands of clients each year, ranging in age from infants to seniors. About two-thirds of Full Service Partnerships are with clients over the age of 16 and one-third are with clients 15 and under, which is important as FSP service delivery largely differs by age group. Below is a brief description of each of the five categories of FSPs. Of these five, four are age specific and one is focused on justice-involved adults.

- Child FSPs provide intensive, in-home mental health services for children ages 0-15 and their families. Using a wraparound approach, these FSPs work with children and families on goals that support safety, wellbeing, health, and stability of the family.
- Transition Aged Youth (TAY) FSPs provide comprehensive, high-level outpatient mental health services that use a team approach to meeting the behavioral health needs of youth ages 16-25 experiencing social, behavioral, and emotional distress.
- Adult FSPs are designed for adults ages 26-59 who have been diagnosed with a serious mental illness. Adult FSPs assist with housing, employment, and education, as well as mental health and substance use services when needed.
- Older adult FSPs are for adults 60 and older with histories of homelessness and/or incarceration. These FSP programs often use the Assertive Community Treatment (ACT) model.
- Forensic FSPs serve justice-involved adults with serious mental health needs and co-occurring substance abuse disorders.

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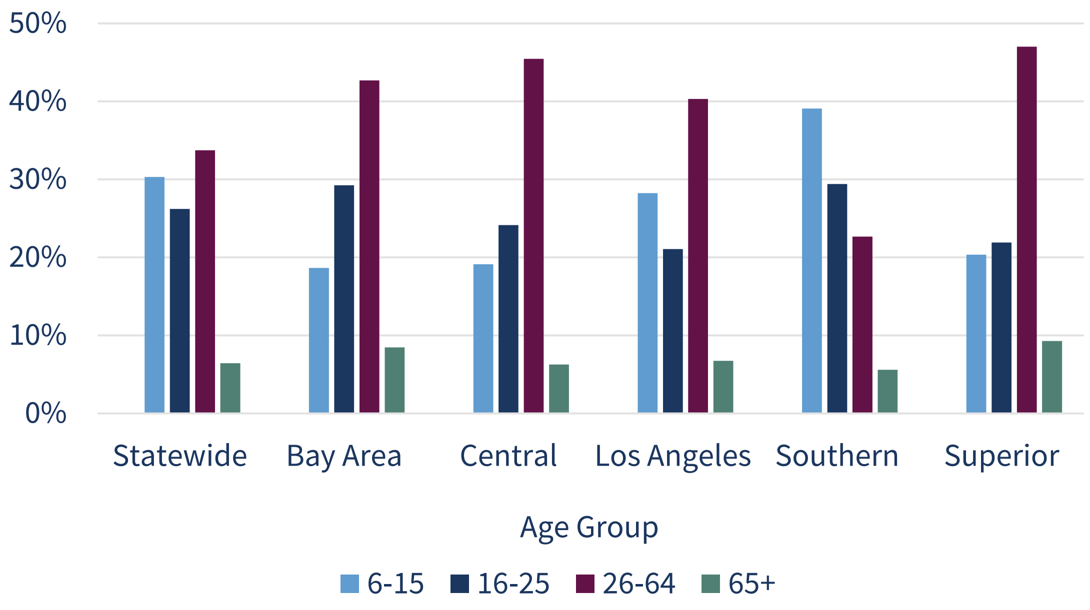
Race and ethnicity of FSP clients can vary vastly by region. Statewide, more than half of FSP clients are people of color. However, white clients remain the largest single racial or ethnic consumer group in every region apart from Los Angeles.

Demographics

For the demographics section we will look at the characteristics of every *partnership* ever recorded in the DCR (N=244,179). This captures the characteristics of the individuals being served through FSPs, and as such some individuals will be captured more than once as they entered into more than one partnership.

Figure 3: Age Composition of Full Service Partnerships

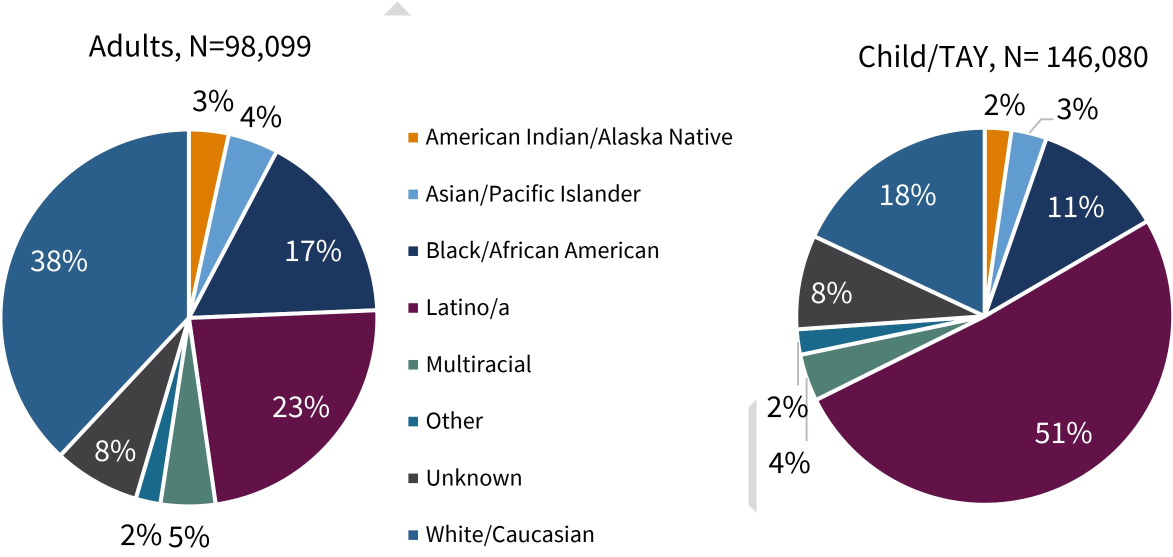


Notes: N=244,179. Data Tables can be found here. Age is age at completion of PAF. For more information on methodology for demographic reporting visit here.

Since their earliest inception, FSPs have served a diverse group of clients across California. The statewide average paints a picture of relative uniformity, where partnerships are split similarly between children, TAY, and adult clients. However, this statewide story is a combination of two different patterns. For most of the state, the Central Valley, Los Angeles, and Superior regions the composition of partnerships leans heavily toward adult clients, with adult and older adult partnerships together outnumbering child and TAY partnerships by up to 25 percentage points. In the Bay Area this gap is a little smaller at 14 percentage points. However, the Southern region shows an opposite trend, with most partnerships held by child clients, outnumbering all other groups by six percentage points.

With regards to race and ethnicity, Figure 4 illustrates how the racial and ethnic composition of adult (26+ years old) and child/ partners. Statewide, people of color make up more than half of all Adult FSP partnerships. However, the largest single racial or ethnic consumer group for adults is white consumers, comprising 38 percent of all partnerships. For most regions of California this pattern holds true. The exception to this is Los Angeles, where partnerships held by Black/African American consumers slightly outnumber those held by White and Latino/a consumers.

Figure 4: Statewide Race and Ethnicity Composition of Full Service Partnerships



Notes: N=244,179. Data tables can be found here. For more information on methodology for demographic reporting visit here.

The pattern differs substantially for children and TAYs where Latino/a clients comprise the greatest percent of partnerships both at the state level and within nearly every region, with the exception of the Superior region. The dark gray portion of pie graph in Figure 4 demonstrates a fundamental concern when reporting on FSP clients: unknown data. While we know a lot there is some we don't know, and what we don't know can make a big difference. For example, 20 percent of children/TAYs in the Bay Area have no race or ethnicity information at all – that's about one in five children. The Commission has no way of knowing whether those children reflect the rest of the clients served in the region or if their racial and ethnic composition is completely different. This matters when researchers are trying to tell a story of

who is being served. It also matters because the Commission – and the behavioral health system at large – know individuals have better participation and outcomes when they receive culturally competent services.

The number of partnerships for whom the Commission does not have race and ethnicity data *increased* in recent years. Even still, the drop in partnerships exceeds the gain. In fact, between 2019 and 2022 the Commission saw an overall loss of 4,667 partnerships, with the loss being fairly steady year-to-year and across age groups. Given the pandemic, it is possible that data tracking and input suffered as service providers had to adapt to virtual delivery models and increased staff turnover.

Overall, a blip in a single county or a single region, or even for a single year is expected from time to time, especially during environmental, social, or political unrest. However, this blip is a small illustration of much larger concerns in the quality of the data the State receives from counties.

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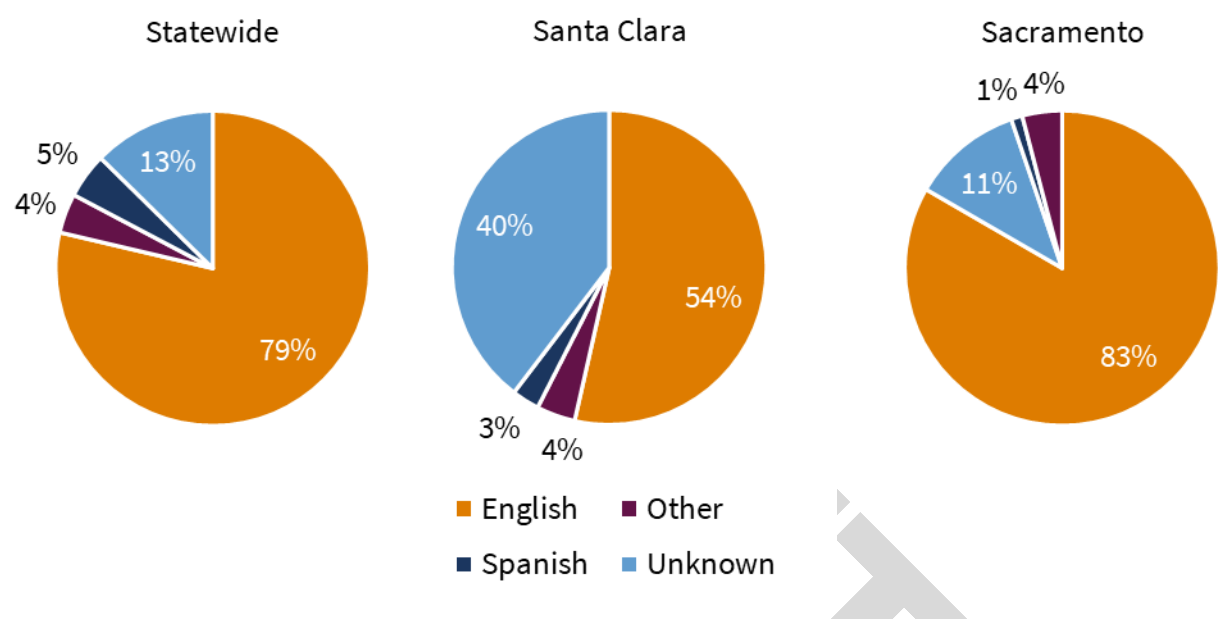
Data on gender appears slightly more reliable and generally unremarkable. The split of partnerships by gender falls mostly to male clients, with 52 percent of adult partnerships attributed to clients identified as male, 43 percent to clients identified as female, and the remaining 5 percent unknown. There was a small number of clients who identified as “other” gender, but those numbers were not large enough to be reported here without risking client privacy. As with race and ethnicity there are regions with higher percentages of unknown gender, mostly concentrated in the Bay Area and Los Angeles. There are no striking differences in gender composition between adult and child/TAY clients, at least at the regional level. A county level table on gender composition is available here.

Another area where the Commission see the impact of missing data is in the primary language spoken by clients. The majority of partnerships are held by clients whose primary language is English. This is true across regions. However, there is extreme variation in the accuracy of this estimate. In some counties like Mendocino and Humboldt, data are nearly complete, and 96 percent of clients are primary English speakers, with the percent unknown coming in at under 5 percent. Sacramento has a smaller percent of primary English speakers at 83 percent, and yet has just 1 percent unknown, with 4 percent Spanish speakers, and the remaining 11 percent attributed to other languages. These examples illustrate the kind of variation researchers expect when data is nearly complete. Alternatively, when data is incomplete, it makes assessing the language needs of clients statewide nearly impossible.

There are many counties where missing data for primary language exceed 20 percent – 15 counties for adults and 32 counties for children/TAY. In some, such as Modoc, Fresno, and Santa Clara counties, the percent of unknown for child/TAY clients reaches nearly half.

Examining just the partnerships where English is the primary language, it would appear that half of partnerships in these counties is with a child whose primary language is other than English. If this were true this would be incredibly important information for resource allocation, staffing decisions and local and state policy. However, because the remainder of partnerships are reported as "unknown", the Commission cannot know whether the substantially lower percent of reported English speakers truly reflects their clients or if it is simply a biproduct of poor record keeping.

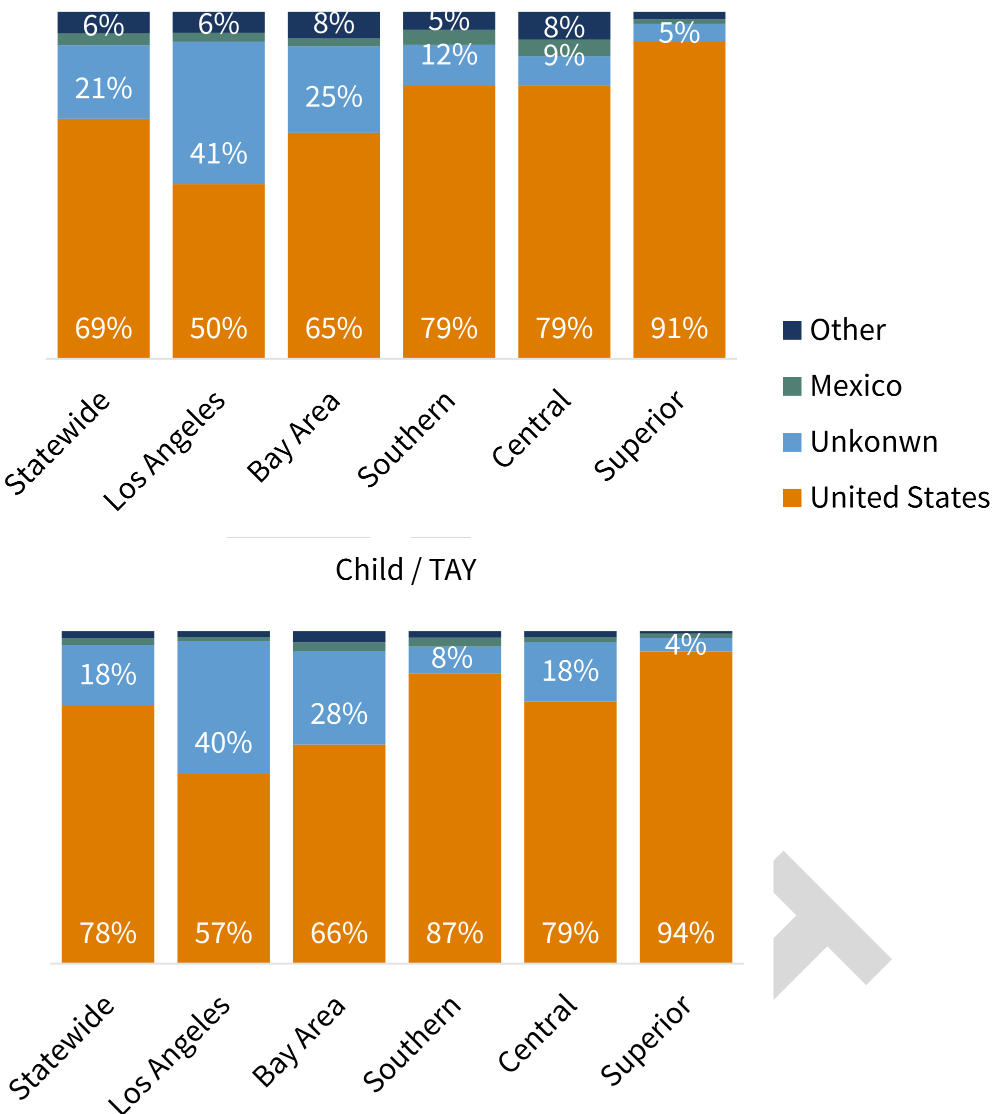
Figure 5: Counties Vary Drastically in the Percent of Missing Data They Report



Notes: N=244,179. Data tables can be found here. For more information on methodology for demographic reporting visit here.

The same scenario applies to place of birth. Again, the majority of partnerships are held by clients who were born in the United States, but the percent of "unknown" ranges from 5 percent in the Superior region to more than 40 percent in Los Angeles for both adult and child/TAY clients. Place of birth data can be sensitive to collect, and it is not surprising that certain regions of the state serve more immigrant clients, but it is difficult to know how great the need for additional services are when the Commission has incomplete data.

Figure 6: The Vast Majority of FSP Clients are Born in the United States



Notes: N=244,179. Data tables can be found here. For more information on methodology for demographic reporting visit here.

Individuals eligible for FSPs are more likely to be homeless, more often to seek out emergency room services, and more likely to be incarcerated than the general public. While we do not currently have updated incarceration and recidivism data on FSP clients, we do know that statewide, nearly 80 percent of unhoused individuals in California have a previous incarceration, and approximately 30 percent had been detained during their most recent

experience of homelessness. This suggests a strong relationship between living unhoused and being involved in the criminal justice system. Beyond this general statement The Commission is limited on what it can say about FSP clients and their criminal justice background or outcomes. The Commission does, however, have data on emergency department visits and, to some extent, a rough measure of housing instability.

Housing insecurity occurs when someone does not have safe or stable housing. This report measures housing insecurity instead of homelessness because it more closely aligns with the intent of FSPs to divert individuals from becoming homeless or to help individuals who are currently homeless. Homelessness is often not a linear trajectory with individuals cycling in and out over time. The Commission really wants to measure the portion of FSP clients who have a tenuous housing situation and are at risk of becoming homeless or who are currently homeless. To do this the Commission brings together multiple data sources that measure multiple types of homelessness and housing insecurity. You can read the Commission's methodology on measuring housing insecurity here.

The resulting data show that at a minimum 61 percent of adult client and 32 percent of child/TAY clients are or were housing insecure. The Commission expects that this number underestimates the actual count as data on homelessness is often incomplete. Figure 7 shows how this breaks down by age group.

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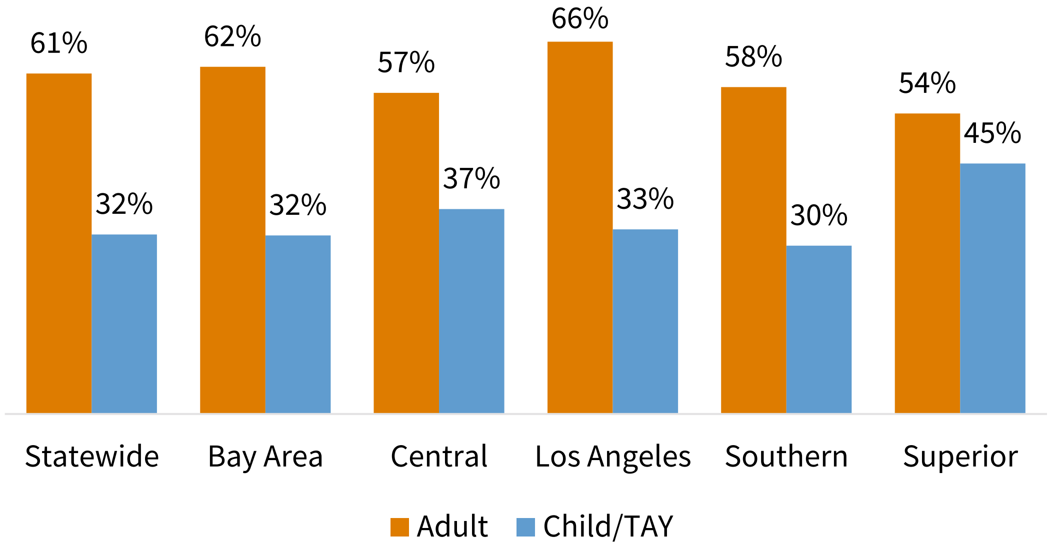
FIGURE 7: Percent of FSP Partnerships Where Clients are Housing Insecure or Homeless

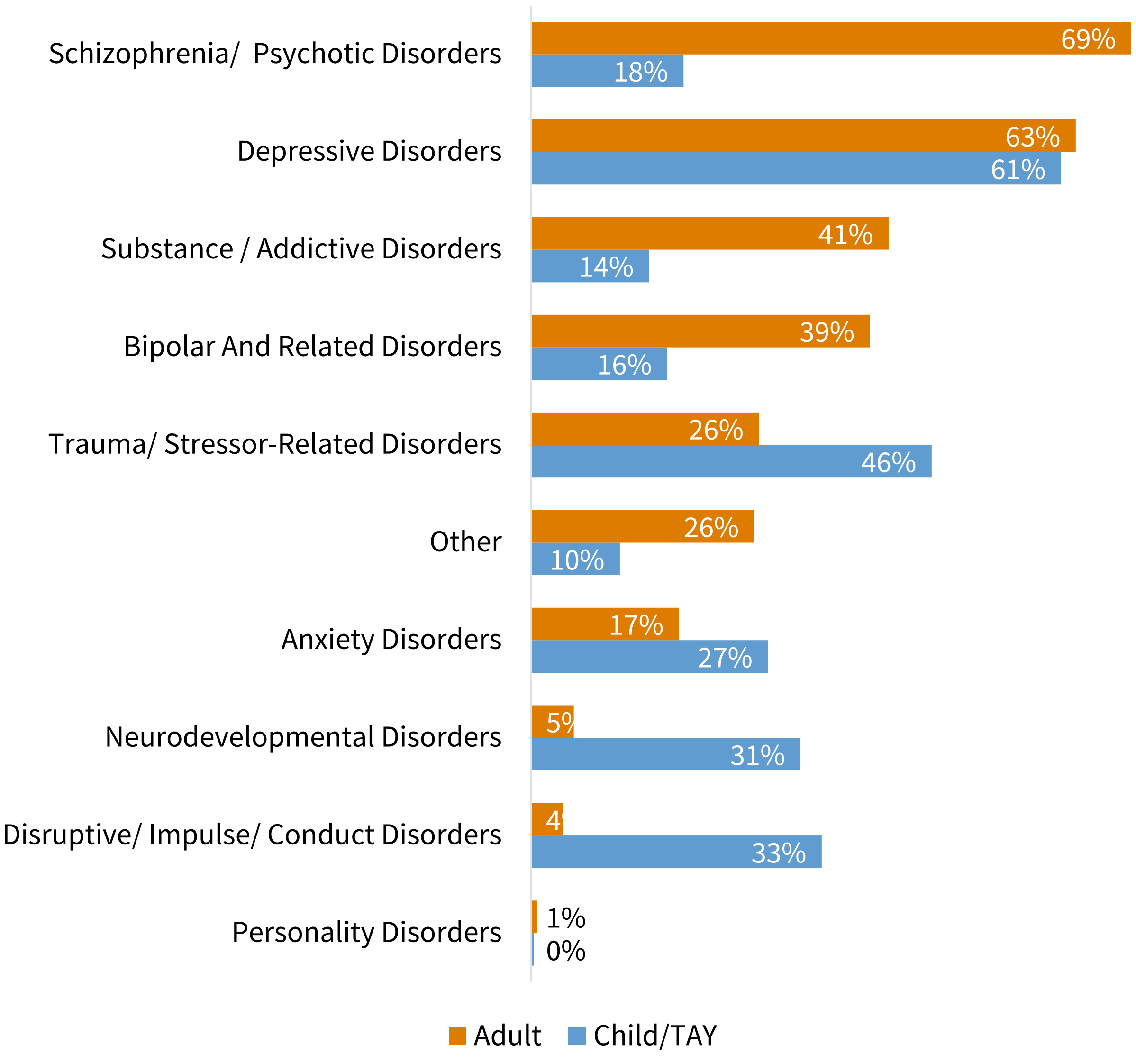


Notes: N=244,179. Data tables can be found here. For more information on methodology for demographic reporting visit here.

This next section looks at what common diagnoses FSP clients have received over time and examines emergency department and inpatient psychiatric holds for clients in the five years leading up to joining an FSP.

FSPs are designed to serve individual with serious mental illness and serious emotional disturbances. Figure 8 shows an overview of the primary and secondary diagnoses of FSP partners. As diagnoses can change over time and by attending medical provider, clients could receive more than two primary and secondary diagnoses in the data. It is common for individuals experiencing mental health challenges to also experience substance use disorders (SUD), and thus SUDs are included in Figure 8.

Figure 8: Percent of Partners with a Given Diagnoses by Category and Age Group



Notes: N=244,179. This figure presents the percent of partnerships where the client received a given diagnoses at any time between 2000 and 2022. Diagnoses are not mutually exclusive and are calculated at the partnership level. Only primary and secondary diagnoses are included. It is possible that a client may have more than two psychiatric diagnoses. Data tables can be found here. For more information on methodology visit here.

Importantly, this overview is for *every time a unique primary or secondary diagnosis was assigned to a client between 2000 and 2022 and* is not one diagnosis per client. For adults, the most common primary and secondary diagnoses are: 1) schizophrenia/ psychotic disorders; 2) depressive disorders; and 3) substance-use/ addictive disorders. This aligns with the aims of FSPs and suggests services are reaching the intended population.

The data for children/TAYs presents a different pattern. The most reported diagnoses are: 1) depressive disorders; and 2) trauma/stressor-related disorders. These are followed by disruptive/ impulse-control/ conduct disorders, neurodevelopmental disorders, and anxiety disorders. These diagnoses speak to the deep emotional and psychological needs of the young people being served by child/TAY FSPs.

Individuals who have unmet mental health needs are more likely to seek treatment for psychiatric care through emergency services. In later chapters this report will examine whether clients have lower emergency department usage after joining an FSP, but this chapter establishes who FSP clients are and what their service use looks like leading up to joining an FSP.

Statewide, 82 percent of adult FSP clients had at least one visit to the emergency department for psychiatric reasons in the five years prior to joining an FSP, with the average number of visits for those clients being 16. However, in some regions and in some counties this number is much higher, reflecting differences in the client needs and available resources. For instance, in San Francisco County, 87 percent of FSP clients had visited an emergency department for psychiatric reasons in the five years prior to joining an FSP, and for those clients the average number of emergency department visits was 38. One could argue that at least part of this higher average is due to increased homelessness and substance use found in bigger cities.

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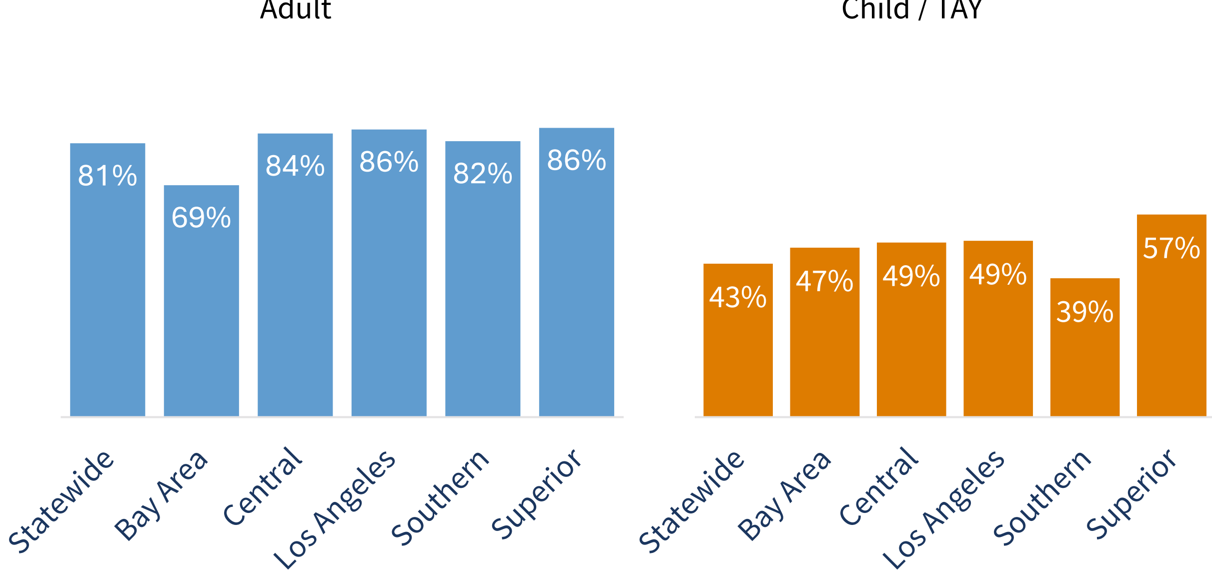
Table 9: Percent of Clients with at Least One Emergency Department Visit for Psychiatric Reasons in the Five Years Prior to Joining an FSP



Notes: N=244,179 Data are at the partnership level and represent the percent of partnerships where the client had at least one emergency department visit on the five years prior to joining an FSP. Data tables can be found here. For more information on methodology visit here.

These numbers are much lower for child/TAY FSP clients. Statewide, 43 percent of child/TAY clients had visited an emergency department for psychiatric reasons in the five years prior to joining an FSP, with the average number for these clients being 5 visits. The highest county for emergency department visits was Shasta County, where 63 percent of child/TAY clients had visited an emergency department for psychiatric reasons in the five years prior to joining and FSP, with 14 average visits for these clients. At first glance, this looks like thankful news: younger clients are experiencing fewer emergency department visits than their more senior counterparts. But considering that younger clients have also had less time to accrue a higher count of emergency department visits, the trend is concerning.

Now this report will examine the total number of holds FSP clients experienced over time. Hold data is incredibly unreliable, with numerous counties reporting no holds at all, and about half reporting hold numbers so low they are most likely inaccurate. This hampers the ability to tell an accurate statewide story. For instance, only 1 percent adult FSP clients in Los Angeles County had a psychiatric hold on file in the five years prior to joining an FSP, a number so low Commission researchers question its accuracy. For adults in Los Angeles County who did have holds, their average number of holds was two. Numbers for children and

TAY in Los Angeles are even lower with 0.7 having a hold on file in the five years prior to joining, and the average number being 1.7 for this group. Compare this with Humboldt County, which had the highest hold numbers of the 44 counties with psychiatric hold data. In Humboldt County 88 percent of adult FSP clients had a psychiatric hold on file in the five years leading up to joining an FSP, with the average number of holds being 3.3 for this group. The percent of child/TAY clients with a psychiatric hold on file in the five years prior to joining an FSP was slightly lower at 76 percent, and the average number of holds being 4.2 for this group. These two counties illustrate the vast range of hold data the Commission receives.

CHAPTER 7: SERVICE UTILIZATION AND OUTCOMES

> *"If I don't make suggestions and phone calls to contact people [to ask for services], I can get lost in the system and things become unreliable and uncertain." – FSP client*

Who is included in this section of the report?

The previous chapter looked at the characteristics of the nearly quarter-million Californians who have joined Full Service Partnerships (FSPs) since their inception more than two decades ago. This chapter looks at a subset of those clients; those who have received at least one service in the last year. The Commission refers to these clients as *active clients.* Appendices A describes how the Commission determines who an active client is, why it prefers to report on active clients rather than total clients when reporting on outcomes, and how its methodology results in different client counts for some counties. If you would like to read more about how the Commission determines who is an active client before reading this chapter, you can find that information here.

Where do we get our data?

The data from the previous chapter largely come from the Client Services Information (CSI) and the Data Collection Reporting (DCR) data sets, both managed by the Department of Health Care Services (DHCS). All the demographic data this report presents, other than date of birth, come from the CSI, and FSP service information comes from the DCR. Therefore, it is important that we are able to match clients in both data sets to get a full picture. Currently, the Commission is able to match about 91 percent of its FSP clients to the CSI data.

This chapter looks at service use such as number of crisis services used, emergency department visits, and psychiatric hospitalizations before and after joining an FSP. These data come from a variety of sources including CSI data and Department of Health Care Access Information (HCAI) data. HCAI data include information on hospitalization, emergency department visits, and in-patient psychiatric holds.

For more information on methodology please visit here.

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Participation

Joining an FSP can be an incredibly important step towards stability and health for many people living with serious mental illnesses and/or substance use disorders. But joining an FSP is just the first step. Clients must stay long enough to reap the full benefit of the services provided. How long a client stays in a partnership is impacted by numerous factors including level of need, ability to access services, available time and capacity to prioritize FSP services, perceived benefit of those services, and environmental, financial and social barriers to receiving services.

One characteristic that does seem to relate to how long clients are attached to an FSP is age. As Figure 10 below shows, child and TAY clients tend to have shorter enrollment periods than adults. The blue and orange lines represent individuals who joined an FSP between 2018 and 2020. The height of the line represents the percent of clients who exited the FSP over time. We can see the lines start at the 3-month mark and increase rapidly. At the two-year mark, 50 percent of adult clients were no longer active members of their FSP partnership. Compare this to child and TAY clients where 77 percent were no longer actively enrolled by the two-year mark.

Part of this difference may be due to aging out of TAY services. For example, if a TAY client joined an FSP on their 23rd birthday they would have a maximum of two years to receive services before no longer being eligible through that specific FSP. They could, in theory, move to an adult FSP, but the Commission's conversations with service providers indicate this is not common. Regardless of the reason, child and TAY clients become disconnected from FSP services sooner than adult clients. A positive interpretation of this might be that younger clients are reaching their goals faster than older clients. A more concerning explanation might be that children and youth are becoming lost in the system or are not responding to FSP service providers.

The lower retention rates for TAY clients begs the question of why clients are leaving. This report next looks at the documented reasons for individuals who exited FSP partnerships. It is important to note that this data below can only speak to those individuals for whom the Commission has a documented exit reason or who have been discontinued by the county for inactivity. Individuals who have stopped receiving services but haven't been officially discharged or discontinued would not have an official exit reason and are therefore not included.

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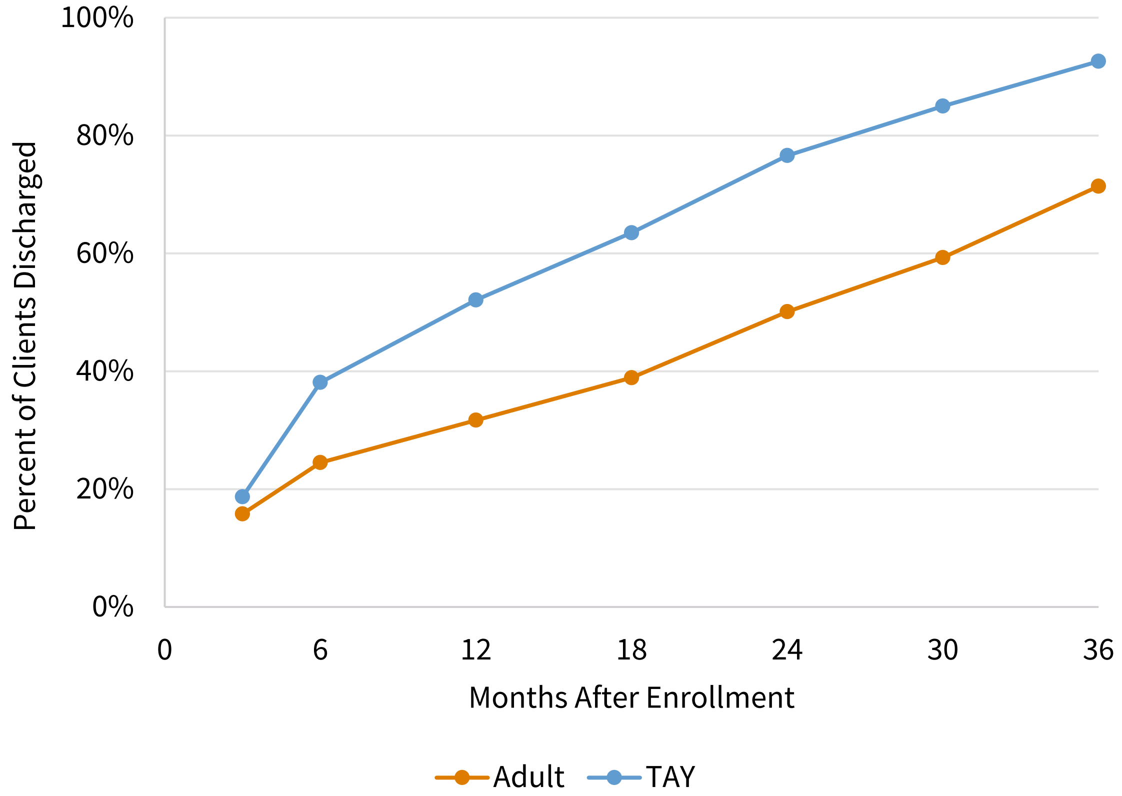
Figure 10: Percent of Client Discharged/Disenrolled Over Time



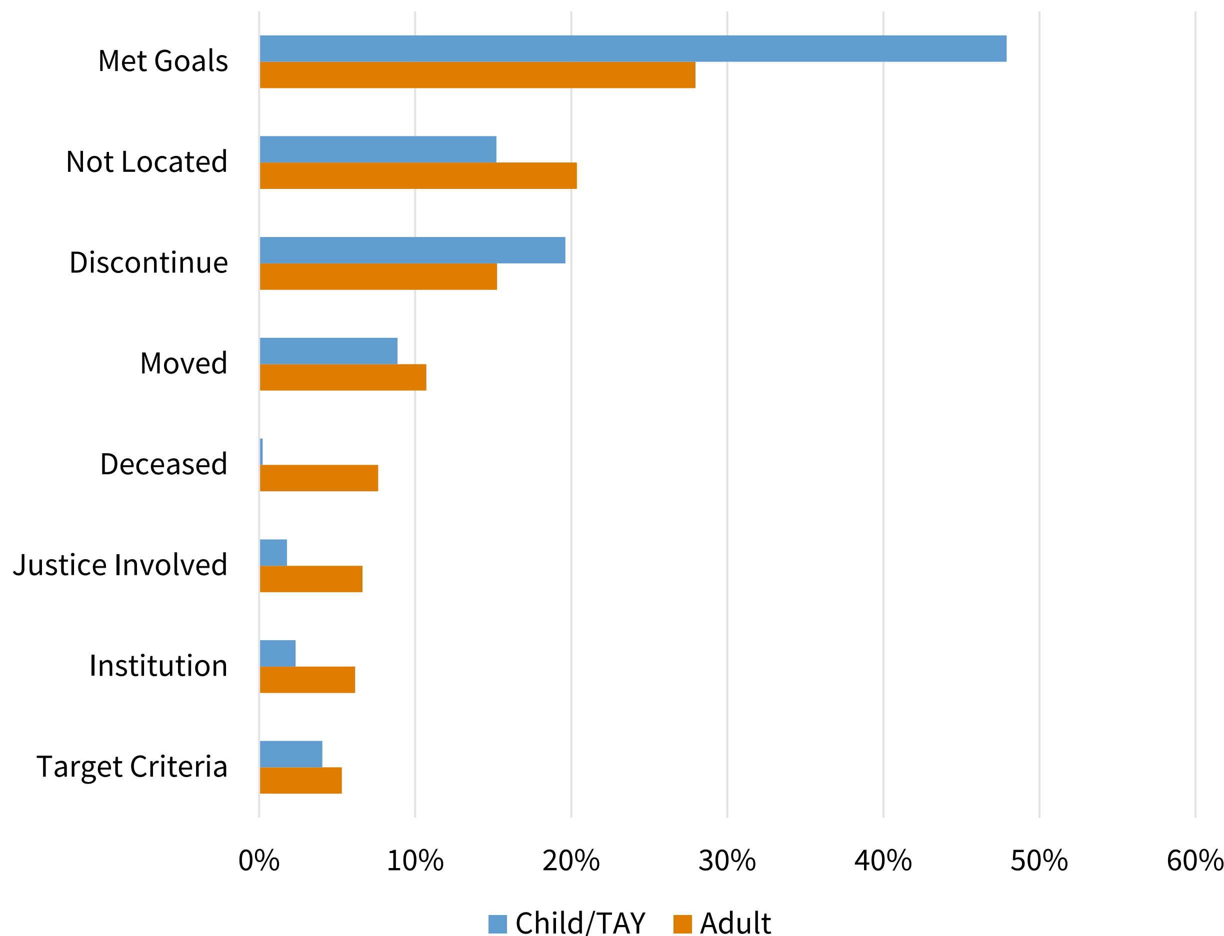
Notes: N= 21,186. The above data are restricted to the 2019 cohort to allow for at least 36 months of data. Tables can be found here. For more information on methodology visit here.

Overall, the most common reason for exiting an FSP partnership is meeting one's goals. This is the most ideal situation. And while the Commission does not have detailed information about what each client's individual goals are, it can at least characterize these departures as positive, and indicative of a positive outcome for clients. Figure 11 below illustrates the composition of exit reasons for adult clients vs child/TAY clients. A greater percentage of child/TAY clients exited their partnership because they met their goals.

The next most common reasons for both child/TAY clients and adult clients ending an FSP are not being able to locate the client or the client being discontinued. A client is discontinued when the county has determined that the client is no longer receiving services and has not met their goals. It is not possible to know what happened to these clients, and, at least for adult clients, that more clients were lost or discontinued than met their goals. When interpreting these numbers keep in mind the challenges providers face when serving such

high need clients, and the difficulties in staying connected with individuals who are experiencing homelessness.

Figure 11: Meeting One's Goals was the Most Common Exit Reason



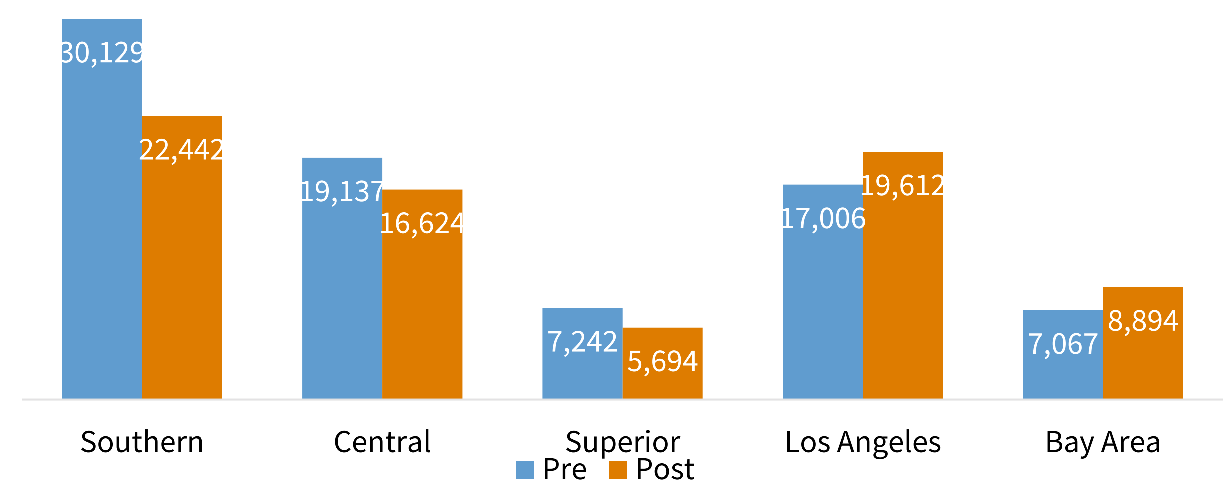
Notes: N=244,179 Data are at the partnership level. Clients may enter into more than one partnership. Data tables can be found here. For more information on methodology visit here.

Outcomes

Next, this report examines client's outcomes. Because clients can enter into FSPs with different needs and histories of engaging services, we compare client's use of services one year prior to becoming connected with an FSP to one year afterwards. This gives us the best measure of what kind of immediate change a client may be experiencing in services after joining an FSP.

Figure 12 below presents pre- and post-crisis service use for individuals enrolled in an FSP between 2019 and 2022. The blue bar represents the total crisis services FSP clients used one year prior to joining an FSP, and the orange bar represents the total services used in the year after joining an FSP. If service use was the same before and after, the orange and blue bars would be at the same height. Rather, in the Southern, Superior, and Central regions clients had higher service use prior to joining an FSP. This is a different pattern than in Los Angeles and the Bay Area, where clients' service use went up after getting connected to an FSP.

Figure 12. Crisis Service Usage Pre and Post FSP Enrollment Varies by Region



Note: Data for this figure is restricted to clients who entered a partnership between 2012 and 2022 as hospitalization data is not available prior to 2011.

Ideally, crisis service use would go down after FSP enrollment, but depending on the needs of the clients, it might be appropriate to see a short-term bump in such services while clients and providers work together to coordinate the client's care. For instance, if a client with coexisting conditions of a mental health diagnosis and substance use disorder enters into an FSP they may temporarily see a spike in crisis service use while they are connected to the appropriate array of health care providers. However, the goal of an FSP is to reduce crisis service use over time.

Data shows a decrease in both number of inpatient psychiatric admissions and in total days clients spent in the hospital for those stays. FSP clients experienced 85,590 psychiatric hospital admissions in the year prior to joining an FSP compared to 58,638 in the year after joining an FSP, a reduction of 41 percent. Similar trends exist for days spent in the hospital for

those admissions, with hospital days in the year prior to joining an FSP coming in at 818,653 versus 568,348 afterwards, a reduction of 31 percent. This pattern appears strong, regions varying by no more than two or three percentage points.

Figure 13: Comparing Psychiatric Hospitalization Pre and Post Joining an FSP

Note: Data for this figure is restricted to clients who entered a partnership between 2012 and 2022 as hospitalization data is not available prior to 2011.

As mentioned in Part One, the ability to tell a statewide story is limited by access to high-quality data. DHCS is currently in the process of reworking FSP data collection and reporting procedures to ensure accuracy and completeness of the data collected by providers and received by DHCS. Such an undertaking is key in supporting the goals of transparency and accountability of Proposition 1, and in turn the ability of providers to ensure high quality service delivery and outcomes for clients.

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Appendix A: Analytic Methods

Appendix A1: Operational Definition and Parameters

Demographics - All demographics are calculated based on the total partnerships since the inception of FSPs through December 31st, 2022 (N= 244, 179). Of these 98,099 were adult clients (26 years and older), and 146, 080 were child or TAY clients (0-25 years).

Age Group: Refers to the age at intake, based on the following DCR codes:

- 1 = Child PAF
- 4 = TAY PAF
- 7 = Adult PAF
- 10 = Older Adult PAF

Age: Calculated based on date of birth in DCR.

Gender: Based on DCR as primary source and CSI as secondary source. Gender categories are male, female, other, and unknown.

Primary language: Coded from CSI file variable "prim language" and coded according to MHSOAC category practices. Categories are: English, Spanish, Other, and Unknown.

Place of birth: Coded from CSI data element "Place of Birth". Categories capture the most frequently occurring country categories: Mexico, United States, Other and Unknown.

Race / ethnicity: Coded from CSI variables to identify race and ethnicity. Race / ethnicity categories are exclusionary based on the following rules.

a. If a partner ever self-reported American Indian or Alaska Native then the partner is flagged as American Indian or Alaska Native.
b. If a partner is not in Category A and they self-reported as "Hispanic" then the partner is flagged as Latino.
c. If a partner is not in Category A or B and more than one race indicated, the client is flagged as Multiracial.
d. Otherwise, the value is flagged as reported.

Area/Region/County: Data is reported for the county where the partner is enrolled in an FSP. County data is aggregated to a regional level.

Diagnoses: Diagnoses are based on CSI variables "Principal Mental Health Diagnosis" and "Secondary Mental Health Diagnosis". ICD9 and ICD10 code groupings were created by MHSOAC clinical staff. Diagnoses are not mutually exclusive and are calculated at the partnership level. Only primary and secondary diagnoses are included. It is possible that a partner may have more than two psychiatric

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diagnoses. Any primary or secondary psychiatric diagnoses received by a partner for any service between 2000 and 2023 is included. However, a given diagnosis is only counted once per partnership regardless of how many times a partner received said diagnosis.

Service Usage

Crisis Services: Crisis services data are restricted to outpatient services (Mode=15) with Service Fact IDs codes between 70 and 79, and include all partnerships originated between Jan 1 2012 and Dec 31 2022. CSI data is not reliably available before 2012. Services designed to provide short-term or sustained therapeutic intervention for persons experiencing acute and/or ongoing psychiatric distress (Cal. Code Regs. Title 9, Section 543). Furthermore, crisis services are short-term (lasting less than 24 hours), urgent services that cannot wait for a regularly scheduled visit. Services typically involve assessment, collateral services and therapy.

Services received prior to FSP partnership are calculated as the total services received between the date of partnership and 365 days prior. Services received post FSP partnership are calculated as total services received within 365 days after the date of partnership. Number of admissions is calculated based on the hold's admission date.

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Inpatient Holds: Inpatient holds are calculated for the five years prior to partnership date for partnerships originated between January 1sts 2018 through Dec 31st 2022. Holds are derived from the CSI "Legal Class-Admission" and include the following "involuntary civil" hold codes:

- 72 Hour Evaluation and Treatment for Adults (W&I Code, Section 5150)
- 72 Hour Evaluation and Treatment for Children (W&I Code, Section 5585)
- 14 Day Intensive Treatment (W&I Code, Section 5250)
- Additional 14 Day Hold (W&I Code, Section 5260)
- Additional 30 Day Hold (W&I Code, Section 5270.15)
- Additional 180 Day Hold (W&I Code, Section 5300)
- Other involuntary civil status

"Involuntary criminal" holds for person's held for psychiatric reasons related to criminal justice involvement are not included.

Ever Homeless: In this report we combine measures of homelessness and housing insecurity into a single variable that captures a lack of stable housing. Homelessness is often cyclical, and individuals who were previously homeless are likely to be homeless again in the future. Therefore, we define someone as "Ever Homeless" if they meet any of the following criteria:

- Referred to an FSP from a homeless shelter (source: PAF)
- Client indicated they are or were homeless, or in are or were in a shelter (source PAF)
- Client indicated they are currently living in a shelter (source KET)

- HCAI data indicates zip code for Emergency Department visit or Inpatient Psychiatric Hold as "ZZZZZ" or ICD-10 code as Z590
- California Department of Education records indicate the client meets/met the definition of homeless according to McKinney-Vinto Act.

Emergency Department Visit: Restricted to partnerships established between 2018 and 2022 and are presented as the sum of all visits for the five years prior to entering into the FSP partnership.

Discontinue Reason: Partnership discontinuation reason is determined based on the following codes in the DCR:

- Code 7- Met Goals Met Goals
- Code 2- Discontinued/Lost Contact
- Code 4- Not Located Discontinued/Lost Contact
- Code 5- Institution Jailed/Institution
- Code 6- Serving in Jail Jailed/Institution
- Code 9- Placed Juvenile Hall Jailed/Institution
- Code 10- Placed DJJ Jailed/Institution
- Code 11- Serving Prison Jailed/Institution
- Code 1- Target Criteria Not Met Other
- Code 3- Moved Other
- Code 8- Deceased /other

In this analysis we combine codes 6, 9, 10 and 11 as "Justice Involved."

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Appendix A2: Defining Active Partnerships

As of 2019, there have been 244,179 partnerships since data reporting started in 1991, with all but five of these partnerships beginning after 2001. When a client enters a Full Service Partnership (FSP) they are assigned an ID number, and this ID number is specific to that partnership only, not the individual. Each partnership is tracked separately over time. When a client exits a partnership, they are no longer counted as active. Counties report this number through the Data Collection and Reporting system (DCR) to the Department of Health Care Services (DHCS). However, there are several reasons why the numbers received by the State may differ from those tracked internally by partners and counties.

First, an issue arises when partners stop receiving services but are not exited out of their partnership. If a partner doesn't receive an exit code and has not received services for an extended time, counties may flag those partnerships as discontinued. As the previous chapter noted, a large portion of partnerships end up being discontinued.

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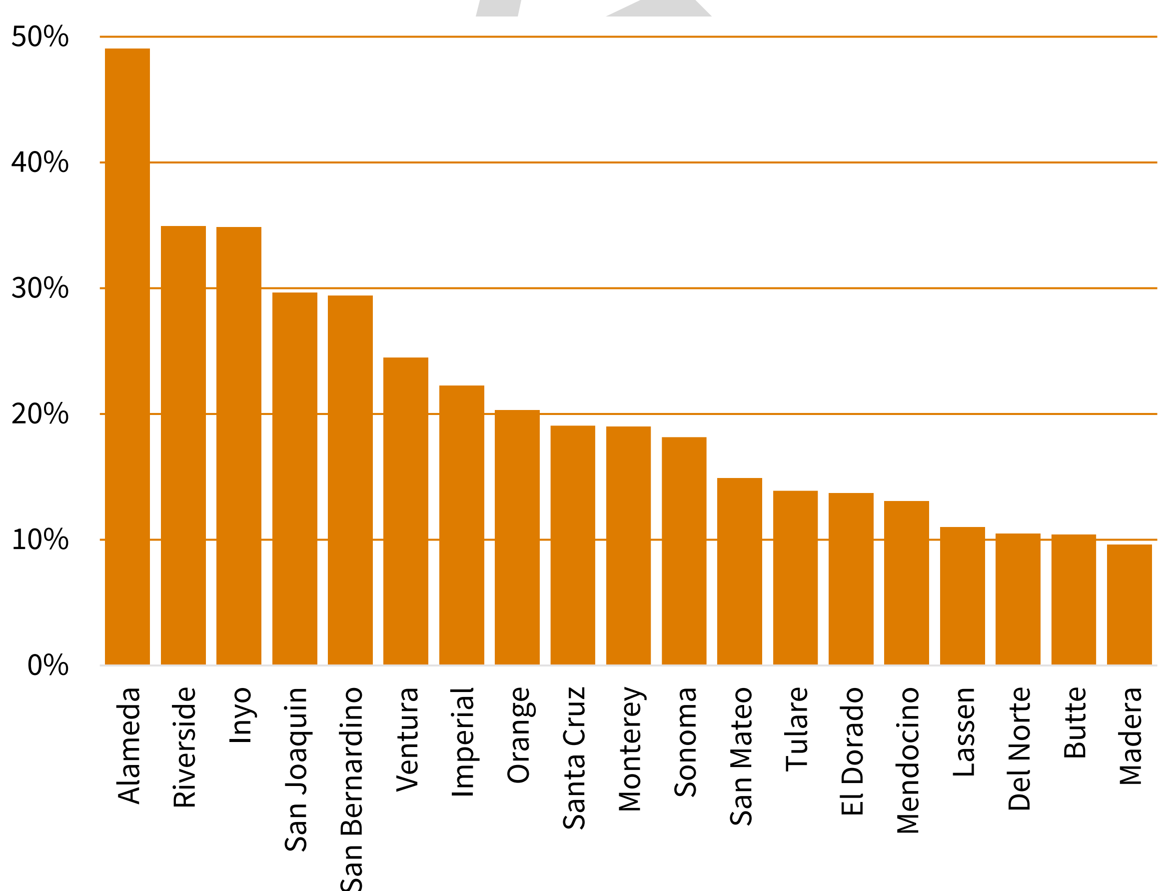
Figure X: Percent of Reported Active Partnerships Deemed Inactive by the Commission



Even still, around 1 percent to 2 percent of partnerships that should be labeled as inactive slip through the cracks each year. Over time, this adds up. As of 2022, 15 percent of all partnerships submitted through the DCR had to be reclassified as inactive by the MHSOAC. These are partnerships where the client did not receive any DCR reported services for at least 18 months. We refer to these partnerships as "administratively discharged" to distinguish them from those discontinued by the county. Figure X depicts counties where the Commission had to reclassify more than 10 percent of the enrollment data submitted. In total, out of the 58 counties, all but 28 needed some level of recalculating of their enrollment counts.

The Commission considers any partnership that does not have an exit code, is not labeled discontinued by the State, and has not been reclassified as administratively discharged by the Commission as "active." Table X provides an annual summary of total FSP partnerships created (in blue), followed by the number of partnerships with exit codes or were discontinued by the county, and those who were administratively discharged by the Commission (in green). The number in the blue column, minus the total from both green columns provides the calculated "active clients" found in the orange column.

Of the near quarter of a million partnerships that have been established over time, 189,980 have been exited or discontinued by the county, and 25,878 have been administratively discharged by the Commission, leaving 28,321 as active. As previously stated, about 15 percent of the active records the Commission receives are recoded as administratively discharged.

In addition to issues around calculating the number of active partnerships, there are questions about the number of *clients served* by FSPs. This arises because clients may have multiple IDs. If an individual joins FSP 1 in County A, and then later joins FSP 2 in County A they would receive two partnership IDs. Because one person may have more than one partnership over time, counties try and match multiple partnerships to the same person by assigning a client ID as well. This means each client within a county has one client ID but may have multiple FSP partnership IDs.

Sometimes a client relocates to a different county. When this happens, the client is given a new client ID specific to that county and new partnership IDs for each partnership within that county. Counties collect and report their own data, so they have no way of matching the records for their county to those of another county. This means a single individual may have multiple client IDs and partnership IDs. These data are submitted to the DCR and the Commission, in turn, receives these data from the DHCS.

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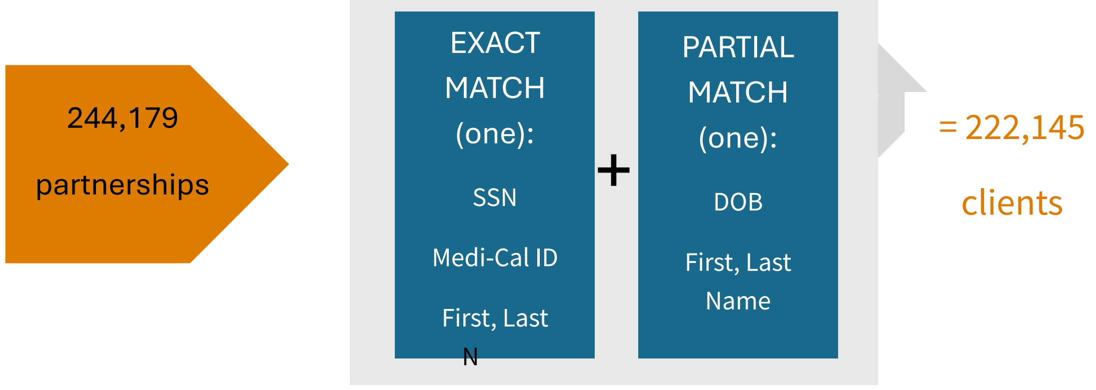
Table X: The Number of Clients Administratively Discharged Compiles Over Time

Year	Total Created	Exited or Discontinued	Administratively Discharged	Continued Partnerships
2001	65	0	0	0
2002	89	0	0	0
2003	108	0	0	0
2004	138	0	0	0
2005	196	1	3	192
2006	1,594	83	19	1,492
2007	10,329	1,534	112	8,683
2008	21,590	6,152	386	15,052
2009	35,170	13,946	904	20,320
2010	48,258	23,819	1,495	22,944
2011	60,440	34,857	2,109	23,474
2012	72,790	45,527	2,888	24,375
2013	86,640	56,947	4,073	25,620
2014	100,675	70,258	5,067	25,350
2015	114,284	83,072	5,923	25,289
2016	131,040	96,224	6,691	28,125
2017	149,870	111,213	8,347	30,310
2018	168,785	127,255	10,213	31,317
2019	189,971	144,211	12,359	33,401
2020	208,400	159,577	15,235	33,588
2021	227,660	175,874	20,239	31,547
2022	244,179	189,980	25,878	28,321

The Commission's job is to take these various records, determine how many records belong to the same individual across counties, and estimate how many clients are being served at any given time. This ends up being a multi-step process. The Commission identifies clients with multiple client IDs as the same person if they meet two criteria. First, they must have an *exact* match on one of the following: Social Security number, Medi-Cal ID number, or first and last name. Then they must have a close (but not necessarily exact) match on a second criteria, including name and date of birth. For example, if two client IDs have the exact same Social Security number and birthdates that are similar (but maybe slightly off), the Commission would assume that is the same individual and one of those birthdates was probably entered incorrectly. Alternatively, if two client IDs had the exact same first and last name but had completely different birthdates, the Commission would not match those records as the same person, and they would remain in Commission data as two separate records. This process is run up to 60 times to be sure the Commission captures clients that may have had multiple partnerships in multiple counties.

After completing this matching process, the Commission now has information on the number of partnerships and an estimate of the number of clients served. Figure X illustrates this process and how the Commission arrives at its final client count.

Figure X: Matching Clients Across Counties Is a Multi-step Process



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Appendix B: List of Counties and Organizations Engaged (all projects)

Counties Engaged

1. Alameda
2. Butte
3. Del Norte
4. El Dorado
5. Fresno
6. Glenn
7. Humboldt
8. Imperial
9. Lake
10. Lassen County
11. Los Angeles
12. Madera
13. Marin
14. Mendocino County
15. Merced
16. Modoc
17. Monterey County
18. Napa
19. Nevada
20. Orange
21. Placer
22. Plumas
23. Riverside County
24. Sacramento
25. San Benito
26. San Bernardino
27. San Diego
28. San Francisco
29. San Luis Obispo
30. San Mateo
31. Santa Barbara
32. Santa Clara
33. Santa Cruz
34. Shasta
35. Siskiyou County
36. Solano
37. Stanislaus
38. Stanislaus County
39. Sutter
40. Tehama County
41. Trinity County
42. Tulare
43. Ventura
44. Yolo
45. Yuba

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Organizations Engaged

1. Abode
2. Alameda County Behavioral Health Care Services
3. Amiyoko A. Shabazz
4. Association of Community Human Service Agencies
5. Aviva
6. Bay Area Community Services (BACS)
7. BHSD Santa Clara County
8. Black Men Speak
9. Cal Voices
10. California Association of Local Behavioral Health Boards and Commissions (CalBHBC)
11. California Association of Mental Health Peer-Run Organizations (CAMHPRO)
12. California Department of Corrections and Rehabilitation (CDCR)
13. California Department of Social Services (CDSS)
14. California Health and Human Services (CalHHS)
15. California Hospital Association (CHA)
16. California Mental Health Services Authority (CalMHSA)
17. Casa Ubuntu
18. Catalyst
19. Center Star ACT
20. Child and Family Center
21. Children's Institute
22. Coloma Center-Homeless Intervention - Turning Point
23. Community Solutions
24. Comprehensive Youth Services
25. Corporation for Supportive Housing (CSH)
26. County Behavioral Health Directors Association (CBHDA)
27. County of Marin Behavioral Health Recovery Services
28. County of Santa Clara Behavioral Health Services
29. CRF Behavioral Health Care
30. CRF Behavioral Health Care, South Bay Guidance Center
31. Del Norte County Behavioral Health Services
32. Department of Health Care Services (DHCS)
33. Disability Rights
34. Downtown Women's Center
35. El Dorado County Health and Human Services Agency (HHSA): Behavioral Health
36. Exceptional Parents Unlimited
37. Felton Institute
38. Glenn County Behavioral Health
39. Hillsides
40. Hope Cooperative
41. Hope Horizon Mental Health
42. Housing and Community Development
43. Imperial County Behavioral Health Services
44. Indian Health Center of Santa Clara Valley
45. LA County Department of Mental Health

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46. Lassen County Behavioral Health
47. Masada Homes
48. Mental Health America of Los Angeles
49. Mental Health America of Northern California
50. Mental Health Data Alliance / Opeeka
51. Mental Health Systems/TURN
52. Mesa FSP
53. NAMI
54. Nevada County Behavioral Health Department
55. No Place Like Home Program at the California Department of Housing and Community Development
56. Orange County BH Department
57. Pathways
58. Seneca Family of Agencies
59. Steinberg Institute
60. Telecare Corporation
61. Vanna Health
62. Youth Leadership Institute
63. Victor Community Services

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Appendix C: Analytic Tables

Appendix C1: Annual Enrollment of Full Service Partnerships by Age Group

ENROLLMENT BY YEAR AGE GROUP AT ENTRY					
YEAR	CHILD	TAY	ADULT	OLDER ADULT	TOTAL
1991	1				1
1994	1				1
1996			1		1
1999	1				1
2000			1		1
2001	3	3	53	1	60
2002	1	3	12	8	24
2003		2	16	1	19
2004	2	1	26	1	30
2005	7	9	40	2	58
2006	198	324	767	109	1,398
2007	1,609	2,012	4,323	791	8,735
2008	2,679	2,681	5,003	898	11,261
2009	2,957	3,503	6,167	953	13,580
2010	4,038	3,380	4,754	916	13,088
2011	3,675	3,312	4,350	845	12,182
2012	4,160	3,376	4,093	721	12,350
2013	4,398	3,508	4,978	966	13,850
2014	5,053	3,445	4,670	867	14,035
2015	4,658	3,445	4,556	950	13,609
2016	6,649	3,779	5,375	953	16,756
2017	8,178	4,042	5,468	1,142	18,830
2018	8,407	4,104	5,218	1,186	18,915
2019	8,766	4,763	6,362	1,295	21,186
2020	7,503	4,127	5,699	1,100	18,429
2021	7,643	4,648	5,820	1,149	19,260
2022	7,374	3,652	4,626	867	16,519
Grand Total	87,961	58,119	82,378	15,721	244,179

Note: The above table depicts partnerships not clients. Clients can be enrolled in more than one partnership. There have been 244,179 partnerships for 222,145 FSP clients through December 31, 2022.

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Appendix C2: Enrollment by Age Group, Region and County

		Age Group					
		0-5	6-15	16-25	26-64	65+	Total
Statewide	California	8,034	74,018	64,028	82,378	15,721	244,179
Region	Bay Area	260	5,114	8,015	11,698	2,319	27,406
	Central	1,898	7,265	9,175	17,277	2,383	37,998
	Los Angeles	2,222	17,222	12,845	24,582	4,112	60,983
	Southern	3,530	42,644	32,084	24,724	6,097	109,079
	Superior	124	1,773	1,909	4,097	810	8,713
County	Alameda	20	49	523	1,287	287	2,166
	Alpine		*	*	*	*	0
	Amador	*	39	54	153	**	246
	Berkeley City	*	**	60	148	45	253
	Butte	25	448	471	465	198	1,607
	Calaveras	*	81	116	223	**	420
	Colusa		41	**	52	*	93
	Contra Costa	20	504	757	778	48	2,107
	Del Norte	*	*	53	236	22	311
	El Dorado	35	338	270	447	39	1,129
	Fresno	1,269	836	1,504	3,121	120	6,850
	Glenn	20	267	202	327	35	851
	Humboldt			70	457	100	627
	Imperial	*	548	1,765	1,199	**	3,512
	Inyo	*	*	20	50	15	85
	Kern	108	1,575	2,269	2,462	648	7,062
	Kings	18	290	187	548	71	1,114
	Lake	*	**	114	290	79	483
	Lassen		*	23	69	*	92
	Los Angeles	2,222	17,222	12,845	24,582	4,112	60,983
	Madera	*	232	292	424	**	948
	Marin	*	**	505	578	287	1,370
	Mariposa	*	114	64	72	*	250
	Mendocino		*	160	236	**	396
	Merced	57	672	310	188	18	1,245
	Modoc		11	41	162	22	236
	Mono	*	14	38	90	**	142
	Monterey	55	326	605	772	206	1,964
	Napa	*	211	301	382	**	894
	Nevada	55	647	337	326	52	1,417

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	Age Group					
	0-5	6-15	16-25	26-64	65+	Total
...continued						
Orange	79	1,798	4,660	3,486	535	10,558
Placer	73	563	396	640	94	1,766
Plumas		47	46	164	23	280
Riverside	461	1,766	4,058	3,289	1,412	10,986
Sacramento	62	869	1,993	3,614	708	7,246
San Benito	*	118	145	159	21	443
San Bernardino	517	6,272	4,835	3,326	418	15,368
San Diego	2,297	29,341	12,081	6,924	1,986	52,629
San Francisco	73	1,045	1,159	1,385	322	3,984
San Joaquin	163	1,944	1,667	3,565	538	7,877
San Luis Obispo	18	320	359	442	95	1,234
San Mateo	**	460	568	*		1,028
Santa Barbara	*	375	365	906	**	1,646
Santa Clara	17	979	2,140	4,375	386	7,897
Santa Cruz			221	231	130	582
Shasta	*	**	117	375	65	557
Sierra		*	*	43	*	43
Siskiyou	17	188	151	635	108	1,099
Solano	15	697	509	974	193	2,388
Sonoma	32	493	522	628	208	1,883
Stanislaus	*	337	977	2,292	456	4,062
Sutter/Yuba	118	397	321	180	37	1,053
Tehama		*	73	190	**	263
Tri-City	36	510	731	1,274	160	2,711
Trinity	*	*	22	70	14	106
Tulare	54	348	722	935	56	2,115
Tuolumne	*	82	91	195	**	368
Ventura		139	961	1,416	422	2,938
Yolo	22	101	150	531	62	866

*Note: N=244,179. Client's age is determined at time of entry into the FSP. * Groups with 10 and under are suppressed for client privacy. ** Data has been secondarily suppressed to ensure suppressed cells cannot be deduced mathematically.*

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Appendix C3: Percent of Full Service Partnerships Missing CSI Number

YEAR	PARTNERSHIPS	MISSING CSI NUMBER	% MISSING
1991	1	0	0.0%
1994	1	0	0.0%
1996	1	0	0.0%
1999	1	0	0.0%
2000	1	1	100.0%
2001	60	0	0.0%
2002	24	0	0.0%
2003	19	0	0.0%
2004	30	0	0.0%
2005	58	1	1.7%
2006	1398	8	0.6%
2007	8735	105	1.2%
2008	11261	298	2.6%
2009	13580	238	1.8%
2010	13088	381	2.9%
2011	12182	433	3.6%
2012	12350	506	4.1%
2013	13850	534	3.9%
2014	14035	533	3.8%
2015	13609	534	3.9%
2016	16756	590	3.5%
2017	18830	722	3.8%
2018	18915	613	3.2%
2019	21186	762	3.6%
2020	18429	611	3.3%
2021	19260	616	3.2%
2022	16519	726	4.4%
Total	244179	8212	3.4%

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Notes: The table above depicts the number and percent of Full Service Partnerships without a Client Services Information number used to link DCR data to other state data sets. Clients may be enrolled in more than one partnership and therefor may be counted more than once.

Appendix C4: Percent of Partnerships Administratively Discharged by County

REGION	SIZE	COUNTY	% ADMINISTRATIVELY DISCHARGED
Bay	Large	Alameda	49%
Southern	Large	Riverside	35%
Central	Small	Inyo	35%
Central	Large	San Joaquin	30%
Southern	Large	San Bernardino	29%
Southern	Large	Ventura	24%
Southern	Small	Imperial	22%
Southern	Large	Orange	20%
Bay	Medium	Santa Cruz	19%
Bay	Medium	Monterey	19%
Bay	Medium	Sonoma	18%
Bay	Large	San Mateo	15%
Central	Medium	Tulare	14%
Central	Small	El Dorado	14%
Superior	Small	Mendocino	13%
Superior	Small	Lassen	11%
Superior	Small	Del Norte	10%
Superior	Medium	Butte	10%
Central	Small	Madera	10%
LA	Large	Los Angeles	9%
Central	Small	Kings	8%
Central	Large	Fresno	8%
Bay	Large	Santa Clara	7%
Central	Medium	Placer	7%
Central	Small	Mariposa	6%
Central	Small	Alpine	6%
Central	Medium	Yolo	6%
Southern	Medium	Santa Barbara	5%
Bay	Medium	Marin	5%
Bay	Small	Napa	5%
Southern	Medium	Tri-City	4%
Southern	Medium	San Luis Obispo	3%
Superior	Small	Tehama	3%
Central	Large	Sacramento	2%
Bay	Medium	Solano	2%
Central	Medium	Merced	1%
Superior	Small	Lake	1%

Notes: See Appendix A.2 for definitions and methodology for administratively discharging clients. The following counties have no administratively discharged partners and are therefore not show above: San Francisco, City of Berkeley, San Diego, Contra Costa, Nevada, Kern. Amador, Calaveras, Colusa, Glenn. Humboldt, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter/Yuba, Trinity, Tuolumne

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Appendix C5: Partner Enrollment Status by Year

YEAR	New Partnerships	Discontued Partnerships	Last Service	Inactive Partners	Actvie Partnerships	Met Goals	% Met Goals
1991	*	*	*	*	*	*	*
1994	*	*	*	*	*	*	*
1996	*	*	*	*	*	*	*
1999	*	*	*	*	*	*	*
2000	*	*	*	*	*	*	*
2001	60						
2002	24						
2003	19						
2004	30						
2005	58	*	*	*	191	*	
2006	1,398	82	19	101	1,488	12	15%
2007	8,735	1,451	191	1,642	8,581	255	18%
2008	11,261	4,618	480	5,098	14,744	1,089	24%
2009	13,580	7,794	519	8,313	20,011	2,338	30%
2010	13,088	9,873	613	10,486	22,613	3,616	37%
2011	12,182	11,038	640	11,678	23,117	4,203	38%
2012	12,350	10,670	972	11,642	23,825	4,133	39%
2013	13,850	11,420	1,294	12,714	24,961	4,715	41%
2014	14,035	13,311	860	14,171	24,825	5,616	42%
2015	13,609	12,814	667	13,481	24,953	6,445	50%
2016	16,756	13,152	1,122	14,274	27,435	5,973	45%
2017	18,830	14,989	2,233	17,222	29,043	6,206	41%
2018	18,915	16,042	1,748	17,790	30,168	7,441	46%
2019	21,186	16,956	2,548	19,504	31,850	7,657	45%
2020	18,429	15,366	3,331	18,697	31,582	6,877	45%
2021	19,260	16,297	6,025	22,322	28,520	7,816	48%
2022	16,519	14,106	5,034	19,140	25,899	6,727	48%
Total	244,174	189,979	28,296	218,275		81,119	33%

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*Note: N=244,179. Data presented are at the partnership level. Clients may be enrolled in more than one partnership and therefor may be counted more than once. * Groups with 10 and under are suppressed for client privacy. Discontinued partnerships are partnerships that have been ended with an exit category from the county. Last Service depicts individuals who do not have an exit code but have ceased receiving services. Inactive Partnerships is the total of Discontinued and Last Service. Active Partnerships are all partnerships that have not been discontinued and continue to receive services. Met Goals are individuals who were exited from their partnership with an exit code to indicate they met their service goals.*

Appendix C6: Length of Enrollment by Age Group

	Adult		Child/TAY	
Months	Number	Cumulatice Percent	Number	Cumulatice Percent
0	289	1.4%	538	1.4%
1	1412	6.8%	2723	7.2%
2	2618	12.6%	4926	13.1%
3	3286	15.8%	7033	18.7%
4	3906	18.7%	9525	25.3%
5	4528	21.7%	12014	31.9%
6	5107	24.5%	14371	38.1%
7	5661	27.1%	16251	43.1%
8	6156	29.5%	18006	47.8%
9	6609	31.7%	19619	52.1%
10	7100	34.0%	21060	55.9%
11	7578	36.3%	22464	59.6%
12	8112	38.9%	23929	63.5%
13	8623	41.3%	25147	66.8%
14	8999	43.1%	25988	69.0%
15	9343	44.8%	26682	70.8%
16	9796	47.0%	27623	73.3%
17	10147	48.6%	28274	75.1%
18	10445	50.1%	28871	76.6%
19	10938	52.4%	29616	78.6%
20	11206	53.7%	30082	79.9%
21	11472	55.0%	30571	81.2%
22	11850	56.8%	31134	82.6%
23	12129	58.1%	31582	83.8%
24	12378	59.3%	32030	85.0%
25	12722	61.0%	32470	86.2%
26	12958	62.1%	32775	87.0%
27	13156	63.1%	33036	87.7%
28	13432	64.4%	33387	88.6%
29	13671	65.5%	33606	89.2%
30	13878	66.5%	33838	89.8%
31	14132	67.7%	34114	90.6%
32	14328	68.7%	34348	91.2%
33	14483	69.4%	34514	91.6%
34	14705	70.5%	34715	92.2%
35	14885	71.4%	34878	92.6%
36+	20860	100.0%	37670	100.0%

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Appendix C7: Race and Ethnicity of Adult Full Service Partnerships by County

ADULT									
		American Indian/Alaska Native	Asian/ Pacific Islander	Black/ African American	Latino/a	Multiracial	Other	Unknown	White/ Caucasian
Statewide	California	3,342	4,237	16,306	22,936	4,612	2,086	7,266	37,314
Region	Bay Area	464	716	1,976	2,540	817	168	2,734	4,602
	Central	942	1,480	2,485	4,686	741	262	1,134	7,930
	Los Angeles	556	1,327	8,327	7,309	1,249	1,269	1,356	7,301
	Southern	896	680	3,417	7,970	1,631	367	1,776	14,084
	Superior	484	34	101	431	174	20	266	3,397
County	Alameda	50	100	627	152	102	62	48	433
	Alpine	*			*				*
	Amador	11		*	16	*		*	128
	Berkeley City	*	*	39	*	*	*	85	46
	Butte	39	*	31	55	17	*	33	481
	Calaveras	23		*	19	*		*	199
	Colusa		*		17	*	*	*	27
	Contra Costa	37	38	211	161	65	11	*	293
	Del Norte	33	*	*	15	*	*	*	191
	El Dorado	12	*	*	41	15	*	13	389
	Fresno	80	128	458	1,057	94	46	539	839
	Glenn	26	*	*	74	14	*	*	234
	Humboldt	78	*	15	32	12		*	407
	Imperial	**	*	51	995	34	29	66	235
	Inyo	*			*		*	19	35
	Kern	77	51	378	979	61	41	60	1,463
	Kings	14	*	61	196	13	*	81	238
	Lake	24	*	11	47	17	*	*	263
	Lassen	*			*	*		*	52
	Los Angeles	556	1,327	8,327	7,309	1,249	1,269	1,356	7,301
	Madera	14	*	38	175	20	*	60	165
	Marin	18	23	58	94	49	12	91	520
	Mariposa	*	*		*	*		*	66
	Mendocino	31	*	*	21	*	*	21	184
	Merced	*	*	23	71	*	*	*	89
	Modoc	23	*	*	13	11		*	124
	Mono	*		*	15	*		*	69
	Monterey	**	29	50	329	33	*	164	348
	Napa	30	*	13	99	20	*	54	342
	Nevada	34	*	*	27	15		19	280

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ADULT								
…continued	American Indian/Alaska Native	Asian/ Pacific Islander	Black/ African American	Latino/a	Multiracial	Other	Unknown	White/ Caucasian
Orange	154	143	206	837	442	37	125	2,077
Placer	34	*	17	89	38	*	43	505
Plumas	11		*	14	*		16	141
Riverside	118	62	657	1,135	197	87	278	2,167
Sacramento	167	665	875	506	216	58	181	1,654
San Benito	*	*	*	95	*	*	*	71
San Bernardino	123	46	667	951	146	36	131	1,644
San Diego	276	296	1,098	1,761	548	46	666	4,219
San Francisco	46	82	389	241	142	26	185	596
San Joaquin	329	525	725	1,159	132	84	41	1,108
San Luis Obispo	37	*	12	66	24	*	*	391
San Mateo							**	*
Santa Barbara	18	25	64	291	37	*	**	640
Santa Clara	159	362	238	1,061	254	25	1,893	769
Santa Cruz	*	*	*	47	*	*	59	223
Shasta	21	*	*	12	12	*	113	273
Sierra	*			*			*	40
Siskiyou	114	*	22	60	24	*	*	501
Solano	**	57	316	163	92	*	97	379
Sonoma	37	*	27	94	39	*	43	581
Stanislaus	120	102	175	775	105	43	18	1,410
Sutter/Yuba	*	*	*	31	13		15	136
Tehama	33	*	*	27	23		*	145
Tri-City	36	22	195	451	76	55	351	248
Trinity	*		*	*	*	*	*	54
Tulare	50	**	47	378	31	*	55	413
Tuolumne	20	*	*	19	*		*	183
Ventura	37	33	89	504	66	28	81	1,000
Yolo	35	*	43	124	32	*	45	298

*Note: N= 98,099. Data presented are at the partnership level. Clients may be enrolled in more than one partnership and therefor may be counted more than once * Groups with 10 and under are suppressed for client privacy. ** Data has been secondarily suppressed to ensure suppressed cells cannot be deduced or mathematically calculated. Data above represent the age of every client at time of partnership. Methodology for determining race and ethnicity can be found in Appendix A1: Operational Definition and Parameters.*

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Appendix C8: Race and Ethnicity of Child Full Service Partnerships by County

		CHILD/TAY							
		American Indian/Alaska Native	Asian/ Pacific Islander	Black/ African American	Latino/a	Multiracial	Other	Unknown	White/ Caucasian
Statewide	California	3,339	4,428	16,452	74,630	5,913	3,182	11,818	26,318
Region	Bay Area	386	502	1,862	4,958	764	185	2,731	2,001
	Central	669	900	1,995	6,156	827	237	2,995	4,559
	Los Angeles	275	1,023	6,274	18,461	812	1,444	1,259	2,741
	Southern	1,607	1,972	6,253	44,279	3,328	1,299	4,651	14,869
	Superior	402	31	68	776	182	17	182	2,148
County	Alameda	29	44	244	101	51	23	16	84
	Alpine	*						*	*
	Amador	*		*	20	*		*	59
	Berkeley City	*	*	21	*	*	*	51	12
	Butte	106	**	35	214	67	*	28	471
	Calaveras	15		*	26	*		*	141
	Colusa	*		*	33	*	*	*	17
	Contra Costa	66	34	248	594	119	15	21	184
	Del Norte	14	*		*			*	40
	El Dorado	39	*	16	104	23	*	74	378
	Fresno	54	65	233	1,084	70	54	1,635	414
	Glenn	34	*	*	182	*	*	*	248
	Humboldt	14			*	*		*	38
	Imperial	20	*	40	1,998	**	50	51	119
	Inyo	*			*			*	*
	Kern	66	36	467	2,084	100	79	76	1,044
	Kings	20	*	59	218	18	*	70	104
	Lake	12		*	35	11	*	*	99
	Lassen	*		*	*			*	17
	Los Angeles	275	1,023	6,274	18,461	812	1,444	1,259	2,741
	Madera	19	*	31	308	16	12	33	106
	Marin	*	*	43	377	25	*	93	138
	Mariposa	13			30	*	*	*	133
	Mendocino	25		*	27	*	*	*	90
	Merced	26	14	55	569	47	*	105	213
	Modoc	*			*	*	*	*	27
	Mono	*			22			*	21
	Monterey	12	13	22	643	34	30	141	91
	Napa	13	*	11	264	12	*	72	138
	Nevada	102	*	*	166	37	*	44	673

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CHILD/TAY								
…continued	American Indian/Alaska Native	Asian/ Pacific Islander	Black/ African American	Latino/a	Multiracial	Other	Unknown	White/ Caucasian
Orange	171	539	168	3,472	530	62	268	1,327
Placer	38	11	37	201	46	13	149	537
Plumas	*			13	*		*	69
Riverside	96	51	719	3,281	210	190	618	1,120
Sacramento	139	536	715	642	226	46	138	482
San Benito	*	*		182	*	*	*	57
San Bernardino	292	107	1,800	5,348	432	220	838	2,587
San Diego	874	1,202	2,873	26,413	1,869	532	2,296	7,660
San Francisco	45	174	770	607	195	30	295	161
San Joaquin	125	192	675	1,288	206	52	570	666
San Luis Obispo	35	*	*	193	44	*	*	399
San Mateo	21	45	82	328	49	23	319	174
Santa Barbara	21	*	19	445	22	*	31	206
Santa Clara	48	126	82	1,079	91	11	1,524	175
Santa Cruz	*	*	*	95	*	*	35	74
Shasta	*		*	16	11		48	78
Sierra	*		*	*				*
Siskiyou	54	*	*	38	16		14	222
Solano	71	32	299	329	119	17	71	283
Sonoma	57	14	35	354	55	13	89	430
Stanislaus	42	50	91	680	56	**	*	379
Sutter/Yuba	51	**	30	219	50	*	20	443
Tehama	*			18	*		*	38
Tri-City	*	15	120	562	50	146	302	77
Trinity	*			*	*	*	*	15
Tulare	44	*	30	642	28	*	123	245
Tuolumne	*	*	*	22	*	*	*	130
Ventura	27	*	39	483	34	13	164	330
Yolo	17	*	17	76	17	*	40	97

Note: N= 146,080. *Data presented are at the partnership level. Clients may be enrolled in more than one partnership and therefor may be counted more than once. * Groups with 10 and under are suppressed for client privacy. ** Data has been secondarily suppressed to ensure suppressed cells cannot be deduced or mathematically calculated. Data above represent the age of every client at time of partnership. Methodology for determining race and ethnicity can be found in Appendix A1: Operational Definition and Parameters.*

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Appendix C9: Gender Composition of Full Service Partnerships by County

		Adult				Child / TAY			
		Female	Male	All Other	Unknown	Female	Male	Other	Unknown
Statewide	California	42,261	51,150	44	4,644	62,116	76,377	166	7,421
Region	Bay Area	4,673	6,888	*	**	4,923	6,290	*	**
	Central	9,071	9,836	*	**	6,968	9,037	15	2,318
	Los Angeles	12,217	16,431	17	29	14,179	18,023	38	49
	Southern	13,857	15,696	17	1,251	34,332	41,059	93	2,774
	Superior	2,443	2,299	*	**	1,714	1,968	*	**
County	Alameda	**	984		*	209	383		
	Alpine	*	*			*	*		*
	Amador	99	70			59	35		
	Berkeley City	36	73		84	22	23		51
	Butte	305	358			**	496		*
	Calaveras	126	129			110	**	*	
	Colusa	**	26		*	**	35		*
	Contra Costa	**	459		*	634	642	*	*
	Del Norte	135	123			32	32		
	El Dorado	**	275		*	298	329		16
	Fresno	1,011	1,755		475	**	1,343	*	1,575
	Glenn	238	**		*	255	231		*
	Humboldt	226	331			23	47		
	Imperial	673	719		39	**	1,379		*
	Inyo	19	30		16	*	15		*
	Kern	1,540	1,527	*	**	2,004	1,911	*	**
	Kings	285	258		76	186	251		58
	Lake	200	**		*	101	62	*	*
	Lassen	44	28			13	15		
	Los Angeles	12,217	16,431	17	29	14,179	18,023	38	49
	Madera	194	229		58	202	291	*	**
	Marin	387	442		36	237	432		36
	Mariposa	47	35			**	115		*
	Mendocino	122	149			70	91		
	Merced	**	124		*	**	499	*	87
	Modoc	121	**		*	28	**		*
	Mono	54	**		*	**	35		*
	Monterey	467	511			**	528		*
	Napa	259	262	*	**	213	259	*	**
	Nevada	147	218		13	414	585	*	**

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	Adult				Child / TAY			
	Female	Male	All Other	Unknown	Female	Male	Other	Unknown
Orange	1,601	2,320		100	2,420	3,852		265
Placer	290	444			**	617		*
Plumas	97	76	*	**	**	44		*
Riverside	2,243	2,447		11	2,567	3,701		17
Sacramento	2,066	2,243		13	**	1,761		*
San Benito	106	**		*	139	**		*
San Bernardino	1,987	1,677		80	4,879	6,341		404
San Diego	3,677	4,612	*	**	19,984	22,010	87	1,638
San Francisco	550	1,099	*	**	855	1,285		137
San Joaquin	2,233	1,856		14	1,704	1,695		375
San Luis Obispo	280	255	*	*	290	401	*	*
San Mateo	*			**	368	467		206
Santa Barbara	554	**		*	340	404		*
Santa Clara	976	1,661		2,124	705	810		1,621
Santa Cruz	**	226		*	**	154		*
Shasta	157	176		107	49	70		45
Sierra	**	17		*	*	*	*	
Siskiyou	438	**		*	176	**		*
Solano	446	640		81	536	624		61
Sonoma	**	461		*	**	558	*	*
Stanislaus	1,384	1,355	*	*	**	719	*	
Sutter/Yuba	103	99		15	338	486	*	**
Tehama	122	**		*	28	45		*
Tri-City	531	575		328	515	495		267
Trinity	**	46		*	**	14		*
Tulare	485	453		53	488	514		122
Tuolumne	126	**		*	**	87	*	
Ventura	771	1,024		43	402	565		133
Yolo	253	324		16	94	153		26

*Notes: N=244,179. Data presented are at the partnership level. Clients may be enrolled in more than one partnership and therefor may be counted more than once. * Groups with 10 and under are suppressed for client privacy. ** Data has been secondarily suppressed to ensure suppressed cells cannot be deduced mathematically. Methodology for determining gender can be found in Appendix A1: Operational Definition and Parameters.*

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Appendix C10: Country of Birth Composition for Full Service Partnerships by County

		Adult				Child/TAY			
		Mexico	Other	United States	Unkonwn	Mexico	Other	United States	Unkonwn
Statewide	California	3,387	6,063	67,839	20,810	3,200	2,867	113,651	26,362
Region	Bay Area	316	1,068	9,133	3,500	358	447	8,829	3,755
	Central	945	1,563	15,464	1,688	274	326	14,468	3,270
	Los Angeles	716	1,739	14,449	11,790	402	567	18,489	12,831
	Southern	1,341	1,591	24,313	3,576	2,118	1,500	68,291	6,349
	Superior	69	102	4,480	256	48	27	3,574	157
County	Alameda	20	132	1,159	263	*	30	469	83
	Alpine			11				*	*
	Amador	*	*	165	*	*	*	91	*
	Berkeley City		*	99	88	*	*	42	51
	Butte	*	12	637	*	*	*	904	24
	Calaveras	*	*	246	*	*	*	194	*
	Colusa	*		42	**			**	*
	Contra Costa	38	77	618	93	83	38	1,028	132
	Del Norte		*	233	20		*	61	*
	El Dorado	*	*	470	*	*	*	615	20
	Fresno	109	98	2,529	505	38	23	1,959	1,589
	Glenn	24	*	320	*	19	*	463	*
	Humboldt	*	**	522	18		*	66	*
	Imperial	233	15	1,094	89	136	*	2,128	**
	Inyo			48	17	*		19	*
	Kern	184	114	2,690	122	90	42	3,772	48
	Kings	21	11	492	95	*	*	414	71
	Lake	*	*	345	*	*	*	158	*
	Lassen	*	*	69	*			28	
	Los Angeles	716	1,739	14,449	11,790	402	567	18,489	12,831
	Madera	**	*	362	65	**	*	454	45
	Marin	*	94	654	108	59	84	504	58
	Mariposa		*	77	*	*	*	176	*
	Mendocino	*	*	259		*	*	155	
	Merced	20	**	166	*	**	*	908	107
	Modoc	*	*	169	*	*		46	*
	Mono	*	*	88	*	*		46	*
	Monterey	33	33	507	405	**	*	514	435
	Napa	38	27	446	57	35	15	409	62
	Nevada	*	*	353	14	*	*	990	38

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	Adult				Child/TAY			
	Mexico	Other	United States	Unkonwn	Mexico	Other	United States	Unkonwn
Orange	78	345	2,684	914	287	293	4,302	1,655
Placer	*	19	638	71	11	20	859	142
Plumas	*	*	164	18			**	*
Riverside	155	191	4,152	203	100	49	5,997	139
Sacramento	34	666	3,580	42	17	162	2,720	25
San Benito	28	*	141	*	13	*	248	*
San Bernardino	87	117	3,115	425	167	73	9,817	1,567
San Diego	426	646	6,957	881	1,227	1,003	39,501	1,988
San Francisco	23	172	1,269	243	23	113	1,638	503
San Joaquin	472	498	2,638	495	75	53	2,647	999
San Luis Obispo	*	18	492	22	18	*	657	**
San Mateo				*	16	*	336	**
Santa Barbara	29	26	1,006	34	23	*	708	**
Santa Clara	96	420	2,270	1,975	58	104	1,434	1,540
Santa Cruz	*	**	219	121	*	*	131	78
Shasta	*	*	310	123		*	111	**
Sierra	*	*	44	*			12	
Siskiyou	*	14	715	**	*	*	344	*
Solano	14	69	974	110	12	29	1,080	100
Sonoma	12	15	777	32	*	11	996	30
Stanislaus	123	162	2,235	228	32	24	1,209	57
Sutter/Yuba	*	14	181	17	*	*	785	39
Tehama	*	*	217	*	*	*	67	*
Tri-City	56	41	630	707	31	20	544	682
Trinity		*	81	*			**	*
Tulare	78	23	810	80	32	*	960	128
Tuolumne		*	216	**			**	*
Ventura	88	78	1,493	179	39	*	865	**
Yolo	19	36	512	26	*	*	230	29

*N=244,179. Data presented are at the partnership level. Clients may be enrolled in more than one partnership and therefor may be counted more than once. * Groups with 10 and under are suppressed for client privacy. ** Data has been secondarily suppressed to ensure suppressed cells cannot be deduced mathematically. Methodology for determining country of birth can be found in Appendix A1: Operational Definition and Parameters.*

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Appendix C11: Primary Language Composition for Full Service Partnerships by Region

		Adult				Child/TAY			
		English	Other	Spanish	Unknown	English	Other	Spanish	Unknown
Statewide	California	77,165	3,986	4,545	12,403	101,291	2,594	13,599	28,596
Region	Bay Area	9,445	1,256	437	2,879	7,817	1,194	1,195	3,183
	Central	15,762	1,164	995	1,739	13,085	350	846	4,057
	Los Angeles	23,056	923	1,639	3,076	24,514	476	3,766	3,533
	Southern	24,782	590	1,419	4,030	53,057	553	7,694	16,954
	Superior	4,120	53	55	679	2,818	21	98	869
County	Alameda	1,449	67	42	16	546	17	24	*
	Alpine	*			*	*			*
	Amador	115	*	*	49	58			36
	Berkeley City	13			180	**	*		79
	Butte	583	*	*	64	771	*	**	128
	Calaveras	224	*	*	26	149	*	*	47
	Colusa	38		*	**	44		*	**
	Contra Costa	535	31	42	218	800	18	148	315
	Del Norte	218	*	*	38	50	*		**
	El Dorado	464	*	*	16	564	*	**	63
	Fresno	2,403	61	126	651	1,665	21	218	1,705
	Glenn	279	*	**	60	324	*	**	125
	Humboldt	538	*	*	*	66	*		*
	Imperial	1,033	*	254	**	1,620	*	457	**
	Inyo	43		*	**	15	*	*	*
	Kern	2,337	30	192	551	2,787	14	253	898
	Kings	442	*	22	152	297		28	170
	Lake	297		*	**	123	*	*	41
	Lassen	65	*	*	*	**			*
	Los Angeles	23,056	923	1,639	3,076	24,514	476	3,766	3,533
	Madera	332	*	**	107	331	*	**	163
	Marin	666	40	32	127	348	15	158	184
	Mariposa	71		*	*	126	*		**
	Mendocino	260	*	*	*	154		*	*
	Merced	176	*	*	16	617	11	51	360
	Modoc	142	*		**	26		*	**
	Mono	80	*	*	15	31		*	**
	Monterey	913	*	44	**	862	*	69	**
	Napa	385	*	**	148	274	*	**	164
	Nevada	330	*	*	43	688	*	*	341

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… continued	Adult				Child/TAY			
	English	Other	Spanish	Unknown	English	Other	Spanish	Unknown
Orange	3,455	163	94	309	4,518	197	703	1,119
Placer	705	*	*	11	908	*	**	68
Plumas	144	*	*	41	62		*	**
Riverside	4,176	67	188	270	4,961	22	517	785
Sacramento	3,602	493	50	177	2,404	189	66	265
San Benito	128		19	33	184		22	59
San Bernardino	3,166	73	93	412	8,905	39	563	2,117
San Diego	6,656	188	357	1,709	27,648	260	4,800	11,011
San Francisco	670	860	52	125	798	1,018	172	289
San Joaquin	3,086	450	514	53	3,117	81	162	414
San Luis Obispo	472	*		**	462	*	**	198
San Mateo	*				557	28	113	343
Santa Barbara	987	21	59	28	547	*	121	**
Santa Clara	2,549	190	135	1,887	1,332	63	236	1,505
Santa Cruz	323	*	**	17	190	*	19	*
Shasta	314	*	*	118	102	*		61
Sierra	45		*	*	12			
Siskiyou	589	*	*	142	282		*	**
Solano	1,014	29	19	105	992	17	75	137
Sonoma	799	11	15	11	919	*	82	**
Stanislaus	2,255	102	117	274	999	20	76	227
Sutter/Yuba	178	*	*	28	579	*	*	240
Tehama	202	*	*	20	62	*		**
Tri-City	991	18	93	332	797	*	205	272
Trinity	**			*	**			*
Tulare	822	*	**	85	849	*	**	155
Tuolumne	217	*		17	166			12
Ventura	1,509	25	89	215	812	*	**	241
Yolo	539	11	15	28	209	*	**	43

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Appendix C12: Gender Composition for Full Service Partnerships by Region

		Adult				Child/TAY			
		English	Other	Spanish	Unknown	English	Other	Spanish	Unknown
Statewide	California	77,165	3,986	4,545	12,403	101,291	2,594	13,599	28,596
Region	Bay Area	9,445	1,256	437	2,879	7,817	1,194	1,195	3,183
	Central	15,762	1,164	995	1,739	13,085	350	846	4,057
	Los Angeles	23,056	923	1,639	3,076	24,514	476	3,766	3,533
	Southern	24,782	590	1,419	4,030	53,057	553	7,694	16,954
	Superior	4,120	53	55	679	2,818	21	98	869

*Notes: N=244,179. Data presented are at the partnership level. Clients may be enrolled in more than one partnership and therefor may be counted more than once. * Groups with 10 and under are suppressed for client privacy. ** Data has been secondarily suppressed to ensure suppressed cells cannot be deduced mathematically. Methodology for determining primary language can be found in Appendix A1: Operational Definition and Parameters. County level composition is not presented for primary language as little county level data was shareable post data suppression. Data is suppressed for groups with 10 and under counts at the county level.*

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Appendix C13: Percent of Partners with a Given Diagnosis by Age Group

	Anxiety	Bipolar And Related	Depressivs	Disruptive, Impulse-Control, Conduct	Neurodevelopmental	Other	Personality	Schizophrenia And Other Psychotic	Substance-Related And Addictive	Trauma-And Stressor-Related
Adult										
Statewide	17%	39%	63%	4%	5%	26%	1%	69%	41%	26%
Bay Area	11%	30%	41%	3%	4%	25%	1%	62%	42%	25%
Central	19%	36%	60%	4%	6%	36%	1%	66%	39%	34%
Los Angele	13%	40%	74%	4%	3%	11%	0%	75%	35%	20%
Southern	21%	44%	65%	4%	6%	32%	1%	70%	50%	26%
Superior	23%	36%	52%	3%	9%	33%	1%	59%	28%	36%
Child / TAY										
Statewide	27%	16%	61%	33%	31%	10%	0%	18%	14%	46%
Bay Area	24%	18%	55%	25%	25%	15%	1%	24%	17%	49%
Central	22%	17%	52%	30%	30%	13%	0%	21%	13%	48%
Los Angele	23%	19%	74%	46%	36%	6%	0%	24%	11%	48%
Southern	31%	13%	59%	31%	30%	10%	0%	13%	14%	44%
Superior	34%	19%	60%	29%	30%	16%	1%	18%	12%	57%

*Notes: Data presented are at the partnership level. Clients may be enrolled in more than one partnership and therefor may be counted more than once. * Groups with 10 and under are suppressed for client privacy. ** Data has been secondarily suppressed to ensure suppressed cells cannot be deduced mathematically. Methodology for determining primary language can be found in Appendix A1: Operational Definition and Parameters. County level composition is not presented for primary language as little county level data was shareable post data suppression. Data is suppressed for groups with 10 and under counts at the county level.*

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Appendix C14: CSI Services Received by Age Group and Diagnosis Category

	Age Group	Year 2018	2019	2020	2021	2022
Anxiety Disorders	0-5	46	99	73	80	71
	6-15	1,877	2,405	2,149	2,129	2,122
	16-25	1,656	2,059	2,159	2,412	2,106
	26-64	1,145	1,256	1,374	1,591	1,508
	65+	241	243	250	267	262
Bipolar And Related Disorders	0-5	*	*	*		*
	6-15	203	216	222	200	154
	16-25	950	1,247	1,146	1,132	898
	26-64	3,035	3,734	3,564	3,442	3,013
	65+	455	494	470	517	435
Depressive Disorders	0-5	33	84	78	78	68
	6-15	3,864	5,444	4,966	4,724	3,944
	16-25	4,160	5,428	5,275	5,561	4,837
	26-64	4,099	5,451	5,039	4,831	4,207
	65+	823	1,013	985	995	819
Disruptive, Impulse-Control, And Conduct Disorders	0-5	77	110	72	68	52
	6-15	2,268	2,744	2,232	1,576	1,316
	16-25	891	1,149	1,079	906	633
	26-64	53	47	50	49	42
	65+	*	*	*	*	*
Neurodevelopmental Disorders	0-5	165	318	273	265	226
	6-15	2,751	3,321	3,018	2,550	2,466
	16-25	828	917	878	849	806
	26-64	273	281	291	261	232
	65+	25	20	24	26	26

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		Year				
	Age Group	2018	2019	2020	2021	2022
Other	0-5	13	*	16	*	*
	6-15	270	292	333	347	306
	16-25	400	477	501	591	565
	26-64	1,217	1,170	1,111	1,026	859
	65+	202	190	197	200	164
Personality Disorders	0-5					
	6-15	*	*	*	*	*
	16-25	14	27	24	22	12
	26-64	22	19	16	16	14
	65+	*	*	*	*	*
Schizophrenia And Other Psychotic Disorders	0-5	*	*	*	*	*
	6-15	130	128	140	122	110
	16-25	1,643	2,243	2,066	1,959	1,584
	26-64	10,753	13,531	13,383	13,468	12,205
	65+	1,307	1,520	1,566	1,657	1,511
Substance-Related And Addictive Disorders	0-5		*	*	*	*
	6-15	180	204	168	126	112
	16-25	1,364	1,562	1,455	1,229	852
	26-64	4,634	4,804	4,578	4,533	4,013
	65+	355	395	432	418	355
Trauma-And Stressor-Related Disorders	0-5	293	556	483	497	468
	6-15	2,762	4,300	4,185	3,855	3,543
	16-25	1,847	2,514	2,637	2,802	2,515
	26-64	2,241	2,590	2,680	2,781	2,533
	65+	205	252	231	279	247

*Notes: Data presented for all services received by individuals actively enrolled in an FSP between January 1, 2018 and December 31, 2022. * Groups with 10 and under are suppressed for client privacy. Diagnoses are not mutually exclusive and are calculated at the partnership level. Only primary and secondary diagnoses are included. It is possible that a partner may have more than two psychiatric diagnoses. Methodology for determining diagnoses can be found in Appendix A1: Operational Definition and Parameters.*

Appendix C15: Number of Holds by County Five Years Prior to Joining an FSP

		Adult			Child/TAY		
		Partnerships with at least one hold	Total Holds	% With at least One Hold	Partnerships with at least one hold	Total Holds	% With at least One Hold
	Statewide	5,739	13,337	17%	2923	5652	5%
Region	Bay Area	1,197	3,223	20%	417	988	8%
	Central	1,449	3,342	24%	530	1028	7%
	Los Angeles	269	474	3%	75	126	1%
	Southern	2,445	5,293	25%	1788	3242	5%
	Superior	379	1,005	27%	113	268	11%
County	Alameda	136	472	55%	435	1706	71%
	Alpine			0%			
	Amador			0%	*	*	*
	Berkeley City			0%			0%
	Butte	*	*	*	27	81	52%
	Calaveras	*	*	*	15	19	9%
	Colusa			0%	*	*	*
	Contra Costa	44	125	15%	121	310	43%
	Del Norte	12	42	52%	34	75	36%
	El Dorado	22	50	7%	69	174	49%
	Fresno	33	56	3%	66	116	5%
	Glenn	16	28	8%	22	32	13%
	Humboldt	22	93	88%	174	566	76%
	Imperial	*	*	*	*	*	*
	Inyo			0%			0%
	Kern	368	774	17%	576	1196	42%
	Kings	*	*	*	43	94	17%
	Lake	25	46	46%	37	94	39%
	Lassen						
	Los Angeles	75	126	1%	269	474	3%
	Madera	26	39	23%	20	47	17%
	Marin	*	*	*	12	13	4%
	Mariposa			0%	*	*	*
	Mendocino	*	*	*	*	*	*
	Merced	*	*	*	37	114	66%
	Modoc	*	*	*	16	24	29%
	Mono			0%	*	*	*
	Monterey	85	136	15%	176	365	35%
	Napa	41	65	31%	71	144	36%
	Nevada	12	21	4%	27	66	43%

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… continued	Adult			Child/TAY		
	Partnerships with at least one hold	Total Holds	% With at least One Hold	Partnerships with at least one hold	Total Holds	% With at least One Hold
Orange	18	32	1%	58	99	7%
Placer	21	50	4%	103	250	46%
Plumas	*	*	*	*	*	*
Riverside	414	765	12%	557	1425	31%
Sacramento	74	110	5%	378	660	26%
San Benito	*	*	*	*	*	*
San Bernardino	68	121	2%	118	249	16%
San Diego	799	1,287	3%	706	1159	22%
San Francisco	22	44	4%	52	93	13%
San Joaquin	70	150	5%	194	482	26%
San Luis Obispo	32	87	19%	82	237	48%
San Mateo	*	*	*			0%
Santa Barbara	33	55	9%	126	294	43%
Santa Clara	40	57	2%	170	260	6%
Santa Cruz						
Shasta	*	*	*	*	*	*
Sierra			0%	*	*	*
Siskiyou	*	*	3%	15	18	6%
Solano	32	66	7%	156	324	41%
Sonoma	*	*	*	*	*	*
Stanislaus	161	332	23%	432	1141	35%
Sutter/Yuba	61	117	25%	33	100	37%
Tehama			0%	*	*	*
Tri-City			0%	25	42	4%
Trinity			0%	*	*	*
Tulare	40	81	12%	32	98	46%
Tuolumne			0%	*	*	*
Ventura	45	92	44%	195	588	55%
Yolo	*	*	*	12	24	5%

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*Notes: Data above includes individuals actively enrolled in an FSP between January 1, 2018 and December 31, 2022. Data represent the number of partnerships in each county where clients had at least one hold in the five years prior to completing a PAF. Total hold is the total holds received by those individuals in the five years prior to completing a PAF. Percent with at least one hold is the percent of total partnerships in the county where clients have at least one hold in the five years prior to completing a PAF. * Groups with 10 and under are suppressed for client privacy. Methodology for determining inpatient holds can be found in Appendix A1: Operational Definition and Parameters.*

Appendix C16: Emergency Department Visits by County Prior to Joining an FSP

		Adult			Child/TAY		
		PARTNERSHIPS	TOTAL VISITS	% AT LEAST ONE	PARTNERSHIPS	TOTAL VISITS	% AT LEAST ONE
	Statewide	27,154	431,889	81.5%	26,184	127,142	42.9%
Region	Bay Area	4,048	76,969	69.0%	2,497	16,105	47.4%
	Central	5,163	89,137	84.4%	3,462	23,162	48.8%
	Los Angeles	8,855	130,824	85.6%	5,402	27,404	49.3%
	Southern	7,881	119,971	82.1%	14,228	56,364	38.8%
	Superior	1,207	14,988	86.1%	595	4,107	56.7%
County	Alameda	571	15,393	93.6%	202	2,331	81.1%
	Alpine						0.0%
	Amador	23	180	92.0%	*	*	*
	Berkeley City	*	*	*	*	*	*
	Butte	51	994	98.1%	89	599	70.1%
	Calaveras	155	1,729	95.7%	75	513	65.2%
	Colusa	19	175	55.9%	2	17	50.0%
	Contra Costa	261	6,715	92.2%	239	2,207	80.5%
	Del Norte	84	1,176	89.4%	21	262	91.3%
	El Dorado	133	1,591	95.0%	150	787	45.5%
	Fresno	906	16,302	74.1%	423	3,615	40.5%
	Glenn	137	1,528	80.6%	102	472	49.8%
	Humboldt	211	3,070	92.1%	25	260	100.0%
	Imperial	119	1,084	77.8%	431	2,658	69.3%
	Inyo	*	*	*	*	*	*
	Kern	1,194	17,558	86.6%	1,133	6,274	51.4%
	Kings	220	3,720	85.9%	99	535	50.5%
	Lake	79	858	83.2%	37	292	68.5%
	Lassen						
	Los Angeles	8,855	130,824	85.6%	5,402	27,404	49.3%
	Madera	55	630	46.6%	45	219	40.5%
	Marin	254	3,567	77.4%	110	637	43.5%
	Mariposa	16	261	94.1%	11	57	36.7%
	Mendocino	94	1,542	92.2%	37	356	78.7%
	Merced	48	936	85.7%	116	602	47.9%
	Modoc	46	608	83.6%	*	*	*
	Mono	16	180	84.2%	*	*	*
	Monterey	437	6,160	87.6%	258	1,520	44.5%
	Napa	154	2,043	79.0%	69	289	51.5%
	Nevada	54	464	85.7%	103	538	36.4%

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	Adult			Child/TAY		
...continued	PARTNERSHIPS	OTAL VISIT	% AT LEAST ONE	PARTNERSHIPS	OTAL VISIT	% AT LEAST ONE
Orange	743	9,762	86.5%	551	2,745	38.8%
Placer	205	3,581	90.7%	220	1,173	41.7%
Plumas	62	637	83.8%	16	118	76.2%
Riverside	1,548	21,214	87.2%	1,605	7,422	48.1%
Sacramento	1,290	27,608	89.2%	989	7,239	69.9%
San Benito	61	597	83.6%	46	231	38.0%
San Bernardino	559	6,393	74.1%	1,144	4,734	30.2%
San Diego	2,577	46,513	81.3%	8,791	28,090	36.6%
San Francisco	347	13,278	86.8%	320	2,655	51.9%
San Joaquin	630	10,168	85.8%	519	2,501	33.6%
San Luis Obispo	160	3,049	94.1%	90	864	53.3%
San Mateo	*	*	*	108	390	35.4%
Santa Barbara	259	3,582	88.1%	190	1,254	52.8%
Santa Clara	1,413	19,210	51.0%	560	2,853	32.5%
Santa Cruz						
Shasta	85	1,061	78.0%	29	397	63.0%
Sierra	*	*	*	*	*	*
Siskiyou	203	2,015	87.5%	123	705	63.4%
Solano	323	5,977	85.4%	327	1,715	66.7%
Sonoma	225	4,013	90.7%	257	1,264	56.1%
Stanislaus	1,098	17,308	89.1%	423	3,505	60.9%
Sutter/Yuba	71	879	78.9%	135	750	54.4%
Tehama	56	622	94.9%	*	*	*
Tri-City	398	5,443	57.9%	223	1,533	36.5%
Trinity	20	210	83.3%			0.0%
Tulare	44	634	62.9%	120	543	34.9%
Tuolumne	70	1,168	90.9%	67	377	58.8%
Ventura	324	5,373	91.3%	70	790	68.6%
Yolo	179	2,254	81.7%	56	674	53.3%

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*Notes: Data above includes individuals actively enrolled in an FSP between January 1, 2018 and December 31, 2022. Data represent the number of emergency department (ED) visits in each county where clients had at least one ED visit in the five years prior to completing a PAF. Total hold is the total ED visits by those individuals in the five years prior to completing a PAF. Percent with at least one visit is the percent of total partnerships in the county where clients have at least one ED visit in the five years prior to completing a PAF. * Groups with 10 and under are suppressed for client privacy. Methodology for determining inpatient holds can be found in Appendix A1: Operational Definition and Parameters.*

Appendix C17: FSP Clients Who Have Ever Indicated They Were Homeless

		Adult		Child / TAY	
		Ever Homeless	% of Clients	Ever Homeless	% of Clients
	Statewide	61,315	60.8%	49,163	32.1%
Region	Bay Area	8,986	62.0%	4,474	31.9%
	Central	11,512	57.3%	6,924	36.6%
	Los Angeles	19,654	66.5%	11,029	33.0%
	Southern	18,470	58.4%	24,972	30.0%
	Superior	2,693	53.7%	1,764	44.7%
County	Alameda	1,210	75.0%	370	60.2%
	Alpine	*	*	*	*
	Amador	96	53.4%	34	34.6%
	Berkeley City	153	77.1%	32	32.4%
	Butte	314	45.4%	459	48.1%
	Calaveras	153	54.7%	105	49.3%
	Colusa	32	52.9%	19	27.4%
	Contra Costa	582	68.1%	489	37.5%
	Del Norte	164	62.5%	41	63.1%
	El Dorado	286	56.8%	308	46.8%
	Fresno	2,083	61.4%	867	23.5%
	Glenn	143	40.0%	192	38.9%
	Humboldt	364	64.5%	49	66.7%
	Imperial	343	21.9%	580	24.4%
	Inyo	20	29.2%	*	*
	Kern	1,632	52.9%	1,748	42.4%
	Kings	254	39.5%	128	26.4%
	Lake	208	55.6%	100	58.2%
	Lassen	42	56.9%	18	64.3%
	Los Angeles	19,654	66.5%	11,029	33.0%
	Madera	223	44.2%	161	29.6%
	Marin	587	66.2%	240	33.5%
	Mariposa	49	59.8%	81	43.8%
	Mendocino	175	59.9%	115	70.4%
	Merced	133	64.1%	286	26.0%
	Modoc	59	31.5%	13	26.7%
	Mono	26	24.8%	*	*
	Monterey	593	59.7%	375	35.2%
	Napa	360	61.5%	199	37.2%
	Nevada	238	62.8%	408	36.7%

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	Adult		Child / TAY	
…continued	Ever Homeless	% of Ever Clients	Ever Homeless	% of Ever Clients
Orange	3,363	82.5%	3,679	55.5%
Placer	545	73.4%	396	37.2%
Plumas	81	43.3%	27	30.9%
Riverside	3,054	62.4%	2,240	34.4%
Sacramento	2,962	68.5%	1,527	51.4%
San Benito	47	24.2%	70	25.7%
San Bernardino	1,851	47.2%	4,284	36.5%
San Diego	5,611	61.6%	10,994	23.2%
San Francisco	1,367	78.8%	796	33.7%
San Joaquin	1,911	45.5%	1,502	38.5%
San Luis Obispo	389	72.4%	332	47.1%
San Mateo		0.0%	250	23.2%
Santa Barbara	512	45.3%	314	40.6%
Santa Clara	2,737	55.1%	758	23.2%
Santa Cruz	183	49.0%	100	43.0%
Shasta	267	58.3%	92	55.6%
Sierra	16	32.0%	*	*
Siskiyou	434	57.5%	164	44.0%
Solano	629	52.6%	432	32.3%
Sonoma	538	63.6%	363	33.2%
Stanislaus	1,728	60.9%	612	40.2%
Sutter/Yuba	86	36.9%	281	32.2%
Tehama	101	41.7%	45	59.5%
Tri-City	951	64.1%	461	33.8%
Trinity	55	61.6%	17	59.3%
Tulare	397	36.2%	406	34.2%
Tuolumne	132	53.6%	82	42.8%
Ventura	764	40.1%	340	29.8%
Yolo	423	71.3%	131	47.4%

*Notes: N=244,179. Data presented are at the partnership level. Clients may be enrolled in more than one partnership and therefor may be counted more than once. * Groups with 10 and under are suppressed for client privacy. Methodology for determining homelessness can be found in Appendix A1: Operational Definition and Parameters.*

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Appendix C18: Annual Enrollment of Full Service Partnerships by Age Group

	Type of Disorder	Deceased	Discontinue	Institution	Justice Involved	Met Goals	Moved	Not Located	Target Criteria
		Exit Reason							
Adult	Anxiety	309	746	190	284	1,463	517	913	278
	Bipolar And Related	658	1,344	560	670	2,320	1,045	1,751	439
	Depressive	1,096	2,287	751	985	4,222	1,572	3,035	741
	Disruptive, Impulse-Control, And Conduc	71	208	99	187	319	127	312	74
	Neurodevelopmental	82	231	115	171	374	158	280	115
	Other	516	733	459	411	1,317	564	927	344
	Personality	*	24	11	14	48	16	16	*
	Schizophrenia And Other Psychoti	1,340	2,351	1,302	1,289	4,169	1,752	3,268	851
	Substance-Related And Addictive	943	1,335	682	880	2,111	1,015	2,240	547
	Trauma-And Stressor-Related	448	1,098	310	509	1,920	764	1,559	391
Child / TAY	Anxiety	21	2,752	316	236	6,921	1,116	1,969	451
	Bipolar And Related	24	839	260	197	1,198	571	644	158
	Depressive	69	5,262	799	565	11,442	2,367	3,900	894
	Disruptive, Impulse-Control, And Conduc	23	2,451	497	466	5,176	1,083	1,762	507
	Neurodevelopmental	24	2,491	430	286	6,360	1,178	1,725	535
	Other	14	612	123	79	1,232	339	398	141
	Personality		16	*	*	41	11	14	*
	Schizophrenia And Other Psychoti	40	840	257	247	1,239	573	782	169
	Substance-Related And Addictive	38	1,003	216	370	1,155	442	1,034	145
	Trauma-And Stressor-Related	41	4,059	652	465	10,024	2,142	3,055	871

*Note: N=244,179. Diagnoses are not mutually exclusive and are calculated at the partnership level. Only primary and secondary diagnoses are included. It is possible that a partner may have more than two psychiatric diagnoses. * Groups with 10 and under are suppressed for client privacy. Methodology for determining diagnoses can be found in Appendix A1: Operational Definition and Parameters.*

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Appendix C19: Crisis Services One Year Prior and One Year Post Joining an FSP

		CRISIS SERVICES		
		PRE	POST	RATIO
Statewide	California	80,581	73,266	0.91
Region	Bay Area	7,067	8,894	1.26
	Central	19,137	16,624	0.87
	Los Angeles	17,006	19,612	1.15
	Southern	30,129	22,442	0.74
	Superior	7,242	5,694	0.79
County	ALAMEDA	2,179	4,783	2.20
	ALPINE	*	*	*
	AMADOR	272	207	0.76
	BERKELEY CITY	21	22	1.05
	BUTTE	2,455	2,044	0.83
	CALAVERAS	700	467	0.67
	COLUSA	71	33	0.46
	CONTRA COSTA	350	651	1.86
	DEL NORTE	521	308	0.59
	EL DORADO	807	786	0.97
	FRESNO	2,242	2,266	1.01
	GLENN	366	392	1.07
	HUMBOLDT	1,034	775	0.75
	IMPERIAL	1,456	1,422	0.98
	INYO	15	13	0.87
	KERN	2,272	2,170	0.96
	KINGS	800	576	0.72
	LAKE	283	186	0.66
	LASSEN	136	14	0.10
	LOS ANGELES	17,006	19,612	1.15
	MADERA	666	450	0.68
	MARIN	54	117	2.17
	MARIPOSA	176	51	0.29
	MENDOCINO	366	273	0.75
	MERCED	322	193	0.60
	MODOC	267	310	1.16
	MONO	15	37	2.47
	MONTEREY	1,793	888	0.50
	NAPA	115	64	0.56
	NEVADA	482	407	0.84

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	CRISIS SERVICES		
	PRE	POST	RATIO
… continued			
ORANGE	11,673	6,651	0.57
PLACER	1,024	773	0.75
PLUMAS	176	122	0.69
RIVERSIDE	4,245	4,431	1.04
SACRAMENTO	1,444	2,884	2.00
SAN BENITO	415	273	0.66
SAN BERNARDINO	4,033	2,606	0.65
SAN DIEGO	2,610	2,194	0.84
SAN FRANCISCO	231	672	2.91
SAN JOAQUIN	5,840	3,307	0.57
SAN LUIS OBISPO	601	402	0.67
SAN MATEO	*	*	*
SANTA BARBARA	1,425	896	0.63
SANTA CLARA	665	531	0.80
SANTA CRUZ	165	50	0.30
SHASTA	333	223	0.67
SIERRA	25	29	1.16
SISKIYOU	606	483	0.80
SOLANO	499	289	0.58
SONOMA	579	554	0.96
STANISLAUS	2,475	2,704	1.09
SUTTER/YUBA	226	125	0.55
TEHAMA	26	11	0.42
TRI-CITY	817	942	1.15
TRINITY	95	84	0.88
TULARE	1,262	1,097	0.87
TUOLUMNE	385	260	0.68
VENTURA	997	728	0.73
YOLO	463	425	0.92

Note: The above data include all adult (26 years and older) partnerships originated between Jan 1 2012 and Dec 31st 2022. Pre services are calculated as the total services received between the date of partnership and 365 days prior. Post services are calculated as total services received within 365 days of the day after partnership.

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Appendix C20: Inpatient Psychiatric Holds Pre and Post Joining an FSP

		Admissions			Days Admitted		
		PRE	POST	RATIO	PRE	POST	RATIO
Statewide	California	85,590	58,638	0.69	818653	568348	0.69
Region	Bay Area	8,663	5,833	0.67	90902	61115	0.67
	Central	17,851	11,485	0.64	196397	139371	0.71
	Los Angeles	31,476	22,516	0.72	269234	180252	0.67
	Southern	24,686	16,888	0.68	231700	165015	0.71
	Superior	2,914	1,916	0.66	30420	22595	0.74
County	ALAMEDA	1,687	1,272	0.75	16526	12397	0.75
	AMADOR	41	36	0.88	293	252	0.86
	BERKELEY CITY	30	15	0.50	268	168	0.63
	BUTTE	854	495	0.58	8689	4888	0.56
	CALAVERAS	95	86	0.91	668	820	1.23
	COLUSA	24	13	0.54	196	45	0.23
	CONTRA COSTA	762	471	0.62	7229	4339	0.60
	DEL NORTE	106	93	0.88	1041	1303	1.25
	EL DORADO	350	320	0.91	4781	4904	1.03
	FRESNO	4,080	2,978	0.73	30740	23497	0.76
	GLENN	123	106	0.86	862	763	0.89
	HUMBOLDT	678	351	0.52	6932	6208	0.90
	IMPERIAL	294	289	0.98	1806	1655	0.92
	INYO	*	*	*	19	7	0.37
	KERN	2,761	1,827	0.66	25838	21459	0.83
	KINGS	308	208	0.68	2594	1917	0.74
	LAKE	150	106	0.71	1789	1320	0.74
	LASSEN	24	30	1.25	227	242	1.07
	LOS ANGELES	31,476	22,516	0.72	269234	180252	0.67
	MADERA	217	161	0.74	2187	1969	0.90
	MARIN	524	368	0.70	5397	4058	0.75
	MARIPOSA	40	20	0.50	351	125	0.36
	MENDOCINO	120	80	0.67	1318	777	0.59
	MERCED	320	182	0.57	2683	1412	0.53
	MODOC	66	46	0.70	735	358	0.49
	MONO	*	*	*	43	19	0.44
	MONTEREY	707	504	0.71	5862	3754	0.64
	NAPA	249	208	0.84	2160	1963	0.91
	NEVADA	177	114	0.64	1909	1571	0.82

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...continued	Admissions			Days Admitted		
	PRE	POST	RATIO	PRE	POST	RATIO
ORANGE	2,946	2,146	0.73	28129	24423	0.87
PLACER	873	512	0.59	9202	6329	0.69
PLUMAS	33	25	0.76	232	265	1.14
RIVERSIDE	3,555	2,667	0.75	27452	22673	0.83
SACRAMENTO	5,017	2,734	0.54	84183	55490	0.66
SAN BENITO	87	49	0.56	542	344	0.63
SAN BERNARDINO	2,453	1,617	0.66	15309	10202	0.67
SAN DIEGO	9,288	6,002	0.65	105722	66271	0.63
SAN FRANCISCO	1,321	941	0.71	17365	11078	0.64
SAN JOAQUIN	1,358	928	0.68	13601	7519	0.55
SAN LUIS OBISPO	598	367	0.61	4483	2258	0.50
SAN MATEO	*	*	*	*	*	*
SANTA BARBARA	747	382	0.51	7963	3890	0.49
SANTA CLARA	1,640	1,015	0.62	19018	12025	0.63
SANTA CRUZ	123	54	0.44	1168	594	0.51
SHASTA	221	180	0.81	3785	2922	0.77
SIERRA	*	*	*	66	68	1.03
SISKIYOU	221	187	0.85	1499	1290	0.86
SOLANO	994	552	0.56	10554	6614	0.63
SONOMA	537	384	0.72	4808	3781	0.79
STANISLAUS	3,629	2,334	0.64	28434	23240	0.82
SUTTER/YUBA	169	100	0.59	2442	1928	0.79
TEHAMA	72	60	0.83	642	386	0.60
TRI-CITY	1,205	980	0.81	8041	6334	0.79
TRINITY	39	19	0.49	498	189	0.38
TULARE	717	450	0.63	7453	5271	0.71
TUOLUMNE	186	152	0.82	1819	1402	0.77
VENTURA	839	611	0.73	6957	5850	0.84
YOLO	439	274	0.62	4904	3270	0.67

Note: The above data include all adult (26 years and older) partnerships originated between Jan 1 2012 and Dec 31st 2022. Pre services are calculated as the total services received between the date of partnership and 365 days prior. Post services are calculated as total services received within 365 days of the day after partnership.

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Appendix D: FSP Case Study Protocol

MHSOAC Learning Objectives:

1) What are the current processes for collecting, inputting and extracting client data?
2) What challenges exist in this process?
3) What solutions have counties developed to address these challenges?
4) How is data currently being used by providers to measure client progress?
    a. What data would be helpful to providers to better serve clients?
5) How is data currently being used by counties to measure provider success?
    a. What data would be helpful to you to counties to better measure provider progress?

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Hello, my name is ________ and I'm with the Mental Health Services Oversight and Accountability Commission. One of our roles is to report to the legislature on ways to improve outcomes for FSP partners. Over the past year, we have done extensive community engagement to better understand the needs of counties and identify ways they could be supported to improve client outcomes. We are here trying to better understand the clinical monitoring and accountability structures you currently have in place. This is not an audit in any way. It is purely a learning opportunity for us, and we are thankful for your participation. We do plan on sharing our learnings in a report, but we will not include any identifiable information about you. You should feel free to share as much information as you feel comfortable sharing. Before we proceed, do you have any questions for me?

> *Answer any questions they may have. If they have a question you cannot answer on the spot, ask if you can get back to them at a later date once you've had a chance to look into their question. Once their questions have been answered proceed.*

Is it okay if I ask you some questions about your current data reporting and monitoring practices?

> *If no, thank them for their time and offer to speak with them in the future if they change their mind. Provide a business card.*
>
> *If yes, proceed to the appropriate question block.*

Data Collection

TIME_______________ Meeting with_________________

A. Do you currently collect client-level data? If yes, ask the following. If not, proceed to B.

Can you talk to me a little bit about how you currently collect client data? *For example, by hand, on a laptop etc.*

Does your data collection process differ if you are in the field versus on site somewhere? If so, how?

Do you think the data collection process could be improved? If so, how?

B. Do you currently input client data into the DCR? If yes, ask the following. If not, proceed to C.

How frequently do you enter client data into the DCR? For example, after each meeting, once a week, once a month? If you don't enter data into the DCR, how often do you input it into another data tracking system you may use?

When entering data, do you work from notes or from memory?

What has your experience been like entering data into the DCR?

Have you encountered any specific challenges or barriers to getting data into the DCR?

How do you think the state could improve its current data collection and reporting system?

C. Do you currently input client data into another EHR? If so, what system is that? If not, proceed to D.

How often do you input data into this EHR system?

When entering data, do you work from notes or from memory?

What has your experience been like entering data into the EHR?

Have you encountered any specific challenges or barriers to getting data into this EHR?

How do you think the state could improve its current data collection and reporting system?

D. Is there anything else you would like to share that I haven't asked?

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Data Reporting

TIME_______________ Meeting with_________________

A. Do you currently pull data for FSP service providers? If yes, ask the following. If not, proceed to B.

What systems do you use to generate the data?

Can you talk to me a little bit about what data you pull and how it is used?

Do you experience any challenges in getting quality data from these systems? If so, what are those challenges?

Is there any data you'd like to have that you currently do not have access to?

B. Do you currently pull data for FSP or county supervisors or other individuals monitoring FSP performance? If yes, ask the following. If not, proceed to C.

Who are you typically pulling data for? What's their role?

Can you talk to me a little bit about what data you pull and how it is used?

What form do you usually present those data? For instance, as raw data, as tables/figures, in a short report form etc.?

Is there any data you'd like to have that you currently do not have access to?

C. Is there anything else you would like to share that I haven't asked?

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Data Monitoring

TIME_______________ Meeting with_________________

A. Do you currently use data to measure FSP client progress or outcomes? If yes, ask the following. If not, proceed to B.

What are the key client outcomes you currently track?

Who pulls these data for you and how often?

What form do you usually get these data? For instance, as raw data, as tables/figures, in a short report form etc.?

Are there any client-level data you'd like to have that you currently do not have?

B. Do you currently set performance goals for your FSP providers? If yes, ask the following. If not, proceed to C.

What data do you currently use to set these goals?

Who pulls these data for you and how often?

What form do you usually get these data? For instance, as raw data, as tables/figures, in a short report form etc.?

Is there any data you'd like to have that you currently do not have access to?

C. Is there anything else you would like to share that I haven't asked?

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AGENDA ITEM 12

Action

November 21, 2024 Commission Meeting

Mental Health Student Services Act Report

Summary: The Commission will receive and consider approval of the draft biennial progress report to the legislature on the Mental Health Student Services Act (MHSSA) and a contract up to $4 million for phase 2 of the MHSSA evaluation.

Background: The Mental Health Student Services Act (MHSSA), authorized by Senate Bill 75 as part of the State's 2019 Budget Act, incentivizes partnerships between county behavioral health departments and local education agencies (LEAs) to deliver school-based mental health services to young people and their families. The goals of MHSSA are to provide highly accessible, comprehensive, and effective services in schools where students spend a great deal of time. A key tenet is preventing mental health conditions from developing and intervening early when students show signs of risk, to reduce the need for higher-level, more intensive services. The Commission has awarded MHSSA grant funding (as funding became available) to 57 county behavioral health departments, including two city municipalities, and their LEA partners.

MHSSA Progress Report to the Legislature

The Commission is required to provide a biennial progress report to the fiscal and policy committees of the Legislature on implementation of the MHSSA. The first progress report was submitted to the Legislature in May 2022. The second progress report is due in 2024.

At the August Commission meeting, Commissioners received a presentation on a draft progress report for 2024 and discussed the report's findings and recommendations. Since the August Commission meeting, Commission staff have worked with Commissioners to refine the report.

The revised draft MHSSA Progress Report for 2024 is included in this packet and presented to the Commission for review and approval.

MHSSA Phase 2 Evaluation Contract

The MHSSA Evaluation Project was designed to be conducted in two phases: (1) Phase 1 entails a robust planning process grounded in community engagement that results in a feasible and meaningful plan to evaluate the MHSSA; and (2) Phase 2 involves implementation of the plan to evaluate the MHSSA and dissemination of findings and lessons learned as they become available.

The Commission issued a request for proposal in August 2022 to conduct an evaluation of the MHSSA. The Commission awarded the contract to WestEd, a national leader in research, development, and service with headquarters in San Francisco. For Phase 1, WestEd developed a plan to evaluation the MHSSA and is poised to begin implementing the plan in Phase 2 with the Commission's approval.

Presenter: Melissa Martin-Mollard, Chief of Research and Evaluation

Enclosures (3): (1) 2024 MHSSA Progress Report to the Legislature; (2) MHSSA Evaluation Planning and Implementation Summary; (3) MHSSA Draft Evaluation Plan

Handout (1): PowerPoint Presentation

Motion: That the Commission approve: (1) the biennial progress report to the legislature on the Mental Health Students Service Act (MHSSA), and (2) a contract for up to $4 million for WestEd to begin Phase 2 of the MHSSA evaluation.

Report to the Legislature on the Mental Health Student Services Act

by the Mental Health Services Oversight and Accountability Commission

Submitted to the Fiscal and Policy Committees of the Legislature

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EXECUTIVE SUMMARY

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In testimony before the Commission in July 2024, a presenter shared a story about a high school student in San Diego who recently brought a weapon to school. That day, a trusted teacher recognized that something was amiss with the student. When the teacher checked in with the student, the student disclosed having a weapon. Having received training in mental health literacy, the teacher expressed care and concern rather than disciplining the student. She worked with the student to secure the weapon and asked why they brought it to school. The student answered that they were hearing voices telling them that someone was trying to hurt them.

The school mental health team was able to refer the student to behavioral health services to address the psychosis that led to him being armed on a school campus. Without the trust and training the teacher and the school mental health team brought to school that day, the scenario of a student bringing a weapon to school could have resulted in a very different outcome.

As reflected in this example, California's behavioral health and education leaders are making significant progress in developing, strengthening, and scaling strategies to ensure that schools represent robust opportunities to serve the behavioral health needs of students. Teachers and educational staff are being provided with training to understand and recognize mental health challenges. School mental health funding is supporting on-campus wellness centers and on-site behavioral health services and supports. State investments are supporting stigma reduction, youth engagement, suicide prevention, social-emotional learning, and more.

These recent investments in school mental health have relied heavily on one-time funds, including one-time funds from the Mental Health Student Services Act (MHSSA). Under the Child and Youth Behavioral Health Initiative, the Department of Health Care Services (DHCS) is leading efforts to shift reliance on short-term grant funding to durable financing strategies that tap into health care insurance resources.

These investments recognize that the peak and median age of onset for any mental health disorder are 14.5 years and 18 years. Unmet mental health needs can disrupt learning and lead to negative student academic outcomes such as chronic absenteeism, poor grades, and eventually failure to graduate from high school.

Strong partnerships between education and community behavioral health can increase access to a continuum of behavioral health services, with an emphasis on prevention and early intervention services to reduce the risk of a child developing a mental health disorder and improve educational outcomes.

California's K-12 schools are an essential access point to these services, particularly for underserved communities. Education in partnership with community behavioral health can increase access to a continuum of behavioral health services including critical prevention and early intervention supports to reduce the risk of a child developing a mental health disorder and improve educational outcomes. Effective partnerships can engage students and families to improve understanding and awareness of what constitutes mental health, promote wellbeing, and create pathways to care through referrals and behavioral health services on campus.

The MHSSA incentivizes partnerships between county behavioral health departments and local education agencies to bring an array of behavioral health services to California's K-12 schools.

The Commission's implementation of the MHSSA within the broader work of the Child and Youth Behavioral Health Initiative has reached 57 out of 58 counties – only Alpine County, which has the smallest population of any county in California, is not represented in the grants. California's $280 million in MHSSA grants have reached approximately 45 percent of districts across the state and just under 25 percent of all California schools (see MHSSA at-a-Glance graphic).

The Commission is aware that these investment dollars did not reach all students in all schools across the state of California. Instead, grant partners prioritized the highest-need districts/schools and tailored MHSSA activities and services to meet local needs. Some grant partners focused on capacity building and training at the county and district levels. Others have directed their dollars toward universal, schoolwide prevention efforts, such as suicide prevention and social-emotional learning curricula. Some have prioritized hiring behavioral health staff to provide intensive services to students including individual counseling and crisis services.

There have been many successes reported at the local level. New and strengthened partnerships between education and county behavioral health have expanded access to services for students. However, access to universal prevention, early intervention, and treatment for all students has not yet been achieved. These efforts need to be expanded to include all of California's 9,997 K-12 schools so that all students benefit from a comprehensive statewide strategy for school mental health.

Building from youth perspectives and MHSSA implementation successes and lessons learned, the Commission identified a set of recommendations to ensure that California's school mental health efforts can be scaled and sustained.

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MHSSA at-a-Glance[i]

$280 million

invested in MHSSA to build and strengthen partnerships between county behavioral health, education, and other partners

MHSSA activities and services are tailored to meet local needs and include:

TIER 3
intensive interventions

TIER 2
targeted and early interventions

TIER 1
universal or schoolwide (all students) prevention

IMPLEMENTATION SUPPORT
(teaming, capacity building, and training)

Approximately

242,000
students received Tier 1 services

12,000
students received Tier 2/3 services

through MHSSA in 2022-23, according to grant partner reports

57 of 58

California counties are served by MHSSA, as well as the city municipalities of Berkeley and Tri-City

57
county behavioral health departments

50
county offices of education/superintendent of schools

Approximately

45%
of school districts

25%
of schools and charter schools

39
community-based organizations

480

staff hired by grant partners to provide direct services and support administration, partnership development, and coordination through MHSSA

To support quality improvement and evaluation, the Commission:

Established an MHSSA Learning Collaborative that meets quarterly and has grown to over 300 members since its inception in 2020

Partnered with WestEd to develop a plan to evaluate the MHSSA informed by robust community engagement

Is implementing a statewide school mental health technical assistance strategy to support MHSSA grant partners in achieving sustainability

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[i] Information contained in this report comes from several sources of data that the Commission collects from MHSSA grant partners in each of the 57 participating counties and city municipalities: grant summaries, monthly update reports, quarterly hiring reports, annual fiscal reports, site visits, and data on services and students served.

What Youth Are Saying About School Mental Health

The Commission works across its initiatives to elevate youth voices. The school mental health initiative has leveraged the Commission's youth advocacy work designed to increase youth voices and participation through targeted conversations about school-based mental health. Listening sessions with youth were held in Fresno, Humboldt, Sacramento, San Bernardino, and adjacent counties.

In conversations with these youth about school mental health, they indicate wanting:

A school climate that supports wellbeing (e.g., low stress, no bullying, and everyone getting along)

"A school that centers wellbeing looks like no kids fighting and arguing in schools, no one running down the halls screaming. Just everyone going to class doing what they need to do."

Having trusted adults provide safe spaces at school

"It is important that school staff exhibit safe space behavior – that they practice inclusivity and open-mindedness and promote students to speak respectfully and thoughtfully and [have] open-door policies."

Increased mental health awareness training and resources for seeking help

"[It is good] if more students are reaching out to get resources. If there are a lot of resources, it's not always very effective, because students either aren't aware of their own mental health to know they need help or are otherwise hesitating to reach out."

Increased access to peer services (services provided by youth for youth)

"Kids who are considered 'bad kids' or are causing trouble need support. They often are misunderstood and are for the most part going through a lot, feel alone, and feel like outcasts. School may not resolve these issues. Students need to be heard. Peer counseling can reach kids more successfully than adults who often seem like they are lecturing."

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MHSSA Implementation Successes

MHSSA grant partners report successes in building strong partnerships, transforming schools into centers of wellness by expanding a continuum of school-based mental health services and providing students and families with access to services that are making a difference in their lives. The following themes emerged as successes of MHSSA from the grantee perspective.

MHSSA deepens partnerships at the local level

Local county partners report that MHSSA funding has deepened and enhanced partnerships between K-12 education and county mental health. This includes greater trust and collaboration, improved service coordination for students and families, and leveraging Medi-Cal and private insurance to cover the cost of services.

MHSSA expands the continuum of mental health services in schools

Local MHSSA partners have expanded prevention, early intervention, treatment, and crisis services on school campuses. These are services that would not have been available otherwise, with over 250,000 students served.

MHSSA increases awareness and destigmatizes mental health

By providing outreach/training and expanding the continuum of services and supports, grant partners report increasing mental health awareness and the normalization of students seeking services on school campuses.

MHSSA services are making a difference in the lives of students and families

MHSSA grant partners regularly share with Commission staff stories about how MHSSA is making a difference in the lives of students and families. Anecdotal reports from grant partners demonstrate the different ways that MHSSA services are improving student outcomes.

MHSSA services engage and educate parents and caregivers

Grant partners report that providing individual counseling to students on school campuses has enabled them to involve families in treatment and provide them with education to help them better understand and support their child.

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Lessons Learned

The following are key lessons the Commission has learned from grant and community partners during MHSSA implementation:

1. **Local MHSSA activities and services are heterogeneous and tailored to meet local needs and gaps in services.** Allowing MHSSA grant partners the flexibility to respond to local needs has been a successful feature of the MHSSA grant program but has also presented challenges for conducting a statewide evaluation and establishing consistent metrics for monitoring and reporting.

2. **MHSSA partners have built and strengthened partnerships but need additional guidance to support local success.** Sustainability is a key concern among MHSSA grant partners. Partners report needing additional funding and sustainability planning to meet local needs, particularly since grants are scheduled to end as early as 2025.

3. **The need for school mental health services often exceeds local capacity.** Partners report that the demand for services is often higher than the availability of services. Hiring and retaining staff continues to be a challenge for MHSSA grant partners, especially in rural counties with more severe mental health professional shortages.

4. **School mental health standards are needed in California to drive quality improvement.** MHSSA grant partners have asked the Commission for guidance in building their local school mental health systems. In California, there are currently no agreed-upon guidelines or standards to support local communities in designing their school mental health systems, monitoring implementation, and measuring outcomes.

5. **Alignment of California's school mental health initiatives is important for local success.** Multiple youth and school mental health funding initiatives in California have benefited local communities but also created stress and overburdened staff who prepare grant proposals, manage different grant programs, track different funding streams, and meet different reporting requirements.

These lessons learned provide a roadmap for what California should prioritize next to continue moving closer toward a vision of schools as centers for wellness. Achieving this vision will require effective and sustainable comprehensive school mental health systems that promote a positive school climate and support the mental health and wellness needs of students and school staff. Through MHSSA, the Child and Youth Behavioral Health Initiative, and other school mental health initiatives, California has made tremendous strides in building the capacity of schools to develop comprehensive school mental health systems. However, there is work to be done to promote this model and its core features across the state.

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Recommendations

The MHSSA is part of a broader investment in California's children and youth behavioral health system. To support long-term local success in comprehensive school mental health systems will require a shared understanding across California agencies of both the systems change goals California is working toward and the metrics to measure progress. It is imperative that the state look toward the future and ensure that its investments are efficient, effective, and sustainable.

Based on community feedback and lessons learned during MHSSA implementation, the Commission offers the following three recommendations for the State to consider:

1

LEADERSHIP

The State should establish a leadership structure for youth behavioral health to coordinate and align school mental health initiatives and develop a long-term strategy for building sustainable, comprehensive school mental systems in every K-12 school in California. That strategy should design effective ways for the health and education systems and their partners to collaborate with youth and families to deliver a continuum of behavioral health services and supports in schools.

2

ADEQUATE AND RELIABLE FUNDING

As California builds the necessary capacity and infrastructure for comprehensive school mental health services, the State should make additional investments to fill the gap between implementation and long-term sustainability. Funding should be adequate, consistent, aligned, and incentivized to achieve desired outcomes.

3

ACCOUNTABILITY

The State, as part of its strategy to build comprehensive school mental health systems, should develop an accountability structure including school mental health standards and metrics that reports back to youth, parents, teachers, leaders, and other invested partners to show progress toward established goals. This accountability system should include a heavy emphasis on reducing disparities and promoting educational equity.

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The Imperative for School Mental Health

The mental health crisis of youth is well documented, particularly in light of the COVID-19 pandemic. The 2023-24 California Healthy Kids Survey of California's 11th graders found that:

45% report feelings of optimism about their life

31% report chronic sadness and hopelessness

28% report experiencing social and emotional distress

12%[4] report having considered suicide

Although the mental health of California's youth has slightly improved since the COVID-19 pandemic, the seriousness of the crisis continues, particularly for LBGTQIA students, students in the foster care and juvenile justice systems, students from communities of color, and students living in rural settings.

Unmet mental health needs can disrupt learning and lead to negative student academic outcomes such as chronic absenteeism, poor grades, and eventually failure to graduate from high school. Schools are a primary location for promoting wellbeing, supporting early identification of student mental health needs and access to services.

Improved access to mental health services is foundational to supporting children and youth as they develop into healthy, resilient adults. Comprehensive school mental health models and integrated services that are tailored to individual and family needs have the best chance of improving health and academic outcomes.

The Mental Health Student Services Act (MHSSA) is intended to foster stronger partnerships between education and health systems to leverage resources to help students succeed. The MHSSA incentivized counties and local education agencies to enter into partnerships to provide a continuum of behavioral health services to students, with an emphasis on prevention and early intervention. These partnerships offer an opportunity to reach children and youth in an environment where they are comfortable and that is accessible.

[4] California Healthy Kids Survey, 2023-24: Mental Health Report Card, https://calschls.org/docs/sample_sec_district_mhr_2324.pdf.

DRAFT

Schools as Centers of Wellness

The Commission works to transform systems by engaging diverse communities and employing relevant data to advance policies, practices, and partnerships that generate understanding and insights, develop effective strategies and services, and grow the resources and capacity to improve positive behavioral health outcomes for every Californian. The Commission, with support from the Governor and the Legislature, has developed the distinct roles required to shape policies and drive practices and system-level improvements. As part of its role, the Commission seeks to drive transformational change in school mental health so that every child can succeed and thrive.

In 2020, the Commission released its report "Every Young Heart and Mind: Schools as Centers of Wellness," and recommended that the State make a significant multi-year investment to build and enhance partnerships between county behavioral health departments and local education agencies. The Mental Health Student Services Act (MHSSA) realized this vision.

To achieve the vision of schools as centers for wellness requires effective, comprehensive school mental health systems that promote a positive school climate and support the mental health and wellness needs of students and school staff. As illustrated below, the National Center for School Mental Health identified eight core features of comprehensive school mental systems. These core features are interrelated and essential to the success of implementing comprehensive school mental health systems. For example, schools and their partners (in collaboration) should regularly conduct needs assessments to identify student needs and map existing resources to assess gaps in services and support.

DRAFT

Core Features of a Comprehensive School Mental Health System*

MENTAL HEALTH SCREENING
Proactive universal and targeted assessment of risks, strengths, and needs

EVIDENCE-BASED AND EMERGING BEST PRACTICES

WORKFORCE
Well-trained educators and specialized support personnel

SUSTAINABLE FUNDING
Leverage and apply various financial and nonfinancial resources

LEADERSHIP, CAPACITY BUILDING, AND INFRASTRUCTURE

DATA CAPABILITIES
Data systems, data outcomes, and data-driven decision-making

THOUGHTFUL PLANNING
Needs assessment and resource mapping

COLLABORATION AND TEAMING
Student, family, school, community

MULTI-TIERED SYSTEM OF SUPPORT
Wellness promotion, prevention, early intervention, and crisis response

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California has made considerable progress in building the capacity of schools to develop comprehensive school mental health systems. Governor Gavin Newsom's office released the Master Plan for Kids' Mental Health (California for All, 2023), supporting the vision of schools as centers of wellbeing. The core of CYBHI is a five-year, $4.6 billion investment that reimagines how California supports youth mental health. Several CYBHI workstreams are designed to offer school-linked services, such as the Statewide Multi-Payer School-Linked Fee Schedule, School-Linked Partnerships and Capacity Grants, and the Student Behavioral Health Incentive Program, to name a few. In addition, through the California Community Schools Partnership Act, the state has invested $4.1 billion to establish community schools that connect youth and families to essential services including behavioral health services.

* Adpated from Hoover, S., Lever, N., Sachdev, N., Bravo, N., Schlitt, J., Acosta Price, O., Sheriff, L. & Cashman, J. (2019). Advancing Comprehensive School Mental Health: Guidance from the Field. Baltimore, MD: National Center for School Mental Health. University of Maryland School of Medicine.

MENTAL HEALTH STUDENT SERVICES ACT

DRAFT

The Mental Health Student Services Act (MHSSA), authorized by Senate Bill 75 as part of the State's 2019 Budget Act, provides grants for partnerships between county behavioral health departments and local education agencies (LEAs) to deliver school-based mental health services to young people and their families. The goals of MHSSA are to provide highly accessible, comprehensive, and effective services in schools, which are central to the lives of families and where children spend almost one-third of their lives (180 days a year). A key tenet is preventing mental health conditions from developing and intervening early when students show signs of risk to reduce the need for higher-level, more intensive services.

The Commission awarded MHSSA grant funding in three phases (as funding became available) to 57 county behavioral health departments, including two city municipalities, and their LEA partners. The table on the next page provides a description of the grant phases and total funding amounts. See Appendix A for more information about the history of each phase and the source of funding.

PHASE 1

18 partnership grants awarded in 2020, totaling

$74,849,047

PHASE 2

19 partnership grants awarded in 2021, totaling

$77,553,078

PHASE 3

20 partnership grants awarded in 2022, totaling

$54,910,420

Grant awards are generally for four years, with Phase 3 grants scheduled to end in December 2026. In 2023, the Commission made available additional MHSSA funding to existing MHSSA grant partners through a request for applications (RFA). Forty-one MHSSA grantees were awarded additional MHSSA funds to expand their capacity, activities, and services.

In May 2024, the Commission issued a request for applications to award additional MHSSA funds, totaling $25 million. To identify the best use of these funds, the Commission held community listening sessions and conducted surveys of MHSSA grant partners. The Commission learned of specific needs and gaps that informed the targeted use of MHSSA funds in four categories: (1) services for vulnerable or marginalized youth; (2) universal screening learning community; (3) quality improvement and sustainability; and (4) other areas to be identified by the grant applicant. Fifty-one grants across the four categories were awarded in August 2024 to 29 counties.

To date, the Commission has awarded a total of $280 million in MHSSA grant funding.

Mental Health Student Services Act Grant Program Timeline

	2020	2021	2022	2023	2024
PHASE	Phase 1	Phase 2	Phase 3	Additional funding	New targeted grants*
GRANTEES	18 grantees	19 grantees	20 grantees	41 existing grantees	29 grantees
TOTAL FUNDING	$74,849,047	$77,553,078	$54,910,420	$47,687,455	$25,000,000
Total $ Awarded to County/School Partners = $280,000,000					

* Four categories: (1) services for vulnerable or marginalized youth; (2) universal screening learning community; (3) quality improvement and sustainability; and (4) other areas to be identified by the grant applicant.

DRAFT

MHSSA operates in 57 of California's 58 counties, as well as in the city municipalities of Berkeley and Tri-City.

Grants partners were given the flexibility to design school mental health activities and services that were responsive to local needs. To support local implementation of MHSSA, the Commission established an MHSSA Learning Collaborative that meets quarterly to share best practices and provide implementation support. The Commission, in consultation with MHSSA grant partners, is currently implementing a statewide Technical Assistance (TA) strategy to respond to implementation barriers and challenges and support ongoing learning and quality improvement.

MHSSA grant partners report local successes.

MHSSA is deepening partnerships at the local level by building greater trust and collaboration across sectors, improving service coordination, and leveraging Medi-Cal and private insurance to cover the cost of services. MHSSA also has expanded the availability of a continuum of services in K-12 schools, including crisis services. Grant partners report that the increase of mental health services on school campuses has increased awareness of student mental health needs and led to less fear and stigma in seeking services. Lastly, grant partners report that MHSSA is making a difference in the lives of students by engaging parents and caregivers to increase their mental health knowledge and ability to emotionally support their child. Grant partners are reporting positive student outcomes such as increased school engagement, attendance, and high school graduation.

BUILDING AND STRENGTHENING LOCAL PARTNERSHIPS

DRAFT

MHSSA grants build and strengthen partnerships across behavioral health, education, and the community.

As the figure below illustrates, MHSSA grant partners include county behavioral health departments, county offices of education or superintendent of schools, school districts and schools, charter schools, community-based organizations, and other partners. The list of MHSSA partners continues to grow as counties expand their partnerships to meet the needs of students and families in their local communities. It is anticipated that in the next round of MHSSA funding (August 2024), new partners such as those from the child welfare and juvenile justice systems will be added to MHSSA partnerships to better serve system-involved youth.

"This partnership is helping to break down communication barriers and build partnerships not only across districts but also between district and behavioral health partners."

– MHSSA GRANTEE

MHSSA Partnerships

57

county behavioral health departments

50

county offices of education/county superintendents of school out of 58 counties

440

districts

2,161

K-12 schools

221

charter schools

39

community-based organizations and other partners

MHSSA funded both established and new partnerships. As a result, there is variation across grant partners in their history of working together and degree of collaboration.

Prior to MHSSA, some partners had established inter-agency relationships and agreements; some are using MHSSA dollars to deepen those relationships and address an unmet need and/or service gap in their local schools and communities. For example, prior to the passage of MHSSA, Fresno County Department of Behavioral Health and Fresno County Superintendent of Schools established the All 4 Youth partnership program to provide services to youth and their families in schools, in the community, or in the home. To expand the reach of All 4 Youth, Fresno County used their MHSSA dollars to build and operate four Wellness Centers in four schools in areas of the county where there was a high concentration of underserved students and families.

Other MHSSA grant partners are in the process of building new relationships and strengthening existing relationships. For example, San Benito partners include the San Benito County Behavioral Health Department, San Benito County Office of Education, and local school districts. Together they have established a Mental Health Provider Network and are developing protocols and routines that establish sustainable coordination of services between entities. For example, the San Benito County partners have developed a universal referral form and process that all partners have agreed to use to better serve students and coordinate services.

An evaluation of MHSSA will examine in more detail its impact on cross-system partnerships, and specifically how relationships are built and strengthened to provide a coordinated and sustainable continuum of mental health services and supports to students and their families.

DRAFT

EXPANDING ADMINISTRATIVE CAPACITY AND DIRECT SERVICES

MHSSA grant dollars are primarily used to fund the hiring of staff to provide administrative oversight and direct mental health services on school campuses. In total, MHSSA funds more than 480 staff in 57 California counties. Approximately 73 percent of these staff provide direct mental health services and supports and include licensed clinicians, case managers, and paraprofessionals such as parent advocates and mentors. Since MHSSA partnerships require dedicated staff time and ongoing cultivation, the other 27 percent of staff provide grant administration and support MHSSA partnership development and coordination.

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Staff Funded Under MHSSA

483

staff currently funded under MHSSA

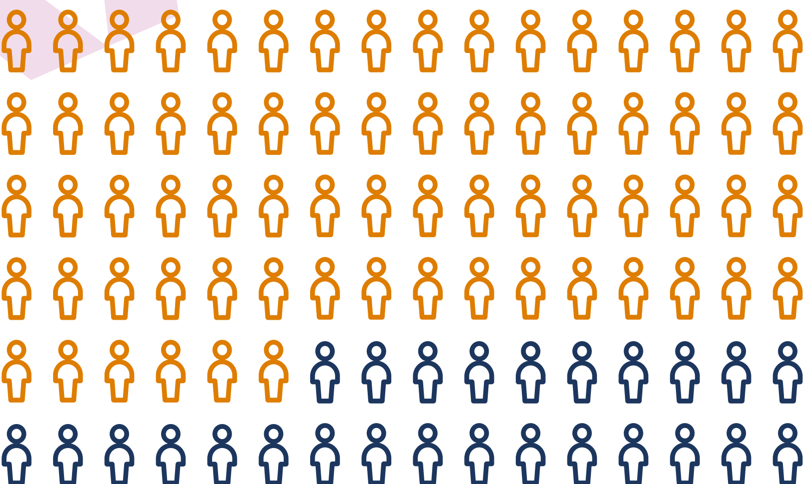
353

staff providing direct mental health services and supports

+

130

staff providing administration, partnership development, and coordination



One figure represents five funded staff members

LOCAL MHSSA SPOTLIGHT

Kern County

Kern County uses MHSSA funds to hire mental health teams that provide direct services on school campuses. These teams include licensed clinical social workers, licensed marriage and family therapists, case managers, substance use specialists, and AmeriCorps mentors. Mental health teams provide the following services to students:

- Screen foster and homeless youth for adverse childhood experiences (ACEs).
- Pilot universal screening for all students.
- Provide check-in/check-out rapid response intervention to support academics, behavior, and social and emotional health.
- Provide school-based therapeutic services for youth during and after school.
- Provide families with community referrals and resources.
- Provide substance use counseling and case management services.

DRAFT

CREATING TAILORED SOLUTIONS

MHSSA legislation allowed for flexibility in grant programs if they meet MHSSA goals (citation). Thus, local partners use MHSSA grant dollars to create solutions tailored to the needs of students, communities, and gaps in service delivery. In other words, there is variation in MHSSA activities and services, target populations, and reach across the county.

To begin to categorize the heterogeneity of MHSSA grant services and activities, the Commission's evaluation partner WestEd conducted a thematic analysis of grant summaries that included for each county its total MHSSA funding, a list of partners, and a high-level narrative of proposed activities and services.

"[We] identify gaps and work to find ways to expand services to meet those needs."

– MHSSA GRANTEE

Based on an analysis of the grant summaries, local MHSSA activities and services can be categorized into four broad categories:

- Implementation support (e.g., teaming, capacity building, and training)
- Tier 1 universal prevention and wellness promotion
- Tier 2 targeted, early intervention
- Tier 3 intensive intervention

The figure on the following page illustrates the types of activities and services that fall into each category. All counties report MHSSA activities and services that span at least two of the four categories, with many touching on all four. One of the key investigations of the statewide MHSSA evaluation will be to learn what activities and services ultimately resulted from the partnerships in each county, and if, how, and why these changed over time.

DRAFT

Categories of MHSSA Activities and Services

TIER 3: INTENSIVE SERVICES

- Individual counseling and treatment
- Case management
- Referral and system navigation
- Telehealth
- Behavioral support
- Substance use treatment
- Crisis services
- Psychiatric services

TIER 2: TARGETED SERVICES

- Small group counseling and support
- Mentoring (e.g., peer-to peer, adult-student)
- Family/parent programs/training
- Youth leadership development
- Check-in/check-out interventions

TIER 1: UNIVERSAL SERVICES

- Mental health awareness/ literacy promotion
- Screening
- Social and emotional learning
- Behavior management/PBIS
- Trauma-informed and restorative practices
- School climate
- Bullying and violence prevention
- Dropout prevention

IMPLEMENTATION SUPPORT

- Collaboration/partnering
- Teaming
- Staff training and professional development
- Coaching and consultation
- Culturally responsive and equity centered
- Systems capacity building and continuous improvement
- Procedure/protocol development
- Medi-Cal billing

DRAFT

Implementation Support

The vast majority of MHSSA grantees (95 percent) reported plans to use MHSSA funds to support systems implementation (i.e., to facilitate capacity building and sustainable systems change). The most common implementation support activities were collaboration and partnering, building teams and teaming, and staff training and professional development.

LOCAL MHSSA SPOTLIGHT

San Diego County

San Diego County expands suicide prevention policies and practice through the Creating Opportunities for Preventing & Eliminating Suicide (COPES) Initiative. To build capacity, 31 COPES local education agencies (LEAs) provided 675 mental health and suicide prevention trainings and events in their school communities that engaged over 60,000 students, 850 staff, and 3,000 parents and caregivers.

All participating COPES local education agencies (LEAs) currently:

- Use an evidence-based screening tool.
- Collect data on suicide risk screenings.
- Receive formal training on conducting risk screenings and providing suicide intervention.

In addition, 84% of participating schools have current resources and information about suicide prevention on their website and 56% offer training to families/caregivers on suicide prevention.

Between July 2022–June 2023, COPES LEAs conducted 3,387 suicide risk screenings.

675

mental health and suicide prevention trainings and events in school communities that engaged over 60,000 students, 850 staff, and 3,000 parents and caregivers

3,387

suicide risk screenings conducted*

84%

of participating schools have current resources and information about suicide prevention on their website

56%

offer training to families/caregivers on suicide prevention

* between July 2022–June 2023

DRAFT

Providing a Continuum of Services and Supports: Tiers 1, 2, and 3

MHSSA grantees report transforming schools into centers of wellness by providing a continuum of services and supports to elementary, middle, and high school students. The most common framework that grantees use for organizing and delivering services in schools is a Multi-Tiered System of Support (MTSS): Tiers 1, 2, and 3. The following provides the percentage of grantees that reported plans to provide a specific tier of service or support using MHSSA grant dollars.

81%

reported plans to provide Tier 1 or universal services and activities.

68%

reported plans to provide Tier 2 or targeted group services and activities.

98%

reported plans to provide Tier 3 or intensive individual services and activities.

46% reported plans to provide crisis intervention services, including general crisis intervention, suicide crisis intervention, and mobile crisis services.

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LOCAL MHSSA SPOTLIGHT

Sacramento County

Sacramento County places a mental health clinician in every school. A partnership between the Sacramento County Office of Education and the Sacramento County Department of Health Services established an innovative way to address children and youth mental health – placing a mental health clinician in every school in the county to work within a continuum of care at the school site, transforming the schools into centers of wellness. The clinicians provide direct mental health services while also working with school staff to integrate social emotional and relationship-building strategies into the entire school community.

In Sacramento County, currently 40 schools in 12 school districts have an onsite mental health clinician that provides services to the school community. Since October 2021 – September 2023, 770 students have received mental health sessions. Of the 7,959 therapy sessions provided, 90% are reimbursable by Medi-Cal.

40 SCHOOLS & 12 SCHOOL DISTRICTS

are provided with services

770 STUDENTS

received direct mental health services since October 2021

90% OF THERAPY SESSIONS

are reimbursable by Medi-Cal

DRAFT

Wellness Centers

Approximately one in four MHSSA grantees report planning to establish wellness centers on school campuses to provide a continuum of mental health services and supports (often using an MTSS framework) to students and families. Wellness centers provide safe and supportive environments for students to step out of the stresses of a school day, seek mental health support and information, and connect with others. The Commission facilitated student-led discussions on preferred strategies to meet student mental health needs and wellness centers represented the most student-friendly proposal under discussion. The Commission has supported cross-partnership collaboration on how to best design and implement student wellness centers to meet student mental health needs.

LOCAL MHSSA SPOTLIGHT

Santa Clara County

Santa Clara County partners established wellness centers and programs on 18 school campuses. Wellness center activities and services:

- Are informed by Youth Advisory Boards
- Adapt to meet the culture and climate of the school community
- Provide a full continuum of services and support (MTSS)

In the 2022-2023 school year, wellness centers supported over 10,000 student visits. Students reported feeling calmer and less anxious after visiting a wellness center, and over 97 percent said they would like to return for a visit.

Santa Clara Office of Education published "An Introduction to the Wellness Center Model" to support local education agencies and their partners in planning and implementing wellness centers.

DRAFT

STUDENTS RECEIVING MHSSA SERVICES AND SUPPORTS

The Commission collects data on a biannual basis from MHSSA grantees on services provided, the number of students served and their demographic characteristics to meet legislative reporting requirements. To develop a data reporting tool for MHSSA, the Commission conducted extensive engagement with grantees to understand what data are available and feasible to collect/report.

The Commission learned that grant partners vary in their capacity to collect, store, and report MHSSA data. Thus, the data the Commission receives varies in terms of completeness, accuracy, and quality. Thus, the student numbers presented below are approximations of students served and are likely an undercount. The Commission is in the process of establishing MHSSA technical assistance to improve the grant partner's ability to collect and report school mental health data.

The Commission conducted a survey on technical assistance (TA) needs and found that more than 80 percent of MHSSA grant partners reported needing TA for data collection and reporting, and specifically:

- **Setting up data collection systems.**
- **Navigating HIPAA and FERPA laws to share data across partners.**
- **Utilizing data to inform program planning and decision making.**

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During the 2022-23 school year, the Commission received data submissions from 45 out of 57 grant partners. The table below presents the approximate number of students receiving Tiers 1, 2, and 3 services funded under MHSSA in 2022-23 by grade level. Other demographic variables such as race-ethnicity are not included in this report due to a lack of consistent reporting.

Twenty-one grantees reported providing Tier 1 services and 37 grantees reported providing Tier 2 and 3 services.

Approximate Number of Students Statewide Receiving MHSSA Services By Grade in 2022-23

	TIER 1 SERVICES (21 grantees reporting)	TIERS 2 & 3 SERVICES (38 grantees reporting)
Elementary schools (grades PreK-6)	109,000	4,000
Middle schools (grades 7-8)	43,000	2,000
High schools (grades 9-12)	83,000	4,200
Other/Unknown	7,000	2,000
TOTAL	**242,000**	**12,200**

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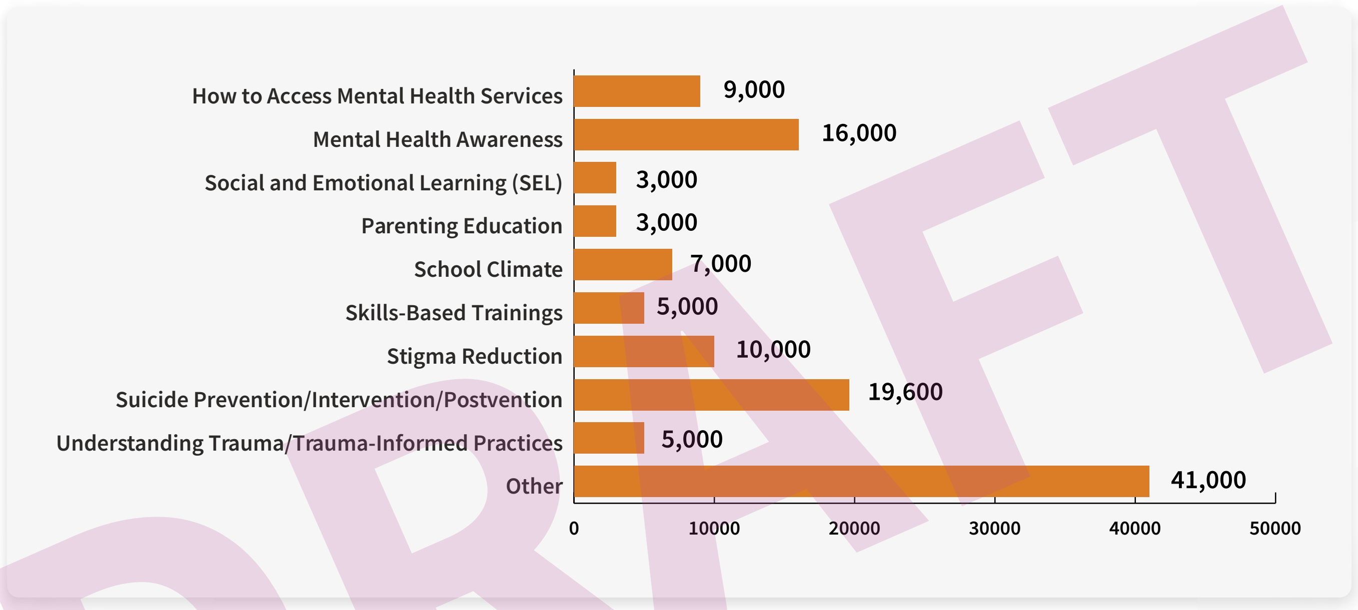
In addition to direct services, MHSSA grants support outreach and training for students, parents, staff, and others in the community. The figure below provides the approximate number of individuals trained in 2022-23 by type of training and outreach, as reported by 24 MHSSA grant partners. Please note individuals may have been trained across several training types. We will continue to work with state agencies, MHSSA grantees, students, parents, and other community partners to identify outcomes that matter for a wide range of perspectives.

Type of Training/Outreach and Approximate Number of Individuals Trained in 2022-23*



** 24 grantees reporting*

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IMPLEMENTATION SUCCESSES AND LESSONS LEARNED

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MHSSA grant partners report successes in building strong partnerships, transforming schools into centers of wellness by expanding a continuum of school-based mental health services and providing students and families with access to services that are making a difference in their lives. The following highlights a few of these successes and stories.

Implementation Successes

MHSSA Deepens Partnerships at the Local Level

Local county partners report that MHSSA funding has deepened and enhanced partnerships between K-12 education and county mental health. Specifically, MHSSA grants:

- **Build greater trust and collaboration across education and county mental health systems.**
  Grant partners report that MHSSA has been the impetus for bringing a diverse group of partners together to improve access to services in schools. By holding regular planning meetings, partners get to know each other, build trusting relationships, and establish common goals for working together.

> *"[For MHSSA] representatives from all five school districts, the County Office of Education, and the County Health and Human Services Agency (HHSA) have participated in the Project Implementation Workgroup and Steering Committee meetings. Within each Catchment area, representatives from the district, vendor, and HHSA attend regional committee meetings. A partnership/planning team consisting of the County HHSA and the Office of Education meet monthly to discuss implementation and ensure alignment."*
>
> **— STAFF/PROVIDER**

→ **Improve service coordination for K-12 students and their families.**
Grantees report that MHSSA partnerships are co-developing and implementing processes for improving the coordination of services, including improved referral pathways and closed referral loops.

> *"A high school student needing crisis services was evaluated using the Columbia Suicide Rating Scale. The tool called for referral to behavioral health for crisis services. This linkage was successful and demonstrated a seamless integration between [county name] Wellness Center sites and county mental health."*
>
> **— STAFF/PROVIDER**

→ **Leverage Medi-Cal and private insurance to cover the cost of services.**
Grantees report that their partners are working together to bill Medi-Cal and private insurance.

> *"The County's success continues to be the collaborative relationship that is being created between County Behavioral Health and the County Office of Education. This collaboration will help our students for years to come. We have a plan to Medi-Cal site certify all school campuses in [name] County."*
>
> **— STAFF/PROVIDER**

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LOCAL MHSSA SPOTLIGHT

Sustainability

ALAMEDA COUNTY

The Alameda County of Education (ACOE) seeks to align MHSSA and the Student Behavioral Health Incentive Program (SBHIP) assessments, identify additional funding opportunities, and build the infrastructure to support insurance billing during the CalAIM transition.

ACOE is working to support local school districts in building out the infrastructure to bill for services and increase long-term sustainability and expansion of site-based mental health services, as part of SBHIP and CalAIM and the larger landscape. To support this work, ACOE hosts monthly "Funding Learning Exchange" meetings countywide.

NAPA COUNTY

Napa County is building sustainability through the intersection of MHSSA, and the Statewide Multi-Payer School-Linked Fee Schedule.

The Napa County Office of Education (COE) has begun working with Kaiser Permanente as a new partner in the region to provide mental health services to K-12 students in the county. Napa COE reported to the Commission that their school districts are excited to partner with Kaiser, look forward to interconnected support for school mental health services as the Fee Schedule launches across California, and greater coordination of closed-loop referrals, as the wait time for services can be long.

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MHSSA Expands the Continuum of Mental Health Services in Schools

As detailed above, MHSSA through local partnerships has expanded a continuum of Tiers 1, 2, and 3 services, and crisis services on school campuses. These are services that would have not been available without MHSSA funding, with over 250,000 students served. MHSSA grant partners report that the increase of mental health services on school campuses has increased awareness of student mental health needs and led to less fear and stigma in seeking services. These efforts have been augmented by over 26,000 individuals receiving mental health awareness and stigma reduction training through MHSSA.

MHSSA INCREASES AWARENESS AND DESTIGMATIZES MENTAL HEALTH

By providing outreach/training and expanding the continuum of services and supports, grant partners report increasing mental health awareness and the normalization of students seeking services on school campuses.

Imperial County reported that staff and students at one of their schools have been enthusiastic about new mental health campaigns, events, and initiatives. For example, during May 2023, Imperial reported that over 500 students and staff participated in mental health campaign events, and 2,000 students attended a mental health resource fair. Imperial reported that these events have increased school staff mental health awareness and the motivation to look out for students and refer them to school-based mental health services if needed.

Ventura grant partners have observed that ninth-grade students have been the main population accessing high school wellness centers, noting that most of these ninth-graders came from a middle school that had a wellness center on campus. Ventura County reports that these students are extremely comfortable accessing the centers, resources, and services when needed. Many even bring in friends to introduce them to the center. Ventura concludes that the stigma around mental health and services is slowly decreasing due to the introduction of wellness centers across their county.

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MHSSA Services Are Making a Difference in the Lives of Students and Families

"I started feeling very depressed, I had many absences and was going to get kicked out of school. I started going to therapy at school each week. I also learned that it is important to face my anxiety and all my fears and not avoid it. It helped that my therapist talked to my mom a lot because my mom also learned how to help me start feeling better. Today, I am a lot better."

— YOUTH

MHSSA grant partners regularly share with Commission staff stories about how MHSSA is making a difference in the lives of students and families. Anecdotal reports from grant partners demonstrate the different ways that MHSSA services are improving student outcomes. These outcomes include, but are not limited to:

- Increased student wellbeing and quality of life
- Improved ability to reach goals like graduating from high school
- Improved school engagement and ability to make friends
- Improved school attendance and grades
- Reductions in anxiety, depression, self-harm, and other trauma-related symptoms

DRAFT

MHSSA SERVICES HELP STUDENTS GRADUATE

MHSSA legislation identifies several outcomes for the grant programs to achieve, including the reduction of school failure. Across California, grant partners are sharing stories about how MHSSA services are enabling students at risk of school failure to graduate from high school.

In Humboldt County, a student was at risk of not graduating from high school due to poor grades. This student had been diagnosed with a chronic health condition that had impacted his academics and engagement with school and caused significant anxious and depressive symptoms that led to a mental health crisis. Support was provided to the student and family via teletherapy and in-person sessions. The student graduated from high school and began a paid community internship program, which has increased his wellbeing.

In Imperial County, a student's family had experienced a tragedy and were struggling to cope. The student was suffering, and they were at risk of not graduating. The student's goal for seeking services was to "feel okay" and be the first person in his family to graduate from high school. The school-based clinician worked together with the student allowing him space to process the loss and share his trauma for the first time. Talking about how he felt opened the door for him to share with his mom. Having each other's support in their grieving process helped them both. The student met his goal and became the first person in his family to graduate from high school.

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Grant partners report that MHSSA services are engaging parents to improve student outcomes. Under the MHSSA grant program, local communities provide training and education to parents on a range of topics such as mental health awareness, and social and emotional learning.

MHSSA SERVICES ENGAGE AND EDUCATE PARENTS AND CAREGIVERS

Grant partners report that providing individual counseling to students on school campuses has enabled them to involve families in treatment and provide them with education to help them better understand and support their child.

In Riverside County, a student was barely attending school, struggling with anxiety and self-harm, and had no friends. She began receiving services at school and, with staff support and the involvement of her mother in her treatment plan, has made tremendous progress. She is no longer self-harming and has started making friends who she eats lunch with every day. A parent partner is also working with her mother to provide psychoeducation and parenting tips to bring more calmness and stability to the household. The student's younger sibling has significant behavioral issues, and the parent partner is providing support in accessing services for this child as well.

LOCAL MHSSA SPOTLIGHT

Solano County

SOLANO COUNTY SCHOOL-BASED MOBILE CRISIS RESPONSE SYSTEM

Solano County Behavioral Health and Solano County Office of Education (SCOE) have partnered with local education agencies to address increasing rates of Solano County youth requiring intervention for suicidal ideation. Solano County partners established a uniform school-based mobile crisis response system that responds to students experiencing a mental health crisis at school. Solano County provides crisis services to 79 local K-12 schools, which represents most schools in the county.

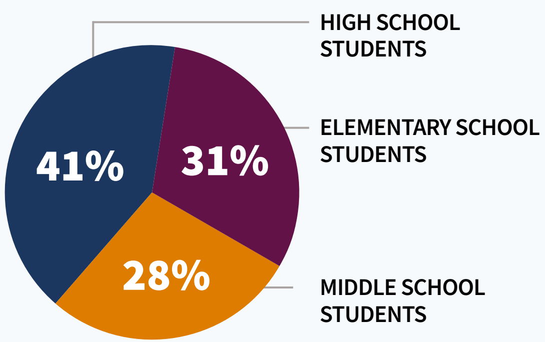
The Mobile Crisis Response team, housed at SCOE, provides the following services during school hours:

- Hotline crisis intake.
- In-person assessments and direct interventions (e.g., de-escalation, safety planning) to students in crisis at school.
- Brief case management to support students' successful integration back into school and linkage to additional services.

There are no insurance requirements for receiving these services. If there is an overt safety risk to students, SCOE responds to the crisis in partnership with local law enforcement.

Solano County partners use data to guide programming and serve their community. Since the beginning of the MHSSA grant, SCOE has responded to 697 student mental health crises (unduplicated students).

PERCENTAGE OF STUDENTS IN CRISIS BY SCHOOL LEVEL



40%

of mental health crises involved LGBTQ+ students

74%

of students (518 out of 697) were stabilized at their school site and did not require an emergency room visit or hospitalization

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Lessons Learned

The following are key lessons the Commission has learned from grant and community partners during MHSSA implementation:

1. **Local MHSSA activities and services are heterogeneous and tailored to meet local needs and gaps in services.** Allowing MHSSA grant partners the flexibility to respond to local needs has been a successful feature of the MHSSA grant program but has also presented challenges for conducting a statewide evaluation and establishing consistent metrics for monitoring and reporting.

2. **MHSSA partners have built and strengthened partnerships but need additional guidance to support local success.** Sustainability is a key concern among MHSSA grant partners. Partners report needing additional funding and sustainability planning to meet local needs, particularly since grants are scheduled to end as early as 2025.

3. **The need for school mental health services often exceeds local capacity.** Partners report that the demand for services is often higher than the availability of services. Hiring and retaining staff continues to be a challenge for MHSSA grant partners, especially in rural counties with more severe mental health professional shortages.

4. **School mental health standards are needed in California to drive quality improvement.** MHSSA grant partners have asked the Commission for guidance in building their local school mental health systems. In California, there are currently no agreed-upon guidelines or standards to support local communities in designing their school mental health systems, monitoring implementation, and measuring outcomes.

5. **Alignment of California's school mental health initiatives is important for local success.** Multiple youth and school mental health funding initiatives in California have benefited local communities but also created stress and overburdened staff who prepare grant proposals, manage different grant programs, track different funding streams, and meet different reporting requirements.

These lessons learned provide a roadmap for what California should prioritize next to continue moving closer toward a vision of schools as centers for wellness. Achieving this vision will require effective and sustainable comprehensive school mental health systems that promote a positive school climate and support the mental health and wellness needs of students and school staff. Through MHSSA, the Child and Youth Behavioral Health Initiative, and other school mental health initiatives, California has made tremendous strides in building the capacity of schools to develop comprehensive school mental health systems. However, there is work to be done to promote this model and its core features across the state.

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BARRIERS AND CHALLENGES TO IMPLEMENTATION

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The Commission collects information from MHSSA grant partners on implementation barriers and challenges, successes, and lessons learned from several sources including monthly reports, site visits, and surveys.

Grant partners report five main barriers and challenges they have encountered (or are encountering) when implementing activities and services:

1. Developing partnerships across sectors
2. Hiring and retaining mental health providers and staff
3. Implementing activities and providing services
4. Collecting and reporting data to the Commission
5. Building fiscal sustainability to continue grant activities and services

These barriers have been consistent and ongoing for many grant partners, particularly in rural areas. One rural grant partner noted the difficulties are *"because rural aspects of living and the challenges that we face are extremely different than those in an urban setting. Isolation plays a huge factor, adequate transportation, poverty needs, everything is exacerbated in rural areas because of unique considerations."*

In response, the Commission is developing a technical assistance approach to provide guidance and support to MHSSA grant partners. Since California's Children Youth Behavioral Health Initiative workstreams (workforce training and capacity, developing ecosystem infrastructure and coverage) seek to address and rectify these common barriers, the Commission will collaborate with California's Health and Human Services Agency and other departments on how to best respond to local needs for capacity building and support.

1 Developing partnerships across sectors

Although MHSSA grant partners report success in building and strengthening local partnerships, some note that developing partnerships requires overcoming several challenges:

- Building trust and rapport with new partners, each of whom has their own unique culture, policies and procedures, etc.
- Overcoming the divide between different sectors to learn each other's language and terminology, systems and service delivery models, etc.
- Strategic planning and conducting needs assessments to set goals and priorities.
- Determining levels of administrative oversight and teaming structures.
- Engaging students and families for consultation and planning services.

2 Hiring and retaining staff mental health providers and staff

Grant partners report that hiring and retaining school mental health providers is a main barrier to implementing their school mental health activities and services. These barriers can include finding and hiring qualified mental health providers, particularly in rural areas, as well as retaining staff throughout the grant cycle.

3 Implementing activities and providing services

Grant partners report several barriers in establishing and providing a continuum of school mental health services on school campuses:

- Locating space on school sites to provide services or establish wellness centers.
- Responding to student and family needs for services, which often exceeds service availability and staff capacity.
- Managing multiple school mental health programs and initiatives makes implementation and coordination of activities and services difficult.
- Lack of community referral loops and providers.

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Collecting and reporting data to the Commission

Although grant partners see the value in collecting data on MHSSA activities and services, they report several barriers to collecting and reporting data to the Commission, including lack of data systems and staff resources dedicated to data reporting, HIPAA/FERPA concerns around reporting individual-level data, and difficulty establishing memoranda of understanding with multiple partners.

Building fiscal sustainability to continue grant activities and services

MHSSA grant partners report concerns about how they will continue school mental health activities and services after MHSSA ends. In a survey of technical assistance needs, 86 percent of grant partners surveyed reported needing support to sustain their MHSSA activities and services after the grant ends. More than half of these grantees report needing support in establishing Medi-Cal billing, partnering with private health insurance companies, and blending and braiding these different funding streams.

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STATEWIDE TECHNICAL ASSISTANCE AND EVALUATION

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School Mental Health Technical Assistance

To address the technical assistance needs of MHSSA grant partners, the Commission partnered with the California School-Based Health Alliance in 2020 to produce the *California Student Mental Health Implementation Guide*.

The guide was recently updated in 2024 and includes resources designed to support local education agencies and county behavioral health departments as they work together to deliver comprehensive, high-quality school mental health.

Recently, the Commission established a Technical Coaching Assistance Grant to establish and implement Technical Coaching Teams to provide direct assistance to MHSSA grantees statewide. Three MHSSA grantees – Placer, Imperial, and Tehama – were awarded the grant to provide technical assistance support and direct consultation to other MHSSA grantees in four subject areas:

PARTNERSHIP DEVELOPMENT

PROGRAM IMPLEMENTATION

DATA COLLECTION AND REPORTING

SUSTAINABILITY

These four subject areas were identified by the Commission as creating barriers to success for MHSSA grant partners. In addition, a web-based information hub will be developed by a third-party statewide coordinator to be selected in 2024. The Technical Coaching Teams will begin providing support to MHSSA grantees in the summer/fall of 2024. The statewide coordinator will survey what technical assistance related to school mental health is being provided across the state, and work with those to providers to explore better coordination and alignment, so efforts are not duplicative.

MHSSA Evaluation

MHSSA legislation requires the Commission to develop metrics and a system to measure and publicly report on the performance outcomes of services provided using the grants. The Commission aims to conduct an evaluation that meets this legislative requirement and supports transformational change in school mental health. **In June 2023, the Commission partnered with WestEd to develop a framework and plan for evaluating the MHSSA.**

The Commission's primary goals for the evaluation are to:

1. Understand MHSSA implementation and successes, challenges, and lessons learned.
2. Understand the impact of MHSSA on different levels (a) cross-system partnerships; (b) services in schools and communities; and (c) student and family outcomes.
3. Understand the experiences of student subgroups and the provision of mental health services to close the equity gap.
4. Develop performance metrics that cut across systems to create a shared understanding of student success and wellbeing and close equity gaps.
5. Build capacity of school-county partnerships for data-driven approaches that inform continuous improvement toward effective and sustainable school mental health systems.

To evaluate the MHSSA, the Commission and its partner WestEd have engaged:

6 MHSSA Evaluation Workgroup meetings

24 listening sessions

16 youth from diverse backgrounds participating in a Youth Advisory Group

WestEd will submit a final evaluation plan to the Commission for approval in October 2024, after which implementation of the evaluation will begin. The MHSSA evaluation will be designed to promote systems change and a culture of learning for both MHSSA grant partners and the Commission which will be supporting technical assistance.

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OPPORTUNITIES AND RECOMMENDATIONS

Under Governor Newsom's administration, California has made monumental investments to better support the mental health of its young population. Through initiatives such as the Children and Youth Behavioral Health Initiative, the Mental Health School Services Act, and its modernized public healthcare system known as CalAIM, California is building a full continuum of infrastructure and service systems that emphasize prevention and early intervention in mental health services.

Schools are an important access point for mental services in this continuum. To support long-term local success in school mental health will require a shared understanding across California agencies of both the systems change goals California is working toward and the metrics to measure progress.

California's historic investments in school mental health, including the Mental Health Student Services Act, have allowed for initial steps to be taken to develop school-based mental health services and supports across the state. However, many of these investments are one-time funds. In the next two to three years, MHSSA grant partners will be facing a "fiscal cliff" as their grants end, with many still in the process of building their partnerships and comprehensive school mental health systems. MHSSA grant partners are still learning to leverage Medi-Cal, private insurance, and blend and braid various funding streams. Grant partners need additional time and preparation to implement sustainability plans with the help of the Commission's statewide technical assistance team.

> *"Implementing new strategies for funding mental health in schools is not a sprint. It is a marathon and will take time and preparation. To be successful will require new partnerships, strategies, and staff collaborations."*
>
> **– COMMISSION PARTNER AND SUBJECT MATTER EXPERT**

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Based on lessons learned during MHSSA implementation, the Commission offers the following three recommendations for the State to consider:

State School Mental Health Leadership

The State should establish a leadership structure for youth behavioral health to coordinate and align school mental health initiatives and develop a long-term strategy for building sustainable, comprehensive school mental systems in every K-12 school in California. The leadership structure would simplify the complex network of leadership, funding, and reporting under which counties currently operate, and foster collaborative leadership among state agencies, local governments, educational institutions, youth, and families. This will promote a unified approach to school mental health, enhance resource allocation, and enable the sharing of best practices across different regions and communities.

A long-term comprehensive school mental health strategy should design effective ways for the health and education systems and their partners to collaborate with youth and families to deliver a continuum of behavioral health services and supports in schools. To strengthen partnerships, the State should establish policies that codify these partnerships, create incentives to encourage collaborative behavior, and build metrics into an accountability system to monitor collaboration.

School Mental Health Funding

As California advances toward establishing a robust infrastructure for comprehensive school mental health services, it is crucial to secure additional funding to bridge the gap between initial implementation and long-term sustainability. The State should increase its investment through the Mental Health Services Act (MHSSA) to allow behavioral health and education partners more time to continue to strengthen partnerships, build capacity, and implement a continuum of services and support that began under the initial investment. The State should also invest in programs, services, and resources to support the mental health of teachers and school staff. If California makes a targeted investment, behavioral health and education partners will be able to address immediate funding needs, support the scalability of successful programs, and ensure that mental health services in schools are sustainable and able to adapt to evolving student needs over time.

State School Mental Health Standards and Metrics

The State, through the youth behavioral health leadership structure, should develop and implement robust mental health standards and metrics that establish clear guidelines for comprehensive school mental health systems. These standards should encompass essential components such as prevention, early intervention, crisis support, and school climate indicators to ensure a holistic approach to student wellbeing. Metrics should be designed to track progress, assess program effectiveness, and drive continuous improvement. As part of accountability, the State should establish a data collection and reporting system to collect consistent, school-wide data on mental health services and supports for students. By creating a shared framework and data system for evaluating and enhancing school mental health systems, the State can foster consistency in quality, promote accountability, and support schools in their efforts to deliver impactful mental health support.

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APPENDIX A

Description of MHSSA Grant Award Phases

PHASE 1	PHASE 2	PHASE 3
18 partnership grants awarded in 2020, totaling	19 partnership grants awarded in 2021, totaling	20 partnership grants awarded in 2022, totaling
$74,849,047	**$77,553,078**	**$54,910,420**

Grant awards are generally for four years, with Phase 3 grants scheduled to end in December 2026. In 2023, the Commission made available additional MHSSA funding to existing MHSSA grant partners through a request for applications (RFA). Forty-one MHSSA grantees were awarded additional MHSSA funds to expand their capacity, activities and services.

PHASE 1 GRANTS WERE AWARDED TO 18 OUT OF 38 APPLICANTS IN 2020.

Phase 1 grants were awarded in two categories: (1) An existing history of partnership between county and local education agencies (n = 10); and (2) New and/or emerging partnerships between county and local education agencies (n = 8).

A total of $75 million was issued for the four-year MHSSA grants, with awards determined by county size (small, medium, and large). Phase 1 grantees were slated to begin their programs in Fall 2020 but many experienced significant delays in hiring staff and implementing their programs due to the COVID-19 pandemic. As a result, the four-year grants were amended to allow for a fifth year.

PHASE 2 GRANTS WERE AWARDED TO 19 APPLICANTS IN 2021.

The Budget Act of 2021 provided an additional $95 million to fund applicants who applied to the first round of MHSSA funding (Phase 1) but did not receive a grant. These applicants were approached by the Commission to see if they were still interested in the MHSSA grants and whether their proposal was still applicable. One original applicant chose not to participate. Phase 2 grant contracts were issued to 19 counties between August 2021 and March 2022. In addition, grantees were given additional time to make changes to their original proposal and submit a modified budget within 90 days after the contract was executed.

PHASE 3 GRANTS WERE AWARDED TO 17 APPLICANTS IN FEBRUARY 2022.

The Federal American Rescue Plan (ARPA) provided up to $100 million through the State Fiscal Recovery Fund (SFRF) to support the remaining 20 California counties in establishing an MHSSA program. The Commission surveyed the 20 eligible counties to understand why they did not apply for a Phase 1 grant and asked what their main barriers would be for submitting a proposal. Counties reported a lack of resources and staff to develop a plan and submit a proposal as the primary barrier to participating in the MHSSA program. It should be noted that most of these counties are small, rural counties, many of which had been significantly affected by natural disasters such as wildfires as well as the pandemic. The Commission offered one-on-one sessions, confidential guidance on plan development, and a four-month planning phase to overcome barriers. Phase 3 grant contracts were executed on March 1, 2022.

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In addition, approximately $48 million dollars, which was not awarded in the previous RFAs, were distributed to the 41 grantees that applied for it to expand their capacity, activities, and services.

MHSSA Funding Table (as of January 2024)

COUNTY	SIZE	PHASE 1: 18 GRANTS (2020)	PHASE 2: 19 GRANTS (2021)	PHASE 3: 20 GRANTS (2022)	ADDITIONAL MHSSA FUNDS
Alameda	Large			$6,000,000	$1,619,403
Alpine	Small				
Amador	Small		$2,487,384		
Berkeley City	Small			$2,500,000	
Butte	Medium			$4,000,000	$1,079,602
Calaveras	Small	$2,500,000			$674,751
Colusa	Small			$2,500,000	
Contra Costa	Large		$5,995,421		$1,618,167
Del Norte	Small			$0	$2,500,000
El Dorado	Medium			$4,000,000	$1,044,665
Fresno	Large	$6,000,000			$1,619,403
Glenn	Small		$2,500,000		
Humboldt	Small	$2,500,000			$674,751
Imperial	Small		$2,500,000		$674,751
Inyo	Small			$2,499,444	
Kern	Large	$6,000,000			$1,619,403
Kings	Small			$2,500,000	$674,751
Lake	Small		$2,499,450		
Lassen	Small			$2,274,040	
Los Angeles	Large		$6,000,000		$1,619,403
Madera	Small	$2,499,527			$674,623
Marin	Medium		$4,000,000		$1,079,602
Mariposa	Small			$0	$2,500,000
Mendocino	Small	$2,500,000			$674,751
Merced	Medium			$4,000,000	$810,949
Mono	Small			$2,500,000	
Monterey	Medium		$3,999,979		
Napa	Small			$2,500,000	$454,476
Nevada	Small		$2,499,448		$674,602
Orange	Large	$6,000,000			$1,619,403

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COUNTY	SIZE	PHASE 1: 18 GRANTS (2020)	PHASE 2: 19 GRANTS (2021)	PHASE 3: 20 GRANTS (2022)	ADDITIONAL MHSSA FUNDS
Placer	Medium	$4,000,000			$1,079,602
Plumas	Small			$1,749,800	
Riverside	Large		$5,862,996		$1,409,487
Sacramento	Large		$6,000,000		$1,619,403
San Benito	Small			$0	$2,500,000
San Bernardino	Large		$5,998,000		
San Diego	Large		$6,000,000		$1,111,133
San Francisco	Large		$6,000,000		
San Joaquin	Large			$6,000,000	$1,619,403
San Luis Obispo	Medium	$3,856,907			
San Mateo	Large	$5,999,999			
Santa Barbara	Medium	$4,000,000			$1,022,151
Santa Clara	Large	$6,000,000			$1,619,403
Santa Cruz	Medium		$4,000,000		$1,079,602
Shasta	Small		$2,500,000		$465,755
Sierra	Small			$1,566,204	
Siskiyou	Small			$2,500,000	$674,751
Solano	Medium	$4,000,000			$1,079,602
Sonoma	Medium		$4,000,000		$1,079,602
Stanislaus	Medium			$4,000,000	$1,079,602
Sutter-Yuba	Small		$2,215,438		$402,746
Tehama	Small	$2,500,000			$674,751
Tri-City	Medium			$3,820,932	$1,031,272
Trinity-Modoc	Small	$2,492,684			$453,146
Tulare	Medium	$4,000,000			$1,079,602
Tuolumne	Small		$2,494,962		
Ventura	Large	$5,999,930			$1,619,384
Yolo	Medium	$4,000,000			$1,079,602
TOTAL		**$74,849,047**	**$77,553,078**	**$54,910,420**	**$47,687,455**

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EVALUATION OF THE MENTAL HEALTH STUDENT SERVICES ACT (MHSSA)

This document provides an overview of the evaluation of the MHSSA. In June 2023, the Commission partnered with WestEd to plan and conduct the evaluation, which is being completed in two phases:

Phase 1: Evaluation Planning. The Commission and its evaluation partner WestEd collaborated on a robust evaluation planning process, grounded in community engagement, that resulted in a feasible and meaningful plan to evaluate the MHSSA (presented below).

Phase 2: Evaluation Plan Implementation and Dissemination. The Commission and WestEd will implement the plan to evaluate the MHSSA and disseminate findings and lessons learned on a regular basis as they become available.

PHASE 1: EVALUATION PLANNING

The MHSSA Evaluation planning process took place between June 2023 and October 2024. During this time, the Commission and WestEd have made significant investments in community engagement activities to foster trust, solicit feedback, collaborate, and codesign the evaluation with partners. Activities were designed to solicit feedback on deliverables including a community engagement plan, theory of change and logic model, evaluation questions and metrics, and a draft evaluation plan.

The following briefly summarizes the activities and events that occurred during the evaluation planning process. The Commission and WestEd:

- Held six MHSSA Evaluation Workgroup meetings to engage subject matter experts and the public.
- Held over 30 Listening Sessions with diverse community partners including students, parents, educators, mental health providers, and others.
- Established a Youth Advisory Group comprised of 16 youth from diverse backgrounds to guide evaluation planning.
- Presented at MHSSA Collaboration meetings.

A principal insight from those activities is that partners value having a voice in the evaluation process and are committed to ongoing collaboration.

In addition, several methodological constraints and priorities emerged from community engagement with partners during the MHSSA Evaluation planning phase. Each MHSSA grantee has taken a unique approach to funding services and supports that address student mental health needs and improve student wellbeing. This is because the MHSSA provides critically important flexibility for grantee partners to innovate. However, this flexibility

introduces methodological challenges in evaluating the statewide implementation of a heterogeneous set of MHSSA-funded activities and services.

An additional challenge for this evaluation's design relates to the timeline of MHSSA implementation versus that of the evaluation. The MHSSA Evaluation planning process began after grants were awarded. MHSSA local implementation has been underway since the first phase of funding in 2020. This timeline presents constraints on the methods that can be used, particularly quantitative research methods that require a baseline comparison.

Phase 2: Evaluation Plan Implementation and Dissemination

The MHSSA Evaluation Plan has been designed to measure how this early and substantial statewide investment has impacted interagency collaboration and transformational systems change to ultimately support schools in becoming centers of wellbeing and healing. The Evaluation has been codesigned by WestEd, the Mental Health Services Oversight & Accountability Commission (the Commission) and a broad group of community partners to ensure that the Evaluation reflects diverse community perspectives.

Community engagement activities will be embedded throughout implementation of the evaluation. WestEd's engagement strategy will build upon previous community engagement efforts in Phase 1 to include youth empowerment, youth-facilitated data collection, and ongoing partner collaboration.

The evaluation will be implemented between November 2024 and June 2027, and the scope of work includes four key evaluation components.

1. Contextual Descriptive Analyses
2. Process and Systems Change Evaluation
3. Grantee Partnership Case Studies
4. Implementation and Impact School Case Studies

The following table provides a brief description of the four proposed methods for evaluating the MHSSA. The table also includes community engagement feedback from the planning phase (Phase 1) that informed each component of the evaluation.

Evaluation Components	**Community Engagement Feedback**
1. Contextual Descriptive Analyses The current state of the mental health and wellbeing of students in California will be described by county and include exploration of school, district, and community characteristics that are related to students' mental health and wellbeing.	Grant and community partners stated that it was critical to understand and measure variation in student mental health across different regions and populations.

2. Process and Systems Change Evaluation The evaluator will conduct a statewide evaluation to understand implementation of MHSSA and how it has brought about systems change. The evaluation includes collecting survey data from all grantees on their partnerships, implementation of MHSSA-funded activities and services, community strengths/needs, other school mental health initiatives, and outcomes. The evaluation will be designed to provide grantees with useful feedback that can support their local planning and programming efforts.	Grant and community partners shared that they would like to engage with meaningful and useful data through the MHSSA Evaluation. They wanted to use evaluation findings to share successes and challenges they have encountered. They emphasized the importance of collecting data that would be used not only to satisfy reporting requirements but also to support continuous improvement.
3. Grantee Partnership Case Studies The evaluator will conduct case studies with 10 county behavioral health and education grant partners to contextualize and describe how school communities across the state are reimagining systems change through local incentivized partnerships to build comprehensive and effective school mental health systems.	Grant and community partners emphasized that MHSSA is unique because it incentivizes interagency partnerships. They are proud of the work they do and want to demonstrate how LEAs and county behavioral health departments are "better together."
4. Implementation and Impact School Case Studies The evaluator will conduct case studies of 12 MHSSA-funded schools that will explain the impact of MHSSA-funded activities and services, and school mental health system changes on school and student outcomes. It will also explore intervention conditions and describe MHSSA implementation in the context of each participating school.	Grant and community partners expressed an interest in understanding the school-level mental health system in which MHSSA-funded activities and services were implemented so that they could assess the extent to which different approaches may apply in their own school-level mental health systems.

Next Steps

If approved by the Commission, the MHSSA Evaluation will be implemented beginning in November 2024. As the evaluation unfolds, the Commission and WestEd will publicly disseminate findings as they emerge. It is our goal to keep community partners informed and produce findings and lessons learned on a regular basis that can be incorporated into school mental health planning and practice.

The Mental Health Student Services Act (MHSSA) Evaluation Plan

Prepared by WestEd
Submitted October 1, 2024

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WestEd is a nonpartisan, nonprofit organization that aims to improve the lives of children and adults at all ages of learning and development. We do this by addressing challenges in education and human development, reducing opportunity gaps, and helping build communities where all can thrive. WestEd staff conduct and apply research, provide technical assistance, and support professional learning. We work with early learning educators, classroom teachers, local and state leaders, and policymakers at all levels of government. For more information, visit WestEd.org.

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Executive Summary

The MHSSA Evaluation has been designed to measure how this early and substantial statewide investment has impacted interagency collaboration and transformational systems change to ultimately support schools in becoming centers of wellbeing and healing. The Evaluation has been codesigned by WestEd, the Mental Health Services Oversight & Accountability Commission (the Commission) and a broad group of community partners to ensure that the Evaluation reflects diverse community perspectives.

This technical report describes the plan for implementing the Mental Health Student Services Act (MHSSA) Evaluation based on a planning process that WestEd facilitated from June 2023 to October 2024. The report includes an introduction that describes the history and context of the MHSSA, and an overview of the multidisciplinary body of research and WestEd's community engagement findings that informed the MHSSA Evaluation Plan. The report then describes the MHSSA Evaluation Framework, which delineates the mechanisms of change underlying the intent and goals of the MHSSA, research questions, and a logic model depicting the relationships between inputs, activities, outputs, and outcomes of the MHSSA. Finally, the report details the MHSSA Evaluation Plan, including plans for sampling and recruitment, measures, methods, analysis, and reporting and dissemination. Included in this section is a description of community engagement and, when applicable, of technical assistance opportunities specific to all components of the MHSSA Evaluation Plan.

Through its participatory design, the MHSSA Evaluation will

- center the experiences and wisdom of those who are closest to school mental health systems, particularly those of youth;
- lift up community strengths;
- foster collaborative problem-solving with key partners and interest holders;
- facilitate authentic partnerships with youth to gather and make sense of data and meaningfully contribute to systems change within their communities; and
- encourage self-reflection and learning throughout all stages of the evaluation—individually and collectively.

The evaluation will be implemented November 2024–February 2027 and consists of four evaluation components:

1. Contextual Descriptive Analyses

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2. Process and Systems Change Evaluation
3. Grantee Partnership County Case Study
4. Implementation and Impact School Case Study

Table 1 provides an overview of the MHSSA Evaluation research questions, the components of the MHSSA Evaluation that will answer each research question, and the associated data sources.

Table 1. MHSSA Research Questions Addressed by Evaluation Component with Associated Data Sources

Research Question	Evaluation Component				Data Source
	1	2	3	4	
1. Who was involved in the MHSSA-funded partnerships?		X			Grantee Survey
2. What were the facilitators and/or barriers related to leadership teaming and collaboration?			X		Grantee Partnership Planning Process (G3P)
3. What were the facilitators and/or barriers related to the implementation of school mental health systems change at each level (county, district, school)?			X	X	G3P, MHSSA Implementation Liaison Interview
4. What was the relationship between MHSSA grantee partnerships and the county-level school mental health system?		X	X	X	Grantee Survey, Grantee Sensemaking Sessions, G3P, MHSSA Implementation Liaison Interview

5. What was the relationship between MHSSA-funded activities and services and the school-level mental health system?				X	MHSSA Implementation Liaison Interview, School Staff Focus Group (FG), School Mental Health Staff FG
6. What was the relationship between the county-level and the school-level mental health system?		X	X	X	Grantee Survey, Grantee Sensemaking Sessions, G3P, MHSSA Implementation Liaison Interview
7. How did the MHSSA grantee partnerships support the implementation of MHSSA-funded activities and services?			X	X	G3P, MHSSA Implementation Liaison Interview
8. What activities and services were implemented using MHSSA funding?		X		X	Grantee Survey, Grant Monitoring Data, MHSSA Implementation Liaison Interview
9. How were MHSSA-funded activities and services selected, designed, and implemented to close the equity gap?			X	X	G3P, MHSSA Implementation Liaison Interview, School Site Staff FG, School Mental and Behavioral Health Professional FG
10. What were the facilitators and/or barriers to implementing MHSSA-funded activities and services?				X	MHSSA Implementation Liaison Interview, School Site Staff FG, School Mental and Behavioral Health Professional FG

11. What were the mental health strengths and needs of young people and their school communities?	X	X	X	X	Grantee Survey, Grantee Sensemaking Sessions, California Healthy Kids Survey (CHKS), California Longitudinal Pupil Achievement Data System (CALPADS), US Census, California Open Data Portal, Project Implicit, G3P, School Site Staff FG, School Mental and Behavioral Health Professional FG, Student FG, Parent FG
12. How did community factors serve as facilitators and/or barriers to school mental health systems change at each level (county, district, school)?			X	X	CHKS, US Census, California Open Data Portal, Project Implicit, G3P, School Site Staff FG, School Mental and Behavioral Health Professional FG, Student FG, Parent FG
13. How did other school mental health initiatives serve as facilitators and/or barriers to the implementation of school mental health systems change at each level (county, district, school)?		X	X	X	Grantee Survey, Grantee Sensemaking Sessions, G3P, MHSSA Implementation Liaison Interview, School Site Staff FG, School Mental and Behavioral Health Professional FG
14. How did improvements in the school-level mental health system support students' mental health needs and for whom?			X	X	Grantee Survey, CHKS, CALPADS, G3P, Student FG, Parent FG

The MHSSA Evaluation Plan situates the MHSSA within California's larger school mental health landscape and builds on the understanding that mental health is inextricably linked to school success. The MHSSA Evaluation has been designed to capture how school communities across the state are reimagining school mental health systems in which students thrive and have access to effective mental health supports and services.

Introduction

Now more than ever, there is a nationwide focus on the urgency of addressing the mental health needs of young people. This complex challenge requires reimagining and transforming the systems that support the mental health and wellbeing of young people, their families, and the communities in which they learn and live (Office of the Surgeon General, 2021; United States Department of Health and Human Services, 2024). California has been a national leader responding to the call for school mental health systems change that leverages the strengths and resources of school communities.

History and Context of the MHSSA Evaluation

In August 2022, Governor Newsom and First Partner Jennifer Siebel Newsom launched the Master Plan for Kids' Mental Health—a 5-year initiative to address the significant mental health needs of students (California for All, 2023). This plan describes a fundamental overhaul of California's mental health system—boosting coverage options, service availability, and public awareness so that all children and youth are routinely assessed, supported, and served. As a key component of the governor's plan, the state allocated $4.7 billion to create the statewide Children and Youth Behavioral Health Initiative, designed and implemented by the California Health and Human Services agency with education agencies, other state agencies, and community partners.

Communities across California have also leveraged other statewide school mental health initiatives to support young people and their families. For example, the Student Behavioral Health Incentive Program supports the goals of California's Advancing and Innovating Medi-Cal (CalAIM) initiative and provides new investments in behavioral services, infrastructure, information technology and data exchange, and workforce capacity for school-based and school-affiliated behavioral health providers. In 2021, California invested $3 billion in the California Community Schools Partnership Program, which has since been extended to 2031. In 2022, the state also expanded the California Collaborative for Educational Excellence's Community Engagement Initiative, which builds the capacity of local education agencies (LEAs) for transformational community engagement. Further, in 2021, California appropriated $50 million to continue support for school- and districtwide implementation of services and practices within a multi-tiered system of support (MTSS) through the Scaling Up MTSS Statewide Partner Entity grant, which includes a focus on social and emotional learning; trauma-informed practices; and culturally relevant, affirming, and sustaining practices.

Led by the Mental Health Services Oversight and Accountability Commission (the Commission), the Mental Health Student Services Act (MHSSA) is one of California's historic investments to deliver timely, equitable, and quality mental health services

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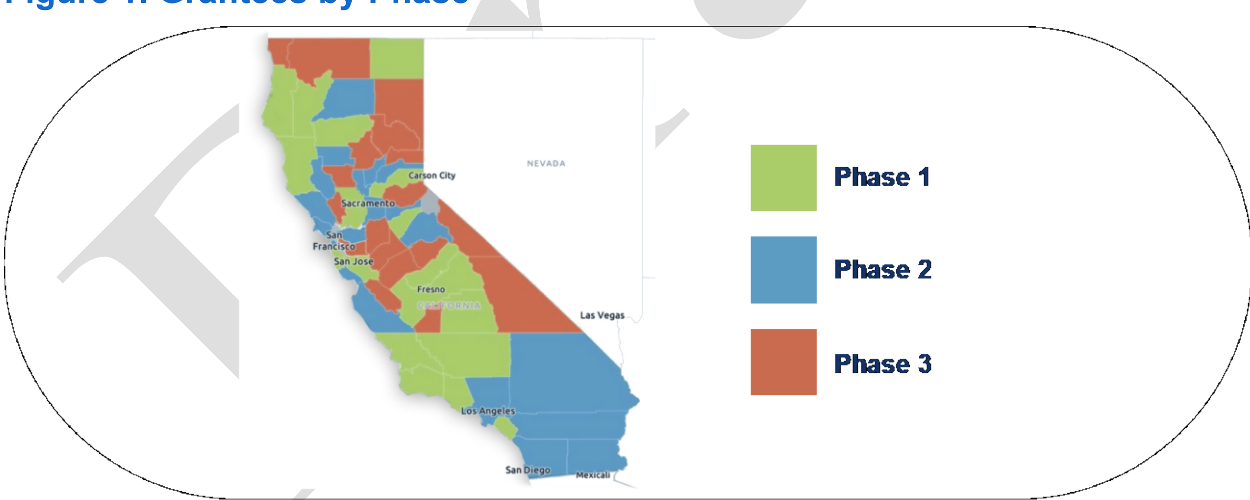
within school communities. The MHSSA was enacted in 2019 to provide financial support to counties in addressing student mental health needs related to COVID-19. Since its launch, the MHSSA vision has expanded to center schools as a core component of the community behavioral health system. To accomplish this, the MHSSA provided funding to incentivize change through local partnerships between county behavioral health departments and local education agencies (LEAs). In addition, the legislation offered flexibility in how funds are used to meet the diverse and immediate needs of counties across the state. MHSSA funding has been distributed across four phases. Phase 4 funding was announced in August 2024 and will provide $25 million to partnerships focused on the following priorities: (a) Marginalized and Vulnerable Youth, (b) Universal Screening, (c) Sustainability, and (d) “Other Priorities” to address unique needs within a county. The focus of the current statewide evaluation is on Phases 1–3.

Funding Phases 1 Through 3

In 2019, Senate Bill 75 established the MHSSA and provided $40 million in one-time and $10 million in ongoing funding to establish partnerships between county behavioral health departments and LEAs focused on school mental health systems change. To date, the Commission has provided MHSSA funds to support school mental health partnerships to 57 grantees for a total investment of $255 million. See Figure 1 for a map of the grantees by phase.

Figure 1. Grantees by Phase



For Phase 1, launched in 2020, awarded funding to a total of 18 grantees. The funding for these 4-year grants totaled $74,849,047. Grantees in this first phase included Calaveras, Fresno, Humboldt, Kern, Madera, Mendocino, Orange, Placer, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Solano, Tehama, Trinity-Modoc, Tulare, Ventura, and Yolo. Ten grantees received Category 1 (existing partnerships) funding, and eight grantees received Category 2 (new or emerging partnerships) funding. Of these Phase 1 grantees, five counties are urban, seven suburban, and six rural (the California State Association of Counties).

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In response to a great deal of interest in the program, the Budget Act of 2021 allocated additional funding for applicants who applied but did not receive a grant during the initial phase. During this second phase, the Commission funded 19 new grantees in 2021 with a total of $77,553,078. Grantees that received Phase 2 funding included Amador, Contra Costa, Glenn, Imperial, Lake, Los Angeles, Marin, Monterey, Nevada, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, Santa Cruz, Shasta, Sonoma, Sutter-Yuba, and Tuolumne. Nine grantees received Category 1 (existing partnerships) funding, and 10 grantees received Category 2 (new or emerging partnerships) funding. Of these Phase 2 grantees, seven counties are urban, six are suburban, and six are rural.

In addition, the federal American Rescue Plan Act provided additional funds through the State Fiscal Recovery Fund. In 2022, the Commission funded 20 Phase 3 grantees with a total of $54,910,420. These grantees included Alameda, Berkeley City, Butte, Colusa, Del Norte, El Dorado, Inyo, Kings, Lassen, Mariposa, Merced, Mono, Napa, Plumas, San Benito, San Joaquin, Sierra, Siskiyou, Stanislaus, and Tri-City. For Phase 3, grantees were not asked to report if they had existing (Category 1) or new or emerging partnerships (Category 2). Of these Phase 3 grantees, 4 counties are urban, 4 are suburban, and 12 are rural.

To extend the work being done across the state, the Commission awarded $47,687,455 that had not been distributed to 41 grantees that had applied for it during the prior application phases. Due to this additional funding and extensions, all but 15 grantees' Phase 1-3 programs will end in 2026, with the majority ending on December 31, 2026.[1]

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[1] San Mateo's program end date is September 2024, and Orange, San Luis Obispo, Santa Clara, Solano, Trinity-Modoc, Tulare, Lake, Marin, Monterey, Nevada, Sacramento, Santa Cruz, Sonoma, and Tuolumne end in summer or fall 2025.

The MHSSA has had a broad reach, funding over 2,000 schools throughout the state, including 842 elementary schools, 304 middle schools, 425 high schools, and 564 combined schools.[2] Table 2 below details the number of MHSSA-funded schools by grade level and funding phase.

Table 2. Funded Schools by Phase

	Elementary Schools	Middle Schools	High Schools	Combined Schools	Total Schools
Phase 1 Grantees	288 (39.8%)	100 (13.8%)	150 (20.7%)	186 (25.7%)	724
Phase 2 Grantees	338 (43.4%)	120 (15.4%)	161 (20.6%)	161 (20.6%)	780
Phase 3 Grantees	216 (34.2%)	84 (13.3%)	114 (18.1%)	217 (34.4%)	631

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[2] Findings summarized in Table 2 were generated from a Commission file containing a list of schools funded by the MHSSA. The original file contained information about county name, district name, school name, and county-district-school (CDS) code. To create a more complete understanding of the school profile, the file was matched with raw data from the CDE's California school directory (https://www.cde.ca.gov/schooldirectory/). The school data was matched using the CDS code, which is the unique ID for each school. The combined files ultimately utilized the following information: CDS code, county name, district name, school name, school type, EIL name, and grades offered.

Using this information, WestEd categorized each school into the following categories: elementary school, middle school, high school, and combined schools. The categories served as a proxy for student ages. "Elementary school" included schools that served the ranges of PK–5, "middle school" included schools that served Grades 6–8, and "high school" included schools that served Grades 9–12. Schools that served a greater range of grades (e.g., K–8, 6–12) were categorized as "combined schools."

For a complete overview of grantee specific information, please see the Grantee Table document. This includes the phase of funding, grantee size, funding amount, program end date, and school level served by each grantee.

Activities and Services

Each MHSSA grantee has implemented a unique project plan based on local needs, priorities, and constraints. Grantee-specific project plans, as outlined in grant applications, Program Development Phase Plans, and MHSSA Grant Summaries, detail the activities and services each MHSSA-funded partnership planned to implement. County annual fiscal reports and hiring reports provide additional details on the roles and classifications of hired MHSSA personnel. These details offer a granular view of the distribution of funds across staff coordinating and/or implementing activities and services at the county, district, or school levels.

To inform the MHSSA Evaluation Plan, WestEd staff conducted a thematic analysis (Braun & Clarke, 2012) of the MHSSA Grant Summaries submitted to the Commission. This review provided a snapshot of a continuum of statewide MHSSA-funded activities and services (i.e., Tier I, Tier II, and Tier III), as well as information about grantees' proposed plans for implementation. Additionally, WestEd staff coded county-specific contextual information, target populations, and proposed MHSSA staff roles.

Contextual variables. Specific circumstances and elements shaped how grantees tailored their support and implement services. The majority of grantees (71.9%) identified specific populations they planned to support with their MHSSA funding. Regarding school level, 28.1 percent of grantees indicated a focus on high school, 15.8 percent on middle school, 12.3 percent on elementary school, and 5.3 percent on early childhood. Of the grantees, 19.3 percent specified that their services and activities would focus on underserved and/or high-need students, followed by foster care (12.3%) and LGBTQ+ (12.3%) youth. The majority of named MHSSA staff positions included mental health professionals, program managers and coordinators (a total of 33.3%), and care and systems navigators (a total of 26.3%). Finally, in terms of specific settings for accessing MHSSA services beyond schools, 22.8 percent of grantees proposed wellness centers, followed by various locations identified by only one or two grantees. Noteworthy settings specified included a school-based residential program, adult education site, and juvenile detention facility.

Implementation support. An MTSS framework was the most common implementation framework explicitly identified by grantees. Aligned with the MHSSA's focus on incentivizing change through partnerships, 79 percent of grantees included language about their partnerships and/or collaboration, and about half explicitly identified a specific team facilitating the implementation of MHSSA-funded activities and services. Staff training and professional development were noted in nearly half of the grant summaries, followed by numerous other examples of implementation supports for systems capacity building and sustainability. This included communication capacity, systems coaching/consultation, leveraging of various funding streams, procedure and protocol development. The most common types of data use included mental health screening (both universal and targeted, 45.6%), individual assessment (31.6%), and progress monitoring (17.5%).

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Tier I, Tier II, and Tier III. Proposed activities and services were focused across all three tiers. Specifically, 80.7 percent of grantees proposed Tier I activities and services, 68.4 percent Tier II activities and services, and 98.3 percent Tier III activities and services. At Tier I, mental health awareness and literacy promotion and training activities (63.2%) were the most common, followed by mental health and wellness training/skill-building programs that were not further specified (31.6%), and suicide prevention (26.3%). At Tier II, the most common activities and services were unspecified groups (35.1%) and peer-to-peer support/mentoring (19.3%). At Tier III, the most reported activities and services were individual counseling, therapy, and/or supports (86%) and comprehensive case management, including systems navigation, referral, and outreach/engagement (57.9%). Finally, 45.6 percent of grantees proposed crisis intervention services. Table 3 provides a summary of identified MHSSA Tier I, Tier, II, and Tier III services and activities as well as implementation supports across the three phases of grantees.

Table 3. Services, Activities, and Supports by Phase

	Tier I	Tier II	Tier III	Implementation Supports
Phase 1 (n = 18)	77.8% (14)	77.8% (14)	100% (18)	94.4% (17)
Phase 2 (n = 18)	88.9% (16)	61.1% (11)	94.4% (17)	88.9% (16)
Phase 3 (n = 21)	76.2% (16)	66.7% (14)	100% (21)	100% (21)

Grantees in Phases 2 and 3 followed a similar pattern of being most likely to report Tier III supports, followed by Tier I and then Tier II. Phase 1 grantees were equally likely to mention Tier I and Tier II supports. Every Phase 3 grantee discussed how they planned to support MHSSA implementation, as did the majority of Phase 1 and Phase 2 grantees.

Theoretical and Methodological Foundations

The MHSSA Evaluation Plan is informed by a multidisciplinary body of research literature. This research contextualizes the findings from WestEd's community engagement efforts and review of program documents and activities. The plan integrates insights from several research areas and methodologies:

- school mental health systems change
- developmental systems change evaluation and systems thinking
- case-centered research design
- implementation science
- antiracist participatory research

School Mental Health Systems Change

Schools are a natural setting for comprehensive mental health services. The MHSSA provides an opportunity for transforming systems through critical partnerships to create culturally responsive and sustainable conditions that support the mental health and wellbeing of California's diverse school communities.

Comprehensive school mental health systems build capacity among partners to support a full continuum of culturally responsive and sustainable interventions. Such interventions promote mental health and wellbeing while reducing the prevalence and severity of emotional and behavioral problems (Lazarus et al., 2021). School mental health systems are characterized as a cross-agency MTSS designed by and uniquely for a school community (Stephan et al., 2015; U.S. Department of Education, 2021; Weist et al., 2018).

Evolving from a public health approach, this multi-tiered implementation framework targets upstream determinants of mental health (Dopp & Lantz, 2020; Forman, 2015). Primary prevention (Tier 1) aims to address risk factors and promote protective factors, and secondary prevention (Tier II) and tertiary (Tier III) prevention aim to reduce the duration of mental health challenges (Forman, 2015; National Research Council and Institute of Medicine, 2009).

Developmental Evaluation and Systems Thinking

Developmental evaluation offers a framework to measure the impact of systems change initiatives, particularly in complex environments where linear evaluation approaches may not sufficiently account for context. This framework accounts for the complexity of school mental health systems change, which is driven by the unique context of each school, district, and county in which the MHSSA is implemented.

Systems thinking is at the core of this approach to evaluation, which asserts that the whole is greater than the sum of its parts. Complex systems are dynamic and change

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over time, and it is the role of the evaluator to examine the ways in which the key features of the system interact and measure the ways in which those interactions support systems change.

Developmental evaluation centers on key dynamics, or “parts” of a system, encompassing the following: understanding interrelationships; engaging with multiple perspectives; and reflecting on the definition, complexity, and challenges of assessing systems and the interventions within them (Patton, 2015). This dynamic framework informs how the MHSSA Evaluation is designed and, critically, keeps the focus on systems change and the relationships across all parts of the MHSSA and its implementation across the state (McGill et al., 2021).

Case-Centered Research Design

Case-centered research design is focused on one or more cases, which can be understood as complex social units. Throughout the research process, cases are examined within their entirety, thus maintaining the cohesiveness of the social unit (Roller & Lavrakas, 2015). WestEd will employ a collective case study design in the MHSSA Evaluation. Methodologists posit that the utility of a collective, or multiple case design, is the examination of the specifics of a single case to illuminate themes that are more broadly applicable (Stake, 1995). Within a statewide evaluation such as the MHSSA, the study of multiple cases facilitates the evaluation’s understanding of a broader set of research questions.

Critical to this approach is acknowledging the limitations to external validity. Evaluators must be cautious in generalizing from a small group of cases to a broader group of cases that are made up of a different set of complex features (Roller & Lavrakas, 2015). The MHSSA will use a sampling approach that will result in selecting sample counties and schools with a diverse set of characteristics to mitigate some challenges to external validity. However, WestEd will articulate the limits to the evaluation’s ability to generalize based on a small sample of cases.

Implementation Science

Implementation science provides a framework for understanding continuous improvement processes, where implementation variables influence intervention outcomes (Durlak & DuPre, 2008; Fixsen et al., 2005; Sanetti & Kratochwill, 2009). This understanding is critically important for scaling practices to achieve a socially meaningful impact (Horner et al., 2017; Kania et al., 2018). However, beyond changing the practices that have long maintained the status quo of how young people experience mental health supports and services, transformational change will also require what Blasé et al. (2015) describe as “changing hearts, minds, and behavior” among leaders, practitioners, and educators.

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The statewide MHSSA Evaluation provides a unique opportunity to better understand behavioral health and education systems conditions as they relate to partnership capacity to effectively facilitate implementation of MHSSA-funded activities (i.e., who is doing what and how) and continuous improvement toward sustainable school mental health service delivery. In response to requirements stated under WIC Section 5886(k), the MHSSA Evaluation must build the capacity of MHSSA grantees for data-driven approaches informing continuous improvement toward effective and sustainable school mental health systems.

Antiracist Participatory Research

In the work to center equity, the MHSSA Evaluation Plan is guided by antiracist evaluation principles. WestEd's approach to antiracist evaluation centers critical self-reflection and learning; collaborative and equitable partnerships; and attention to cultural, historical, and political contexts throughout all stages of the evaluation (WestEd, 2021). This approach centers close collaboration with those who are most proximal to the program, the initiative, or the organization that is being evaluated.

The MHSSA Evaluation Plan integrates the perspectives and expertise of partners, including Commission staff, county behavioral health staff, county and LEA staff, youth, families and caregivers, subject matter experts, school staff, mental and behavioral health professionals, and evaluation partners. WestEd's antiracist community engagement model, which informed the development of the statewide MHSSA Evaluation Plan, consisted of four primary activities:

- **Relationship building.** Community engagement activities began with building relationships with several key partners and interest holders. These included the Commission Research and Evaluation Division (RED) team, the Community Engagement and Grants (CEG) team, the MHSSA Research and Evaluation Workgroup, Commission staff, MHSSA grantees, behavioral and mental health providers, school staff, families and caregivers, and youth. The goal was to foster relational trust, shared goals, and a unified vision for the MHSSA Evaluation.
- **Listening sessions.** The WestEd team met virtually with partners to learn about the shared and unique goals of the MHSSA for grantees and school-level implementers, the components of grantee partnerships, implementation strategies, and the outcomes that are meaningful and useful to different partner groups.
- **Sense making.** WestEd collected written feedback and met virtually with partners throughout the planning process to collect feedback on the emerging MHSSA Evaluation Plan. Partners have seen and responded to each major evaluation component.
- **Partnering with youth.** As part of the evaluation planning process, WestEd convened a group of 15 youth to make up a youth advisory group (YAG) that met monthly from February 2024 to September 2024. WestEd facilitators taught youth

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about evaluation and created interactive activities for youth to share their ideas, thoughts, and recommendations for the MHSSA Evaluation. Through these activities and discussions, WestEd learned about the MHSSA Evaluation outcomes most important to young people, their priorities for the evaluation, strategies to engage young people in schools, and how youth voice should be incorporated into the evaluation.

Methodological Constraints and Community Priorities

The MHSSA, together with the rest of California's historic investments in student mental health, promises transformational change within the state's school mental health system. However, the extent to which each statewide initiative drives systems change, builds upon other initiatives, and contributes to positive outcomes for students, families, and school communities has yet to be evaluated. There are several methodological constraints and, as previously highlighted, priorities that emerged from community engagement with partners and interest holders during the MHSSA Evaluation planning phase.

Each MHSSA grantee has taken a unique approach to funding supports that address student mental health needs and improve student wellbeing. This is because the MHSSA provides critically important flexibility for grantee partners to innovate. However, this flexibility introduces methodological challenges in evaluating the statewide implementation of a heterogeneous set of MHSSA-funded activities and services.

An additional challenge for this evaluation's design relates to the timeline of MHSSA implementation versus that of the MHSSA Evaluation. As previously noted, the statewide MHSSA Evaluation planning process occurred between June 2023 and October 2024. Meanwhile, MHSSA program implementation has been underway since the first phase of funding in 2020, and for some counties, funding ends as early as fall 2024. Therefore, the MHSSA Evaluation Plan accounts for varying start and end dates across the three phases of funding (see the Grantee Table document).

Table 4 reflects the program implementation timeline for each phase of MHSSA funding and the timeline for the evaluation planning and implementation periods.[3] This timeline presents constraints on the methods that can be used, particularly quantitative research methods that require a baseline comparison.

[3] All dates identified in this report are subject to change dependent upon WestEd's evaluation contract execution date.

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Table 4. Grant Phases and Proposed Evaluation Timeline

<table>
<tr><th></th><th>2020</th><th>2021</th><th>2022</th><th>2023</th><th>2024</th><th>2025</th><th>2026</th><th>2027</th></tr>
<tr><td colspan="9">Grant Phase</td></tr>
<tr><td>Phase 1</td><td colspan="7">2020–2026</td><td></td></tr>
<tr><td>Phase 2</td><td></td><td></td><td colspan="5">2022–2026</td><td></td></tr>
<tr><td>Phase 3</td><td></td><td></td><td></td><td colspan="4">2023–2026</td><td></td></tr>
<tr><td colspan="9">Proposed Evaluation Timeline</td></tr>
<tr><td>Planning</td><td></td><td></td><td></td><td colspan="2">2023–2024</td><td></td><td></td><td></td></tr>
<tr><td>Implementation</td><td></td><td></td><td></td><td></td><td colspan="4">2024–2027</td></tr>
</table>

One critical feature of any evaluation plan is its clear alignment with the evaluation framework, which includes conceptual and measurement models, research questions, and a logic model (Ravitch & Riggan, 2016). In developing the MHSSA Evaluation Framework, WestEd utilized an iterative process that began with developing a framework inclusive of those outputs and outcomes specified in Welfare and Institutions Code section 5886(k). This initial framework served as a starting point for conversations with community partners, leading to a series of revisions that now yield a framework that is more reflective of community needs and perspectives. Through this community engagement process, WestEd learned about the evaluation outputs and outcomes that various groups found to be meaningful and useful.

The WestEd team also engaged in a systematic metrics mapping process. This process helped to determine the feasibility of measuring each output and outcome specified in legislation. This process yielded an additional set of practical and methodological constraints that further informed the revision of the MHSSA Evaluation Framework and the broader MHSSA Evaluation Plan. To the greatest extent possible, WestEd has developed a plan that aligns with Welfare and Institutions Code section 5886(k) and with community needs and perspectives.

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The MHSSA Evaluation Framework

The MHSSA Evaluation Framework, the foundation of the statewide evaluation, encompasses

- the MHSSA Conceptual Model, which illustrates the mechanisms of change underlying the intent and goals of the MHSSA and represents the relationships between represented elements;
- the MHSSA Logic Model, which depicts the relationships between inputs, activities, outputs, and outcomes for MHSSA;
- research questions that align with the Conceptual Model; and
- measurement models that operationalize each element within the Conceptual Model.

The MHSSA Evaluation Framework is informed by a diverse body of literature, the distinctive characteristics of the California landscape, and findings from extensive engagement with a broad range of community partners and interest holders from across the state.

MHSSA Conceptual Model

The MHSSA Conceptual Model (Figure 2) illustrates the a priori, hypothesized mechanisms of change underlying the intent and goals of the MHSSA and represents the relationship between elements within the model. While acknowledging that additional elements and relationships might exist, this Conceptual Model provides the most direct and measurable framework to evaluate the implementation and impact of the MHSSA.

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Figure 2. The MHSSA Conceptual Model

Note. **Districts are represented both within grantee partnerships—as they collaborate with the county-level school mental health system—and within MHSSA-funded activities and services—as they provide leadership and support to school-level mental health systems.**

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This evaluation does not attempt to isolate the MHSSA's unique effect on a series of distal outcomes. Instead, it focuses on two vital relationships: MHSSA grantee partnerships and the county-level school mental health systems, and MHSSA-funded activities and services and the school-level mental health system. The evaluation framework emphasizes the cumulative effect of school mental health systems change through MHSSA grantee partnerships and MHSSA-funded activities and services on schools and young people.

The Conceptual Model illustrates how the MHSSA supports establishing new and emerging partnerships, or leveraging existing partnerships, between county behavioral health departments and Local Education Agencies (LEAs). These partnership teams design MHSSA-funded activities and services that are implemented within county, district, and/or school communities.

This model takes a complex systems approach, depicting the interrelated and interactive parts of school mental health systems at the state, county, and school levels. The Conceptual Model uses bidirectional arrows to illustrate the feedback loops that reflect the nonlinear nature of the MHSSA mechanisms of change (Mayne, 2023).

The model's logic posits that effective grantee partnerships facilitate transformational change toward one cohesive county-level school mental health system. Similarly, the model assumes that the implementation of MHSSA-funded activities and services impacts and is impacted by transformational change toward one cohesive school-level mental health system. The model also depicts the bidirectional relationship between the county-level and school-level mental health system such that change within one system can facilitate change within the other system.

The Conceptual Model represents two key factors that influence the MHSSA's implementation and impact: community factors and other school mental health initiatives. Counties, districts, and schools throughout California are layering, blending, and braiding funds to meet the distinct mental health needs of the young people within their communities. Each MHSSA grantee contributes to this effort by funding school mental health activities and services to improve the mental health of select school communities within their county and to improve student wellbeing. The MHSSA functions as one of several inputs within this complex and contextually unique system. Its impact may be diminished or amplified depending on the system's overall response to these many inputs (McGill et al., 2021).

In California's vast and diverse landscape, it is critical that this evaluation considers the community context and the interplay between the MHSSA; other school mental health initiatives; and the federal, state, and local funding streams.

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Logic Model

The MHSSA Logic Model (Figure 3) depicts the relationships between resources and inputs, activities, outputs, and outcomes, in alignment with the Conceptual Model, while also incorporating contextual factors, community and social determinants, other school mental health initiatives, and youth-serving systems.

Figure 3. The MHSSA Logic Model

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The MHSSA Logic Model identifies key inputs such as MHSSA legislation and funding, Commission and grantee leadership and expertise, and partnerships between education and behavioral health agencies. The activities that follow these inputs include the Commission funding grantee partnerships; providing ongoing oversight, accountability, technical assistance, and evaluation support; reporting to the legislature, and facilitating engagement with community partners. Finally, activities include the implementation of project plans by grantee partners.

The outputs resulting from these activities are multifaceted: they include the formation or strengthening of grantee partnerships, whereby MHSSA partners collaboratively work with districts to support schools with implementing MHSSA-funded activities and services. Additional outputs, aligned with those in the Conceptual Model and Welfare and Institutions Code section 5886(k), encompass recognition of mental health challenges, response to the need for additional services, access to services for underserved populations, response to the needs of all student subgroups, linkages to ongoing services, and prevention of mental health challenges from becoming severe or disabling.

The outcomes listed in the Logic Model include improving mental health and wellbeing, improving school climate, reducing stigma and discrimination around mental health challenges, reducing prolonged suffering, increasing social–emotional learning skills, reducing suicide and attempted suicide, and reducing school failure or dropout.

Measurement Models and Research Questions

The measurement models (Figures 4-8) operationalize the elements of the MHSSA Conceptual Model, outlining the theoretical underpinnings of each element, anchoring them within their respective bodies of research. At the end of each measurement model section are the research questions aligned with the MHSSA Conceptual Model element, and together, these sections shape the MHSSA Evaluation Plan. All research questions, organized by conceptual model element, are presented in Table 5.

Table 5. MHSSA Research Questions

Conceptual Model Element	Research Question
Grantee Partnership	1. Who was involved in the MHSSA-funded partnerships?
	2. What were the facilitators and/or barriers related to leadership teaming and collaboration?

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County-Level and School-Level Mental Health System	3. What were the facilitators and/or barriers related to the implementation of school mental health systems change at each level (county, district, school)?
	4. What was the relationship between MHSSA grantee partnerships and the county-level school mental health system?
	5. What was the relationship between MHSSA-funded activities and services and the school-level mental health system?
	6. What was the relationship between the county-level and the school-level mental health system?
MHSSA-Funded Activities and Services	7. How did the MHSSA grantee partnerships support the implementation of MHSSA-funded activities and services?
	8. What activities and services were implemented using MHSSA funding?
	9. How were MHSSA-funded activities and services selected, designed, and implemented to close the equity gap?
	10. What were the facilitators and/or barriers to implementing MHSSA-funded activities and services?
Community Factors	11. What were the mental health strengths and needs of young people and their school communities?
	12. How did community factors serve as facilitators and/or barriers to school mental health systems change at each level (county, district, school)?
Other School Mental Health Initiatives	13. How did other school mental health initiatives serve as facilitators and/or barriers to the implementation of school mental health systems change at each level (county, district, school)?
Meaningful and Equitable Outcomes	14. How did improvements in the school-level mental health system support students' mental health needs and for whom?

Equity-Centered School Mental Health Systems

The MHSSA Conceptual Model represents the interrelated mechanisms of the school mental health system. It shows the bidirectional relationships at the county, district, and school levels within the larger state context. Sustainable implementation of a school mental health system requires partnerships that facilitate alignment and coordination of the school mental health service delivery system across these levels. A school mental health system is a continuum of tiered interventions within an MTSS framework that creates conditions to promote the mental health and wellbeing of everyone within a school community (Barrett et al., 2013; Hoover et al., 2019; U.S. Department of Education, 2021; Weist et al., 2018). Figure 4 depicts critical components of a school mental health system engaging in continuous improvement towards meaningful and equitable mental health outcomes. While the county- and school-level mental health systems each play a distinct but interconnected role in facilitating school mental health systems change, these critical components apply to all levels (county, district, school) of the school mental health system.

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Figure 4. Measurement Model of Equity-Centered School Mental Health Systems

Equity-Centered School Mental Health System Research Questions

- What were the facilitators and/or barriers related to the implementation of school mental health systems change at each level (county, district, school)?
- What was the relationship between MHSSA grantee partnerships and the county-level school mental health system?
- What was the relationship between MHSSA-funded activities and services and the school-level mental health system?
- What was the relationship between the county-level and the school-level mental health system?

Grantee Partnerships

The vision guiding the MHSSA was to transform schools into centers of wellbeing that address students' unmet needs and improve their access to services. To that end, the MHSSA aims to foster stronger school–community mental health partnerships that can leverage resources to bolster student success. This goal is achieved by incentivizing counties and LEAs to establish partnerships that provide a comprehensive and integrated model of school mental health services.

School mental health systems bring together partners to align and coordinate supports and services (Barrett et al., 2017; CCSSO and NCSMH, 2021), thus expanding access to services for young people and their families. While MHSSA partnerships range from existing to new and emerging, they are the proximal result of the MHSSA and are an integral part of all subsequent MHSSA-funded activities and services implemented in schools and communities. Therefore, the MHSSA Evaluation focuses on measuring the strengthening or formation of partnerships.

The specific roles and responsibilities of school and behavioral health partners will vary by community and team. However, collaborative practices and teaming are critical at all levels of the service delivery system (state, county, district, and school) to ensure the ongoing implementation of a culturally responsive and sustainable school mental health system (Bohnenkamp et al., 2023; Eber et al., 2019; Malone et al., 2022).

Figure 5 illustrates the MHSSA partnerships, encompassing both those that are existing and those that are newly developed. People, teaming practices, and collaboration form the core components of each of these partnerships. The people component involves the leadership team's composition, roles, and participation—essentially, the "who." The teaming practices and procedures of cross-agency leadership teams (e.g., operating procedures; data-based decision-making informed by school, community, and student data; referral pathway protocols; data sharing; meeting agendas and action plans) are essential for implementing an integrated school mental health system (Weist, Garbatz, Lane, & Kincaid, 2017; Splett et al., 2017).

Finally, the collaboration component involves sharing knowledge and resources to accomplish more than either agency could do on its own (Mellin & Weist, 2011). It has been characterized by newly defined relationships and roles, interdependence, and collective ownership and accountability and through shifting beliefs, establishing a shared understanding, and addressing power disparities (Bronstein, 2003; Mellin & Weist, 2011; Splett et al., 2017).

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Figure 5. Measurement Model of Grantee Partnerships

Grantee Partnerships

Existing

New & Emerging

People

Teaming

Collaboration

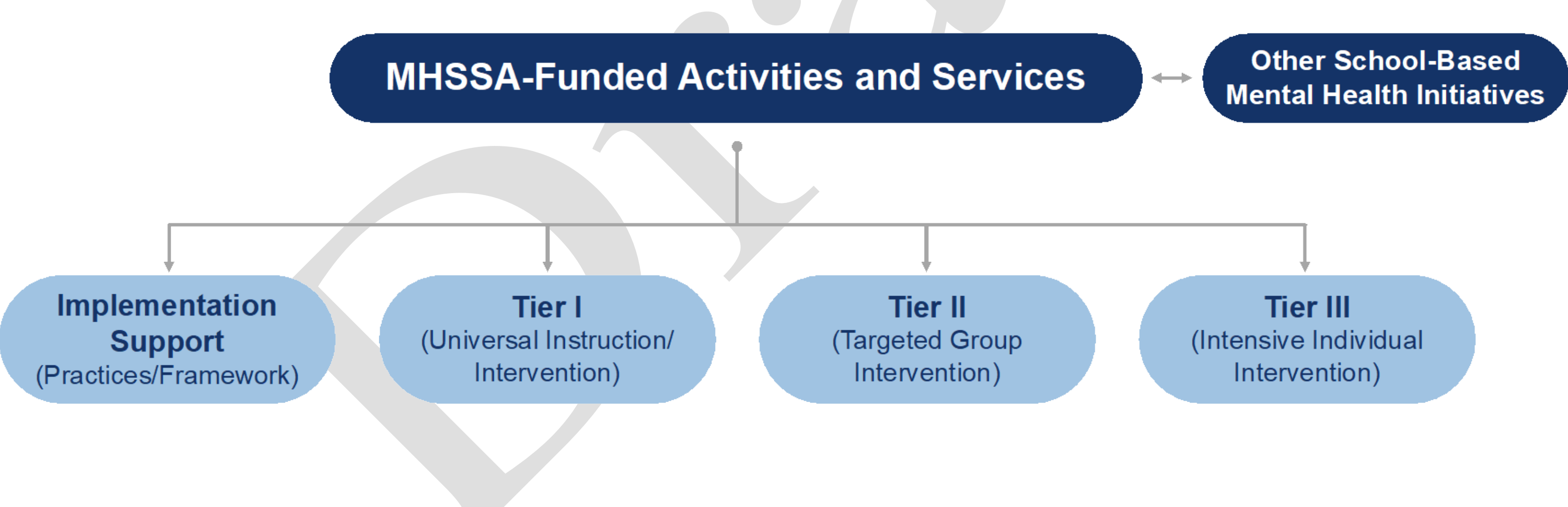
Grantee Partnership Research Questions

- Who was involved in the MHSSA-funded partnerships?
- What were the facilitators and/or barriers related to leadership, teaming, and collaboration?

MHSSA-Funded Activities and Services

The groupings of MHSSA-funded activities and services (Figure 6) are derived from a comprehensive review of all documents from grantees and the Commission, the Grant Summaries Review, and feedback collected from community engagement activities. As detailed previously, these activities and services have been organized into four main categories: implementation support, Tier I, Tier II, and Tier III. It is important to note that grantees often implement MHSSA-funded activities and services across multiple categories. Thus, MHSSA-funded activities and services will be reflected in nuanced classifications within the evaluation's analysis and reporting.

Figure 6. Measurement Model of MHSSA-Funded Activities and Services



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As previously stated, MHSSA-funded activities and services occur within a broader mental health landscape of state, county, and school levels. As such, other school mental health initiatives, and their associated funding streams, may have impacted the selection and implementation of MHSSA-funded activities and services. The relationship between MHSSA-funded activities and services and other school mental health initiatives is bidirectional. MHSSA-funded activities and services can also influence how schools, districts, or counties implement other mental health initiatives.

MHSSA-Funded Activities and Services Research Questions

- How did the MHSSA grantee partnerships support the implementation of MHSSA-funded activities and services?
- What activities and services were implemented using MHSSA funding?
- How were MHSSA-funded activities and services selected, designed, and implemented to close the equity gap?
- What were the facilitators and/or barriers to implementing MHSSA-funded activities and services?

Meaningful and Equitable Outputs and Outcomes

The statewide MHSSA Evaluation Plan provides an a priori theoretical map of the ways in which this initiative positively impacts school mental health systems change and students. Within the plan, the focus is on outputs and outcomes that are meaningful—that is, facilitate learning and continuous improvement to key partners and interest holders—and that center equity and aim to close the equity gap.

The outputs and outcomes listed in Figure 7 were identified through an iterative process that originated from the outcomes specified in Welfare and Institutions Code section 5886(k). Community partners contributed to refining these initial outcomes, aiding the WestEd team in broadening our conceptualization of impact. This iterative process led WestEd to reimagine the ways in which outputs and outcomes relate to the broader model and are incorporated into the MHSSA Evaluation Framework.

Outputs are defined as changes resulting from MHSSA activities that are relevant to the achievement of outcomes. In other words, the implementation of an MHSSA-funded activity or service resulted in the outputs listed below. In the MHSSA Conceptual Model, these outputs are measured as part of the school-level mental health systems change construct.

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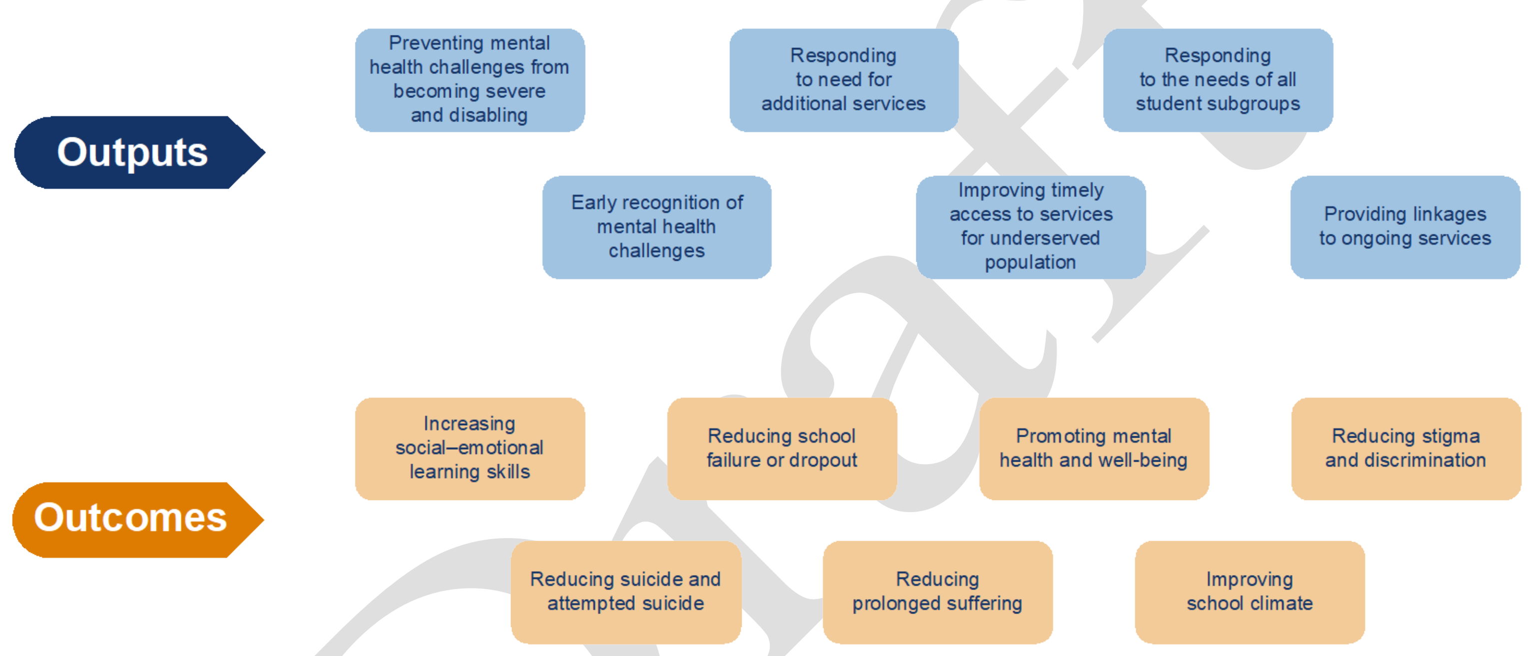
Figure 7. Measurement Model of the Meaningful and Equitable Outputs and Outcomes of the MHSSA



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Meaningful and Equitable Outcomes Research Question

- How did improvements in the school-level mental health system support students' mental health needs and for whom?

Community Factors

Community factors play an integral role in child and youth development, impacting achievement, health, and wellbeing (Bronfenbrenner, 1979; Center for Health and Health Care in Schools [CHHCS] et al., 2020). A common method of conceptualizing community factors is viewing them as social influencers. Social influencers of health and education refer to the characteristics of children's and youths' local environment that affect a broad range of health, wellbeing, and learning outcomes (Braveman & Gottlieb, 2014; CHHCS et al., 2020, 2021). This includes, for example, access to safe and stable housing, food security, neighborhood social connectedness, access to important resources, and language barriers. Each of the identified community factors can be a source of strength (e.g., strong public transportation options making access to services possible) or a barrier (e.g., lack of public transportation preventing access to services). As depicted in Figure 8, the MHSSA Evaluation will account for these important influencers, for which there is tremendous variability across the state.

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Figure 8. Measurement Model of Community Factors

Community Factors

Housing
Food
Technology
Language/ Culture
Transportation
Social Connectedness
Diversity
Safety
Resources
Religion/ Spirituality
Racism
Inclusiveness

Community Factors Research Questions

- What were the mental health strengths and needs of young people and their school communities?
- How did community factors serve as facilitators and/or barriers to school mental health systems change at each level (county, district, school)?

Other School Mental Health Initiatives

This evaluation examines the implementation and impact of the MHSSA within the broader school mental health landscape, particularly focusing on how counties and schools access/leverage funding streams to support school mental health systems change. Fiscal sustainability is an area of great interest among MHSSA partners. The evaluation will explore the ways in which county- and school-level decision-makers have utilized other school mental health funds to sustain the work of the MHSSA. It will also investigate the MHSSA's relationship with other program-funded services and activities, exploring their cumulative impact on school mental health systems at the county, district, and school levels.

Other School Mental Health Initiatives Research Question

- How did other school mental health initiatives serve as facilitators and/or barriers to the implementation of school mental health systems change at each level (county, district, school)?

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MHSSA Evaluation Plan

The purpose of an evaluation plan is to outline how data will be collected and analyzed to answer key evaluation questions (Brinkerhoff et al., 1983). It ensures that the evaluation is methodologically sound, allows for credible and reliable results, and enhances the transparency and accountability of the evaluation process.

Integrating Community Engagement Conducted During Evaluation Planning into the Evaluation Design

The MHSSA Evaluation design incorporates feedback from a diverse group of community partners and interest holders. WestEd identified key themes from all community engagement meetings during the planning phase and summarized the findings by each MHSSA Evaluation design component below.

Ongoing Community Engagement

WestEd has made significant investments in community engagement activities to foster trust, solicit feedback, collaborate, and codesign with partners. A principal insight from those activities is that partners value having a voice in the evaluation process and are committed to ongoing collaboration as the MHSSA Evaluation Plan is implemented. During listening sessions, partners conveyed the importance of being consulted and having opportunities to provide feedback to WestEd regarding questions or concerns related to the evaluation. They expressed appreciation when WestEd shared back a summary of their input, stating that this made them feel like the WestEd team cared about correctly interpreting the insights that were shared. Those partners with whom WestEd has engaged more deeply expressed an interest in regular and sustained collaboration centered on advising WestEd throughout the evaluation process.

Partners also expressed their interest in collaborating with WestEd to make sense of data throughout the evaluation. Partners emphasized that they bring unique insights, which are shaped by their communities and the school mental health systems in which they operate. For WestEd and its partners, collaborative sense making is key to ensuring that insights generated by the MHSSA Evaluation are valid, grounded in context, and reflect multiple perspectives, not just those of the WestEd team.

Partners also expressed an interest in reviewing MHSSA data to reflect on their school mental health systems change work and consider opportunities for continuous improvement.

To honor partners' interest in long-term collaboration, the MHSSA Evaluation will include engagement with partner groups that contributed to the development of the

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MHSSA Evaluation Plan, ensuring ongoing transparency and community collaboration. WestEd will engage with such groups in a variety of ways and throughout the evaluation, including regular listening sessions, a youth advisory group (YAG), and data sense making sessions. Responding to the expressed interests of different partner groups, engagement may take the form of information dissemination or deeper forms of engagement such as codesigning processes and protocols and collective sense making.

Contextual Descriptive Analyses

Partners agreed that in a California statewide evaluation, it is critical to understand and measure variation in school mental health across different regions and populations. They explained that because grantees were afforded flexibility in selecting and implementing school mental health activities and services, they tailored MHSSA-funded activities and services to meet the needs of their local communities. Partners emphasized that, in many cases, their ability to respond to the stated needs of schools and communities resulted in the innovation that was required during the COVID-19 pandemic.

In addition, while some school mental health data may be difficult to access, partners agreed that it was critical for the MHSSA Evaluation to leverage data that paints a picture of the diverse California school mental health landscape. There was an interest in better understanding outcome data related to school climate and student mental health and wellbeing.

In contrast, some partners cautioned against using quantitative data to measure the MHSSA's unique impact on student and school outcomes. Partners shared that the school mental health funding landscape was so complex that it would be difficult to disentangle the impact of MHSSA funds from the other funding sources that have been braided and blended to support the same set of outcomes.

In response to these insights and feedback, WestEd will conduct analyses using data on MHSSA outcomes to describe the school mental health landscape, measuring variation across geographic regions and school- and community-level characteristics. These analyses will not attempt to isolate the unique effects of the MHSSA on student- and school-level outcomes. Rather, they will highlight the diverse needs and experiences of communities throughout the state, providing a rich and nuanced context for the school mental health landscape in which the MHSSA was implemented. In addition, the quantitative descriptive analyses will be supplemented by qualitative case study data on outcomes, which is described below.

Process and Systems Change Evaluation

Partners shared that they would like to engage with meaningful and useful data through the MHSSA Evaluation. They wanted to use evaluation findings to share successes and

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challenges they have encountered around interagency collaboration, systems change, and the implementation of MHSSA-funded activities and services. Because there is significant variation in local context, school mental health systems, and the use of MHSSA funds, partners agreed that it would be beneficial to see not only statewide results but also results from schools and counties that are similar to their own.

Partners identified interagency partnerships as an area requiring additional data. Some partners wanted to see and use data to describe how MHSSA funds were used at the county-level, for which there is no consistent metric. They emphasized the importance of collecting data that would be used not only to satisfy reporting requirements but also to support continuous improvement efforts. At the same time, some partners were overwhelmed by the prospect of collecting and submitting large amounts of data for the MHSSA Evaluation. They were concerned that time-intensive data reporting would put additional strain on already overburdened teams.

To balance the interest in meaningful and useful data with concerns about the investment of time required to satisfy MHSSA Evaluation requirements, WestEd will collect targeted data that closely align to the MHSSA mechanisms of change. The MHSSA Evaluation will include a onetime online grantee survey that measures process and systems change data. WestEd will also facilitate sense making sessions with grantee teams to identify and share key insights, challenges, and actionable strategies for future school mental health systems change efforts.

Grantee Partnership Case Study

Grantees are proud of the work they do and want to demonstrate how LEAs and county behavioral health departments are "better together." A recurring theme throughout the listening sessions was that the MHSSA is unique because it incentivizes interagency partnerships, which has been an important part of strengthening the county-level comprehensive school mental health system.

Partners and expressed a desire to learn from one another about how interagency collaboration is being used to create sustainable and cohesive school mental health systems that meet the diverse needs of school communities. Building on this topic, many partners expressed an interest in using evaluation findings to inform the ongoing improvement of both MHSSA-funded activities and services and of the broader school mental health system beyond the MHSSA grant period.

Responding to partners' interest in learning from one another, the MHSSA Evaluation will use a case study method, with opportunities for case study grantees to participate in a data-driven grantee partner planning process for sustainability. This methodology will focus on the county context, exploring the relationship between partnerships and the county-level school mental health system and examining how changes at this level supports systems improvement at the district and school levels.

WestEd will consult with the MHSSA Technical Coaching Teams to determine how the

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MHSSA Evaluation can inform or be used to provide additional technical assistance and collaborative learning opportunities for grantees and other MHSSA partners. Case studies at both the county level and school level will use a systematic approach to select a diverse case study sample to measure the mechanisms of change outlined in the MHSSA conceptual model. Aligned with the antiracist participatory evaluation approach, WestEd will ensure that the evaluation is strength-based and does not inadvertently perpetuate disparities in implementation by focusing on a biased sample, while also providing opportunities for learning for counties and schools across a range of contexts, conditions, and MHSSA implementation stages.

Implementation and Impact School Case Study

Partners asserted that a meaningful and useful evaluation should include detailed information about the reasons why MHSSA-funded activities and services were selected, how they were designed to support local needs, what implementation facilitators and barriers were encountered, and what impact was achieved. As previously stated, each grant is tailored to the local context and is responsive to the dynamic needs of the local school mental and behavioral health system. Partners expressed an interest in understanding the school-level mental health system in which MHSSA-funded activities and services were implemented so that they could assess the extent to which different approaches may apply in their own school-level mental health systems.

Partners asserted that there are limitations to how counties with vastly different populations and communities can learn from one another. They shared that meaningful learning happens when they can see how implementation occurs in schools and communities that share characteristics with their own local context. Partners were interested in understanding contextual nuance and how insights gained from MHSSA implementation in similar settings can help them continue to strengthen their own school-level mental health systems.

Partners also recognized the value of thoroughly documenting the implementation process at the local level in addition to reporting statewide aggregate implementation data. They stated that much of the data that they collect and report does not speak to the nuanced impact of the MHSSA on students and schools. They suggested that collecting both detailed implementation data and statewide aggregate data would facilitate meaningful collective learning for a wide range of partners, particularly those implementing MHSSA-funded activities and services in schools. Partners emphasized the importance of incorporating qualitative data from a variety of sources within schools. They shared that, with a broader range of perspectives, the implementation story becomes more robust and comprehensive.

In response to partners' interest in better understanding the factors that improve school-level mental health systems, the MHSSA Evaluation will use a case study method that attends to the local context. This methodology is tailored to the specifics of the local

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school environment in order to investigate the facilitators and barriers related to the implementation of MHSSA-funded activities and services within the school-level system. This methodology will allow WestEd to tell a more comprehensive story of MHSSA implementation and impact. Furthermore, interviews and focus groups with school staff, mental/behavioral health professionals, school-level MHSSA coordinators, and families/caregivers will provide a nuanced description of implementation and impact. The case studies will also include in-depth engagement with students to understand how the MHSSA supported the mental health and wellbeing of young people in schools.

Youth Engagement

Partners emphasized the importance of centering the experiences of youth in the evaluation. For example, members of the YAGs shared many ways that young people can serve as evaluation partners, sharing power with adults and acting on the issues that most affect their lives. Partners also suggested that the evaluation include data collected directly from young people to learn about how youth perceive the impact of their school's mental health system on students, the MHSSA's intended beneficiaries.

Partners made recommendations on the most effective ways to gather data from youth. They emphasized the importance of establishing trust so that young people feel comfortable sharing about their experiences and perspectives. Conversations with partners provided insights into using nontraditional data collection methods to access student experiential data in more authentic ways.

Partners were interested in having young people provide recommendations for school mental health systems change. Youth also expressed their strong desire to communicate directly with leaders and collaborate with adults to improve mental health activities and services in their schools and communities.

Youth engagement and voice will be critical elements of the MHSSA Evaluation, which will offer an opportunity for youth to tell the story how school mental health affects their lives. The materials for the student focus groups and engagement opportunities are shaped by young people's feedback and will be further tailored with the input from students in participating case study schools. Responding to the call to elevate and center youth voice, the MHSSA Evaluation also includes a youth engagement component. It invites students from selected schools to participate in a series of conversations that culminate in a student panel. This panel will provide youth the opportunity to discuss school mental health with state and local leaders, allowing them to directly participate in the systems change process. Young people codesigned processes and protocols for youth engagement as part of the MHSSA Evaluation, and youth partners will collaborate with WestEd to cofacilitate youth engagement sessions.

Evaluation Design

The following section describes the methodological and analytic approach and

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dissemination strategy for the six MHSSA Statewide Evaluation activities listed below. Relevant instruments, protocols, and process documents are hyperlinked throughout the report.

1. Community Engagement
2. Contextual Descriptive Analyses
3. Process and Systems Change Evaluation
4. Grantee Partnership Case Study
5. Implementation and Impact School Case Study
6. Dissemination and Strategic Communication

Community Engagement

Brief Summary

WestEd will implement ongoing community engagement with a broad group of partners and interest holders throughout the MHSSA Evaluation. WestEd's engagement strategy will build upon previous community engagement efforts to include youth empowerment, youth-facilitated data collection, and ongoing partner collaboration and sense making.

Youth Advisory Group

A key component of the MHSSA Evaluation community engagement strategy will build on the YAG that participated in MHSSA Evaluation planning from February 2024 through October 2024. The YAG will be a key advisory body for the evaluation with the goal of empowering youth members to offer insights and feedback on evaluation activities and findings (Costa & Kallick, 1993). Additionally, as described below, four selected YAG members will be trained as youth data collectors and will facilitate youth engagement and codesigning of evaluation activities.

The YAG will consist of 10–15 diverse youth members, aged 14–20, who will participate in various activities to promote youth-centered and culturally responsive evaluation practices. The YAG may also support the development of outward-facing products that describe youth experience with the evaluation for dissemination to interest holders and the public. Two WestEd staff will plan and facilitate YAG sessions and meetings will be held quarterly on Zoom, each lasting 1.5 to 2 hours, with up to 1 hour of asynchronous work between sessions. Members will receive honorarium payments of $100 in the form of a gift card for completing prework and attending each meeting. YAG members may be invited to complete ad hoc tasks and be compensated further at a rate of $50 per 90 minutes.

Youth Data Collectors

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As part of the evaluation, WestEd will equip four youth to participate in data collection and codesign processes. Partnering with youth data collectors involves sharing power and enabling youth to make meaningful contributions to the MHSSA Evaluation.

Youth data collectors will be trained to cofacilitate virtual data collection activities. This will support their personal growth and professional development and improve their research and evaluation skills. Youth data collectors will convene up to eight times for training and debrief sessions. The youth data collector roles and responsibilities are described in the Impact and Implementation School Case Study plan.

Recruitment and Selection

Current YAG members will be invited to continue serving as members and WestEd will recruit new YAG members to ensure a diverse and engaged group across the evaluation period. To recruit additional members, WestEd will distribute a flyer that describes the role of the YAG to MHSSA partners. In outreach communications, WestEd will emphasize the importance of including diverse youth perspectives and outline YAG roles, responsibilities, and incentives. WestEd will also share the flyer with community-based organizations, such as local nonprofits and advocacy groups to reach underrepresented youth.

Interested candidates will be asked to complete an application form, which will be available through a link provided on the recruitment flyer. The application will collect demographic information, interest in mental health advocacy, and availability for scheduled meetings.

YAG applications will be reviewed by WestEd staff using a standardized process to ensure consistency and fairness. The WestEd evaluation team will collectively assess each application, taking into consideration factors such as the applicant's identity, interest in mental health advocacy, availability to attend meetings, past engagement in the YAG, and leadership potential. The final selection will ensure that the YAG comprises members with a wide range of perspectives and backgrounds.

WestEd will obtain parental consent for participants under 18 years old. Additionally, youth participants will be required to provide their own verbal assent when they agree to participate in the YAG.

Youth data collectors will be selected from a subgroup of the YAG. YAG members will learn about this opportunity and indicate through a survey whether they have interest in becoming a data collector. WestEd will select the data collectors based on interest, the groups' diversity, and availability for a minimum of 1 year. To onboard data collectors, WestEd will provide age-appropriate training on research methods, cofacilitation, data analysis, and presentation skills.

Engaging the Commission, Grantees, Other Vested Organizations, Evaluators, and State Agencies

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To ensure the evaluation of MHSSA is both comprehensive and responsive to community needs, WestEd will foster robust collaboration with a broad group of partners, including the Commission staff, grantees, and interest holders from vested organizations and, where appropriate, other state agencies. Community engagement focuses on two key areas: oversight and sense making.

Oversight

WestEd recognizes the unique and shifting contexts at the local and state levels in which the MHSSA Evaluation is being implemented. Consultation with community partners will support WestEd's ability to adapt evaluation approaches, when necessary, to ensure the evaluation remains comprehensive, relevant, and responsive to the needs of different communities (Sabet et al., 2024). Ensuring that evaluation processes are culturally responsive and aligned with community values not only improves transparency and fosters trust but also improves the validity and utility of the evaluation. Ultimately, this community oversight will contribute to more meaningful and actionable findings of the MHSSA Evaluation.

Sense Making

WestEd will conduct sense making sessions to inform the interpretation of data from each component of the MHSSA Evaluation. Sense making is a process where people collectively interpret information to develop a shared understanding, transforming raw data into meaningful insights and actionable knowledge (Intrac for Civil Society). These sessions will bring together partners to discuss emerging evaluation findings, deepen the collective understanding of the results, and refine WestEd's analytic approach and initial interpretation based on community perspectives and input. Each sense making protocol will be tailored to the needs of the evaluation and the specific partner involved.

Reporting

WestEd will summarize community engagement activities by generating brief summaries of each community engagement session. After each session, the summary will be shared back with participants for any additional feedback. Community engagement insights will be shared with the entire WestEd team to ensure that data collection, analysis, and the interpretation of findings integrate partners' perspectives and insights.

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Contextual Descriptive Analyses

Brief Summary

WestEd will use descriptive statistics and multilevel latent factor modeling to describe the current state of the mental health and wellbeing of students in California. Additionally, WestEd will explore school, district, and community characteristics that are related to students' mental health and wellbeing to better understand the differential experiences of students and schools by contextual factors at the county and school levels.

WestEd assessed secondary data sources to leverage in these analyses by determining item alignment with the MHSSA Evaluation Framework. As previously stated, while the MHSSA has been an important driver of school mental health systems change, it is one of many investments in school mental health systems within a larger state and federal funding landscape. Due to the complex nature of systems change within this braided funding scenario, this evaluation will not attempt to isolate the MHSSA's unique effect on the outputs and outcomes outlined in the MHSSA Evaluation Framework. Rather, WestEd will analyze secondary data aligned with these outputs and outcomes to offer context on the school mental health landscape statewide, within counties, and within schools.

Research Questions

The contextual descriptive analysis will address the research question listed in Table 6.

Table 6. MHSSA Research Questions Addressed by the Contextual Descriptive Analyses with Associated Data Sources

MHSSA Evaluation Framework Element	Research Question	Data Sources
Community Factors	11. What were the mental health strengths and needs of young people and their school communities?	California Healthy Kids Survey (CHKS), California Longitudinal Pupil Achievement Data System (CALPADS), Census, US Open Data Portal, Project Implicit

Sample

Descriptive analyses will leverage data from the 2023–24 school year. While a final list of MHSSA-funded schools has not been finalized, WestEd conducted a review of available California Healthy Kids Survey (CHKS) data for a preliminary list of 2,100 MHSSA-funded schools to assess the likely coverage in 2023–24 for the final sample of

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MHSSA-funded schools. This review showed that approximately 40 percent of elementary schools and 50 percent of secondary schools administered the student survey in 2023–24. Approximately 30 percent of MHSSA-funded schools completed the staff survey. This school sample will be used in the analyses described below.

One significant limitation of the contextual descriptive analysis is the available sample. While coverage of MHSSA-funded schools that completed the CHKS is limited, based on the sample outlined above, the schools that completed the survey are in 44 of the 57 funded counties for elementary (77%), 48 for secondary (84%), and 48 for schools completing the staff survey (84%) (see Figures 9–11). There is little to no CHKS usage in parts of the Inland Empire, Northern San Joaquin Valley, and Superior California (The California Complete Count, n.d.).

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Figure 9. Geographic Coverage of MHSSA-Funded Elementary Schools That Completed the CHKS (*n* = 452)

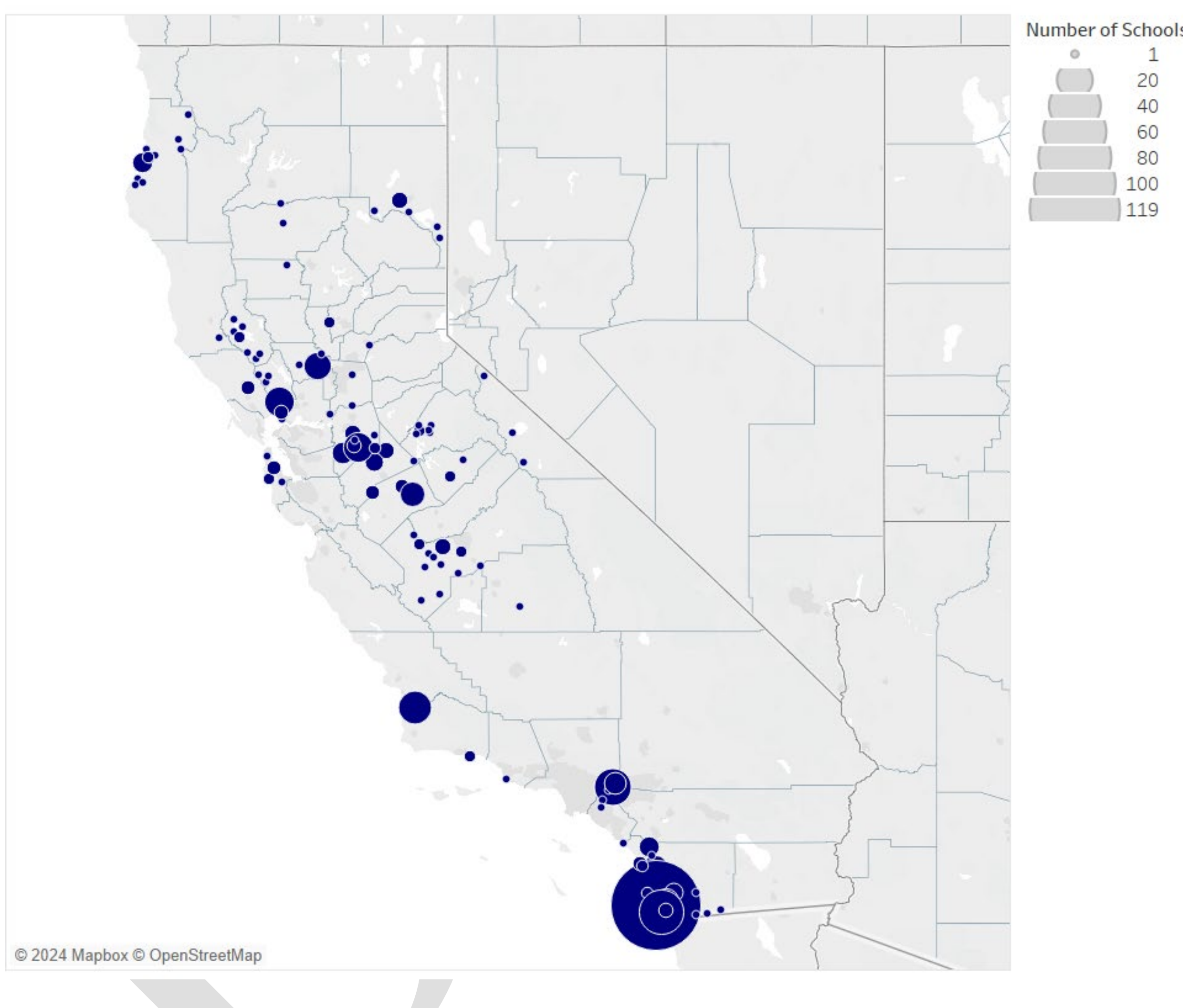


Figure 10. Geographic Coverage of MHSSA-Funded Secondary Schools That Completed the CHKS (*n* = 527)

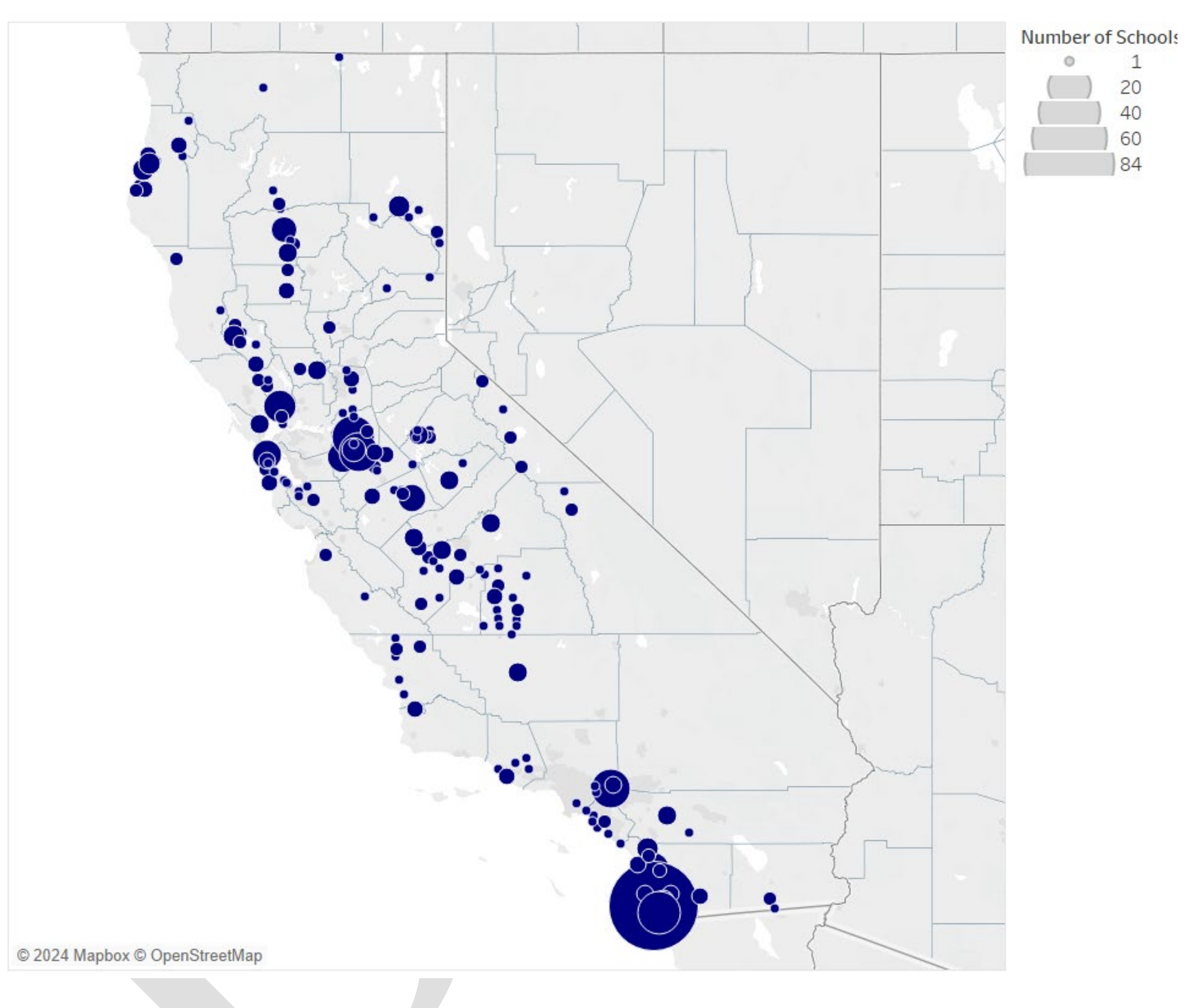
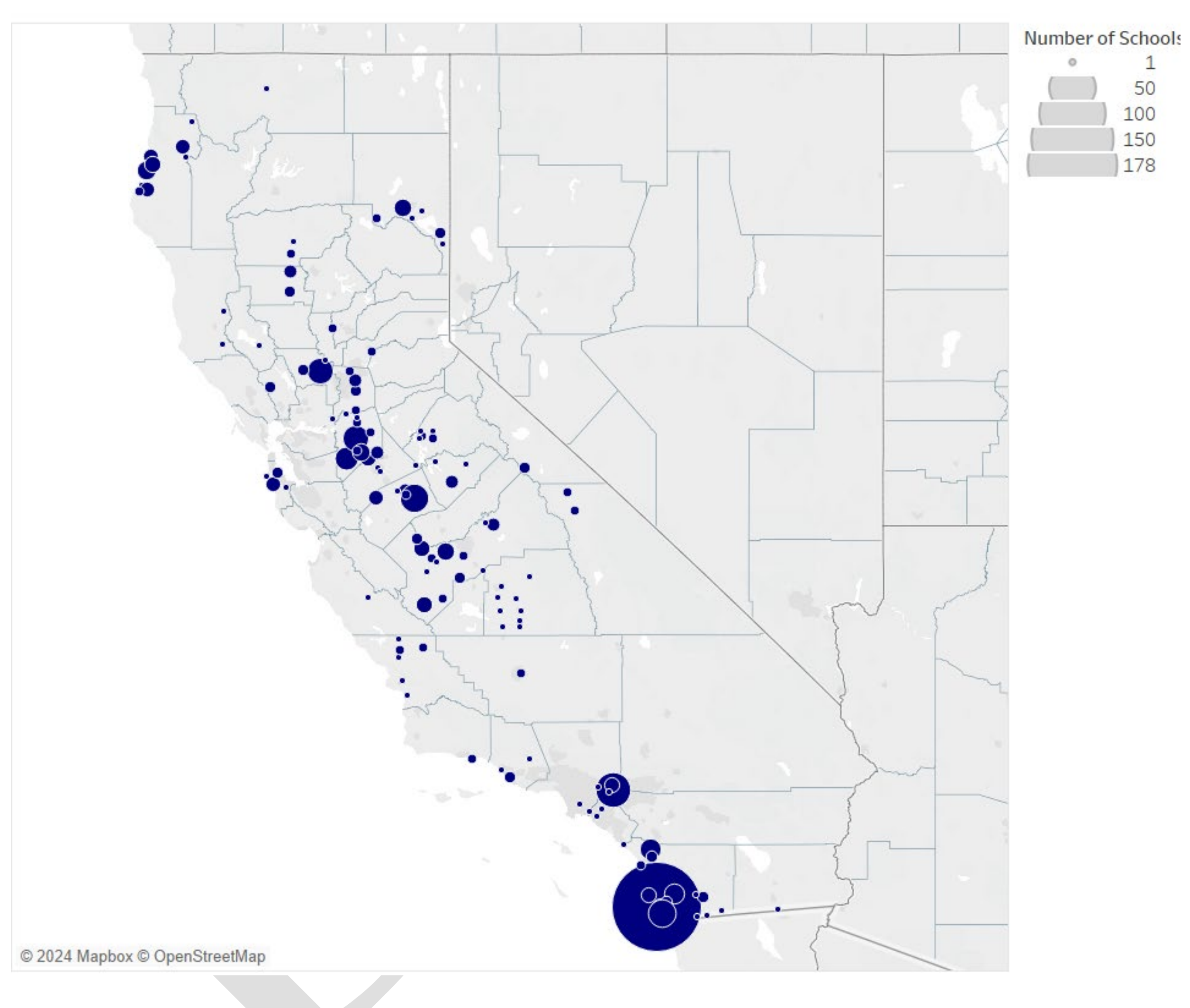


Figure 11. Geographic Coverage of MHSSA-Funded Schools That Completed the California Healthy Kids Staff Survey (*n* = 581)



There are some notable differences between MHSSA-funded elementary schools that completed the CHKS compared to those that did not. MHSSA-funded elementary schools that completed the CHKS were, on average, more urban/suburban (42%/31%) than noncompleters (34%/24%) and less rural (16%) than noncompleters (26%). MHSSA-funded elementary school completers and noncompleters looked very similar across all other school-level demographic characteristics included in this analysis (see Table 7).

A higher percentage MHSSA-funded secondary schools were regular schools (82%) compared to noncompleters (73%), and a lower percentage of secondary completers were alternative education schools (18%) compared to noncompleters (26%). MHSSA-funded secondary school completers were, on average, larger (819 students) than noncompleters (720 students). MHSSA-funded secondary school completers and noncompleters looked very similar across all other school-level demographic characteristics included in this analysis (see Table 8).

MHSSA-funded schools that did and did not take the staff survey looked very similar across all school-level demographic characteristics included in this analysis (see Table 9).

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Table 7. Demographic Characteristics of MHSSA-Funded Elementary Schools That Completed the California Healthy Kids Survey in 2023–24 Compared to MHSSA-Funded Noncompleters

Characteristic	Noncompleters (n = 6621)	Completers (n = 4641)
School type		
Regular school	647 (98%)	462 (100%)
Special education school	3 (0.5%)	0 (0%)
Alternative education school	12 (1.8%)	2 (0.4%)
Locale		
Urban	227 (34%)	196 (42%)
Suburban	161 (24%)	146 (31%)
Town	101 (15%)	50 (11%)
Rural	173 (26%)	72 (16%)
Total students	439.35	461.44
% Female	48.41	48.64
% Male	52.01	51.33
% Nonbinary	0.25	0.24
% American Indian or Alaska Native	2.37	2.11
% Asian	4.80	2.90
% Black or African American	2.60	2.50
% Filipino	1.00	1.30
% Hispanic or Latino	53.04	54.69
% Native Hawaiian or Pacific Islander	0.80	0.68
% Two or more races	5.26	6.30
% White	27.68	25.78
% English learners	23.19	25.98
% Foster youths	1.01	0.73
% Homeless	4.41	5.74
% Migrant	3.06	3.66
% Socioeconomically disadvantaged	67.41	63.22
% Students with disabilities	13.37	14.26

Table 8. Demographic Characteristics of MHSSA-Funded Secondary Schools That Completed the California Healthy Kids Survey in 2023–24 Compared to MHSSA-Funded Noncompleters

Characteristic	Noncompleters (n = 376)	Completers (n = 387)
School type		
Regular school	275 (73%)	317 (82%)
Special education school	4 (1.1%)	0 (0%)
Alternative education school	97 (26%)	70 (18%)
Locale		
Urban	127 (34%)	135 (35%)
Suburban	86 (23%)	99 (26%)
Town	91 (24%)	88 (23%)
Rural	72 (19%)	65 (17%)
Total students	720.19	819.22
% Female	46.03	46.86
% Male	54.64	52.97
% Nonbinary	0.52	0.40
% American Indian or Alaska Native	2.50	2.62
% Asian	3.85	2.60
% Black or African American	2.70	2.00
% Filipino	0.80	1.30
% Hispanic or Latino	56.51	54.21
% Native Hawaiian or Pacific Islander	0.70	0.77
% Two or more races	4.50	5.19
% White	26.65	26.69
% English learners	18.12	17.20
% Foster youths	1.81	0.99
% Homeless	4.53	5.44
% Migrant	3.41	3.05
% Socioeconomically disadvantaged	70.87	64.88
% Students with disabilities	2	0

Table 9. Demographic Characteristics of MHSSA-Funded Schools That Completed the California Healthy Kids Staff Survey in 2023–24 Compared to MHSSA-Funded Noncompleters

Characteristic	Noncompleters (n = 1,5251	Completers (n = 6391)
School type		
Regular school	1,158 (86%)	563 (91%)
Special education school	14 (1.0%)	3 (0.5%)
Alternative education school	174 (13%)	53 (8.6%)
School Level		
Elementary	775 (58%)	351 (57%)
High	308 (23%)	148 (24%)
Middle	200 (15%)	105 (17%)
Not reported	1 (<0.1%)	0 (0%)
Other	60 (4.5%)	15 (2.4%)
Secondary	2 (0.1%)	0 (0%)
Locale		
Urban	467 (35%)	241 (39%)
Suburban	360 (27%)	147 (24%)
Town	241 (18%)	112 (18%)
Rural	278 (21%)	119 (19%)
Total students	564.43	569.41
% Female	47.57	47.92
% Male	52.77	51.99
% Nonbinary	0.47	0.38
% American Indian or Alaska Native	2.10	3.09
% Asian	3.80	2.50
% Black or African American	2.60	2.60
% Filipino	1.10	1.20
% Hispanic or Latino	53.98	54.50
% Native Hawaiian or Pacific Islander	0.78	0.72
% Two or more races	5.21	5.93
% White	27.67	25.80
% English learners	20.63	22.08
% Foster youths	1.27	0.98

% Homeless	4.53	6.00
% Migrant	3.26	3.03
% Socioeconomically disadvantaged	66.23	66.24
% Students with disabilities	14.93	14.62

Measures

Student Mental Health and Wellbeing

WestEd will use mental health and wellbeing subscale scores from the CHKS and student attendance and disciplinary exclusion data, such as suspensions and expulsions, from the CALPADS. The analysis will be conducted at the school level for several reasons: (a) all school-level data are publicly available, (b) the large sample of schools using the CHKS provides ample statistical power, and (c) student-level data is not required to describe state- and community-level mental health status and moderators of that status.

The CHKS is a validated annual, state-subsidized assessment for students aged 10 (i.e., 5th grade) and older facilitated by the California Department of Education (CDE). The Core module includes questions on school climate, social–emotional and physical health, behavioral health and substance use, and other risk behaviors, with versions tailored to students in elementary, middle, and high school, along with a staff survey.

The majority of item responses for the elementary survey used a 4-point scale (i.e., *no, never*; *yes, some of the time*; yes, most of the time; *yes, all of the time*). The middle school, high school, and staff surveys used a variety of response scales, including estimated frequencies (e.g., zero times up to four or more times) and agreement (e.g., *strongly disagree* through *strongly agree*, *not at all true* through *very much true*). Due to the variation across surveys, data from each survey will not be aggregated, and results will be presented by survey.

The following CHKS domains will be included in this analysis. See the Contextual Descriptive Analysis Metrics document for all CHKS domains, example items, and their associated MHSSA Evaluation outputs and outcomes.

California Healthy Kids Elementary and Secondary Core Survey Domains

- Academic Motivation
- Antibullying Climate
- Emotion Regulation
- Fairness
- Life Satisfaction
- Loneliness
- Optimism

- Positive Behavior
- Promotion of Parental Involvement
- Responses to Trauma
- School Coregulation Supports
- School Connectedness
- School Violence Perpetration
- Social and Emotional Learning Supports
- Social–Emotional Distress
- Stress-Associated Health Symptoms
- Suicidal Ideation Indicator
- Total School Environment
- Violence Victimization

California Healthy Kids Staff Core Survey Domains

- Antibullying Climate Scale
- Caring Relationships Scale
- Emotional Safety at School Scale
- Fairness and Rule Clarity Scale
- High Expectations Scale
- Instructional Equity Scale
- Promotion of Parental Involvement Scale
- Respect for Diversity Scale
- Staff Collegiality Scale
- Staff Efficacy for Promoting Student Wellbeing Scale
- Staff Working Environment Scale
- Student Learning Environment Scale
- Student Meaningful Participation Scale
- Student Readiness to Learn Scale
- Support for Social Emotional Learning Scale

The CALPADS is a longitudinal data system used in California to maintain individual-level data, including student demographics, course data, discipline, assessments, staff assignments, and other data for state and federal reporting. In order to comply with federal law as delineated in the Every Student Succeeds Act (ESSA) of 2001 (20 U.S.C. Sec. 6301 et seq.), California Education Code Section 60900 requires LEAs to use

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unique pupil identification numbers (Statewide Student Identifiers, or SSIDs) for students enrolled in California public K–12 LEAs and to retain all data required by ESSA, including, but not limited to, data required to calculate enrollment and dropout and graduation rates.

The following CALPADS student outcome data will be included in this analysis. See the Contextual Descriptive Analysis Metrics document for a list of all CALPADS student outcome data and their associated MHSSA Evaluation outputs and outcomes.

CALPADS Disciplinary Data

- Disciplinary incident
- Action taken for disciplinary incident

School, District, and Community Characteristics

The following CALPADS school-level data will be included in this analysis. See the Contextual Descriptive Analysis Metrics document for a list of all CALPADS school-level items.

CALPADS School-Level Demographic Data

- Grade level
- Gender
- Race/ethnicity indicators, as federally required
- SEO (socioeconomic disadvantage status)
- Homeless status
- Migrant status
- Special education status
- Foster youth status
- Primary language
- The recommended composite measure of high school student success
- Number of days students attended regular school (for all students enrolled under the county-district-school [CDS] code listed)

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CALPADS School-Level English Learner and Academic Data

- English language acquisition status code
- English language acquisition status start date
- English Language Proficiency Assessment for California (ELPAC) scores
- California Assessment for Student Performance and Progress (CAASPP) English Language Arts
- CAASPP Math

Additional data measuring school, district, and community characteristics that are related to students' mental health and wellbeing will come from the U.S. Census, the California Open Data Portal, Project Implicit, and the CHKS. Several surveys are used to gather data for the U.S. Census. The Decennial Census is a survey sent to all U.S. addresses every 10 years to provide an official count of population demographics. The American Community Survey is an annual survey distributed to a sample of U.S. addresses, focusing on specific topics such as jobs, education, internet access, and transportation. The California Open Data Portal is a housing-related website, sponsored by the Government Operations Agency, which offers downloadable state-collected data sets from a wide range of agencies. This project will incorporate county- or community-level data on food accessibility (e.g., affordability, SNAP, WIC), income inequality, and violent crime.

Racism is an important community factor in the MHSSA Evaluation Framework and will be measured by a proxy indicator from Project Implicit. Project Implicit is a multi-university research collaboration founded in 1998, focused on fostering dissemination and application of implicit social cognition using the Implicit Association Test, which is completed through an online portal and open to both the public and research participants. This project will utilize county-level data from the Race Implicit Association Test, in which participants are instructed to quickly categorize faces of varying races and/or positive and negative attributes as a measure of their individual implicit bias.

The following school, district, and community data related to students' mental health and wellbeing will be included in this analysis. See the Contextual Descriptive Analysis Metrics document, which lists all data outlined below and their associated MHSSA Evaluation Framework element.

School, District, and Community Data

- Race
- Ethnicity
- Disability rate and types
- Class of worker
    - Employment rate
    - Industry

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    - Occupation
    - Mean weekly hours worked
- Food affordability
    - SNAP participation
    - WIC redemptions
    - Modified retail food environment index
- Income inequality
- Income/earnings
- Poverty
- Children in house under/over 18
    - Family size
    - Household types (e.g., married, single)
    - Residential mobility
    - Rent
    - Homeownership rate
    - Housing value
- Language spoken at home
    - U.S. and not U.S. born
- Poverty
    - Residential segregation
- Race Implicit Association Test
- Health care coverage
    - Educational attainment
- Violent crime rate
- Violence Victimization Scale
- Antibullying Climate Scale
- School Connectedness Scale
- Caring Relationships Scale
- Computer and internet use
- Means of transportation to work

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Method/Process

WestEd will complete a data sharing application for the California School Climate and Health Learning Survey (CalSCHLS) system project at WestEd, delineating the following details:

- start and end data of the analysis
- purpose of the study
- plan for dissemination
- surveys, administration years, districts, and schools needed
- file type needed
- requested data delivery date

Once approved, the data transfer will occur.

Analytic Plan

To conduct the contextual descriptive analyses, WestEd will first pull and merge all publicly available data for use in this analysis.

WestEd will conduct a data quality analysis to inform the analytic approach aimed at evaluating student health and wellbeing. This analysis will examine the quantitative data across all data sets mentioned in the preceding measures section. The data will be reviewed for quality and completeness to identify any issues that may impact the analyses.

Descriptive Statistical Analysis

Descriptive statistics will provide the foundation for understanding the basic trends and patterns in the data. This will include means, medians, standard deviations, frequencies and percentages for variables measuring student health and wellbeing, along with school, district, and community characteristics.

Multilevel Modeling Analysis

Multilevel modeling will be used to describe the current state of student mental health and wellbeing in California. This analysis will estimate covariate-adjusted community average mental health and wellbeing subscores, as well as attendance and disciplinary exclusions. WestEd's models will include three levels: (a) school, (b) district, and (c) county. Thus, the data are nested, meaning that schools are not independent of their districts or counties, which WestEd's statistical model will account for using multilevel modeling.

Multilevel models, also known as hierarchical linear models (Raudenbush & Bryk, 2002) or mixed-effects models, are regression models that statistically account for data nesting and ensure that the standard errors are correctly estimated. WestEd will conduct all multilevel modeling in R using the *lme4* package (Bates et al., 2015) and estimate covariate adjusted averages for all dependent variables. These values will

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provide a robust estimate of California students' overall mental health and wellbeing.

School and Community Characteristics Analysis

Inclusion of school and community characteristics allow WestEd to explore school, district, and community characteristics that are related to students' mental health and wellbeing to better understand the differential experiences of students and schools by contextual factors at the county and school levels. Each multilevel model will include school- and county-level moderators, with coefficients coded to allow for covariate-adjusted estimates by moderator. These models will provide insights into key differences in student and school outcomes by a range of contextual factors.

Reporting and Dissemination

Findings from the contextual descriptive analysis, which aims to identify patterns in student wellbeing and achievement, will be detailed in the final technical report and final community-facing report, as outlined in the Dissemination and Strategic Communication Section.

The contextual descriptive analysis is scheduled to occur at the beginning of the evaluation to allow for these data to be incorporated into sense making sessions throughout the evaluation. Within these sense making sessions, data from the contextual descriptive analyses will be presented using multiple modalities, including bar chart dashboards disaggregated by subgroup, dashboards illustrating trends over time, and maps utilizing graduated color symbology, as well as a variety of other data visualization strategies. Sense making sessions described here and throughout the MHSSA Evaluation Plan will build the capacity of MHSSA grantees to use data-driven approaches for continuous improvement (WestEd-MHSOAC, 2023).

While all efforts will be made to present findings in accessible ways, WestEd recognizes that, often, quantitative data can be difficult to understand. Without adequate context or clear communication, quantitative data can inadvertently reinforce a deficit narrative about the "achievement gap" experienced by historically marginalized students (Safir & Dugan, 2021). Therefore, WestEd will use data from the contextual descriptive analysis to tell an important but incomplete story of equity across the state, county, and school levels. These data illuminate patterns of inequity in student wellbeing and achievement, ideally pointing participants in a general direction for further investigation.

Recognizing the limitations of findings from the contextual descriptive analysis, WestEd's goal will be to present these quantitative data as one of many sources to inform statewide school mental health systems change efforts.

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Process and Systems Change Evaluation

Brief Summary

WestEd will closely collaborate with the Commission to incorporate MHSSA grant monitoring data into the Process and Systems Change Evaluation. MHSSA grant monitoring data will be collected and analyzed by Commission staff. Key findings from these analyses, possibly including fiscal reporting and MHSSA implementation data, will be included.

In addition, WestEd will collect survey data from grantee leads and teams that provide information about

- grantee partnerships,
- county- and school-level mental health systems change,
- the implementation of MHSSA-funded activities and services,
- community strengths and needs,
- the relationship between the MHSSA and other school mental health initiatives, and
- school mental health outcomes.

Building on the contextual descriptive analyses, grant monitoring data, and grantee survey data, WestEd will facilitate sense making sessions with grantee teams. These sessions aim to identify key insights, challenges, and actionable strategies for advancing future school mental health systems change efforts. The sense making sessions will inform the evaluation and simultaneously provide an opportunity for grantees to engage with their MHSSA Evaluation data.

Research Questions

The Process and Systems Change Evaluation component will address the research questions listed in Table 10.

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Table 10. MHSSA Research Questions Addressed by the Process and Systems Change Evaluation with Associated Data Sources

MHSSA Evaluation Framework Element	Research Question	Data Sources
Grantee Partnership	**1.** Who was involved in the MHSSA-funded partnerships?	Grantee Survey
County- and School-Level Mental Health System	**4.** What was the relationship between MHSSA grantee partnerships and the county-level school mental health system?	Grantee Survey, Grantee Sensemaking Sessions
	6. What was the relationship between the county-level and the school-level mental health system?	Grantee Survey, Grantee Sensemaking Sessions
MHSSA-Funded Activities and Services	**8.** What activities and services were implemented using MHSSA funding?	Grantee Survey, Grant Monitoring Data
Community Factors	11. What were the mental health strengths and needs of young people and their school communities?	Grantee Survey, Grantee Sensemaking Sessions
Other School Mental Health Initiatives	13. How did other school mental health initiatives serve as facilitators and/or barriers to the implementation of school mental health systems change at each level (county, district, school)?	Grantee Survey, Grantee Sensemaking Sessions

Sample

WestEd will invite all grantee partnership teams to complete the grantee survey that will provide statewide process and systems change data for the MHSSA Evaluation. The survey will be limited to grantee partnership leadership, teams, and key staff.

The number of partnership entities (e.g., county behavioral health departments, COEs, County Superintendent of Schools, districts, schools, charter schools) vary considerably from grantee to grantee. Thus, WestEd will request that each grantee partnership have 5–10 key staff at the county level (Behavioral Health and Education) and 3–5 key staff from each district partnership entity complete the survey. Grantees that have focused their efforts at a select number of schools (e.g., implementing wellness centers) may also ask school-level staff to complete the survey.

WestEd anticipates that approximately 1,900 respondents will complete the survey based on the 661 county- and district-level partnership entities listed in the MHSSA Grant Summaries from May 2023. This includes 57 county behavioral health departments, 51 COEs, 13 other county-level offices, and 540 districts contributing a minimum of five surveys completed by each of the 56 counties (n = 280) and three surveys by each of the 540 districts (n = 1,620).

In addition to MHSSA directors, managers, and coordinators, WestEd will invite other key staff involved in leading and facilitating the implementation of MHSSA activities and school mental health systems change at each entity to complete the survey. Other key staff may include those with knowledge and expertise related to school mental health systems change, the MHSSA partnership and/or other school mental health initiatives, and the implementation of MHSSA activities and services within and across the county, district, and school mental health system. These may include administrators, mental/behavioral health and health staff, educators, parent and youth leaders, and key partners from other partnering agencies (e.g., Child Welfare, Juvenile Justice).

Survey completion will require knowledge of the MHSSA-funded activities and services as well as the broader school mental health system. It is unlikely that any single individual will have the breadth of knowledge required to answer every question within the survey. Thus, it is important to ensure representation from all key partnership entities and to draw from a range of roles and expertise—such as mental/behavioral health, education, equity, family youth engagement, evaluation, information technology, fiscal, legal, youth, and family decision-making authority—needed to lead their school mental health systems change to deliver timely, equitable, and high-quality mental health services within school communities.

Measures

Grant Monitoring Data

The Process and Systems Change Evaluation component of the evaluation will include grant monitoring data that has been collected and analyzed by the Commission. Grant monitoring data, as determined by the Commission, may include data from annual fiscal reports, quarterly hiring reports, and/or the MHSSA data reporting tool.

Grantee Survey

WestEd is developing the grantee survey to align with the MHSSA conceptual model. The survey will focus on the following measurement models: grantee partnerships, school mental health systems, MHSSA-funded activities and services, and student mental health outcomes. It will also gather information about the factors influencing MHSSA implementation and impact, including community factors/social influencers and other school mental health initiatives. The focus of the survey will be on school mental health systems, including partnerships and collaboration at all levels of California's school mental health service delivery system (county, district, school). Following

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completion, the survey will be submitted to the Commission by December 15.

WestEd is developing the grantee survey using a validation process consistent with DeVellis and Thorpe's (2021) instrument development standards. The initial step involves a thorough review of the related literature on school mental health and systems change to identify the critical components of implementation across the various levels of the service delivery system. WestEd has inventoried and reviewed over 30 validated school mental health and partnership (i.e., collaboration and teaming) measures, instruments, and tools—which were summarized in a School Mental Health metrics report submitted to the Commission by WestEd on July 17, 2024. This review not only informed the elements of the measurement models within the conceptual framework but will also guide their refinement throughout the survey development process into clearly defined domains (i.e., constructs).

To generate the initial item pool for the survey, a team of senior researchers with expertise in school mental health is reviewing, coding, and sorting the existing measures to ensure alignment with the conceptual model's elements. This initial pool of items will be based on this review of existing instruments, research literature, and relevant contextual factors identified through community engagement.

The preliminary draft of the survey will be reviewed by two to three senior WestEd researchers. The survey will be further refined based on their feedback. Then, a panel of additional nationally recognized content experts, the Commission, and grantees will review the survey. Using a 4-point scale, each panelist will review the survey and provide feedback on the relevance and clarity of each item, providing suggestions on how to improve low-scoring ones. The panel will review the survey in its entirety regarding its feasibility, utility, and extent to which equity and culturally sustainable practices are infused into the items.

The WestEd team will use a structured process to analyze the feedback provided by panel members and revise to improve the survey as needed. WestEd will consider 80 percent or higher agreement among panel members as the criterion for determining that an item was relevant, and those that meet this criterion will be retained in their current form.

Finally, WestEd will conduct cognitive interviews with two to three grantees leading implementation of the MHSSA and school mental health systems change. The cognitive interviews will be conducted to solicit feedback on the clarity of the survey items and to ensure that partners are interpreting the survey items correctly. Interviewers will follow a structured protocol in which interviewees verbalize their interpretation of each item, their thought process while rating each item, and any questions they may have (Beatty & Willis, 2007; Drennan, 2003; Schecter et al., 1996; Willis, 1999). Participants will also provide feedback on any terms or phrases that were confusing or included jargon. WestEd will revise any items identified as problematic during this process.

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Data Collection

WestEd will collaborate with grantees to recruit participants in the first few months of the evaluation. The survey will be administered in winter 2025. During this data collection window, SurveyMonkey will be used to collect the grantee survey, allowing WestEd to track completion efficiently. Participants will have 2 months to complete and submit the survey. WestEd will be available and in communication with grantee leads and teams throughout the process, providing reminders, support, and answers to any questions or concerns grantee teams may have.

Analytic Plan

The grantee survey will be analyzed for two purposes: first, as part of the purpose of the sense making process described below, and second, for final reporting.

Analysis for Sense Making

Data cleaning and analysis will occur in winter 2025. Following a thorough data cleaning process within the SurveyMonkey platform, which will support the development of data dashboards (described below), the quantitative data will be reviewed for quality and completeness. This analysis aims to identify any potential data issues that may impact subsequent analyses.

Qualitative data (e.g., open-response items) will be analyzed using thematic analysis conducted in a coding software (Dedoose). Thematic analysis involves a six-step process: *familiarizing* by reading and reviewing the text (often multiple times); *coding* the data based on recurring or prominent points; *creating* themes based on the codes; *reviewing* the themes; *defining and labeling* the themes; and finally, *writing* the findings (Caulfield, 2023; Naeem et al., 2023).

Analysis for Final Report

WestEd will analyze grantee survey data using descriptive statistics, multilevel modeling, and confirmatory factor analysis.

Descriptive Statistics

Means, medians, and standard deviations will be used to describe variables that measure partnership and collaboration across the different levels of California's school mental health service delivery system. Frequencies and percentages for categorical variables will also be reported. Furthermore, WestEd will explore patterns across domains aligned with the MHSSA conceptual model and descriptively analyze data at the county, district, and school levels.

Confirmatory Factor Analyses

WestEd will conduct a confirmatory factor analysis (e.g., Brown, 2015) on the grantee survey data to increase the credibility of this measure and demonstrate its usability for future research and evaluations. Confirmatory factor analysis provides evidence for the constructs measured by a tool while also estimating the tool's reliability within a given

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sample. WestEd will use the domains related to the MHSSA conceptual model to inform the structure to be tested using the confirmatory factor analysis. The confirmatory factor analysis will result in both an estimate of the internal consistency reliability of the tool and domain-based subscales, as well as confirmation of which items best align with their respective subscales.

With the proposed sample, WestEd anticipates there will be a large number of survey responses to make a confirmatory factor analysis possible. However, if the number of respondents is much lower than anticipated, WestEd will assess the viability of the confirmatory factor analysis and report, at minimum, internal consistency estimates from the obtained sample.

Multilevel Modeling

Multilevel modeling will be used to explore covariate-adjusted relations between grantee-level predictors and grantee survey outcomes across aspects of school mental health systems. WestEd's models will include two levels: (a) respondent and (b) grantee. Thus, the data are nested, meaning that respondents are not independent of their grantees, which will be accounted for using multilevel modeling.

Multilevel models, also known as hierarchical linear models (Raudenbush & Bryk, 2002) or mixed-effects models, are regression models that statistically account for data nesting and ensure that the standard errors are correctly estimated. WestEd will conduct all multilevel modeling in R using the *lme4* package (Bates et al., 2015) and estimate covariate adjusted averages for all dependent variables. These values will provide a robust estimate of MHSSA grantees' overall school mental health systems.

Respondent and Grantee Characteristics Analysis

Inclusion of respondent and grantee characteristics will allow WestEd to explore respondent and grantee characteristics that are related to reported school mental health systems characteristics and understand the differential experiences by contextual factors at the respondent and grantee level. Each multilevel model will include respondent- and grantee-level moderators, with coefficients coded to allow for covariate-adjusted estimates by moderator. These models will provide insights into key differences in reports of school mental health systems by a range of contextual factors.

Reporting and Dissemination

Summary of Results for Sense Making

WestEd will customize a SurveyMonkey data dashboard for each grantee, highlighting key findings from all grantee team respondents. The SurveyMonkey data dashboard data and data presentation will be customized to best support grantee learning. Each grantee will receive a separate qualitative data summary report that succinctly presents key insights from open-response items.

Summary of Results for the Final MHSSA Evaluation Report

Refer to the Final Report description under the Strategic Communication and Dissemination section below.

Sense Making Process

The WestEd team will facilitate sense making sessions with grantees to help the WestEd and grantee teams understand and contextualize the grant monitoring and survey data results. This process will support grantee in using MHSSA Evaluation data, as well as ensuring that the grantee teams validate the final presentation of findings.

Grantee data sense making sessions will occur in spring 2025. WestEd will facilitate these optional sessions, which will include a reflective discussion amongst grantees based on the survey results related to MHSSA district/county partnerships and school-level mental health systems change, grant monitoring data, and CalSCHLS and CALPADS data. Grantees will identify key insights and initial ideas for using applicable data with guidance and support from WestEd staff. For details on these sessions, please see the Grantee Data Sense Making Session Protocol.

Grantee Partnership Case Study

Brief Summary

WestEd will conduct case studies with 10 grantees to contextualize how school communities across the state are reimagining school mental health systems change. The partnership case study will inform the evaluation while also providing a technical assistance opportunity for grantees to engage in the Grantee Partnership Planning Process (G3P). The G3P will involve WestEd supporting grantee partners in gathering, reviewing, analyzing, and action planning for sustainability. Data will include grantee-specific survey data, quantitative (descriptive) data collected by WestEd and the grantee, and qualitative data that will be gathered throughout the G3P. The sessions with the grantee leadership team will explore

- grantee partnerships,
- county- and school-level mental health systems change,
- the implementation of MHSSA-funded activities and services,

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- community strengths and needs,
- the relationship between the MHSSA and other school mental health initiatives, and
- school mental health outcomes.

The G3P will involve grantee partners participating in a sequence of meetings that follow a data-driven cycle of inquiry and sense making with the support of WestEd facilitators (Butler et al., 2015; Pedaste et al., 2015). The G3P will align with best practices in leveraging systems tools, measures, and data to support leadership teams facilitating school mental health systems change (Hoover et al., 2019; Kincaid & Romer, 2021; Splett et al., 2017). The G3P will

- focus on grantee-specific MHSSA and school mental health priorities;
- provide multiple qualitative and quantitative data sources to better understand the partnership, school mental health system, implementation, and contextual factors;
- support grantee partners in data analysis and sense making; and
- result in an initial set of action items toward an effective and sustainable school mental health system.

The G3P is currently in development, and the final version and all supporting documentation will be submitted to the Commission on December 15, 2024. A team of senior WestEd staff is leading the development of the survey and the corresponding G3P that will guide the partnership case study.

Research Questions

The grantee partnership case study will address the research questions listed in Table 11.

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Table 11. MHSSA Research Questions Addressed by the Grantee Partnership Case Study with Associated Data Sources

MHSSA Evaluation Framework	Research Question	Data Sources
Grantee Partnership	2. What were the facilitators and/or barriers related to leadership teaming and collaboration?	G3P
County- and School-Level Mental Health System	3. What were the facilitators and/or barriers related to the implementation of school mental health systems change at each level (county, district, school)?	G3P
	4. What was the relationship between MHSSA grantee partnerships and the county-level school mental health system?	G3P
	6. What was the relationship between the county-level and the school-level mental health system?	G3P
MHSSA-Funded Activities and Services	7. How did the MHSSA grantee partnerships support the implementation of MHSSA-funded activities and services?	G3P
	9. How were MHSSA-funded activities and services selected, designed, and implemented to close the equity gap?	G3P
Community Factors	11. What were the mental health strengths and needs of young people and their school communities?	G3P
	12. How did community factors serve as facilitators and/or barriers to school mental health systems change at each level (county, district, school)?	G3P
Other School Mental Health Initiatives	13. How did other school mental health initiatives serve as facilitators and/or barriers to the implementation of school mental health systems change at each level (county, district, school)?	G3P
Meaningful and Equitable Outcomes	14. How did improvements in the school-level mental health system support students' mental health needs and for whom?	G3P

Sample and Recruitment

WestEd will conduct a systematic sampling of 10 grantee partnership teams, ensuring diversity based on a set of several county-level characteristics.[4] First, the sampling process will begin with the separation of partnerships by cohort. WestEd will aim to recruit teams from three to four counties per cohort. Within Cohorts 1 and 2, partnership type will then be prioritized, aiming for two existing and one new partnership within Cohort 1, as well as one existing and two new partnerships within Cohort 2. Partnership type does not exist for Cohort 3 and will therefore not be prioritized for this cohort.

Next, the regional distribution of counties will be considered, with a goal of including one county from each designated region (i.e., Northern, Central, and Southern) within each cohort. Finally, the county's locale will be considered based on the California State Association of Counties caucus designations, with a recruitment goal of at least one urban, one suburban, and one rural county within each cohort.

Partnership teams will be composed of 5–10 members. As the survey and inventory are developed, guidance on the composition and structure of the partnership team will be finalized. To recruit the sample of grantee team members from partnership entities leading the implementation of MHSSA activities and services and school mental health systems change, WestEd will collaborate with behavioral health agency and education county and district grantee leads.

Method/Process

School Mental Health System Inventory

The G3P is currently being developed to use a school mental health systems change planning process that aligns with the grantee survey, which will assess the MHSSA conceptual model elements of this case study (see p. X). The G3P will be informed by the cycle of inquiry and collaborative inquiry research (Butler et al., 2015; Pedaste et al., 2015) and will consist of a four to five session sequence of 1.5- to 2-hour Zoom meetings. WestEd will work closely with grantee leads to schedule sessions (e.g., a partnership team may prefer more frequent, shorter meetings).

An example session sequence follows:

Session 1: Overview of G3P (2 hours)

- Provide overview of the G3P process.
- Identify partnership team goals and priorities.
- Present summaries of the grantee survey and other data gathered by WestEd.

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[4] Timing of the Grantee Partnership Case Study is critical to ensure the inclusion of all grantees across Phases 1–3 in the sampling frame. The following counties have contracts that end in summer or fall 2025: San Mateo, Orange, San Luis Obispo, Santa Clara, Solano, Trinity-Modoc, Tulare, Lake, Marin, Monterey, Nevada, Sacramento, Santa Cruz, Sonoma, and Tuolumne.

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- Identify additional data that partnership teams may provide related to the unique focus of their MHSSA activities and services and/or school mental health systems change.
- Assesses overall readiness to engage in the G3P.
- Assign next steps (e.g., review of data prior to next meeting).

Session 2: Team Calibration (1.5 hours)

- Review questions, observations, and concerns related to specific domains of the survey and other data sources.

Session 3: Analysis of Data (2 hours)

- Facilitate data analysis using a sequence of data visuals and guiding questions.

Session 4: Action Planning (1.5 hours)

- Use action planning to move from data to practice by focusing on equitable implementation outcomes, improvement plans, and aspects of sustainability.

As previously noted, WestEd is developing the G3P alongside the grantee survey. The G3P will be reviewed by three to four internal and external subject matter experts, as well as by the Commission and grantees.

Data Collection

G3P

The G3P will be completed by five grantee partnership teams in the spring of 2025, followed by another five teams in the fall. Grantee partnership teams whose contracts end in summer 2025 will participate in the spring 2025.

Secondary Data

WestEd will collect relevant documents at the county and district levels from each county's school mental health system to contextualize each case study. Documents and aggregated data at the school, district, or county levels will be used in the secondary data analysis. WestEd will not request any individual-level student data.

Analytic Plan

Data from Grantee Partnership Case Study will be analyzed at each stage of the G3P. The following provides a high-level overview of the planned analyses within each phase. Throughout the sessions, partnership teams will review data, complete G3P activities that will serve as process artifacts, and respond to guiding questions within this process. Sessions will be recorded for the WestEd team to review for clarification as necessary.

Prework

Prior to the first Grantee Partnership Case Study session, WestEd will create a summary of each grantee's survey data, as well as data from the Contextual Descriptive

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Analyses. Means, medians, and standard deviations will be used as descriptive statistics. Frequencies and percentages of categorical variables will also be reported. Data visualizations (e.g., line graphs and scatter plots) will be created as appropriate.

Postsession Analyses

Each Grantee Partnership Case Study session will be guided by a set of questions. Following each session, responses to these questions will be summarized to identify key areas of strength and need, as well as additional information to hypothesize root causes. Data will be synthesized across the participating 10 grantee teams to identify cross-case themes that will inform collective learning from the MHSSA Evaluation.

Reporting and Dissemination

Partnership case study findings will be included in the ongoing strategic communications and final report described at the end of this report. WestEd will collaborate closely with grantees to gather input and feedback on how the findings from G3P are summarized and presented in the final evaluation and other communications.

Case Study Reports

WestEd will create a brief case study report about each school that participated in the Implementation and Impact School Case Study.

Summary of Results for the Final MHSSA Evaluation Report

The results of the cross-case thematic analysis will be reported in the final evaluation report. The summary of results will include the themes identified through the analysis, as well as a summary of insights gained through sense making.

Implementation and Impact School Case Study

Brief Summary

WestEd will conduct a multimethod case study of 12 MHSSA-funded schools. Case-centered research design is a strategy in which researchers conduct an in-depth study of one or more cases. The cases are time and activity bound, and researchers collect detailed information over an established period using a variety of data collection procedures (Creswell, 2009).

WestEd will collect qualitative data for the Implementation and Impact School Case study through interviews, focus groups, and document reviews (Denzin & Lincoln, 2011; Patton, 2002). WestEd will collect existing MHSSA-related documents at the school and district levels, as well as data on mental health and wellbeing activities and services at each school, to contextualize each case study. Primary data collection will include interviews and focus groups with school staff, mental/behavioral health professionals, students, and families/caregivers. As part of a Youth Engagement Supplement (YES), WestEd will partner with students from four schools to co-interpret data and support

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young people in making recommendations for school mental health systems change to state and local school mental health system leaders.

The Implementation and Impact School Case study will help to explain the impact of MHSSA-funded activities and services and school mental health system changes on school and student outcomes. It will also explore intervention conditions and describe MHSSA implementation in the context of each participating school.

Research Questions

The Implementation and Impact School Case Study will address the research questions listed in Table 12.

Table 12. MHSSA Research Questions Addressed by the Implementation and Impact School Case Study with Associated Data Sources

MHSSA Evaluation Framework	Research Question	Data Source
County- and School-Level Mental Health System	3. What were the facilitators and/or barriers related to the implementation of school mental health systems change at each level (county, district, school)?	MHSSA Implementation Liaison
	4. What was the relationship between MHSSA grantee partnerships and the county-level school mental health system?	MHSSA Implementation Liaison
	5. What was the relationship between MHSSA-funded activities and services and the school-level mental health system?	MHSSA Implementation Liaison School Staff School Mental and Behavioral Health Professionals
	6. What was the relationship between the county-level and the school-level mental health system?	MHSSA Implementation Liaison
MHSSA-Funded Activities and Services	7. How did the MHSSA grantee partnerships support the implementation of MHSSA-funded activities and services?	MHSSA Implementation Liaison
	8. What activities and services were implemented using MHSSA funding?	Document Review MHSSA Implementation Liaison

	9. How were MHSSA-funded activities and services selected, designed, and implemented to close the equity gap?	Document Review MHSSA Implementation Liaison School Staff School Mental and Behavioral Health Professionals
	10. What were the facilitators and/or barriers to implementing MHSSA-funded activities and services?	MHSSA Implementation Liaison School Staff School Mental and Behavioral Health Professionals
Community Factors	11. What were the mental health strengths and needs of young people and their school communities?	Document Review School Staff School Mental and Behavioral Health Professionals Students Families/Caregivers
	12. How did community factors serve as facilitators and/or barriers to school mental health systems change at each level (county, district, school)?	Document Review School Staff School Mental and Behavioral Health Professionals Students Families/Caregivers
Other School Mental Health Initiatives	13. How did other school mental health initiatives serve as facilitators and/or barriers to the implementation of school mental health systems change at each level (county, district, school)?	MHSSA Implementation Liaison School Staff School Mental and Behavioral Health Professionals
Meaningful and Equitable Outcomes	14. How did improvements in the school-level mental health system support students' mental health needs and for whom?	School Mental and Behavioral Health Professionals Students Parents

Sample and Recruitment

WestEd will systematically sample a diverse group of 12 MHSSA-funded schools to participate in the case study based on several school-level characteristics. While data will be collected in two to three waves, school sampling will occur prior to the first wave of data collection. Recruitment will take place prior to each wave of data collection and sample selection adjusted accordingly.

Inclusion and Exclusion Criteria

Based on an initial list of MHSSA-funded schools, there are 842 elementary schools, 304 middle schools, 425 high schools, and 564 combined schools that have received funding through the MHSSA. WestEd will consult with the Commission and grantees to update the list of MHSSA-funded schools that will be used as the sampling pool.

Schools will be eligible for inclusion in the Implementation and Impact School Case Study if

- the school used funding from MHSSA to directly fund staff;
- the school received an adequate amount of funding to allow for sufficient school-level dosage of MHSSA-funded activities and services;[5]
- The school recently completed a schoolwide student survey and can provide WestEd with aggregate school-level data that is aligned with the MHSSA Evaluation Framework (CHKS or similarly aligned survey).

Selection

Sampling will follow the Grantee Partnership Case Study methodology described above. WestEd will sample a group of 12 MHSSA-funded schools based on the funding phase and several school-level characteristics listed in Table 13 below. WestEd will select schools for participation using stratified random sampling (Kalton, 2002). Strata will be defined by school-level variables using a cluster analysis, a methodology for identifying similar patterns across observations and creating classifications (Tipton, 2013).

The final school case study sample will be selected to reflect the variety of MHSSA-funded activities and services. This approach ensures that the narratives generated from the Implementation and Impact School Case Study reflect the diversity of MHSSA-funded activities and services implemented statewide. WestEd will validate the selection of schools with grantees to ensure their readiness and fit.

Table 13. School Case Study Sampling Frame Data Sources

Relevant variables	Secondary data source
• **Elementary, middle or high school** • **% White, non-Hispanic** • **Average daily attendance** • **% Socioeconomically disadvantaged**	CALPADS school-level data
• **Urban/rural/suburban designation**	CA State Association of Counties

[5] Dosage criteria will be determined in collaboration with partners before the school sampling is conducted

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Site Recruitment

WestEd will recruit four schools from each funding phase that include at least one elementary school, one middle school, and one high school. The first wave of recruitment will prioritize Phase 1 schools within MHSSA grantee counties whose grant awards expire in 2025 (n = 4). The next wave(s) of data collection will include Phases 2 and 3 schools in MHSSA grantee counties with later grant end dates (n = 8).

To support initial outreach, WestEd will partner with grantees from the sample school's county to connect WestEd to an MHSSA Implementation Liaison (see Table 14 below for roles and responsibilities of each school case study partner and participant) to ensure that the data collection plan and timeline is appropriate for the school. WestEd will share recruitment materials that outline the purpose and the goals of the MHSSA Evaluation, participation requirements, a data collection timeline, and potential risks and benefits to participating in the case study with prospectives sites. As an incentive for schools to participate in the case study, WestEd will provide a $1,000 gift card for the purpose of purchasing school supplies.

Method/Process

Data Sharing Agreements

WestEd will establish a data sharing agreement with each school that will include

- start and end data of the case study,
- purpose of the study,
- requested information,
- data type,
- requested data delivery/collection date, and
- plan for dissemination.

Secondary Data Collection

WestEd will collect related school- and district-level related documents about each selected site's school mental health system for the purpose of contextualizing each case study. Data may include documents as well as aggregated data at the school- or district-level. WestEd will not request any individual-level student data.

Primary Data Collection Planning and Coordination

Protections to Ensure the Health and Wellbeing of Evaluation Participants

Several safeguards are in place to protect the health and wellbeing of evaluation participants. Before data collection begins, WestEd will get Institutional Research Board (IRB) approval the from the California Committee for the Protection of Human Subjects and from WestEd's Office of Research Integrity. All WestEd research staff will be trained on guidelines to protect participant confidentiality and securely handle data (see the Data Security Plan document). At the start of each focus group, behavioral

guidelines will be discussed, including agreements to keep the information shared during the focus group confidential and to limit the use of names of individuals not in the focus group.

Due to the sensitive topics covered in qualitative interviews and focus groups, adults and students may feel embarrassed or experience strong emotions during conversations with WestEd researchers. To proactively support students, a trusted adult from the school community will be present during all student data collection activities.

WestEd will follow research guidelines outlined in the Adapted Trauma-Informed Social Research Guide. All data collection protocols have been developed using a trauma-informed lens (Alessi & Kahn, 2023; Dowding, 2021) and will be reviewed by three to five mental health professionals before data collection begins. Contacts at school sites will also have the opportunity to review protocols before they are implemented. Consent and assent will be revisited throughout the data collection process. Senior WestEd staff will debrief with all data collectors following each round of interviews and focus groups, which will help uncover any new risks or potential issues.

To protect participant anonymity within their school, interview and focus group notes and transcripts will be de-identified from the start. The data manager will maintain a list of participants and assign them a unique project ID number. Interviewers will use this ID number on the hard copy focus group protocol, notes, and recordings/transcripts. The use of names will be avoided as much as possible during the notetaking process.

For in-person and virtual interviews and focus groups, notes will be taken on encrypted WestEd laptops and the notetaker will upload their notes and recordings to a designated project box folder. Once the data manager confirms that data has been properly synced and is complete, the manager will notify the interview notetaker, who will then delete the data from their recording devices and laptops.

Aside from uploading data privileges for the interview/focus group notetakers, only the project directors and the Implementation and Impact School Case Study lead will have full access to this special project Box folder. Information will be stored in such a way that no unauthorized persons (including unauthorized WestEd staff) can retrieve or alter it using a computer, remote terminal, or any other means. The notes and transcripts will be reviewed by the focus group manager to ensure that names or other identifiers are deleted. Once cleaned, de-identified focus group notes will be transferred to a project analysis folder.

De-identified focus group data will be analyzed using qualitative data analysis software, and the analysts will use copies of these de-identified data to categorize and code the data. Selected summaries of these analyses or copies of selected de-identified interview/focus group notes may be shared with the larger WestEd research team for analysis.

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Site-Specific Process Planning

The Impact and Implementation School Case Study will include virtual and on-site data collection. WestEd will conduct a 2-day site visit to each school with two or three WestEd facilitators who bring expertise in participatory qualitative research, are trained in trauma-informed data collection methods, and have experience collecting data in school settings.

WestEd will conduct interviews and focus groups with school staff, mental/behavioral health providers, students, and families/caregivers. These discussions (see Table 14 for more information about each group) will focus on the coordination and implementation of MHSSA-funded activities and services. Additionally, they will address the impact of MHSSA-funded activities and services on the broader school mental health system and the impact of school mental health systems change on school and student outcomes.

For documentation purposes, all interviews and focus groups will be audio recorded. WestEd will partner with each site to establish the appropriate processes and procedures for on-site data collection activities, ensuring protocols accommodate participant schedules. This includes the option to use Zoom for data collection when on-site methods are not feasible for select evaluation participants. WestEd will collaborate with the MHSSA Implementation Liaison, the Site Coordinator, and the Student Liaison to facilitate data collection planning and preparation (see Table 14 for roles and responsibilities).

Table 14. Implementation and Impact School Case Study Role Information

Role/Title	Description/Role	Compensation[6]
MHSSA Grantee Contact	The point of contact from the grantee partnership who works directly with someone at the school to coordinate implementation of MHSSA-funded activities and services	N/A
MHSSA Implementation Liaison	An individual funded by MHSSA at the school who is responsible for communicating or coordinating with the MHSSA grantee partnership team. The MHSSA implementation liaison will provide a referral for the site coordinator and a student liaison and participate in an interview.	School incentive $1,000
Trusted Adult	A school staff member, possibly school counselor or other mental health professional, who attends youth focus groups and youth engagement sessions, both on-site and virtual. The trusted adult should have appropriate training to provide support to students if their participation in an evaluation activity causes distress.	$200 digital gift card

[6] In cases where local policies do not allow monetary compensation, WestEd will collaborate with the school to identify alternative compensation of the same amount.

Student Liaison[7]	A student leader identified in partnership with the MHSSA Implementation Liaison to inform the student focus group recruitment strategy	$25 digital gift card
State and Local School Mental Health System Leaders	Adults with leadership roles in the school mental health system. Leaders will be invited to participate in sessions 4 and 5 of the YES.	N/A
Site Coordinator	A site staff member identified by the MHSSA Implementation Liaison who will facilitate scheduling onsite sessions and focus group recruitment.	$200 digital gift card
School Site Staff	School-based staff who interact with students on a regular basis as teachers, coaches, administrators, or other role (e.g. bus driver). They will participate in the school case study as focus group participants.	$50 digital gift card
Mental and Behavioral Health Professionals	Community-based providers, school counselors, social workers, school psychologists, wellness center directors, etc. They will participate in the school case study as focus group participants.	$50 digital gift card
Students	Young people who attend the school selected for the case study. They will participate in the school case study as focus group participants.	Pizza party $50/session for students participating in the YES
Youth Data Collectors	Young people who are a part of the MHSSA YAG and are trained to cofacilitate youth engagement sessions.	$50 per hour
Family/Caregiver	Family or caregiver of a student who attends the school. They will participate in the school case study as focus group participants.	$50 digital gift card Light refreshments at focus groups

MHSSA Implementation Liaison

WestEd will virtually meet with the MHSSA Implementation Liaison as part of the outreach process described above to establish a relationship and begin planning for data collection. WestEd will ask the MHSSA Implementation Liaison to select an appropriate individual to act as the site coordinator.

Site Coordinator

WestEd will meet virtually with the Site Coordinator to better understand the school context and tailor recruitment materials and data collection protocols for each site's specific needs. In addition, WestEd will ask the Site Coordinator to identify an

[7] Implementation and Impact School Case Study methods will be adapted in elementary school settings. All coordination activities will take place with the support of adults only.

appropriate student to serve as the student liaison and recruit for and schedule on-site data collection to account for school and community events, professional development or early-release days, and other site-specific opportunities or constraints.

One month before data collection begins, WestEd will ask the Site Coordinator to distribute data collection information flyers to the school community. Interested individuals will be asked to complete a brief interest survey that includes contact and demographic information, as well as group-specific questions to determine their fit for the MHSSA Evaluation data collection activity. WestEd will select individuals to participate in data collection activities based on their answers to the brief survey. The Site Coordinator will also be asked to communicate directly with students and their families/caregivers to obtain consent.

Student Liaison

WestEd will meet virtually with the Student Liaison to gather input on how to best adapt recruitment materials and/or data collection protocols and processes to be culturally responsive. WestEd will work with the Student Liaison to identify a trusted adult within the school to attend student focus groups and engagement sessions.

Primary Data Collection

WestEd will conduct interviews and focus groups with school staff, mental/behavioral health professionals, students, and families/caregivers using a trauma-informed and culturally responsive approach. Table 15 provides detailed information about each data collection activity.

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Table 15. Interview and Focus Group by Implementation and Impact School Case Study Participant

Participant	Interview/Focus group	Number of participants per session	Protocols
MHSSA Implementation Liaison[8]	One 60-minute interview	1–4	MHSSA Implementation Liaison Interview Questions
School Staff	Up to two 60-minute focus groups	6–10	School Staff Focus Group Questions
School Mental and Behavioral Health Professionals	Up to two 60-minute focus groups	6–10	School Mental and Behavioral Health Professionals Focus Group Questions
Students from Grades 5–12	One 90-minute focus group	10–15	Student Focus Group Questions
Family/Caregiver	Up to two 60-minute focus groups	6–10	Family/ Caregiver Focus Group Questions

Youth Engagement Supplement (YES)

The YES is a five-session protocol designed to deeply engage young people in the MHSSA Implementation and Impact School Case Study. WestEd will cofacilitate engagement activities across four schools selected from the sample of Implementation and Impact School Case Study sample. This supplement aims to gather deeper student insights and perspectives on school mental health services and foster student engagement state and local school mental health systems change initiatives.

The YES sample will be limited to late middle and high school students who are at a critical developmental stage where they can fully participate in all MHSSA Evaluation engagement activities.

Each of the four participating schools will follow a cohort model, in which the same group of students from each school will be invited to participate in all five sessions.

[8] If the MHSSA Implementation Liaison works closely with additional staff at the school for MHSSA implementation, the protocol will be adapted for a focus group.

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School Selection and Onboarding

Four schools will be selected from an initial pool of 12 case study schools, representing diverse local contexts and MHSSA-funded activities and services. To qualify, schools must be a middle or high school, and the site coordinator must have the capacity to support session coordination. If more than one school meets the inclusion criteria, WestEd will randomly select a participating school.

Youth Recruitment

In partnership with the Site Coordinator and Student Liaison, WestEd will recruit up to 15 middle and high school students (ages 13–19) utilizing flyers and a social media campaign. WestEd will collect an online application form and selected students will be contacted with information about the sessions to set appropriate expectations. WestEd will ask interested students to attend all sessions to foster trust and cohesion among the student cohort.

Session Protocols

WestEd will partner with each school to adapt the YES implementation plan to meet the needs of each student community. Planning will involve initial meetings with each school's site coordinator to finalize session dates and ensure there is an appropriate space for each session.

A subgroup of the MHSSA Evaluation YAG consisting of high school and early college-aged students from across California will be trained to serve as youth data collectors for the YES. These youth data collectors will play an active role in facilitating the YES sessions. They will contribute by creating introductory content, facilitating virtual discussions, and taking notes during key activities. The sections that follow provide an overview of the goals and activities of each of the five sessions.

Session 1: In the first session, WestEd facilitators will assist students in becoming familiar with and interpreting data sources relevant to their school's case study, such as CHKS data and school focus group data. While on-site in a designated classroom, WestEd facilitators will lead relationship-building activities, orient students to data sources, and engage in small and full group discussion making meaning of the data (EdTrust, 2024). While not directly participating in the session, youth data collectors will create an introductory video about themselves and the MHSSA to establish a youth-centered atmosphere. Across all five sessions, the same trusted and appropriately trained school staff member will be present and will be invited to cofacilitate sections of each session to support trust-building and ensure ethical protections of youth during and after the sessions.

Session 2: During the second session, WestEd will gather youth perspectives about school and community mental health strengths and needs (Burns et al., 2012). Using a protocol adapted from the Advancement Project, WestEd facilitators will incorporate student insights into a product (map or list) that will be shared with state and local school mental health system leaders during Session 4.

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Session 3: In the third session, WestEd facilitators will help students prepare to share their perspectives about school mental health with state and local school mental health system leaders. Held virtually, this session will continue to emphasize trust building, while also including a presentation skills workshop and practice session to prepare for the student panel.

Session 4: In the fourth session, WestEd will facilitate a virtual student panel with state and local school mental health system leaders. Students will present their insights and asset map in a structured panel format.

Session 5: In the final session, WestEd will facilitate a reflective discussion about student experiences participating in the five-session series. The meeting will close with an opportunity for students to consider opportunities for ongoing engagement with student mental health systems change.

Analytic Plan

WestEd researchers will meet weekly during the Implementation and Impact School Case Study data collection, analysis, and reporting periods to engage for reflective discussions and peer debriefing to ensure that any biases or assumptions have minimal impact on data collection and analysis (Roller & Lavrakas, 2015).

Following transcription, WestEd will conduct a summative thematic analysis of the transcripts using the process described in the Grantee Partnership Case Study section above. The goal of the thematic analysis will be to identify trends within and across schools to gain insight on the associated research questions. Following an initial analysis, WestEd will engage in sense making with youth data collectors and other partners and findings will be refined, revised, and disseminated.

Reporting and Dissemination

WestEd will disseminate case study findings to each participating case study school, as well as with broader MHSSA partners, using the strategic communications and final report described in the following section.

Case Study Reports

WestEd will prepare a brief case study report for each school that participated in the Implementation and Impact School Case Study with key findings.

Summary of Results for the Final MHSSA Evaluation Report

WestEd will report the findings from the cross-case thematic analysis in the final evaluation report. For more information, please refer to the Final Report description under the Strategic Communication and Dissemination section below.

Dissemination and Strategic Communication

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Brief Summary

WestEd will produce content for quarterly products for key audiences to ensure transparency, solicit input, and increase the visibility of the MHSSA Evaluation. WestEd will also produce two final MHSSA Evaluation reports, one community facing and one technical, as well as a final presentation of evaluation findings to present to Commission staff at the end of the evaluation.

Method/Process

Quarterly Communication Products

WestEd will develop content for quarterly products for key audiences. These products will include disseminating evaluation findings and highlighting evaluation products generated during the evaluation. Examples include a newsletter containing preliminary evaluation findings; a county, school or participant impact story; or a presentation from a YES cohort.

Final Reporting

WestEd will develop a technical summative evaluation report that includes an executive summary, introduction, evaluation questions, research design, results, and discussion. Data from all evaluation components will be used to generate the results.

WestEd will also create a community-facing summative evaluation report that will provide information necessary for a general audience to understand the MHSSA Evaluation's purpose, approach, and outcomes. WestEd will follow several recognized methods for effectively communicating evaluation findings to nontechnical audiences to ensure the report is accessible to policymakers and practitioners. WestEd will integrate data visualizations into the body of the report in accordance with Evergreen's (2017) design principles.

WestEd is skilled at visually representing data using current techniques and trends, allowing readers to better understand study results and will ensure that the visualized insights are understandable and compelling for the intended audiences. Within the community-facing report, WestEd will avoiding jargon and highly technical terms to describe evaluation findings (Torres et al., 2005).

WestEd research staff will work with the WestEd Communications Department, which includes professional editors and designers, to create final reports. WestEd's Communications Department has an efficient quality assurance review process for all reports and ensures that high-visibility reports are thoroughly reviewed and made accessible to all audiences.

The MHSSA Evaluation will leave behind data infrastructure and evaluation technical assistance resources that the Commission, grantees, and participating school sites can continue to use after the evaluation period.

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Lastly, WestEd staff will prepare an in-person presentation of the key evaluation findings to share with Commission staff. The presentation will be tailored to the needs of the Commission staff, with the goal of summarizing the study’s findings and generating ideas and discussion.

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Appendix A. Associated Document List

Appendices B-P contain the following documents:[9]

- Appendix B. Grantee Table
- Appendix C. Contextual Descriptive Analysis Metrics
- Appendix D. Grantee Data Sense Making Session Protocol
- Appendix E. Data Security Plan
- Appendix F. Adapted Trauma-Informed Social Research Guide
- Appendix G. MHSSA Implementation Liaison Interview Questions
- Appendix H. School Staff Focus Group Questions
- Appendix I. School Mental and Behavioral Health Professionals Focus Group Questions
- Appendix J. Student Focus Group Questions
- Appendix K. Family/Caregiver Focus Group Questions
- Appendix L. Youth Engagement Supplement (YES) Session 1 Agenda
- Appendix M. Youth Engagement Supplement (YES) Session 2 Agenda
- Appendix N. Youth Engagement Supplement (YES) Session 3 Agenda
- Appendix O. Youth Engagement Supplement (YES) Session 4 Agenda
- Appendix P. Youth Engagement Supplement (YES) Session 5 Agenda

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[9] WestEd communications department, community partners, and content experts will complete their review of documents included in Appendices B-P by December 15th.

Appendix B. Grantee Table

Grantee Table

Grantee	Phase	Size	Total funding	Contract end date	MHSSA-Funded Elementary schools	MHSSA-Funded Middle schools	MHSSA-Funded High schools	MHSSA-Funded Combined schools
Calaveras	1	Small	$3,174,751	12/31/26	7	0	0	3
Fresno	1	Large	$7,619,403	8/31/26	171	38	57	78
Humboldt	1	Small	$3,174,751	12/31/26	18	8	15	25
Kern	1	Large	$7,619,403	8/31/26	0	6	2	0
Madera	1	Small	$3,174,150	9/30/26	0	1	1	4
Mendocino	1	Small	$3,174,751	12/31/26	7	3	6	7
Orange	1	Large	$7,619,403	8/31/25	7	5	5	1
Placer	1	Medium	$5,079,602	12/31/26	4	0	0	0
San Luis Obispo	1	Medium	$3,856,907	8/31/25	1	5	1	2

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Grantee	Phase	Size	Total funding	Contract end date	MHSSA-Funded Elementary schools	MHSSA-Funded Middle schools	MHSSA-Funded High schools	MHSSA-Funded Combined schools
San Mateo	1	Large	$5,999,999	9/30/24	13	6	10	3
Santa Barbara	1	Medium	$5,022,151	9/30/26	22	6	11	7
Santa Clara	1	Large	$7,619,403	10/31/25	0	3	3	0
Solano	1	Medium	$5,079,602	8/31/25	0	0	0	4
Tehama	1	Small	$3,174,751	9/30/26	10	6	4	11
Trinity-Modoc	1	Small	$2,945,830	9/30/25	3	1	10	14
Tulare	1	Medium	$5,079,602	8/31/25	0	5	6	17
Ventura	1	Large	$7,619,314	12/31/26	1	0	7	0
Yolo	1	Medium	$5,079,602	12/31/26	24	7	12	10
Amador	2	Small	$2,487,384	8/31/26	6	2	3	0
Contra Costa	2	Large	$7,613,588	12/31/26	0	2	0	0
Glenn	2	Small	$2,500,000	7/31/25	3	2	4	0
Imperial	2	Small	$3,174,751	7/31/26	0	0	10	2
Lake	2	Small	$2,499,450	9/30/25	7	3	11	16
Los Angeles	2	Large	$7,619,403	12/31/26	0	0	7	0

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Grantee	Phase	Size	Total funding	Contract end date	MHSSA-Funded Elementary schools	MHSSA-Funded Middle schools	MHSSA-Funded High schools	MHSSA-Funded Combined schools
Marin	2	Medium	$5,079,602	7/31/25	0	3	4	0
Monterey	2	Medium	$3,999,979	8/31/25	14	3	5	1
Nevada	2	Small	$3,174,050	8/31/25	3	0	0	0
Riverside	2	Large	$7,272,483	8/31/26	0	0	5	1
Sacramento	2	Large	$7,619,403	8/31/25	12	5	9	4
San Bernardino	2	Large	$5,998,000	1/31/26	19	5	7	4
San Diego	2	Large	$7,111,133	6/30/26	263	70	67	99
San Francisco	2	Large	$6,000,000	9/30/26	0	13	3	0
Santa Cruz	2	Medium	$5,079,602	8/31/25	3	4	6	0
Shasta	2	Small	$2,965,755	12/31/26	0	0	4	6
Sonoma	2	Medium	$5,079,602	7/31/25	7	7	11	3
Sutter-Yuba	2	Small	$2,618,184	1/31/26	1	1	3	17
Tuolumne	2	Small	$2,494,962	10/31/25	0	0	2	8
Alameda	3	Large	$7,619,403	12/31/26	3	12	5	3
Berkeley City	3	Small	$2,500,000	6/30/26	11	3	2	0

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Grantee	Phase	Size	Total funding	Contract end date	MHSSA-Funded Elementary schools	MHSSA-Funded Middle schools	MHSSA-Funded High schools	MHSSA-Funded Combined schools
Butte	3	Medium	$5,079,602	9/30/26	12	7	5	9
Colusa	3	Small	$2,500,000	12/31/26	5	2	4	4
Del Norte	3	Small	$2,500,000	12/31/26	5	1	2	7
El Dorado	3	Small	$5,044,665	12/31/26	23	8	10	11
Inyo	3	Small	$2,499,444	6/30/26	4	1	2	2
Kings	3	Small	$3,174,751	12/31/26	3	2	1	1
Lassen	3	Small	$2,274,040	6/30/26	3	2	5	12
Mariposa	3	Small	$2,500,000	12/31/26	0	0	3	7
Merced	3	Medium	$4,810,949	12/31/26	13	4	9	4
Mono	3	Small	$2,500,000	6/30/26	2	1	3	3
Napa	3	Small	$2,954,476	12/31/26	17	6	7	7
Plumas	3	Small	$1,749,800	6/30/26	3	0	3	5
San Benito	3	Small	$2,500,000	12/31/26	1	4	2	15
San Joaquin	3	Large	$7,619,403	12/31/26	40	12	31	93
Sierra	3	Small	$1,566,204	6/30/26	2	0	1	2

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Grantee	Phase	Size	Total funding	Contract end date	MHSSA-Funded Elementary schools	MHSSA-Funded Middle schools	MHSSA-Funded High schools	MHSSA-Funded Combined schools
Siskiyou	3	Small	$3,174,751	12/31/26	0	0	0	1
Stanislaus	3	Medium	$5,079,602	12/31/26	40	14	10	21
Tri-City	3	Medium	$4,852,204	12/31/26	29	5	9	10

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Appendix C. Contextual Descriptive Analysis Metrics

Contextual Descriptive Analysis Metrics

This document provides a series of tables that show the MHSSA Evaluation metrics and their associated data sources. The document covers all secondary data sources that will be used in the contextual descriptive analysis, including the California Healthy Kids Survey (CHKS), the California Longitudinal Pupil Achievement Data System (CALPADS), the California Open Data Portal, Project Implicit, and the U.S. Census. It also lists the CALPADS school-level demographic data that will be used in the Contextual Descriptive Analysis.

Table 1. MHSSA Evaluation Metric and Associated CHKS Data

MHSSA Evaluation Outputs and Outcomes	CHKS Domain/Scale
Promoting mental health and wellbeing	**Student Surveys** • School Co-Regulation Supports Scale • Responses to Trauma Scale • Stress Associated Health Symptoms Scale • Loneliness Scale • Optimism Scale • Life Satisfaction Scale
	Staff Survey • Caring Relationships Scale • High Expectations Scale • Student Readiness to Learn Scale
Providing linkages to ongoing services	**Student Surveys** • School Co-Regulation Supports Scale
	Staff Survey • Staff Efficacy for Promoting Student Well-Being Scale
Improving timely access to services for underserved populations	**Student Surveys** • School Co-Regulation Supports Scale

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<table>
<tr><td rowspan="2">Improving school climate</td><td>Student Surveys
Total School Environment Domain and Subdomains
School Connectedness Scale
Academic Motivation
Social and Emotional Learning Supports Scale
Fairness Scale
Positive Behavior Scale
Violence Victimization Scale
Antibullying Climate Scale
Promotion of Parental Involvement Scale
School Violence Perpetration Scale</td></tr>
<tr><td>Staff Survey
Student Learning Environment Scale
Staff Working Environment Scale
Staff Collegiality Scale
Caring Relationships Scale
High Expectations Scale
Student Meaningful Participation Scale
Promotion of Parental Involvement Scale
Support for Social and Emotional Learning Scale
Fairness and Rule Clarity Scale
Respect for Diversity Scale
Instructional Equity Scale
Antibullying Climate Scale</td></tr>
<tr><td rowspan="2">Reducing prolonged suffering</td><td>Student Surveys
Social Emotional Distress Scale
Optimism Scale
Life Satisfaction Scale</td></tr>
<tr><td>Staff Survey
Staff Efficacy for Promoting Student Well-Being Scale</td></tr>
<tr><td>Increasing SEL skills</td><td>Student Surveys
Emotion Regulation Scale
Social and Emotional Learning Supports Scale
Positive Behavior Scale
Staff Survey
Support for Social and Emotional Learning Scale
Student Readiness to Learn Scale</td></tr>
<tr><td>Reducing suicide/attempted suicide</td><td>Student Surveys
Suicidal Ideation Indicator</td></tr>
<tr><td>Reducing school failure/dropout</td><td>Student Surveys
Academic Motivation Scale</td></tr>
<tr><td>Reducing stigma/discrimination</td><td>Student Surveys
Emotional Safety at School Scale</td></tr>
</table>

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Table 2. MHSSA Evaluation Metric and Associated CALPADS Data on Student Outcomes

MHSSA Evaluation Outcome	Aligned CALPADS Domain
Reducing school failure/dropout	**Disciplinary Outcome** • Disciplinary incident • Action taken for disciplinary incident

Table 3. CALPADS School-Level Demographic Data Used in the Contextual Descriptive Analysis

Data Type	Data Items
Demographics	• Grade level • Gender • Race/ethnicity indicators as federally required • SEO (socio-economic disadvantage status) • Homeless status • Migrant status • Special education status • Foster youth status • Primary language • The recommended composite measure of high school student success (that would replace A-G courses completed) • Number of days students attended regular school (for all students enrolled under the CDS code listed)
English Learner Outcomes	• English language acquisition status code • English language acquisition status start date • ELPAC scores
Academic Outcomes	• CAASPP ELA • CAASPP Math

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Table 4. MHSSA Evaluation Metric and Associated Secondary Data Source

MHSSA Evaluation Community Factors	Relevant Items from Existing Tool
Diversity	**Census** • Race • Ethnicity • Disability rate and types
Employment	**Census** • Class of worker • Employment rate • Industry • Occupation • Mean weekly hours worked
Food	**CA Open Data Portal** • Food affordability • SNAP participation • WIC redemptions • Modified retail food environment index
Household Income	**CA Open Data Portal** • Income inequality **Census** • Income/earnings • Poverty
Housing	**Census** • Children in house under/over 18 • Family size • Household types (e.g., married, single) • Residential mobility • Rent • Homeownership rate • Housing value
Language/Culture	**Census** • Language spoken at home • U.S. and not U.S. born
Racism	**Census** • Poverty • Residential segregation **Project Implicit** • Race Implicit Association Test (IAT)

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Resources	**Census** • Health care coverage • Educational attainment
Safety	**CA Open Data Portal** • Violent crime rate
	CHKS • Violence Victimization Scale • Antibullying Climate Scale
Social Connectedness	**CHKS** • School Connectedness Scale • Caring Relationships Scale
Technology	**Census** • Computer and internet use
Transportation	**Census** • Means of transportation to work

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Appendix D. Grantee Data Sense Making Session Protocol

Grantee Data Sense Making Session Protocol

The WestEd team will facilitate sense making sessions with grantees to develop understanding and contextualize the grant monitoring and survey data results. This protocol provides an overview of what will occur during these sessions.

Objectives:

- WestEd will facilitate a data-based reflective discussion.
- Grantees will identify key insights to support the next steps of MHSSA implementation or the implementation of related school mental health initiatives.

Participants:

- 10 grantee sites per session
  - Representation includes leads and teams and at least one representative each from the county behavioral health department and county department of education.
- 10 WestEd facilitators

Duration:

- 2 hours

Materials Needed:

- Data summaries and visualizations for each grantee generated from the following sources:
  - Grantee Survey
  - CHKS Data (if available)
  - CALPADS
  - US Open Data Portal
  - Census
- PowerPoint

Community Agreements:

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- Keep an open mind while challenging ourselves and one another.
- Communicate directly, openly, and clearly.
- Support yourself. Be respectful and patient with one another.
- Be present in the work and when engaging with each other.
- Center youth and community.

Agenda:

1. Welcome and Introduction (10 minutes)
    - Facilitator welcomes participants and introduce the session’s objectives.
    - Facilitator briefly reviews the agenda and community agreements for the session.
2. Data Overview (10 minutes)
    - Facilitator presents data structure and content to grantees.
    - Facilitator explains the Group Reflection Protocol.
3. Grantee Group Reflection Protocol (60 minutes)
    - Facilitator asks grantees to
        - review the data with their teams and describe what they see without judgment or interpretation. (15 mins)
        - interpret the data, answering the question: “What does the data suggest?” (15 mins)
        - discuss the implications of the data by answering the question: “What does this mean for our county/district/school?” (30 mins)
4. Break (10 mins)
5. Group Presentations (25 minutes)
    - Each group presents their key learnings to the larger group.
    - WestEd allows time for questions and clarification after each presentation.
6. Closing and Next Steps (5 minutes)
    - WestEd thanks participants for their contributions and participation.

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Appendix E. Data Security Plan

Data Security Plan

This document provides an overview of WestEd's data security approach, infrastructure, and resources.

WestEd maintains a secure computing infrastructure, employing the latest hardware and software technology on a robust network to deliver information and technology services to staff and projects. WestEd operates industry-standard network devices for communications, file sharing, email, database applications, and videoconferencing.

WestEd promotes and enables the protective measures necessary to secure all data. WestEd's data security system has been developed in accordance with the ISO 27001 standard for information security management, as well as with the Federal NIST800-53 standard for security and privacy controls. In addition, WestEd implements a range of security procedures to maintain network and data security. Using tools such as virtual private networks, network firewalls, centralized secure servers, antivirus applications, deniable file systems, and multifactor authentication, WestEd uses the same care with coordinating the collection, management, and analysis of all data.

In consultation with their Institutional Review Board and Data Security teams, WestEd will develop an internal data security plan to detail steps for the storage, transfer, and access of sensitive data (including personally identifiable information [PII]). All data files containing PII data will be encrypted using currently approved National Institute of Science and Technology (NIST) algorithms when being electronically transferred across an internal network. If appropriate, WestEd's Secure Computing Environment (SCE) will also be used to handle highly sensitive data. The SCE is a highly secure online cloud-based storage and processing environment for highly sensitive data. WestEd's SCE is engineered to provide a workspace for client data to be analyzed and assessed, minimizing risk of integrity, compromise, and loss. Using Microsoft's Azure services, WestEd provides a platform backed by industry-leading security standards. The Data Protection Office at WestEd, in collaboration with WestEd's Information Services, controls the policy and deployment of the architecture to ensure that compliance is met.

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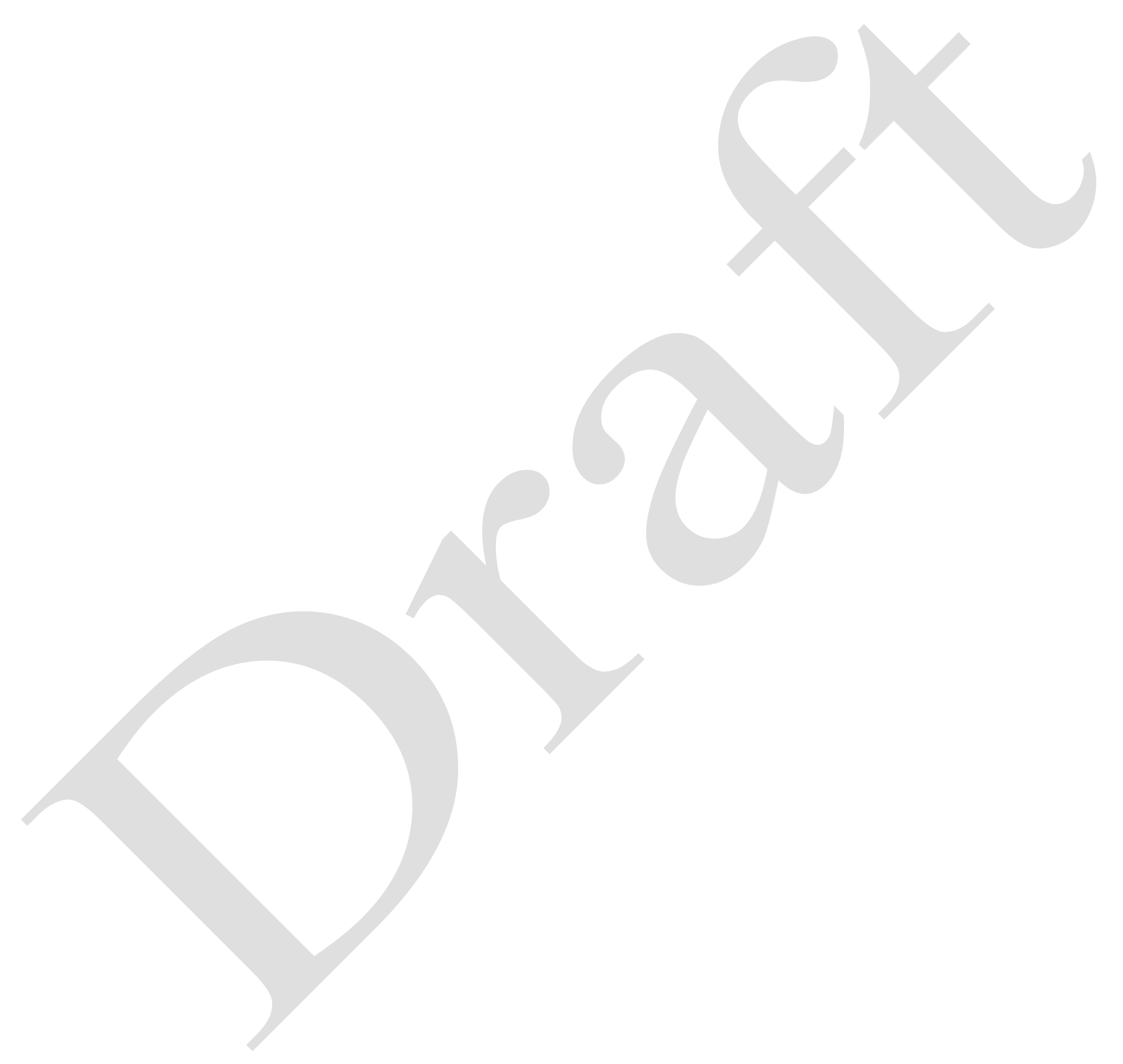
In addition, to preserve anonymity and confidentiality, randomly generated numbers (pseudocodes) will be assigned to each individual participant, district, and school, and all data files will be deleted once the project is complete.



Appendix F. Adapted Trauma-Informed Social Research Guide

Adapted Trauma-Informed Social Research Guide

This guide is adapted from Dowding's Trauma-Informed Social Research guide. It provides practical advice on applying the principles of trauma-informed practice to research activities. For WestEd's purposes, this guidance will specifically inform the planning, execution, and follow-up to focus groups and one-on-one interviews. The tips are organized by before, during, and after the focus group or interviews take place.

Research Checklist: Before

- Participant preferences have been considered when choosing the physical or online venue
- Any accessibility needs are known and have been met collaboratively
- If you will be discussing sensitive topics, participants have had an opportunity to see the questions in advance
- Participants have received accessible information about facilitator(s), the purpose and what to expect, where and when the session will be happening, and if there are refreshments
- Participants have been offered the chance to meet with the facilitator(s) ahead of the session if subject matter is potentially activating
- Whether the session will be recorded is decided, alongside how you will ask for consent to record
- Questions are checked to ensure each question helps you meet a specific aim (i.e., that you are not asking people to share any sensitive information unnecessarily)
- Plans are in place if anyone becomes distressed in the session and needs to take a break
- *Focus groups only:* Potential power dynamics between participants (like line managers and employees, workers and clients) have been considered and there are plans to keep people feeling safe to share their views
- *Focus groups only:* Each topic has enough time allocated, so that everyone can be heard and can explore their views in detail

Research Checklist: During

- Introductions, the purpose, and confidentiality are explored with opportunities to ask questions

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- Participants will be asked whether they are comfortable with being recorded, and will be made aware that they can retract anything they share later on
- Participants will be told about their options if they feel overwhelmed and they would like a break
- Participants are told where recording devices are and when they are turned on and off
- The facilitator(s) planned to meet participants' basic needs throughout, including toilet breaks and water
- Participants will be asked to speak generally rather than ask specific people to feedback (as this could feel pressuring)
- The facilitator(s) plan to pay attention to non-verbal cues or discomfort and address them appropriately
- *Focus groups only:* A group agreement will be made about how everyone is expected to act in the space to keep it feeling respectful and safe
- *Focus groups only:* Participants will be told how all others in the space handle any information that is shared
- *Focus groups only:* Facilitator(s) are aware of their role to facilitate the group discussion, not to present
- *Focus groups only:* Participants will be reminded to be respectful to all people and views, and plans are in place for if this does not occur
- *Focus groups only:* Every participant will be supported to speak and reflect equally

Research Checklist: After

- Participants are told about opportunities to add anything they feel is important before the session closes, and notified if they can continue to contribute after the session
- Facilitator(s) have summarized key points and reassured participants that the information was heard and valued and anyone who became distressed in the session is individually checked in with
- Participants have been thanked for their time and energy
- Signposting materials and debriefing options have been shared for anyone who may be impacted by the contents of the session
- Participants have been given an opportunity to comment on any draft reports, or to be informed when a final report is made available
- Participants have been given the opportunity to feedback on the process in person or via email, during or after the session
- The facilitator(s) have created a dedicated space to reflect on the session and to continuously develop trauma-informed practices

Draft

Appendix G. MHSSA Implementation Liaison Interview Questions

MHSSA Implementation Liaison Interview Questions

Introduction Questions

1. To start, can you tell us your title, role, and how long you have been in this role?

County- and School-Level Mental Health Systems

First, we want to talk about county/school collaboration related to the MHSSA and school mental health more broadly. We will use the term "school mental health system," and when we do, we are referring to the full array of supports and services that promote positive school climate, social and emotional learning, and mental health and well-being, while reducing the prevalence and severity of mental illness. School mental health systems also include the strategic collaboration between school staff, mental and behavioral health professionals, students, families, and community health and mental health partners. These systems also assess and address the social, political and environ-mental structures, like public policies and social norms, that influence student mental health outcomes. Do you have questions about this definition?

2. How have you been involved in MHSSA-funded work at the county- and school-level?
3. What does collaboration between the county and school look like related to school mental health?
4. To what extent has collaboration between the county and school changed since MHSSA funding became available? What has that looked like?
5. How does school mental health systems work within [name of county] affect school mental health systems work at [name of school]?
6. Conversely, how does school mental health systems work at [name of school] affect school mental health systems work within [name of county]?

Implementation

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7. Please describe the activities and services funded by the MHSSA at [name of school].
8. How did local needs within [name of school] or [name of city or town] influence the [MHSSA-funded activities and services] that is/are being implemented at [name of school]?
9. How have [MHSSA-funded activities and services] been implemented over time.
    a. Please describe any challenges in the implementation process.
    b. Please describe how [MHSSA-funded activities and services] connect to broader school mental health efforts at [name of school].
10. In what ways has collaboration between [name of school] and [name of county] supported the implementation of [MHSSA-funded activities and services]?

Outputs and Outcomes

11. What equity gaps, if any, have you seen [MHSSA-funded activities and services] address?
12. How has the implementation of [MHSSA-funded activities and services] impacted the school-level mental health system?
    a. Preventing mental health challenges from becoming severe and disabling ***(output)***
    b. Early recognition of mental health challenges ***(output)***
    c. Responding to need for additional services ***(output)***
    d. Improving
        i. timeline access to services for underserved populations ***(output)***
    e. Responding to the needs of all student subgroups ***(output)***
    f. Providing linkages to ongoing services ***(output)***
    g. Increasing social-emotional learning skills ***(outcome)***
    h. Reducing ***(outcome)***
        i. suicide and attempted suicide
        ii. school failure or dropout
        iii. prolonged suffering
        iv. stigma and discrimination
    i. Promoting ***(outcome)***
        i. Mental health and wellbeing
        ii. Positive school climate

Closing

Before we end, we want to give you the opportunity to share anything else that we haven't asked about.

13. Is there anything else you would like to share related to how the MHSSA has affected the school's capacity and connections for school mental health?

Draft

Appendix H. School Staff Focus Group Questions

School Staff Focus Group Questions

Introduction Questions

1. To get started, please share your name and role, and one way in which you have seen students benefit from the mental and behavioral supports at your school.

School Mental Health System

We want to hear a bit about your perceptions of [name of school]'s school mental health system. By school mental health system, we are referring to the full array of supports and services at [name of school] that promote positive school climate, social and emotional learning, and mental health and well-being, while reducing the prevalence and severity of mental illness.

2. How well equipped do you feel to support student wellbeing and how has your school helped build your capacity to do so?
3. How are teachers and other school staff equipped to support student wellbeing?
4. What are some of the most significant student mental and behavioral health needs at [name of school]?
    a. Are there certain groups of students (e.g., racial/ethnic groups, low-income students, homeless youth, etc.) whose needs are not being met?
    b. What resources are needed to serve the needs of all students in this school?
5. How well is the school mental health system at [name of school] addressing these needs?
    a. How does the school mental health system promote mental health and wellbeing?
    b. How does the school mental health system prevent mental health challenges from becoming severe and disabling?
    c. How does the school mental health system enable the early recognition of mental health challenges?
    d. How does the school mental health system ensure timely access to services for underserved population?
    e. How does the school mental health system respond to the need for additional services?
6. What are the barriers at [name of school] or in the broader community that make it difficult to meet students' mental health needs?
7. In the time you have been in this role, have you seen changes, either positive or negative, to the way [name of school] has supported student mental health?
    a. This could include changes in promoting positive student outcomes or reducing the prevalence and severity of mental illness.

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8. If you have seen changes occur, what are some of the things that were driving that change?
9. What are some of the structural things that still need to occur at [name of school] to adequately support the mental health needs of all students?

MHSSA within the Broader School Mental Health System

We want to hear a bit more about how MHSSA-funded activities and services fit within the broader continuum of care at your school.

10. For those of you who are involved in or aware of the activities and services at [name of school] that are funded by the MHSSA, please describe:
    a. How these new activities and services may have contributed to positive systemic change in the way [name of school] supports student mental health.

The Relationship between County- and School-Level School Mental Health Systems

11. To what extent are you aware of and/or involved in county-level work to strengthen school mental health systems county-wide? If you are aware of and/or involved in county-level school mental health systems work, please describe the ways in which you and/or your colleagues at [name of school] collaborate/communicate with the county towards a shared goal of promoting schools as centers of wellbeing.

Closing

Before we end, we want to give you the opportunity to share anything else that we haven't asked about.

12. Is there anything else you would like to share related to school mental health systems and systems change?

Draft

Appendix I. Mental and Behavioral Health Professionals Focus Group Questions

School Mental and Behavioral Health Professional Focus Group Questions

Introduction

1. To get started, please share your name, your role, and a sentence or two about the school mental health programs or supports you provide at [name of school]

Student Needs and the School Mental Health System

Our first series of questions focus on the needs of students and how they can be supported by [name of school's] school mental health system. By school mental health system, we are referring to the full array of supports and services that promote positive school climate, social and emotional learning, and mental health and well-being, while reducing the prevalence and severity of mental illness. School mental health systems also include the strategic collaboration between school staff, mental and behavioral health professionals, students, families, and community health and mental health partners. Finally, these systems also assess and address the social, political and environmental structures like public policies and social norms that influence student mental health outcomes. Do folks have questions about this definition?

2. What are some of the most significant student mental and behavioral health needs at [name of school]?
    a. Are there certain groups of students (e.g., racial/ethnic groups, low-income students, homeless youth, etc.) whose needs are not being met? If so, please describe.
    b. What resources are needed to serve the needs of all students in this school?
3. How well is the school mental health system at [name of school] addressing these needs?
    a. How does the school mental health system promote mental health and wellbeing?

Draft

   b. How does the school mental health system prevent mental health challenges from becoming severe and disabling?
   c. How does the school mental health system enable the early recognition of mental health challenges?
   d. How does the school mental health system ensure timely access to services for underserved populations?
   e. How does the school mental health system respond to the need for additional services?
4. What are the barriers at [name of school] or in the broader community that make it difficult to meet students' mental health needs?
5. What are the things within [name of school] that help make it easier to provide student mental health services?
6. In the time you have been in this role, have you seen changes, either positive or negative, to the way [name of school] has supported student mental health?
   a. This could include changes in promoting positive student outcomes or reducing the prevalence and severity of mental illness.
   b. If you have seen changes occur, what are some of the things that were driving that change?
7. What are some of the structural things that still need to occur at [name of school] to adequately support the mental health needs of all students?

MHSSA within the Broader School Mental Health System

We want to hear a bit more about how MHSSA-funded activities and services fit within the broader continuum of care at your school.

8. For those of you who are involved in or aware of the activities and services at [name of school] that are funded by the MHSSA, please describe:
   a. How these activities and services have been implemented over time.
   b. Any challenges in the implementation process.
   c. How these new activities and services connect to broader school mental health efforts at [name of school].
   d. How these new activities and services may have contributed to positive systemic change in the way [name of school] supports student mental health.

The Relationship between County- and School-Level School Mental Health Systems

9. To what extent are you aware of and/or involved in county-level work to strengthen school mental health systems county-wide?
   a. If you are aware of and/or involved in county-level school mental health systems work, please describe the ways in which you and/or your colleagues at [name of school] collaborate/communicate with the county towards a shared goal of promoting schools as centers of wellbeing.

Community Needs and Strengths

10. Lastly, we are interested in learning about the needs and strengths of the [name of city/town] community and how they inform the student mental health supports provided at [name of school].

Draft

Closing

Before we end, we want to give you the opportunity to share anything else that we haven't asked about.

11. Is there anything else you would like to share related to school mental health systems and systems change?

Draft

Appendix J. Student Focus Group Questions

Student Focus Group Questions

Introduction[10]

1. Let's start with introductions. Please share your first name and one thing at school that makes you feel encouraged, comfortable, or happy.

Student Needs

2. What does student wellbeing mean to you?
3. What kind of mental health supports and services do students at your school need?

School Mental Health Supports and Services

4. What do you think schools should do to support students' mental health and wellbeing?
5. Please describe the mental health supports and services at your school.
    a. Where do students at your school go when they need mental health support?
6. What is your school doing especially well to support student mental health?
7. How could your school improve the way it supports student mental health?
8. Your school offers [describe MHSSA-funded activity and service]. Have you ever had the opportunity to use the service?
    a. If yes, how was it? What went well and what could be better?
    b. If not, why not?

Contextual Factors

9. What are the mental health and wellness supports and services outside of school that young people in your community access?
10. What are things other than school that impact students' mental health and wellbeing?
    a. What about what's happening in your neighborhood?
    b. What about what's happening on social media?
    c. What about what's happening in your home life?

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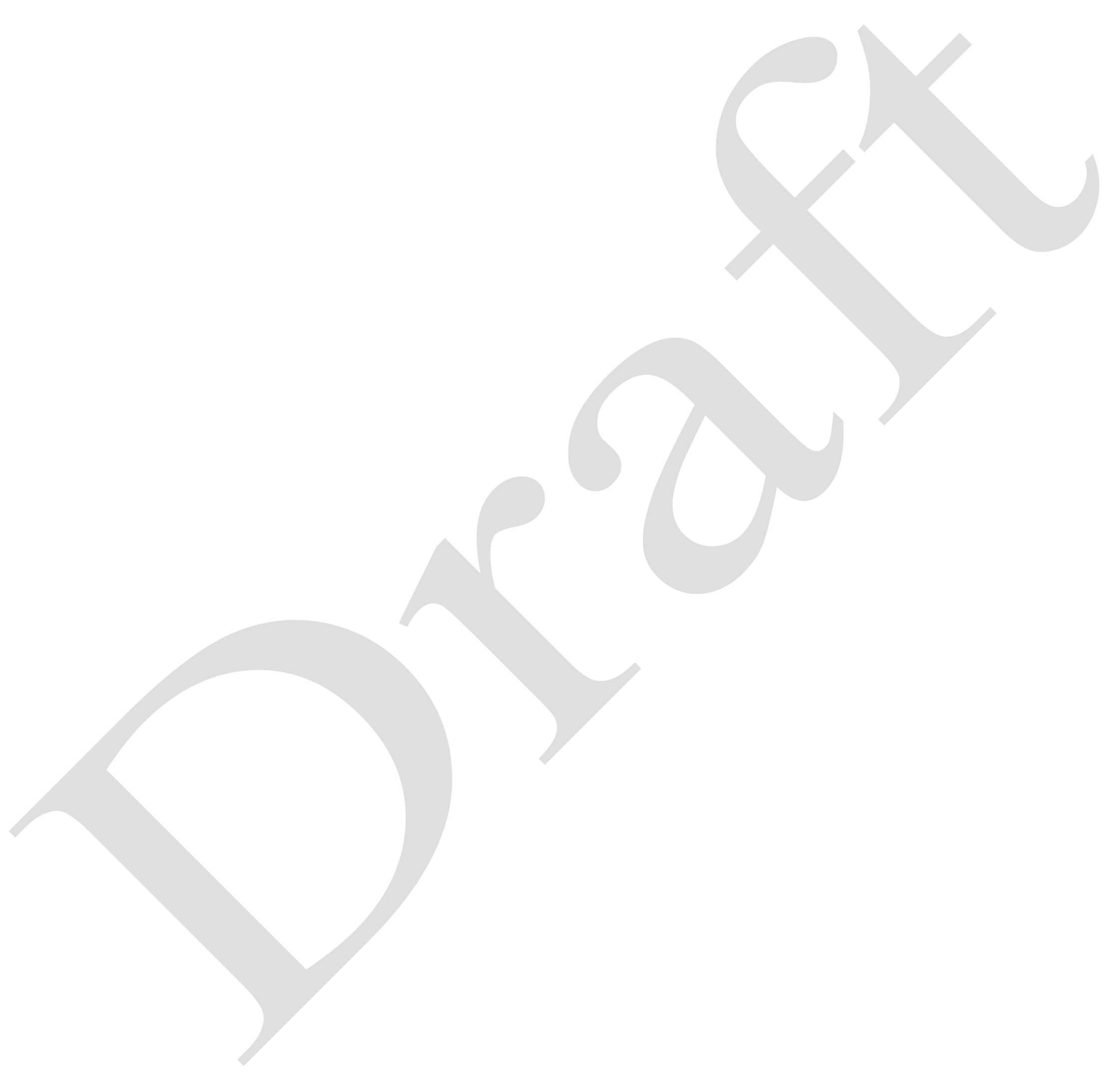
[10] Language used with younger aged students will be appropriately leveled.

Draft

Closing

Before we end, we want to give you the opportunity to share anything else that we haven't asked about that you think is important to share.

11. Is there anything else you would like to share related to student mental health and wellbeing at [your school]?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Appendix K. Family/Caregiver Focus Group Questions

Family/Caregiver Focus Group Questions

Introduction
Let's start with introductions.

1. Please share your first name and your child's grade at [name of school].

How Schools Support Student Mental Health and Wellbeing
We'd like to learn more about how your school supports student mental health and wellbeing.

2. What does student wellbeing look like for your child?
3. What is the school's role in supporting student mental health and wellbeing?
4. How likely are you to turn to [name of school] for mental health support and services for your child? Why or why not?
5. What do you think [name of school] is doing well to support student wellbeing?
6. What do you think [name of school] could improve to support student wellbeing?
7. What kinds of activities or services support students' mental health and wellbeing at [name of school]?
8. What kinds of activities or services at [name of school] help families and caregivers support their child's mental health and wellbeing?

Closing
Before we end, we want to give you the opportunity to share anything else that we haven't asked about that you think is important to share.

9. Is there anything else you would like to share related to students' mental health and wellbeing at [name of school]?

Draft

Appendix L. Youth Engagement Supplement (YES) Session 1 Agenda

Youth Engagement Supplement (YES) Session 1 Agenda

Session Objectives

- Provide an overview of the goals and purpose of the YES
- Familiarize youth with basic principles of data interpretation
- Explore available and relevant school case study data and engage in shared sense-making through a data equity walk

Time

- 110 minutes

Location and Set-up

- Onsite in a designated classroom with WestEd facilitators and a trusted adult from the school

List of Materials

- Post-it notes, poster paper, printouts of case study data

TIME	ACTIVITY
10 minutes	**Welcome, Introductions, Icebreaker & Community Agreements**
10 minutes	**Overview of Youth Engagement Supplement** ▪ About the school case study ▪ Goals and objectives of the YES ▪ Q&A ▪ Review agenda
15 minutes	**Framing and Key Concepts** ▪ Group discussion: What do we already know about this topic? How do your peers understand this topic? ▪ What is the role of schools for supporting students' mental health? ▪ The 'why' of school mental health systems
10 minutes	**Introduction to School Case Study Mental Health Data**
5 minutes	**BREAK**

Draft

45 minutes	**Data Equity Walk** (*adapted from EdTrust West's Data Equity Walk protocol*) ▪ Overview of data equity walk group agreements ▪ Orientation to available data (CHKS data, county-level mental health data, etc.) ▪ Round 1 data equity walk – youth add post-it notes to data on posters around the room in response to *guiding questions (see below)* ▪ Think-pair-share – discuss *guiding questions* ▪ Whole-group discussion of *guiding questions* **Guiding Questions**[11] 1. What are your general reactions to the data? What questions do these data raise for you? 2. What's the story behind the data? How does this connect to your personal experience? 3. What further information would be helpful? 4. What solutions can you think of to address the issues raised by these data?
15 minutes	**Closing** ▪ Recap of Session 1 and preview Session 2 ▪ Feedback survey

Draft

[11] A trauma informed script will be used that sets norms for how individuals might share in a way that feels safe.

Appendix M. Youth Engagement Supplement (YES) Session 2 Agenda

Youth Engagement Supplement Session 2 Agenda

Session Objectives

- Gather students' perceptions about school mental health services and supports
- Engage in a facilitated discussion about available mental health resources and needs in the school community
- Collaboratively develop a student mental health and wellbeing assets map using a Participatory Asset Mapping protocol

Time

- 120 minutes

Location and Set-up

- Onsite in a designated classroom with WestEd facilitators and a trusted adult from the school

List of Materials

- Post-it notes, poster paper, markers

TIME	ACTIVITY
10 minutes	**Welcome and Icebreaker**
10 minutes	**Stage Setting** ▪ Recap of Session 1 ▪ Session 2 agenda
10 minutes	**Introduction to Participatory Asset Mapping** (*adapted from the Advancement Project*)

Draft

75 minutes	**Participatory Asset Mapping** ▪ Conversation norm setting ▪ Individual reflection (*sample questions below*) ▪ Think-pair-share ▪ Whole-group discussion ▪ Collaborative mapping
15 minutes	**Closing** ▪ Recap of Session 2 and preview of Session 3 ▪ Feedback survey

Sample Questions[12]

5. What do you know about the available mental health resources at school (in-person and/or virtual)?
6. What other mental health resources are there in the community?
7. Where do students get information about how to access mental health resources? What supports have you heard of that work well for students?
8. What kinds of supports do you think students could use more of?
9. Based on your experience, are there students who have an easier or harder time accessing mental health services at your school?

[12] A trauma informed script will be used that sets norms for how individuals might share in a way that feels safe.

Appendix N. Youth Engagement Supplement (YES) Session 3 Agenda

Youth Engagement Supplement Session 3 Agenda

Session Objectives

- Prepare students for communicating their Participatory Asset Map and panel questions with state and local education school mental health system leaders

Time

- 65 minutes

Location and Set-up

- Virtual via Zoom with WestEd facilitators, MHSSA Youth Data Collectors[13], and a trusted adult from the school

List of Materials

- Laptop and reliable internet connection

TIME	ACTIVITY
10 minutes	**Welcome** • Introduce MHSSA Youth Data Collectors • Icebreaker • Temperature Check
5 minutes	**Stage Setting** ▪ Recap of Session 1 and Session 2 ▪ Session 3 agenda

[13] Roles and responsibilities of the MHSSA Youth Data Collectors will be determined during the Youth Data Collector training.

Draft

45 minutes	**Preparation for Student Panel** (*sample questions below*) ▪ Share participant protections within this context ▪ Individual reflection ▪ Group discussion ▪ Rehearsal
5 minutes	**Closing** ▪ Recap of Session 3 and preview of Session 4 ▪ Feedback survey

Sample Student Panel Questions[14]

10. What kind of school mental and behavioral supports positively impact the wellbeing students?
11. What makes it easy to access these mental and behavioral supports at school?
12. What makes it more difficult to access these mental and behavioral supports at school?
13. What additional school mental and behavioral supports are needed?
14. What is one hope you have related to student mental health and wellbeing at your school?

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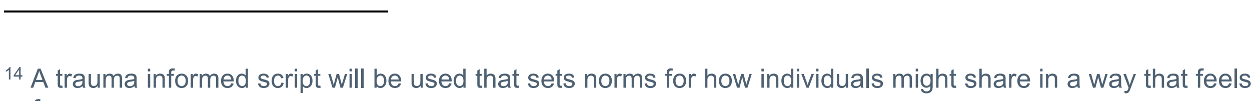

[14] A trauma informed script will be used that sets norms for how individuals might share in a way that feels safe.

Appendix O. Youth Engagement Supplement (YES) Session 4 Agenda

Youth Engagement Supplement Session 4 Agenda

Session Objectives

- State and local school mental health system leaders listen to youth share their insights about school mental health
- Students share Participatory Asset Map and responses to panel questions with state and local school mental health system leaders

Time

- 85 minutes

Location and Set-up

- Virtual via Zoom with WestEd facilitators, MHSSA Youth Data Collectors[15], a trusted adult from the school, and state and local school mental health system leaders

List of Materials

- Laptop and reliable internet connection

TIME	ACTIVITY
10 minutes	**Welcome and Icebreaker**
10 minutes	**Session Overview** ▪ Goals and objectives of the Student Panel ▪ Conversation norm setting ▪ Review agenda ▪ Introduce Student Panel presenters

[15] Roles and responsibilities of the MHSSA Youth Data Collectors will be determined during the Youth Data Collector training.

Draft

60 minutes	**Student Panel** ▪ Students respond to panel questions (*sample questions below*) ▪ Students present Asset Map ▪ State and local school mental health system leaders ask questions that were shared with students prior to the session for a structured Q&A
5 minutes	**Closing** ▪ WestEd facilitators close meeting ▪ Feedback survey

Sample Student Panel Questions

15. What kind of school mental and behavioral supports positively impact the wellbeing students?
16. What makes it easy to access these mental and behavioral supports at school?
17. What makes it more difficult to access these mental and behavioral supports at school?
18. What additional school mental and behavioral supports are needed?
19. What is one hope you have related to student mental health and wellbeing at your school?

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Appendix P. Youth Engagement Supplement (YES) Session 5 Agenda

Youth Engagement Supplement Session 5 Agenda

Session Objectives

- Reflect on experience participating in the 5-session series
- Discuss opportunities for continued youth engagement in school mental health systems change

Time

- 50 minutes

Location and Set-up

- Virtual via Zoom with WestEd facilitators, MHSSA Youth Data Collectors[16], and a trusted adult from the school

List of Materials

- Laptop and reliable internet connection

TIME	ACTIVITY
5 minutes	**Welcome** • Icebreaker • Temperature check
5 minutes	**Overview of Session**

[16] Roles and responsibilities of the MHSSA Youth Data Collectors will be determined during the Youth Data Collector training.

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25 minutes	**Group Reflection and Discussion** ▪ Individual reflection ○ What surprised you about this experience? ○ What was challenging about this experience? ○ What did you enjoy about this experience? ▪ Group discussion
10 minutes	**Thinking Forward** • Consider opportunities for continued engagement in state and/or local school mental health systems change
5 minutes	**Closing and Gratitude**

AGENDA ITEM 13

Action

November 21, 2024, Commission Meeting

School-Based Universal Mental Health Screening Legislative Report

Summary: The Commission will hear a presentation and consider adoption of a legislative report on school-based universal mental health screening (SUMHS). Per a 2023-24 Budget Act request, this report presents findings from a landscape analysis of statewide SUMHS policies and practices and a set of recommendations for implementing SUMHS in support of California's broader youth behavioral health initiatives.

Background: Most mental health challenges begin during childhood or adolescence, affecting as many as one in five U.S. children and youth each year, a number that has steadily increased in the past decade. Identifying and supporting mental health needs early leads to better outcomes, yet on average, a child waits 11 years before receiving services. In the U.S., unaddressed mental health challenges are one of the largest obstacles to learning for K-12 students, and can greatly impact social, educational, and health outcomes later in life. The nation is calling for solutions to address what it is considered a state of emergency for youth mental health, and California is rising to the challenge.

Through historic investments in youth behavioral health services, workforce, infrastructure, and public awareness, California is building an ecosystem of care that prioritizes prevention, early detection, and easy access. The State's approach sees schools as vital touchpoints in this ecosystem and universal mental health screening is an important tool to help schools succeed.

School-based universal mental health screening (SUMHS) is a proactive assessment of all students' mental and behavioral health risks and strengths. Much like the routine health screenings – such as hearing, vision, and fitness – SUMHS aims to identify potential challenges early so students can receive support before such challenges impact their health, behavior, and ability to learn.

The potential benefits are enormous: promoting equity, reducing stigma, increasing access to care, and ultimately, saving lives and dollars. But significant challenges remain. Concerns about school capacity, liability, and stigma have raised questions about how to implement SUMHS responsibly.

For SUMHS to be effective, schools must be equipped with trained staff, community partners, and resources for planning – all elements of a comprehensive school mental health system.

Fortunately, California is already laying the groundwork for SUMHS implementation through its existing youth behavioral health initiatives.

Project and Report: Through the 2023-24 Budget Act, the Legislature requested the Commission to conduct a landscape analysis and deliver a report on universal mental health screening for youth, with attention on data, best practices, and costs for implementing screening in K-12 school settings.

Working closely with the legislature, the Department of Health Care Services, California's Youth Behavioral Health Initiative, and other state and local partners, the Commission contracted with researchers from the University of California, San Francisco, the University of California, Riverside, and WestED to conduct a robust research and public engagement process to inform its legislative report, *Counting What Counts - Data-Driven Prevention through School-Based Universal Mental Health Screening*. In this report, the Commission aims to:

- Establish key definitions, concepts, and evidence relevant to SUMHS;
- Summarize findings from public engagement activities and a statewide school survey to describe the landscape of SUMHS practices, perceptions, and barriers in California schools; and
- Present a set of recommendations to guide future budget and policy considerations for implementing SUMHS as part of California's broader youth behavioral health care ecosystem.

Enclosure (1):SUMHS draft report: *Counting what Counts – Data Driven Prevention through School-Based Universal Mental Health Screening*

Handouts (1): The presentation will be supported by PowerPoint slides.

Proposed Motion: That the Commission approve the School-Based Mental Health Screening Legislative Report.

Counting what Counts

Opportunities for School-Based Universal Mental Health Screening (SUMHS)

Report to the Legislature from the Mental Health Services Oversight and Accountability Commission

Acknowledgements

Commission Chair: Mara Madrigal-Weiss, MA, San Diego County Office of Education

Commission Staff Lead: Kali Patterson, MA, Policy Research Supervisor

Commission Staff Support: Kai LeMasson, Ph.D., MHSSA Lead; Sara Yeffa, Communications Strategist

Contributing Authors: Stephanie Moore, Ph.D., University of California, Riverside; Sara Geierstanger, MPH, & Samira Soleimanpour, MPH, Ph.D., University of California, San Francisco; Natalie Romer, Ph.D., WestEd

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Executive Summary

California's Commitment to Youth Behavioral Health

Half of mental health conditions begin before age 14; 75 percent by the age of 24.[1] Identifying and supporting a person's mental health needs early in life can greatly improve outcomes and yet, on average, a child waits 11 years before receiving mental health services.[2] In the U.S., unaddressed mental health challenges are among the largest reported obstacles to learning for students, and can greatly impact social, educational, and health outcomes later in life. This gap presents tremendous opportunities for innovation, and California is rising to the challenge.

Through historic investments in service delivery, workforce, infrastructure, and public awareness, California is building a behavioral health care ecosystem that prioritizes prevention, early access, and equity. The State's approach sees schools as vital touchpoints in this ecosystem and universal screening is an important tool to help schools succeed.

School-based universal mental health screening (SUMHS) is a proactive assessment of all students' mental and behavioral health risks and strengths.

Much like the routine health screenings most students already complete such as hearing, vision, and fitness, SUMHS aims to identify potential challenges early so students can receive support before these challenges significantly impact their health, behavior, and ability to learn.

SUMHS is part of a comprehensive, multi-tiered system of supports (MTSS) designed to ensure students receive appropriate interventions at the right time, whether they need universal programs or targeted help.[3]

The potential benefits are enormous: reducing stigma, increasing help-seeking behavior and access to care, and ultimately, saving lives and dollars. But significant challenges remain. Concerns about school capacity, the stigma of mental health labels, and the need for adequate follow-up services have raised questions about how to implement SUMHS responsibly. Without sufficient resources and clear guidance, schools may struggle to provide the support students need after being identified.

For SUMHS to succeed, schools must be equipped with adequate staff, training, and partnerships with community agencies. These elements are foundational to all of California's existing initiatives focused on developing comprehensive school mental health systems.

Through the California 2023-24 Budget Act, the Legislature requested the Mental Health Services Oversight and Accountability Commission conduct a landscape analysis and deliver a

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report on universal mental health screening for youth, with attention on data, best practices, and costs for implementing screening in K-12 school settings.

This report summarizes the Commission's findings and presents a set of recommendations to address gaps in knowledge and practice for implementing school-based universal screening in support of California's broader goals and investments for youth mental and behavioral health.

Findings and Recommendations

Finding 1: Evidence supports the use of school-based universal mental health screening to improve students' wellbeing and ability to learn; yet without leadership, guidance, and standards, implementation varies in California and elsewhere.

Despite recommendations from major educational and health authorities, only 6 to 13 percent of U.S. schools have implemented SUMHS. In California, many schools have started using SUMHS, but practices vary due to the lack of consistent standards for planning, implementation, and data collection. Schools interested in adopting SUMHS often struggle with a lack of guidance on where to begin, making it difficult to fully assess its impact and effectiveness across districts.

Recommendation 1: California should designate a state leader charged with aligning youth behavioral health partners and workstreams to implement a statewide strategy for comprehensive school mental health systems in California's K-12 settings.

This strategy should include a community partner-informed process to develop standards and guidance for successful implementation of SUMHS within schools' multi-tiered systems of support.

Finding 2: Myths are driving the narrative around SUMHS, reinforcing stigma, fears, and mistrust that hinder progress for school-based mental health.

Lack of buy-in from teachers, parents, and students is one of the main reasons schools are choosing not to implement SUMHS. Most concerns about SUMHS are rooted in stigma and a general misunderstanding about what SUMHS is and how it is used.

For students and parents, concerns around labeling and discrimination about mental health needs are ever present, as well as tensions regarding parental and student rights to consent and confidentiality. Such concerns can create a culture of mistrust and discourage student and parent participation in school-based mental health screening and services.

Meanwhile, confusion about what SUMHS is and how it is used only reinforces negative perceptions about SUMHS. Definitions and language used to describe SUMHS are inconsistent

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and often misrepresent the goal and utility of universal screening. The lack of information and public awareness means that myths are driving the narrative and decisions about SUMHS.

Real or perceived, concerns and fears among students, parents, and teachers point to the need for greater outreach and education to gain the trust and buy-in necessary for effective SUMHS.

Recommendation 2: To ensure success of its school-based behavioral health strategy California must do more to improve the mental health culture and climate in schools and diminish the stigma and fear associated with screening and seeking mental health support.

As part of this effort, the State must invest more in supporting the mental health needs and competencies of teachers and school staff, and help schools strengthen participation, buy-in, and trust in school-based behavioral health services.

Finding 3. Capacity barriers are outweighing the benefits of SUMHS. Schools need resources and technical support to use SUMHS effectively.

The majority of school representatives engaged by the Commission expressed broad support for the use of SUMHS. Yet, many schools are already stretched thin and worry that they do not have the capacity to implement SUMHS. Capacity barriers underlie many of the ethical and legal concerns about implementing SUHMS, as schools fear they may not be able to respond to identified student needs when those needs exceed available resources. Youth, parents, caregivers, and school staff alike emphasized the need for more resources – workforce, services, data systems, and funding – for schools to be able to effectively identify and support students' mental health needs.

Recommendation 3: In support of the statewide school behavioral health strategy, California must engage with local education and behavioral health partners, as well as students and their families, to assess and address capacity needs for implementing comprehensive school mental health standards, including mental health screening.

The State should provide incentives and resources to support the planning, testing, and scaling of effective SUMHS practices in California, as well as infrastructure and resources to support implementation of SUMHS in alignment with California's broader youth behavioral health investments.

As California faces the next chapter in its youth behavioral health strategy, it must consider how it will sustain the momentum and progress made and bring to fruition its vision to improve the behavioral health and wellbeing of California's current and future young people.

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Now is the time to assess where SUMHS fits within the broader youth behavioral health ecosystem, and this report is intended to guide that work.

Introduction

The Youth Mental Health Crisis Puts a Spotlight on Schools.

Most mental health challenges emerge before age 24, affecting as many as one in five U.S. children and youth each year, a number that has steadily increased in the past decade.[4] [5]

Despite investments in services and research demonstrating the importance of early intervention, the mental health needs of young people are increasingly underserved.[6] Recent data reveals that the majority of Californians under the age of 18 with an existing mental health challenge are not receiving services or support, placing them at increased risk for negative outcomes throughout their lifetimes.[7] Meanwhile suicide has become the second leading cause of death among youth ages 10-24 nationwide.

Unmet mental health needs are impacting students' ability to learn and thrive. When asked about the biggest challenges facing youths' mental health, high schoolers in a focus group said that today's young generation is struggling to stay mentally healthy while dealing with ever-increasing pressures in school and in their personal lives. They report feeling lonely, unheard, and unseen and do not know where or how to get support. Many said they feel shame or embarrassment about their mental health, sometimes among their peers and sometimes in their home.

California's Youth are in Crisis

1 million K-12 students are at risk of developing a mental health challenge.

42% of 11th graders report chronic sadness and hopelessness.

65% of youth mental health challenge are not supported.

3 in 20 secondary students seriously considered suicide in the past 12 months.

527 California youth died by suicide in 2020.

1 in 4 K-12 students were chronically absent during the 2022-2023 school year.

The COVID-19 pandemic exacerbated what was already a steady decline in youth mental health. Between 2011 and 2021 alone, the percentage of U.S. high school students reporting poor mental health increased from 28 to 42 percent.[8] [9] In 2020, California had 527 young people die by suicide – almost half of these occurred before the age of 20.[10]

Families are desperate for mental health support in schools. Parents and caregivers during listening sessions said they are worried about the future and safety of their children but feel

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alone and that they do not have the resources to help them. They also feel like systems have failed them and many are losing trust in education and health care systems. Nationally, 87 percent of U.S. parents and caregivers of school-aged children say they support mental health services in school.[11] In a 2023 survey, mental health was the number one reason parents decide to switch their student to a new school, ranking higher than academic concerns.[12]

Educators and school administrators have also felt the consequences of unaddressed mental health needs among their students, especially after the COVID-19 pandemic. School attendance is at an all-time low across California, contributing to funding concerns for many schools that are already struggling with limited resources.[13] Meanwhile, increases in disruptive behaviors and learning difficulties are making it harder for teachers and staff to do their jobs, leading to stress, burnout, and staff turnover.[14] In a 2022 U.S. survey, 73 percent of K–12 teachers and 85 percent of principals reported experiencing frequent job-related stress – about twice as high as other professions.[15] During the 2022-2023 school year, 23 percent of teachers said that they were likely to leave their job. [16]

Increases in substance abuse,[17] self-harm, and suicide among students are turning many campuses into crisis response centers, causing trauma for students and staff exposed.[18] One principal said “I’ve seen 10-year-olds in the bathroom trying to cut their wrists. I realized that doing something different was not a choice, because either way, we’re dealing with students’ mental health. I’d rather do it in a way that helps them before it’s too late.”

Together, these firsthand accounts and data points underpin what many experts are calling a national state of emergency for youth mental health. In a joint statement, the American Academies of Pediatrics and Child and Adolescent Psychiatry and the Children’s Hospital Association called on policymakers at all levels to ensure “all families and children, from infancy through adolescence, can access evidence-based mental health screening, diagnosis, and treatment.*I*[19]

This harrowing reality of the youth mental health crisis has forced leaders to re-think behavioral health care models, putting a spotlight on the critical role of schools.

Schools are a Cornerstone of California’s Youth Behavioral Health Strategy

Under Governor Newsom’s administration, California has made a landmark commitment to better serving the behavioral health needs of children through its Master Plan for Kids’ Mental Health.[20] This multi-year investment works across systems and disciplines to build an integrated behavioral health care ecosystem capable of providing a full continuum of prevention, early intervention, and crisis services and support to all children, youth, and

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families when, where, and in the way they need it most. California's framework recognizes the critical role of school-based mental health within this broader ecosystem.[21] This unprecedented time of transformational mental health systems change in California presents a significant opportunity to undertake the important work of identifying and implementing data practices and systems, including mental health screening, that advance mental health equity.[22]

Schools offer Convenience, Community, and Context for Identifying and Supporting Student Needs

Like many health and learning needs of students – such as hearing, vision, and reading skills – schools provide a natural and logical setting for preventing, identifying, and supporting young people's mental health needs early, which is crucial to improving outcomes. [23]

Although mental health screening and services can and should occur in clinical care settings, it has been reported that many youth under 18 face barriers to accessing routine medical care such as annual well child visits.[24]Children spend most of their time at school -– services should be offered where kids are.

In addition to proximity schools also offer community and context. Schools are uniquely positioned to provide information, safe environments, and nurturing relationships that reduce risk and promote resiliency.[25] Unlike clinical settings which are not equipped to address contextual risk factors impacting students' mental health (e.g., food insecurity, housing instability), schools possess the infrastructure and partnerships to provide and/or facilitate access to community-based supports.[26]

For all of these reasons, schools are considered an optimal setting for providing routine and proactive screening and assessment of all students' mental and behavioral health needs, also referred to as School-Based Universal Mental Health Screening (SUMHS).[27]

The Universal Mental Health Screening Project and Report

Through the California 2023-24 Budget Act, the Legislature requested the State's Mental Health Services Oversight and Accountability Commission to conduct a landscape analysis and deliver a report on universal mental health screening policies and practices in schools settings, with attention on data, tools, and costs for implementation.[28]

Under the direction of the Commission, and in collaboration with the Legislature, California's Children and Youth Behavioral Health Initiative, California's Department of Health Care Services, community members, and education and behavioral health partners, the

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Commission conducted a robust research and engagement process to inform the present report. In the following sections, this report aims to:

- Establish key definitions, concepts, and evidence relevant to SUMHS;
- Summarize findings from public engagement activities and a statewide school survey to describe current SUMHS practices, perceptions, barriers, and opportunities in California K-12 schools; and
- Present a set of recommendations to guide future budget and policy considerations for implementing SUMHS as part of California's broader youth behavioral health care ecosystem.

A Primer on School-based Universal Mental Health Screening

School-based Universal Mental Health Screening Defined

School-based universal mental health screening (SUMHS) is the proactive assessment of <u>all students</u>' mental, behavioral, and relational health risks and strengths.[29]

Establishing a common language and shared understanding is essential to the success of SUMHS.

A universal screener is a brief assessment given to all students to help identify which students are at risk for academic and non-academic difficulties.[30]

Common examples in schools are vision screenings and hearing screenings. The logic in providing these screenings in schools is that students learn best when they can see and hear. While we could rely on educators to notice when a child is squinting to see the board or when a child is asking for directions to be repeated, we know that it is better to not wait until the child has missed instruction, so schools perform screenings and intervene early.

The same logic holds for mental health screening. A child's ability to thrive and learn is hampered when they are experiencing a mental health challenge.[31] Teachers alone cannot be expected to notice all the small – and sometimes invisible – signs of a child's mental health needs. [32]

Definition of Mental Health

Mental health encompasses a person's emotional, psychological, and social wellbeing. It affects how they think, feel, learn, and act, and is an essential component of their overall health.

For children, good mental health helps them cope with difficulties, build friendships, and make positive choices. Conversely, poor mental health in children and youth can lead to issues like anxiety, depression, and behavior challenges, affecting their growth, learning, and relationships.

Mental health is a "springboard of thinking and communication skills, learning, emotional growth, resilience, and self-esteem."

– U.S. Surgeon General's Report on Mental Health, [illegible]

By focusing on both risks and strengths, SUMHS helps schools support a range of student needs by informing school-wide policies and programs that promote mental wellbeing and address environmental factors that put students at risk for various mental health problems.[33]

Common Questions

What are schools screening for?

SUMHS tools can be used to screen an array of risks and strengths, depending on the student's age and purpose of screening.[34]

Mental health risk examples:

- Externalized behaviors (e.g., self-injury and aggression)
- Internalized behaviors (e.g., anxiety, depression, withdrawal, and isolation)
- Contextual or situational risk factors (e.g., economic hardships, abuse, divorce of a parent, or extreme loss)

Mental health strength examples:

- Resiliency traits: (e.g., executive functioning, social and emotional intelligence, coping strategies)
- Contextual or situational protective factors (e.g., the presence of a caring and consistent adult in the home, access to health care and other resources that promote wellbeing).

Who is involved?

Screening practices are led by a diverse team that reflects the school community and has expertise in student mental and behavioral health assessment and intervention. In addition to health professionals, parents, teachers, and staff are engaged throughout the planning and implementation process including the review of screening data. Screening can be administered by teachers during devoted classroom time, by parents, or by other trained health or behavioral health professionals during the school day. Depending on the age of the student, parents are required to provide consent for their student to be screened. [35]

When does screening occur?

Universal screening occurs at least once during the school year, usually during the first quarter of instruction. However, depending on the goal of screening, some schools may choose more frequent screening. For example, a school may elect to screening at the beginning (fall), middle (winter), and end (spring) of a school year. [36]

How is screening data used?

Universal screening helps schools understand a range of student needs and make informed decisions to help each student achieve personal and academic success.[37] Screening data can be used to:

- Identify students at risk for emotional or behavioral difficulties.

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- Identify students performing at or above healthy levels of functioning.
- Establish a benchmark for measuring the improvement of a group, class, grade, school, or district (i.e., a reduction in the percentage of students identified to be at risk for behavioral difficulties)

Dispelling Myths about SUMHS

Despite its potential, myths are driving the narrative around school-based universal mental health screening. Establishing a common language and shared understanding is essential to the success of SUMHS. In addition to defining key features, it is also important to clarify what SUMHS is not.

SUMHS is NOT:

- **Diagnostic:** Universal screening is not used to diagnose or make high-stakes decisions, such as for crisis intervention or special education services.
- **Anonymous:** Universal screening does not only assess school-wide trends (i.e., Healthy Kids Survey), but also collects identifiable information so that schools support students with higher needs.
- **Redundant:** Schools cannot identify students with mental health challenges based on behavioral or academic challenges alone.
- **Stigmatizing:** Universal screening does not result in in excessive "labeling" or put children "in a box."
- **Costly:** Universal screening is not overly time consuming and expensive for schools to administer.
- **Isolated:** Universal screening is not intended to replace other types of screening and services, but instead is one part of a continuum of strategies to identify and support students' needs.

SUMHS IS:

- **Preventive:** Universal screening assesses risks and strengths to inform the development and monitoring of MTSS strategies that improve behavioral, health, and educational outcomes.
- **Precise:** Universal screening uses objective and contextual data rather than relying on staff referral or overt behaviors.
- **Destigmatizing:** Universal screening helps normalize mental health needs and support-seeking behavior.
- **Confidential:** Universal screening adheres to strict data privacy laws and policies.
- **Equitable:** Universal screening reduces mental health and educational disparities, especially for historically underserved students and their families.
- **Cost effective:** Universal screening requires investments in planning and resources, but results in cost savings by improving student outcomes and driving systems level change.
- **Integrated:** Universal screening is most effective when implemented within a proactive and adequately resourced comprehensive school mental health system.

SUMHS is Part of a Comprehensive School Mental Health System

Universal screening is one of eight core features of a comprehensive school mental health system, a framework and set of guidelines developed by the National Center for School Mental Health to help schools promote positive school climate, social and emotional learning, and mental health and wellbeing, while reducing the prevalence and severity of mental illness.[38]

Comprehensive school mental health systems work by integrating education, behavioral health, family, and community partners into a single, efficient, and equitable service delivery system).[39] School mental health systems work when each of its core components are in place and integrated. Therefore, SUMHS supports a comprehensive school mental health system *and* is dependent on that system to be most effective.[40]

Core Features of a Comprehensive School Mental Health System

MENTAL HEALTH SCREENING
Proactive universal and targeted assessment of risks, strengths, and needs

EVIDENCE-BASED AND EMERGING BEST PRACTICES

WORKFORCE
Well-trained educators and specialized support personnel

SUSTAINABLE FUNDING
Leverage and apply various financial and nonfinancial resources

DATA CAPABILITIES
Data systems, data outcomes, and data-driven decision-making

THOUGHTFUL PLANNING
Needs assessment and resource mapping

COLLABORATION AND TEAMING
Student, family, school, community

MULTI-TIERED SYSTEM OF SUPPORT
Wellness promotion, prevention, early intervention, and crisis response

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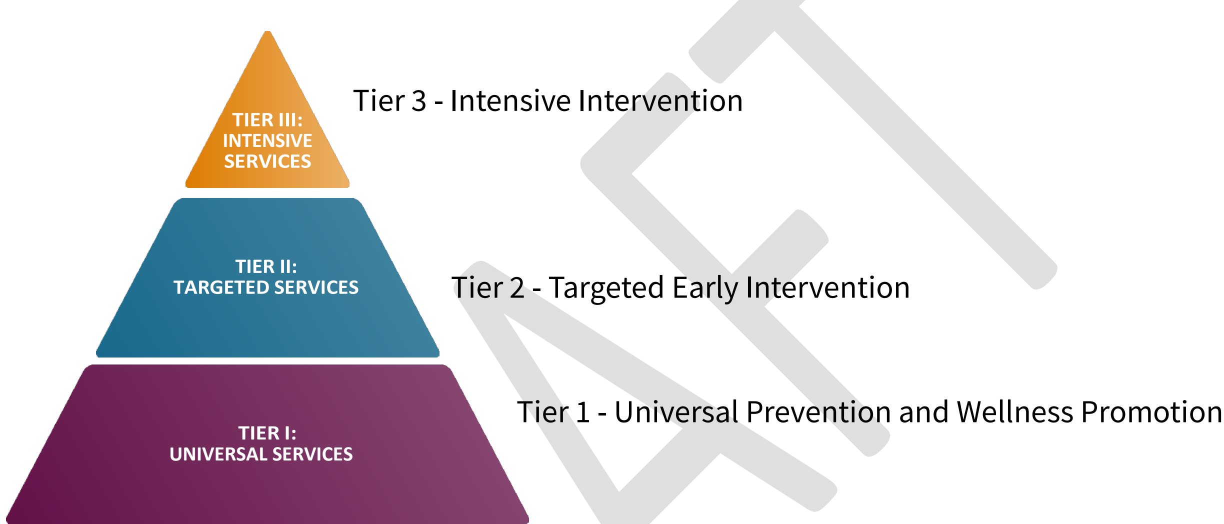
SUMHS Data Informs Multi-tiered Systems of Support

Another core component of a comprehensive school mental health system is the use of **multi-tiered systems of support (MTSS)**.[41] Many schools and districts across the U.S. and California are already using MTSS to coordinate systems and services to address different levels of students' academic, behavioral, and social and emotional needs.[42]

The MTSS framework mirrors a public health approach to promote student well-being by identifying three "Tiers" of supports:



In a well-implemented MTSS, most students would receive Tier 1, universal school-wide and classroom-based wellness promotion and mental health prevention support. Fewer students would receive Tier 2, targeted early intervention services, which may include small group or individual programming. Even fewer students would receive Tier 3, intensive individualized services.[43] For conceptual examples of how services in each tier might work, see Appendix II: Fictional Examples of SUMHS Application.

An MTSS approach leverages student and school-wide data to inform and evaluate a full continuum of prevention, early intervention, and intensive services. Universal screening data are an important part of this continuum, acting primarily as a school's early warning system and are *not* intended to diagnose students.[44]

Table 1 depicts a continuum of assessment within an MTSS in which the intensity (breadth and depth of assessments and data) informing intervention decisions increases at each tier.

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Table 1: Data-informed Multi-Tiered Systems of Support

Level of intervention	Type of services	Type of assessment
Tier 1	**Universal Prevention and Wellness Promotion** Supports, services, and assessments are provided to all students in alignment with students' strengths and needs.	**Universal Screening** Data are used to assess trends and patterns across the school population or specific subpopulations (e.g., third graders, one classroom, boys, race/ethnicity).[45]
Tier 2	**Targeted Supports and Early Intervention Services** Provided for some students who show signs or risk of developing mental health needs or who could benefit from strength or resource-building supports.	**Universal Screening and/or Targeted ("second gate") Assessment** Universal screening can identify high risk students. Additional screening or assessment may be administered to identify individual needs or rule out diagnosis. [46]
Tier 3	**Intensive Services** Services provided to the students with the most intensive mental health needs.	**Clinical Evaluation or Individual Assessment** Used to determine diagnosis and inform tailored intervention.[47]

SUMHS Implementation

SUMHS is most effective when implemented within a proactive and adequately resourced comprehensive school mental health system.

Preparing for and administering SUMHS within a school/district's MTSS requires a substantial and sustained investment of time, resources, and partnerships – features which correspond with a comprehensive school mental health system. (A list of guidance documents can be found in Appendix II: SUMHS Resources).

Table 2 provides an overview of SUMHS best practices organized by the eight components of a comprehensive school mental health system.

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Table 2: SUMHS Best Practices by Comprehensive School Mental Health System Components

Comprehensive School Mental Health System Component [48]	SUMHS Best Practices [49,50]
Thoughtful Planning	• Informed by a robust planning process, including a needs assessment and asset mapping, to ensure screening practices and procedures are ethical, equitable, and aligned with school goals and capabilities.
Workforce	• Led by a diverse team that reflects the school community and includes expertise in student mental health assessment and intervention. • Requires devoted staff time and training to implement screening and follow-up procedures.
Family-School-Community Collaboration	• Conduct outreach and engagement to build trust, buy-in, and collaboration with families, students, and community partners. • Ensure school, family, and students clearly understand the procedures and purpose of screening. • Proactively obtain appropriate parent/guardian consent and youth assent.
Mental Health Screening	• Universal screening alongside targeted screening and assessment for at risk students. • Screening tools and measures are psychometrically validated and selected based on appropriateness, utility, and technical adequacy for the intended population.
Evidence-Based and Emerging Best Practices	• Screening practices are culturally, linguistically, and developmentally relevant, and selected with input from the broader school community. • Screening is followed by clear and efficient follow-up processes and pathways to connect students and their families to appropriate,

	high-quality school and/or community-based care to support their mental and behavioral health needs.
Multi-Tiered System of Support	• Screening data are combined with student and family input and other data sources to inform decisions across MTSS tiers to support a range of student needs through prevention, early intervention, and linkage to intensive care. • Screening data are monitored as part of a continuous improvement processes to evaluate and augment implementation of metal health and behavioral supports over time.
Data Systems and Data-Driven Decision-Making	• Screening and support services are supported by integrated, responsive, and secure data systems and policies to ensure clear, consistent, and timely sharing of screening data with relevant community and school partners. • Developed in consultation with legal and data-system administrators to ensure adherence with relevant privacy laws and data sharing policies.
Sustainable Funding	• Short-term investments are needed for planning, capacity building, and piloting of SUMHS. • Reliable financial and/or non-financial resources are necessary to secure staffing, MTSS services, and data infrastructure to support SUMHS.

Considerations for Ethical and Equitable Screening

Screening is only helpful if it leads to better outcomes. Universal mental health screening can provide valuable information when conducted as part of MTSS but may not be the solution for every school/district.

Implementing SUMHS effectively includes proactive and ongoing efforts to address what can, at times, be complex considerations.[51] First, identifying students without offering support could be harmful; therefore, schools must ensure they have adequate referral pathways and services in place. Additionally, securing teacher buy-in is crucial, as is obtaining parental consent, both of which can be challenging due to the stigma and misconceptions about universal mental health screening.[52] Parents may fear that mental health labels could lead to their child being bullied or isolated by peers, or even treated differently by educators.[53] Furthermore, cultural differences can affect the accuracy of screenings especially when screeners are not tailored to diverse populations. Poorly selected screening procedures can lead to "false positives," where screening results inflate student's actual risk – or worse, "false negatives," allowing students to slip through the cracks.[54] Below are ways schools can avoid potential pitfalls when implementing SUMHS.

Planning for SUMHS

SUMHS practices must be informed by a robust planning process, including needs assessment and resource mapping, to ensure screening practices and procedures are ethical, equitable, and aligned with school goals and capacities.[55]

During the planning phase, schools should address the following:

- What are the goals of screening?
- What procedures are appropriate and who should do it?
- What resources are available and what are potential barriers?
- How will schools avoid doing more harm than good in the process?

Ethical and legal considerations

Planning and implementing SUMHS should involve ongoing collaboration with legal experts to ensure SUMHS practices adhere to ethical[56] and/or legal guidelines. [57]

The ethical and legal considerations associated with SUMHS include but are not limited to:

- Family rights, such as privacy
- Acceptability and stigma associated with mental health services and screening
- Selection of SUMHS instruments that are technically adequate, contextually appropriate, culturally and linguistically inclusive, feasible, and have utility

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- Recognition of the limitations of SUMHS data
- Responsibility for responding to identified student needs while potentially exceeding the school's resources or how supports are provided.
- Parent/guardian consent and student assent procedures
- Data use and access policies

Start small, adapt, and scale

When implementing SUMHS, school teams are encouraged to start "slow" or "small".[58] Beginning with small-scale pilots – for example, screening with just one grade level (e.g., all fifth graders) or at important transition points (e.g., ninth grade) – allows schools to trial their procedures and obtain valuable feedback for quality improvement.[59] Starting SUMHS on a small scale gives schools the time to assess resource demands and to build buy in and trust from staff, parents, and students before rolling out SUMHS more widely.[60]

"... Considering [...] the impact of social determinants of health on educational and mental health inequities, it is imperative to re-envision how we approach mental health screening in schools to center equity [...] Equity-focused mental health screening requires a shift from individual- and deficit-focused approaches to systems- and holistic-focused approaches that (a) identify strengths and stressors among individuals, groups, and communities, (b) dismantle structural forms of oppression (c) promote positive mental health outcomes for minoritized youth..."

-Excerpt from A Roadmap to Equitable School Mental Health Screening [61]

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SUMHS Drives Equity and Improves Outcomes for Students – Saving Lives and Dollars

Done effectively, proactively identifying and responding to student mental and behavioral health needs through a systematic universal screening process has multiple advantages. When implemented as part of an equity-centered MTSS, SUMHS supports early individual identification and population-level (e.g., school, district, county-wide) monitoring, reduces bias and stigma, and promotes more positive and equitable outcomes, ultimately saving lives and dollars.[62]

Removes bias

Traditional methods for identifying students with behavioral or mental health needs, such as staff nomination or reviewing attendance or disciplinary records, typically identify students based on visible behaviors that are considered "problematic." Such approaches are not only subject to bias but also overlook students whose needs are less noticeable but equally acute (e.g., internalizing depression or anxiety symptoms).[63] In contrast, the systematic and proactive nature of SUMHS processes can reduce bias in the identification process[64] and help schools support students much earlier – *before* problem behaviors occur – thereby reducing disparities in youth behavioral health care access and outcomes. [65]

Reduces disciplinary and special education strategies

Research has shown that an overreliance on behavioral referrals in schools can lead to unnecessary disciplinary actions and/or special education referrals in lieu of mental health supports.[66] This is especially true for racially and ethnically minoritized students whose behaviors are more likely to be interpreted as "problematic" by teachers and staff compared to their white peers.[67] Proactively assessing and supporting students' needs via SUMHS may reduce the need for punitive strategies[68] and special education resources, while also addressing mental health and academic inequities among historically marginalized youth.[69]

Comprehensive and holistic

Mental health and academic disparities are driven largely by factors such as access to healthy foods, housing, safe neighborhoods, and health care, and exposure to racism and discrimination, also referred to as the social determinants of health.[70] Educators often see the academic and behavioral challenges associated with these factors, but may not recognize the underlying causes.[71] Implementing SUMHS provides a strategic opportunity for schools to identify contextual factors contributing to a student's mental health risk. Providing this perspective to teachers and staff not only promotes empathy and understanding of students'

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behavioral and academic challenges, but also helps schools intervene and provide resources to address factors contributing to student disparities.[72]

Cost effective

Administering SUMHS is inexpensive, but requires investments in staffing, resources, and infrastructure tied to a robust service network to be effective. While dollar-for-dollar comparisons between universal mental health screen and other referral strategies are limited, those that exist point to screening's improved cost-effectiveness over other identification methods.[73] Evidence also suggests that implementing universal mental health screening as part of a school-based prevention-oriented intervention model, such as MTSS, may reduce schools' financial burden by as much as 20 percent compared to traditional referral approaches.[74] By promoting prevention and early identification, SUMHS has the potential to stop mental health challenges from becoming severe and disabling[75] and, thereby, reduce overall mental health service costs. When used within a school's MTSS, this can translate to downstream benefits,[76] such as fewer referrals for special education, reduced need for intensive psychiatric care, and fewer mental health crises.[77] In the long run, prevention and early intervention services help reduce the widespread consequences and societal costs of unaddressed mental health needs such as homelessness, addiction, incarceration, and suicide.[78] A 2022 global analysis[79] revealed a $24 return for every $1 invested in mental health prevention and early intervention programs among adolescents. Among the interventions studied, universal school-based prevention strategies were the most cost-effective, resulting in a $147 return for every $1 spent.[80]

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The Landscape of School-based Universal Mental Health Screening

As schools across the U.S. evolve their capacity to support the mental and behavioral health needs of children and youth, universal mental health screening has become a focus of policy and practice for school-based mental health systems. Consistent with national trends, California is exploring opportunities for school-based universal mental health screening (SUMHS) within its broader youth behavioral health strategy.

Landscape Analysis

Under the direction of the Legislature, the Commission contracted with researchers from the University of California, San Francisco, the University of California, Riverside, and WestEd to conduct a Landscape Analysis of existing SUMHS practices, perceptions, and barriers in California's K-12 system.

While the landscape analysis is not exhaustive nor representative of all schools' or stakeholders' perspectives, it represents one of the first inquiries into SUMHS practices in California and provides key insights to inform future implementation and state-level guidance.

Findings have been organized by the following sections:

1. Current policies and practices
2. Awareness, perceptions, and buy-in
3. Capacity barriers and resource needs
4. Opportunities within California's youth behavioral health ecosystem

Landscape Analysis Activities

Literature Review:
A comprehensive review of the literature to understand current research on SUMHS implementation and best practices.

Statewide School Survey:
A voluntary survey was administered to assess screening practices among California schools and districts, including those schools not currently screening. The survey was completed by 443 local education agencies (LEAs) representing 55 of California's 58 counties.

Site Visits:
The Commission conducted four site visits in San Diego, Sonoma, Yolo, and Riverside counties to inform case studies of schools modeling SUMHS practices. (Site visit summaries are provided in Appendix I)

Qualitative Analysis:
Data was collected through interviews and virtual listening sessions to understand the perspectives and experiences of students, parents, and schools.

Refer to Appendix IV for a detailed description of landscape analysis activities.

1. Current Policies and Practices

Evidence supports the use of school-based universal mental health screening to improve students' wellbeing and ability to learn, yet without leadership, guidance, and standards, implementation varies in California and elsewhere.

The American Academy of Pediatrics recommends routine mental health screening for all children from birth through age 21, and the U.S. Preventive Services Task Force recommends that universal mental health screening occur in the same settings where physical health screenings occur. Schools are one of such settings, and because of this, school-based universal mental health screening has been recommended by major U.S. education and health authorities to support school-based mental health support systems.[81]

Although SUMHS has shown great promise, implementation has been limited and varied in the U.S. While universal screening for health or academic domains is standard practice in at least 81 percent of U.S. public schools, screening mental health or behavioral domains is only occurring in 9 percent of schools.[82] When schools are conducting SUMHS, research shows wide variability in implementation practices and policies.[83] In California, there are no existing policies or standards for implementing or monitoring SUMHS in K-12 settings, which makes it challenging to describe statewide practices. The following is a preliminary summary of SUMHS practices assessed through a statewide survey and follow-up interviews with local education agencies (LEAs).

Schools Implementing SUMHS

Nearly half of the schools or districts represented in the statewide survey are implementing SUMHS.

During follow-up interviews, LEA survey respondents described why their schools/districts are implementing SUMHS. For example, one LEA said, "[Because] we know kids are falling through the cracks, and we want to find ways to ensure we are supporting all students." Others said they are using SUMHS "to use data to identify students who need more assistance" and "to better direct and support mental health resources."

School Survey Highlight

Percentage of Schools Screening

443 surveys were completed by LEA representatives from 55 counties.

43% are implementing SUMHS
43% are not implementing SUMHS

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Screening Procedures

Who is Being Screened: Half of the survey respondents who reported conducting universal mental health screening were at LEAs that screened all students, while the second largest group was those at LEAs that screened specific grade levels.

School Survey Highlight

Screening by Grade Level

15%	Alternative or continuation
48%	Elementary
45%	Middle/intermediate/junior high
36%	High school
6%	Other

Respondents can choose multiple options, so percentages do not add up to 100%.

Screening tools: Overall, LEAs are using a wide variety of tools through their screening efforts, some of which are available without charge, others that are proprietary screeners owned by publishers, and several that were developed by districts/schools. While tools vary greatly, most are collecting information about students' behavioral or emotional challenges and strengths or wellbeing. Many are also collecting information about students' social skills or social-emotional competencies.

While most (58 percent) of screening tools were evidence-based, a surprising 18 percent of schools currently implementing SUHMS were administering screening tools developed by the school or district, and 24 percent were unaware of the specific tools used.

School Survey Highlight

Screening Focus Areas

78% Behavioral or emotional challenges
(e.g., acting out, stress, anxiety, depression)

75% Emotional or behavioral strengths or well-being
(e.g., social and emotional literacy, school connectedness, belonging)

56% Social skills
(e.g., communication, cooperation, responsibility)

7% Other
(e.g., academics, suicide risk, school climate)

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Administering screening tools: Among those who reported conducting SUMHS, most (66 percent) reported that students completed the screening tool, 38 percent reported that teachers completed the tool, 16 percent were completed by mental health professionals, and 11 percent were completed by parents/caregivers.

Consent: Over half allow parents/guardians to opt their children out of screening, seven percent required parents/guardians to opt their children in.

Equity: Most respondents who were conducting universal mental health screening reported using at least one strategy to center equity in their screening processes. Half (51 percent) focus on culturally responsive school-wide supports, 39 percent analyze disaggregated data to identify and address disparities, 34 percent provide screening tools in the primary language of students/families, and 34 percent include diverse voices in decisions about the screening process. There is room for growth to ensure that all LEAs are incorporating each of these strategies in their work, especially given that 15 percent of respondents reported not using any of these strategies.

Costs and Funding: Only 16 respondents said they were familiar with the costs of implementing SUMHS which ranged from no cost to hundreds of thousands of dollars when accounting for all staff and materials involve during screening and follow-up processes. Local Control Funding was the most common funding source, and many also reported using grant/foundation funds to support SUMHS.

SUMHS within a multi-tiered system of support (MTSS): Many LEAs are intentionally integrating SUMHS into their MTSS. For example, one staff member described how their district mental health team – which includes their school psychologist, mental health counselor, superintendent, family resource center director, two principals, and community behavioral health partners – meet monthly to discuss results of their universal screening. The school psychologist and mental health counselor follow up with those whose results are designated as "moderate and severe or moderate and high scoring." Their team also uses data from their screener to inform universal programming and early intervention efforts: "We go through all the results of the screenings and look for places where someone might need individual services or if there's more Tier 2 small groups can be implemented. Also, if we're seeing sort of a trend across the board, then working on what we can bring into the classrooms in a more Tier 1 universal response … at that point [we] would bring those results and either just talk about trends, or if there are specific families that need things, we can collaborate on that."

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Schools Not Implementing SUMHS

Among the 443 LEAs represented in the School Survey, 43 percent said their school/district was not implementing SUMHS. When asked what they are currently doing to identify students who need mental health supports, 79 percent said they rely on staff referrals, and only 18 percent said such approaches were adequate.

Even with a definition provided to survey respondents, 14 percent of LEAs who participated said they were not sure if SUMHS had been implemented in their schools/districts, and several LEAs who reported using SUMHS were actually using screening practices that did not meet the survey definition of SUMHS.

School Survey Highlight

Schools are asking for guidance and support to implement SUMHS eűectivelyz

LEAs identified what schools needed to support SUMHS implementation:

65% Technical assistance for planning and implementation
55% Direction from district leadership
43% State-level policy requiring screening
43% State-level policy providing standards

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2. Awareness, Perceptions, and Buy-in

Myths are driving the narrative around SUMHS, reinforcing stigma, fears, and mistrust that hinder progress for school-based mental health.

Findings from the Landscape Analysis indicate that school staff, youth, and parents/caregivers recognize the potential of SUMHS to benefit their communities. These benefits include supporting population-level prevention and early identification of student needs, as well as promoting mental health awareness and reducing stigma, each of which contributes to efforts to a healthier school climate. Although most expressed favorable views of SUMHS, staff, students, and parents were clear that lack of awareness and buy-in from communities affect a school's ability to implement SUMHS effectively. Most concerns about SUMHS can be traced back to a lack of understanding about what SUMHS is and how it is used. Such concerns underscored the importance of meaningfully involving staff, youth, and families in designing and conducting SUMHS practices.

School Survey Highlight

SUMHS are widely endorsed yet underutilized due to perceived concerns in the school community.

92% *of LEAs - including those who were and those who were not conducting SUMHS - agree that implementing SUMHS would benefit students, staff, and school communities.*

LEAs that were not conducting SUMHS indicated that concerns from parents/community members (58%), school staff (59%), school/district leadership (46%), or students (40%) would limit their screening efforts.

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Perceived Benefits of SUMHS

- **Promotes early intervention**: SUMHS helps LEAs identify and respond to school population trends with Tier 1 services and connect students with additional needs with the appropriate level of support.
- **Identifies unaddressed needs**: SUMHS helps LEAs identify and support students who "fall through the cracks" with traditional methods. Schools are proficient at identifying students with externalizing behaviors which disrupt classroom flow, but SUMHS can bring forth those with internalizing behaviors which are not apparent in a classroom setting.
- **Promotes awareness**: The process of screening all students can, in and of itself, promote greater awareness and acceptance of mental health needs and help destigmatize support-seeking behavior. Staff who were interviewed also highlighted the potential of universal mental health screening in helping to raise awareness about mental health among different interest groups, including youth, parents/caregivers, and school staff, contributing to a more supportive and equitable school environment.

> **"I feel like if you have these universal [mental] health screens and they start at a really young age in elementary school and they're done yearly as kids go on, it shows these kids that it is serious and there's nothing to worry about when you answer these questions. And overall, I think that could help decrease the stigma with mental health in general. So, while I feel like people won't want to really say or be truthful at first because they're uncomfortable, if it starts early enough, they will be comfortable as they go on. Overall, it will help them later."**
>
> **– Youth**

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Concerns and Misunderstanding

- **Liability burden**: One common myth about SUMHS is that the primary goal is to identify, diagnose, and treat a mental health condition. While SUMHS can identify "red flags" that may warrant additional assessment and intervention, SUMHS are not designed to diagnose and treat all students. Assumptions that SUMHS are diagnostic are not only inaccurate, but cause schools to inflate the perceived resource burden and liability of administering and responding SUMHS.
- **Stigma**: According to students, many young people feel fear or shame that keeps them from opening up about their mental health struggles. Their fears were often related to punitive or exploitative school or community climates around issues such as social media use, sexuality, and drugs/alcohol or based on a perception that their unique challenges were not as significant as their peers and, therefore, not worthy of support. Parents and caregivers similarly shared their concerns about their children being labeled, or that their student may, by participating in a SUMHS process, be somehow othered or "put in a box." Cultural and familial beliefs can further impact students' help-seeking behaviors as well as caregiver skepticism or privacy concerns regarding screening.
- **Privacy and consent**: In general, most parents support school-based mental health services, but they also want to maintain their right to make decisions related to their child's health.[84] Many parents and caregivers were concerned about not being informed about what screening and testing their children experience. Students' concerns also focused on privacy, and wanting agency to determine if, how, and when their screening data or follow-up is communicated to their families.
- **Trust and transparency**: Students, parents, and school representatives were unified in the belief that providing information and transparency is essential to building trust and promoting the integrity of SUMHS processes. Some students said that schools are frequently vague about the purpose of screening, and because of this, students weren't completely honest about the information they provided. The students stressed how important it is that students and staff are informed and assured that screening is being conducted with their best interests in mind. Some parents and caregivers expressed a general lack of trust toward school systems and broader child service systems. When it comes to screening, some parents and caregivers have concerns about the "criminalization" of their families or involvement with child protective services based on the information their child shares. For other families, a lack of trust stems the shortfall of schools and behavioral health systems ability to help their children in the past.

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3. Capacity Barriers and Resource Needs

Capacity barriers are outweighing the benefits of SUMHS. Schools need resources and technical support to use SUMHS effectively.

While schools overwhelming acknowledged the benefits of SUMHS, they also emphasized the need for more resources – both within schools and their surrounding community – for schools to be able to effectively meet students' mental health needs. As one survey respondent explained, "I think universal screenings are good, but the schools need so much financial, educational (training), and additional staff support for this to be successful." Another respondent cautioned that "schools do not need another unfunded mandate with ongoing costs and staffing needs."

School Survey Highlight

Factors that helped schools successfully implement SUMHSz

58%	Adequate school staff to handle referral needs
53%	Communication about screening and supports
48%	Dedicated school time to conduct screenings
46%	Adequate community referral sources
42%	Clear roles and responsibilities of staff involved
40%	Clearly identified student needs
38%	Alignment with school mission and district priorities
35%	Adequate funding
25%	Trainings on how to conduct screening

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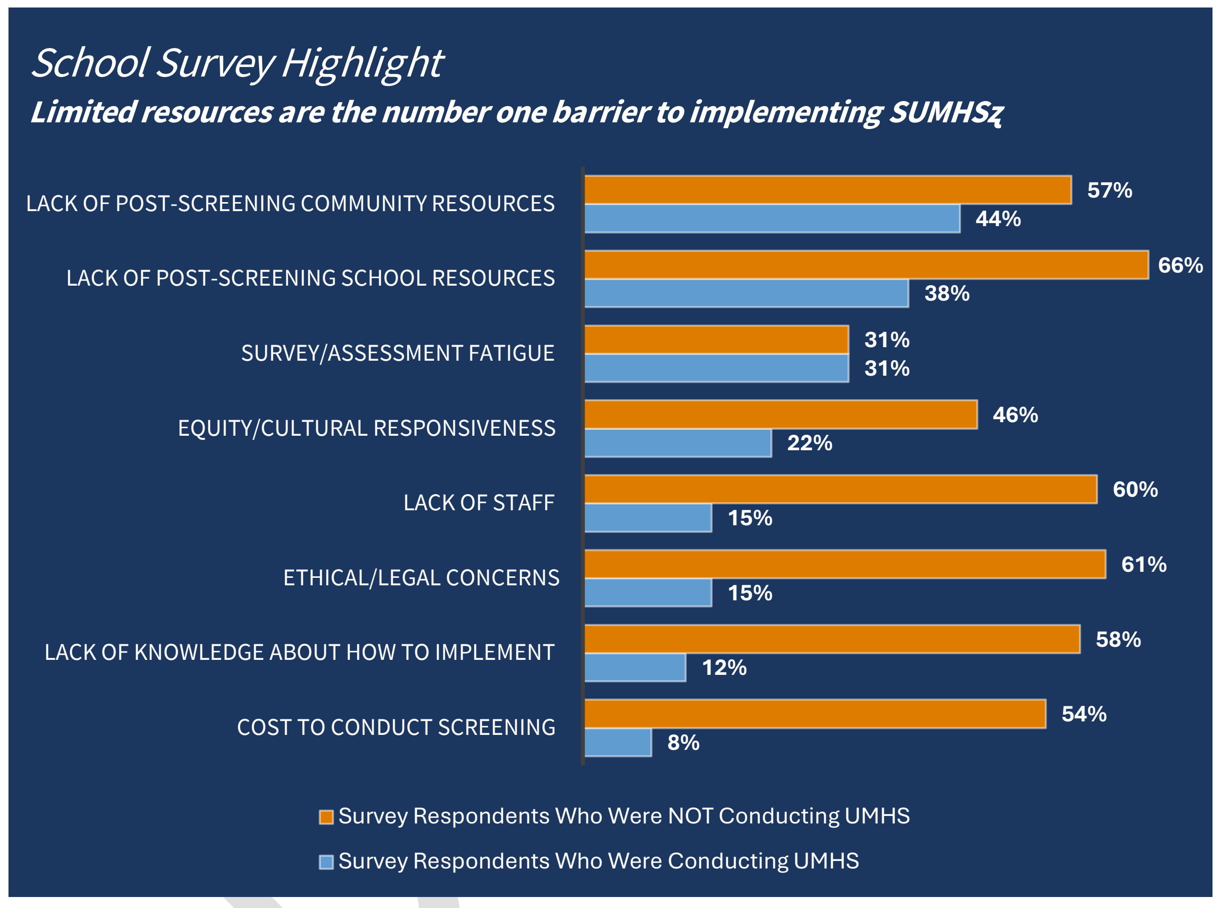
Barriers to Implementing SUMHS

Among all survey respondents, including those who were and were not screening, a lack of external and internal resources was the most frequently reported barriers. Overall, LEAs who were not screening reported more barriers, specifically those related to staffing, ethical and legal concerns, lack of knowledge, and costs needed for conducting and responding to SUMHS.



- **Staffing**: Shortages of both school-employed and community-based mental health providers impact schools' ability to respond in a timely way to screening data. Interviewees shared anxieties that the small number of counselors available for the schools and districts could not possibly meet the need identified by SUMHS – neither in a timely way nor even at all.
- **Training**: School staff also drew attention to the challenges that arise when teachers or other staff are insufficiently trained in student mental health or SUMHS systems, including further delays in responding to identified needs.

- **Data capabilities**: Schools need data systems to quickly analyze the information gathered through screening and to follow up with students that need further support. Yet, data access and sharing is cumbersome and slow, and LEAs lack the resources and technology to navigate data privacy laws.
- **Sustainable funding**: Short-term or temporary funding for SUMHS and related mental health services could pose challenges for some school districts. Finding and applying for grants is difficult, and unstable funding creates unstable staffing. Many local LEAs and behavioral health partners who have benefited from the recent school mental health incentive funds, like the Mental Health Student Services Act and CYBHI capacity grants, are worried about the longevity of their programs as many of these funding streams are about to expire.
- **Ethical and legal obligations**: Capacity and procedural issues underlie many of the ethical and legal concerns about implementing SUHMS. Several survey respondents commented on the challenge of responding to identified student needs when the needs exceed their school's resource capacity. Others noted that when parents/caregivers do not follow through on referrals for counseling, they "feel ethically obligated to take on that student as a client even though our caseloads are at max capacity."

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4. Opportunities within California's Youth Behavioral Health Ecosystem

A keystone moment in addressing California's youth behavioral health crisis was Governor Gavin Newsom's office release of the Master Plan for Kids' Mental Health (California for All, 2022) and with it, a commitment to creating a more proactive, responsive, and equitable youth behavioral health ecosystem. Through broad stroke efforts, California is laying the foundation for that ecosystem by investing in strategic touchpoints where children, youth, and their families interact with service delivery systems, including health care, behavioral health, social services, justice systems, child welfare, and education systems.

At the core of California's Master Plan for Kids' Mental Health is the Children and Youth Behavioral Health Initiative (CYBHI), a 5-year, $4.6 billion initiative that reimagines how systems, regardless of payer, that support behavioral health for all California's children, youth, and their families. The CYBHI is made up of 20 workstreams led by California Health and Human Services Agency to achieve four overarching strategies: workforce training and capacity, service coverage, behavioral health care infrastructure, and public awareness. Several of these workstreams focus directly on school-linked services.

Outside of CYBHI, parallel initiatives and investments in education, health care, and other service systems complement California's evolving youth behavioral health ecosystem. This includes California's Community Schools Partnership strategy to connect youth and families to essential services, allocation of Mental Health Student Services Act funding to strengthen school/county behavioral health partnerships, and most recently, the passing of the Governor's Behavioral Health Reform through Proposition 1, which reinforces school-aged children and youth as a priority for public behavioral health funding.

Many of the investments and workstreams lay the groundwork for implementing comprehensive school mental health systems and can be leveraged to support school-based universal mental health screening (SUMHS) implementation in California's K-12 settings. (see Table 3) Some of these opportunities are highlighted below.

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Table 3: California Initiatives Supporting Comprehensive School Mental Health Systems and SUMHS Implementation

Comprehensive School Mental Health System Components	SUMHS Best Practices [85,86]	California Initiative
Sustainable Funding	• Short-term investments are needed for planning, capacity building, and piloting of SUMHS. • Reliable financial and/or non-financial resources are necessary to secure staffing, MTSS services, and data infrastructure to support SUMHS.	• School Behavioral Health Incentive Program (SBHIP) • CYBHI School-Linked Partnership and Capacity Grants • CYBHI Multi-Payer Fee Schedule
Workforce	• SUMHS practices are planned for and implemented by professionals with expertise in student mental health assessment and intervention. • Requires devoted staff time and training to implement screening and follow-up procedures.	• Youth Mental Health Academy • CYBHI Certified Wellness Coaches • Healthcare Provider Training and eConsult • CYBHI Safe Spaces Trauma-informed training for educators/staff
Family-School-Community Collaboration and Teaming	• SUMHS is led by a diverse team of school community partners and providers. • Outreach and engagement to build trust, buy-in, and collaboration with families, students, and community partners.	• Mental Health Student Services Act Partnership Grants • California Community Schools Partnership Program

	• Ensure school, family, and students clearly understand the procedures and purpose of screening and their rights to consent.	
Comprehensive Planning	• SUMHS is informed by a robust planning process including a needs assessment and asset mapping to ensure alignment with school goals and capabilities.	• School-Linked Partnerships and Capacity Grants • MHSSA Universal Screening Planning Incentive Grant
Multi-Tiered System of Support	• Screening data are combined with other data sources to inform decisions across MTSS tiers to support a range of student needs through prevention, early intervention, and linkage to intensive care. • Screening data are monitored as part of a continuous improvement processes to evaluate and augment implementation of mental and behavioral health supports over time.	• CalHOPE Student Support and Schools Initiative • CYBHI Mindfulness, Resilience, and Well-being Supports • California Department of Education Mental Health Instruction Expansion (SB 224) • Project Cal-Well • California School-Based Wellness Centers
Evidence Based and Emerging Best Practices	• Screening practices are culturally, linguistically, and developmentally relevant, and selected with input from the broader school community. • Screening is followed by clear and efficient pathways to connect students and their families to	• CYBHI Evidence-Based and Community-Defined Evidence Practices Grants • Youth Suicide Crisis Response Pilots • Youth Peer-to-Peer Support Program Pilots

	appropriate, high-quality school and/or community-based MTSS services.	
Mental Health Screening	• Universal screening with targeted screening for at-risk students. • Screening tools and measures are psychometrically validated and selected based on appropriateness, utility, and technical adequacy for the intended population.	• Early and Periodic Screening, Diagnostic, and Treatment (EPSDTY) Medi-Cal benefit • MHSSA Universal Screening Planning Grant • Multi-Payer Fee Schedule (screening and assessment reimbursement)
Data Systems	• Screening and support services are supported by integrated, responsive, and secure data systems and policies to ensure clear, consistent, and timely sharing of screening data with relevant community and school partners. • Developed in consultation with legal and data-system administrators to ensure adherence with relevant privacy laws and data sharing policies.	• CYBHI Data Sharing and Privacy Workgroup and Guidelines • California's Data Exchange Framework • Semi-Statewide Electronic Health Record (CalMHSA)

Comprehensive School Mental Health System Feature:

Sustainable Funding

Building and sustaining comprehensive school mental health systems requires innovative strategies to leverage and apply various financial and nonfinancial resources in a school or district. Schools need to have reliable, efficient, and flexible base funds and billing mechanisms to support ongoing MTSS services and support. To maximize base funds, schools benefit from short-term incentive funds focused on system improvement and combining funds across multiple agencies to achieve shared outcomes.[87]

California Initiatives

School Behavioral Health Incentive Program

School Behavioral Health Incentive Program (SBHIP) is a one-time $388.99 million investment to address behavioral health access barriers for students insured through Medi-Cal through targeted interventions that increase access to preventive, early intervention, or other behavioral health services provided by school-affiliated behavioral health providers for TK-12 children in public schools.[88]

CYBHI SchoolİLinked Partnership and Capacity Grants Program

The School-Linked Partnership and Capacity Grants are a one-time $550 million investment enabling educational entities to build the necessary capacity, infrastructure, and partnerships needed to achieve a long-term and sustainable funding model. It will support school readiness to ensure increased access to behavioral health services and the expansion of service delivery by increasing capacity through training and development of infrastructure. The investment demonstrates California's commitment to early intervention and comprehensive support systems by channeling one-time funding toward a sustainable funding model. [89]

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CYBHI MultiİPayer Fee Schedule

Under CYBHI, the California Department of Health Care Services established a new Multi-Payer Fee Schedule[90] to ensure sustainable reimbursement for certain behavioral health services in school settings, including screening and assessment services, to support and expand behavioral health supports in schools. It mandates Medi-Cal and commercial health plans adhere to set rates for local education agencies and school-affiliated providers. This is significant because many schools and school partner organizations already provide many behavioral health services to students that are enrolled in Medi-Cal or a commercial health plan but receive no reimbursement. In addition, practitioners that haven't billed Medi-Cal in the past – such as school social workers and counselors – will be eligible to bill under the Fee Schedule regardless of network provider status.

Comprehensive School Mental Health System Feature:

Workforce

A comprehensive school mental health system relies on a diverse team of trained professionals to ensure students receive the care and resources they need, from screening to services, in order to thrive academically and emotionally. This includes not only behavioral health providers, but also educators, administrators, and student peers who often encounter a student's mental health challenges first. Equipping front-line workers with training, knowledge, and skills can create a more supportive environment for students and for themselves, and ensure students receive the care and resources they need, from screening to services, to thrive academically and emotionally.[91]

When it comes to SUMHS, the availability of school-employed and community-based mental health providers impacts schools' ability to respond in a timely way to screening data. As such, workforce concerns are one of the primary reasons schools are not implementing SUMHS in California.

California Initiatives

CYBHI Workforce Training and Capacity Investments

A key priority of CYBHI is to create a larger, more representative workforce supporting the emotional, mental and behavioral health of California's young people. Through multiple workstreams led by California Departments of Health Care Access and Information and Health Care Services, these investments aim to fill professional gaps while also promoting an emerging workforce that is culturally and linguistically adept, enriched with lived experiences, and can better understand and serve the needs of California's children, youth, and families.

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Youth Mental Health Academy: CYBHI includes $25 million to support the Youth Mental Health Academy, a community-based career development program for high school students that takes place over the course of 14 months and includes mentorship, paid project-based learning, and paid internships in the mental health field. Through mentorship and paid training for high school students in marginalized communities, the Youth Mental Health Academy aims to close equity gaps, offering opportunities while augmenting the state's behavioral health workforce. This initiative not only paves the way for underrepresented youth into mental health careers but also envisions a future with high-quality mental health services delivered by a workforce that understands and represents the community it serves.

Wellness Coaches: A key component of CYBHI is the launch of the Certified Wellness Coach (CWC) workforce. Supported by a $338 million investment, the CWC profession was created to allow young people to find support from people who they can connect with, who speak their language, understand their communities, and work in places that are convenient to young people such as schools. CWCs can provide services across MTSS continuums including wellness promotion, screening, and crisis referral.

Healthcare Provider Training and eConsult: The CYBHI includes a $155 million investment to support the Healthcare Provider Training and eConsult to provide health care and other non-traditional behavioral health practitioners (e.g., school-based services providers) access to consultation support from licensed behavioral health professionals. In addition to providing remote and real-time consultation support with behavioral health clinical experts, it will offer access to behavioral health resources and trainings to strengthen the workforce and improve the capacity providers supporting the behavioral health needs of children, youth, and young adults.

Implementing Workplace Mental Health Standards for LEAs

Educators are far more likely than other professionals to report stress, burnout, anxiety, and depression due to the high demands of their profession.[92] Left unaddressed, poor mental health of teachers can negatively impact the learning environment and contributes to high turnover rates. Schools that prioritize teacher mental health by offering wellness programs and mental health resources not only help educators but also create a healthier and more supportive learning environment for students.[93]

Comprehensive School Mental Health System Feature:

Family-School-Community Collaboration and Teaming

Supporting student mental health requires codified relationships and strong coordination between schools, mental health professionals, community organizations, policymakers, funders, students, and families. Together, they can address the academic, emotional, and

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behavioral needs of students, leading to better outcomes and more efficient and sustainable support systems within schools. [94]

California Initiatives

Community Schools Partnership Program

California Community Schools Partnership Program (CCSPP) is one of the ways California strengthening school-community relationships to ensure students and families get the resources and support they need to learn and thrive.[95] A community school model involves districts and schools working closely with teachers, students, families, and community partners to organize school and community resources, including mental health support, tutoring, nutrition programs, free school meals, health care, counseling and other social assistance. Through this integrated and wholistic approach, community schools can mitigate the academic and social impacts of emergencies that affect local communities, improve school responsiveness to student and family needs, and address barriers to health and learning. CCSPP includes $4.1 billion over 10 years to make one out of every three schools a community school.

Comprehensive School Mental Health System Feature:

Comprehensive Planning

Before implementing SUMHS, schools must conduct a robust planning process led by a multidisciplinary team to establish screening goals, capabilities, and procedures. Teams must engage in robust needs assessment and asset mapping to inform screening goals and procedures. This process must include careful selection of screening instruments to meet intended goals, protocols for where, when, and by whom screenings are administered and responded to, processes for addressing parental notification and consent, decisions about data use and protection, evaluation of cost, staffing, and time requirements, and securing funding for universal mental health screening.

California Initiatives

Mental Health Student Services Act Ỉ Universal Screening Planning Grants

The Mental Health Student Services Act (MHSSA) provides grants for partnerships between county behavioral health departments and local education agencies (LEAs) to deliver school-based mental health services to young people and their families.

In August 2024, the Commission awarded $8 million of MHSSA funding to support a learning cohort of MHSSA grant partners from 10 counties, varying in size and region, to develop a plan to implement and SUMHS in their school or district Funding will support the development of a local planning team and planning activities, including the assessment of needs, assets, and

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challenges relative to implementing SUMHS. Using their plans, grantees will pilot a SUMHS program, and through a learning cohort, compile lessons learned into a “road map” to support SUMHS planning and implementation in California schools.

Comprehensive School Mental Health System Feature:

Multi-Tiered System of Support

The Multi-Tiered System of Supports (MTSS) framework ensures that every student, whether in general or special education, has access to the full range of services; from universal strategies for all students to targeted programs for those with mild challenges, and individualized support for students needing more intensive care. Universal screening data are an important part of MTSS, helping schools identify school-wide trends while flagging students with higher risks, and informing continuous improvement processes to evaluate and augment implementation of mental and behavioral health services over time.

California Initiatives

CYBHI Mindfulness, Resilience, and Well-being Supports

Under CYBHI, California invested $75 million for wellness, resilience, and wellbeing supports for children, youth, and parents. A portion of this funding ($10 million) is helping to scale parent and family support programs across the state. With remaining funds and in partnership with the Sacramento County Office of Education, the Department of Health Care Services (DHCS) will disseminate grant funding to each of the 58 County Offices of Education to support the adoption and equitable access of evidence-based mindfulness, resilience, and wellbeing tools, resources, and programs for teachers, youth, parents, and families. The program will also expand social and emotional learning (SEL) at school sites and continue to build statewide infrastructure and regional capacity to support successful implementation.[96]

CalHOPE Student Support and School Initiative

CalHOPE Student Support is a youth-centered initiative that leverages California’s existing support network, enabling leaders from all 58 County Offices of Education participate in statewide SEL communities of practice, which aim to build leadership to strengthen SEL in schools across the state. Recognizing the impact of stress, trauma, anxiety and other challenges, CalHOPE Schools Initiative provides additional support materials. By partnering with County Offices of Education, the CalHOPE Student Support program serves communities in culturally competent ways and in partnership with youth.

CYBHI Safe Spaces: Trauma-Informed Training for Education and Early Care Settings

Safe Spaces meets California’s youth where they are, integrating the efforts of the mental health and education systems so that students can get the support they need to thrive in the

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classroom and beyond. Launched in 2023, the training helps school and childcare personnel understand and identify how stress and trauma impact their students, enabling them to foster safe, supportive relationships, better support students and create learning environments that foster wellbeing and academic success.

Project CalİWell

Since 2014, the California Department of Education (CDE) has been implementing Project Cal-Well in partnership with local educational agencies (LEAs) throughout California with funding support from the Substance Abuse and Mental Health Services Administration under the Project AWARE grant. Project Cal-Well is designed to raise awareness of mental health, expand access to school and community-based mental health services for youth and families and create sustainable student mental health infrastructure through leveraged resources.[97]

Comprehensive School Mental Health System Feature:

Evidence-Based and Emerging Best Practices

Using proven, research-based strategies within an MTSS framework ensures that students receive the right support based on their individual strengths and needs. It is not enough for a screening tool or intervention to be to be scientifically tested; it must also be culturally relevant, practical to implement, and suited to the resources available in schools. MTSS allows schools to implement strategies designed for specific groups, making it a flexible and powerful tool to drive equity-centered youth mental health services. [98]

California Initiatives

CYBHI Youth PeerİtoİPeer Support Program

Peer support in California high schools is a key strategy for promoting mental health resilience and wellbeing among adolescents. The Youth Peer-to-Peer Support Program is an innovative collaboration between the Department of Health Care Services and The Children's Partnership, awarding $8 million in grants to initiate peer-to-peer support programs in up to eight high schools across diverse Californian communities. This pilot aims to establish best practices standards for a statewide school-based peer-to-peer behavioral health support systems.[99]

CYBHI Scaling EvidenceİBased and CommunityİDefined Evidence Practices

California invested $429 million to scale evidence-based practices and community-defined evidence practices as part of an equity-focused youth behavioral health ecosystem. Toward that goal, DHCS is distributing grant funding to community-based organizations, schools or school districts, childcare centers, and healthcare entities to build capacity and capabilities

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for delivering culturally and linguistically-affirming behavioral health services to underserved Black, Indigenous, and People of Color (BIPOC) and LGBTQIA+ communities.[100]

Comprehensive School Mental Health System Feature:

Mental Health Screening

Early identification and intervention lead to better outcomes for children. Mental health screening, including assessment of the social determinants of mental health and other contextual factors such as developmental and health-related challenges, is a foundational component of a comprehensive approach to behavioral health prevention, early identification, and intervention services.[101]

California Initiatives

Early and Periodic Screening, Diagnostic, and Treatment

By law, under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit healthcare providers are required to provide routine developmental, social, behavioral, and mental health screening and intervention to all Medi-Cal beneficiaries beginning at birth through age of 21.[102] Under federal Medicaid reimbursement policies, EPSDT services must be validated for young people and can be administered by any qualified provider (Medi-Cal or non-Medi-Cal) operating within the scope of his or her practice, and must be responded to with "corrective treatment," either directly or through referral for any condition detected by a screening. The location of screening is also flexible and can be administered in a range of health care and community settings, including in schools.[103]

Comprehensive School Mental Health System Feature:

Data Systems

Data about student and school needs obtained through SUMHS are considered alongside other student data to inform universal programming and early intervention as part of an MTSS. To be most effective, schools must be prepared to review and follow up on SUMHS data in a reasonable timeframe.[104] A timely response is more likely when universal mental health screening data are readily accessible, and results are interpretable to those on the screening/response team.

Data storage and privacy policies are also important considerations and will depend on district, state, and federal guidelines for maintaining student and family records within the school. Federal guidelines are provided in the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). A transparent data management plan–informed by these policies and detailing where data will

be stored and who will have access–should be established prior to screening and clearly communicated with staff, families, and students.[105]

California Initiatives

CYBHI Data Sharing and Privacy Guidance

California provides State Health Information Guidance (SHIG) to help clarify federal and state laws related to disclosing/sharing sensitive health information in contexts such as behavioral health service delivery, individuals living with HIV/AIDS, and minors and foster youth.

In 2023 the Children and Youth Behavioral Health Initiative created a Technical Advisory Committee and began a stakeholder engagement process to address data sharing and privacy challenges related to the new multi-payer fee schedule for school-based behavioral health services. Through this initiative, CYBHI will develop and disseminate SHIG documents and actionable tools and resources for multiple audiences to clarify the application of HIPAA, FERPA, and California privacy laws when delivering care to children and youth in a school setting.

California's Data Exchange Framework

The California Health & Human Services Data Exchange Framework (DxF[106]) is part of a statewide commitment to providing safe, effective, whole-person care to improve outcomes for all Californians. The DxF is not a new technology or centralized data repository, but instead establishes a set of rules for securely and appropriately exchanging health and social services information across existing standalone health and social services systems and providers. The DxF aims to fill gaps in understanding about social determinants of health and enable providers to address health inequities and disparities, especially in historically underserved and underrepresented communities.

The Data Exchange Framework includes a $47 million investment to provide participating health and social services entities with resources to address critical operational, technical, and technological barriers to DxF implementation. This includes designating Qualified Health Information Organizations to provide data exchange capabilities to under resourced health and social service entities, especially those serving historically marginalized populations and underserved communities.

Semi-Statewide Electronic Health Record

California Mental Health Services Authority (CalMHSA) is leading an initiative to streamline and enhance county electronic health record (EHR) systems to promote holistic behavioral health and human services data aggregation and interoperability.

As part of this initiative, CalMHSA is helping counties implement SmartCare™, an enterprise, cloud-based, single-platform, intelligent EHR technology designed to support data collection

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and coordination between multi-disciplinary service delivery systems, allowing providers to provide truly integrated care management and improve organizational efficiency.

The initial phase launched in July 2023 and involves 23 counties and over 37 percent of the state’s Medi-Cal population. Additional counties are expected to join in 2024.

Recommendations for Implementing SUMHS

Findings about the benefits and barriers to implementing SUMHS reinforce the importance of conducting SUMHS within comprehensive school mental health systems that have sufficient resources to provide a continuum of supports and services across MTSS. They also emphasize the need to meet staff, students, and caregivers where they are by building awareness and trust so they can plan and implement SUMHS effectively.

California has already made foundational investments in workforce development, behavioral health care infrastructure, public awareness, and service coverage, many of which support comprehensive school-based mental health systems. As much of this funding is about to expire, California now needs a long-term strategy and comparable leadership structure to align and coordinate diverse funding and partners supporting its evolving behavioral health ecosystem.

1. Establish leadership and guidance for school-based mental and behavioral health

California should establish a leadership structure to coordinate and align state and local partners and workstreams and build on the progress of its current efforts towards a long-term strategy for youth behavioral health. That strategy should establish standards, guidance, and build capacity for implementing comprehensive school mental health systems in California's public education system.

As part of this strategy, California's youth behavioral health leaders should oversee a public participatory process of model policy and practice development to support successful implementation of SUMHS in California K-12 schools. This process should include:

- Establishing a statutory definition of SUMHS with quality standards and metrics consistent with evidence-based best practice guidelines for planning, implementing, and monitoring SUMHS within K-12 systems.
    - Standards and metrics should be tied to a broader accountability framework for statewide comprehensive school-based mental health systems.
- Providing guidance, tools, and technical assistance to help LEAs implement SUMHS with fidelity to established standards including support and guidance for:
    - Planning activities such as conducting local needs assessments, community outreach, partnerships, tool selection, protocol development, data systems management, and quality control activities.

- Navigating state and federal policies related to privacy, consent, confidentiality, and data sharing and management for student mental health screening and services.
- Braiding existing funding streams and resources to support SUMHS implementation within MTSS, such as those under the Children and Youth Behavioral Health Initiative and Behavioral Health Services Act, among others.

2. Improve awareness, trust, and participation of students, parents, and educators

California's youth behavioral health strategy should focus on improving the mental health culture and climate in schools and reducing the stigma related to screening, referral, and participation in mental health services. This should include:

- Investing in the mental health of teachers and school staff through programs and practices aligned with California's standards for workplace mental health.
- Establishing resources, consultation, training, and curriculum requirements to improve mental health literacy among teachers and staff.
- Supporting districts and LEAs to strengthen family and community participation, buy-in, and trust in school-based behavioral health services.
- Leveraging and expanding youth-led awareness strategies.

3. Build capacity for comprehensive school mental health systems and SUMHS through incentives, resources, and meeting schools where they are

In support of the statewide school behavioral health strategy, the State must engage with local education and behavioral health partners as well as students and their families to assess and address capacity needs for implementing comprehensive school mental health standards. This should include investments in infrastructure, incentives, and resources to support the planning, testing, and scaling of SUMHS practices in California schools. This may include:

- Funding the planning, development, and piloting of SUMHS practices in California schools.
- Leveraging research to practice and multi-county learning models to refine and scale best practices for implementing equity-centered SUMHS.
- Developing modernized, affordable, and universal data systems that support real-time, cross-system data sharing and coordination between local public entities serving children and their families.

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- Providing sustainable funding for school-based Tier 1 and 2 resources, workforce, and services.
- Investing in research and development of innovative, holistic, and culturally affirming screening tools and practices.

Conclusion

In summary, School-Based Universal Mental Health Screening (SUMHS) is a critical step in advancing comprehensive school mental health systems. With thoughtful planning and preparation, SUMHS has the potential to identify mental health needs early, promote equitable access to support, and ensure that every young person has the opportunity to learn and thrive. However, to be successful, schools require ongoing resources, clear state-level guidance, and strong local partnerships to address challenges such as stigma, community trust, and capacity limitations. By embedding SUMHS within its broader youth behavioral health care ecosystem, California can pave the way to a brighter future for children and youth.

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Appendices

Appendix I: School Site Visit Summaries

Sonoma County Office of Education: Post-disaster Screening and Triage to Care

On February 6, 2024, Commissioners and Legislative staff visited Sonoma Valley High School to learn about Sonoma County's school-based mental health screening pilot program.

Trauma can have profound and lifelong effects on a person's physical and mental health. In addition to affecting individuals, trauma can be shared by communities. Community trauma can result from natural disasters, acts of violence such as mass shootings, or systemic adversities that impact populations such as structural racism, discrimination, and socioeconomic disparities. Symptoms of community trauma include severed social networks, a low sense of political efficacy, deteriorating living environments, neighborhood violence, and intergenerational poverty.

Research has shown that each incident of large-scale adversity increases mental health risks of those exposed. Cumulatively, large-scale adversity weakens a community, strips its resilience, and threatens the collective pursuit of healing and wellness.

Children's developing immune and nervous systems make them especially vulnerable to trauma. If not properly addressed, trauma can lead to social, behavioral, and cognitive challenges that can disrupt a child's learning and development, setting the stage for negative academic, relational, and health outcomes later in life.

"California's students are increasingly affected by natural disasters, including the most recent, the COVID-19 pandemic. For students already impacted by traumatic events, the pandemic creates a compounding trauma that affects our students, families and educators." Ỉ Mandy Corbin, Sonoma County Office of Education Associate Superintendent of Special Education and Behavioral Health Services.

Sonoma County School-based Universal Post-Disaster Screening Program

Sonoma County offers a unique example of how universal screening can be used to support students' emotional and behavioral needs in the aftermath of a major crisis or disaster. With its recent history of large-scale disasters – most notably wildfires – Sonoma County was poised to make an innovative investment in their students' wellbeing. The county used the Stepped Triage to Care model, involving post-disaster screenings to identify the risks of post-

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traumatic stress and other mental health needs so schools can help students get the care they need.

This project began after the Sonoma County Office of Education (SCOE) received the Substance Abuse and Mental Health Services Administration grant in 2019 and the School Emergency Response to Violence grant in 2021. The county partnered with trauma specialist and Harbor UCLA Clinical Pediatrics Director, Merritt Schreiber, Ph.D., to implement his program Stepped Triage to Care screening and brief trauma intervention program.

Screening Procedures

Screening tool: Stepped Triage to Care begins by using PsySTART, a brief universal screening tool consisting of 10 to 20 questions to assess disaster-related risk in impacted areas. The tool assess the severity, proximity, and relative impact of an event such as loss of one's home, death of a loved one, or personal injury. It also assesses preexisting risk factors such as past trauma exposure or family social or economic challenges.

The tool is administered via a secure online electronic platform and can be conducted by school staff through an interview with a student or family, or it can be delivered directly to families to complete.

Students with scores indicating "high risk" are connected with a trained provider assesses for trauma-related symptoms using a previously validated Child PTSD symptom scale. Students meeting a threshold of concern are provided with short term Trauma Focused Cognitive Behavioral Therapy (TF-CBT) by trained counselors. Students with more severe symptoms are provided ongoing TF-CBT services.

Outcomes and Impact

Through the Stepped Tirage to Care efforts, the district was able to provide counseling support to more than 500 students in 16 districts in Sonoma County.

Post-disaster resource triage: In addition to identifying and supporting individual student needs, school- and district- level screening results can be used for real-time population-level risk mapping. This kind of information allows schools, health systems, and other disaster response systems allocate resources strategically to people most impacted by the fires, while prioritizing those who are underserved.

"The PsySTART tool allows us to model the population level impact of adverse events and make ethical decisions about the allocation of limited resources. It's a way we can promote equity when responding to disasters," explained Dr. Schreiber, who developed the screening tool.

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This model has been adapted and scaled to respond to other types of community adversities in the U.S. and in developing countries. In 2021 the Washington State Department of Health piloted their own version of the program to support youth ages 8-17 across the state who were at risk of developing behavioral health challenges due to the impacts of COVID-19.

Lessons learned

Well-resourced school staff can, in turn, provide resources to others.

A strength of Sonoma County's approach was ensuring that teachers and staff were well resourced and felt supported. "Early on post-Tubbs Fire, I was told if you do not give the staff resources and a pathway to access them, you will be surprised because staff will freeze, perhaps as if the event never occurred," said county associate superintendent Mandy Corbin, who helped spearhead the project. According to Corbin, resourcing staff included having systems in place to access the supports, providing push-in support in the classroom when needed, providing psychological first aid training, and providing time during the school day for staff to support their students.

"Resourced staff who know there is a sound system in place to care for students are more likely to care for themselves and be able to care for, connect to, and educate our state's children. When adults have a sense of agency during a crisis, they are better able to provide students support, implement curriculum, and engage students in learning during the most challenging of times."

San Diego County, Feaster Charter School: Universal Screening for High-Risk Populations

On December 13, 2023, Commissioners, Commission staff, and researchers from the University of California, San Francisco, visited Feaster Charter School, a school in Chula Vista, CA to hear from school staff, students, and community members about the school's universal screening program.

Feaster Charter School is located in a small community just nine miles from the Mexico/U.S. border, and it serves some of California's most at-risk and underserved students. At least 83 percent of its TK through eighth grade student population is socioeconomically disadvantaged, and many face the challenges that come with immigration, either themselves or others in their family. More than half (55 percent) of students are English learners, and many have to cross the U.S. Mexico border daily to come to school. According to administrators, the Feaster campus is within the vicinity of a major gang, and many students have experienced or been victims of violence starting from a very young age. In a community

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where hardship and trauma are considered the norm rather than the exception, there is a great need for mental health support.

During the visit, teachers and administrators described the ways students' unaddressed mental health needs were showing up at school including chronic absenteeism, behavioral and learning challenges, and students harming themselves. According to staff, crisis response services were needed on a regular basis.

With such great need for mental health support, Feaster Charter School has been working to meet that need through their universal screening program. The school partnered with Campus Clinic, a company helping schools across California implement on-site health and behavioral health services, to implement a universal health screener to all sixth through eighth grade students to assess risk of anxiety, depression, and self-harm.

Screening Procedures

The screening tool used by Feaster is composed of questions from two validated screening instruments, the Patient Health Questionnaire (PHQ-9) and the Generalized Anxiety Disorder 7-item (GAD-7), and included one question assessing self-harm risk, seven questions assessing for anxiety, and eight questions assessing for depression on a Likert scale. Screening takes place in a classroom with teacher supervision and is completed by students using a secure electronic device.

Prior to screening, school staff, with the help of Campus Clinic, conduct outreach to parents and caregivers to gain buy-in and trust. Written communications are also sent out to all parents in both Spanish and English in advance to allow opportunity to opt their children out of the screener (this is considered "passive consent"). Active consent is required for students younger than 12.

Post screening, data are stored and processed in a secure data system provided by Campus Clinic, which provides real-time results to designated school staff.

When students screen high for anxiety and/or depression, Campus Clinic reaches out to families and students are offered on-site mental health services on an ongoing basis. Parents and caregivers are able to see their student's screening score upon request.

If a child is screened as imminent risk, meaning that they responded anything other than "not at all" for self-harm risk, counselors and administrators receive an "Imminent Risk" email. The child is brought into the counseling center and further screened using the Columbia Suicidality Severity Rating Scale (CSSRS). Caregivers of all CSSRS screened students are contacted, debriefed on the results, and given resources. In severe cases, a parent or crisis service provider is called.

Outcomes and Impact

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According to Feaster staff, the needs revealed by the screener were much higher than expected. Nearly half (304 students; 48.5 percent) of students were identified as having a potential risk for anxiety and/or depression, and ninety-nine students (15.8 percent) were at risk of self-harm. Despite the high volume of needs, Feaster was able to ensure ALL students were supported with the help of Campus Clinic.

While the program is still relatively new, staff, parents, and students are already noticing the benefits, and want to see it continued. Screening scores have improved over time, indicating fewer students are at risk, especially when it comes to self-harm. Teachers report fewer problem behaviors in the classroom and the need for crisis services has decreased substantially. Instead, students report that they feel supported by the services offered by the school and Campus Clinic, and that instead of feeling embarrassed or ashamed of needing extra help for their mental health, they see it as something that is "normal" since many of their peers are also getting help. Parents also reported improvements in their children's overall wellbeing and academic achievements and were grateful that such services were provided at school.

Lessons learned

Low cost: By leveraging Medi-Cal and grant funds secured through the help of Campus Clinic, Feaster was able to administer the universal screener and services to students at no extra cost to the school or families. A key was leveraging already existing systems and resources. However, according to Feaster staff, securing ongoing funding and space for screening and services are still barriers to sustainability.

Partnerships and planning are essential: Most of what made Feaster's program successful was the work that happened before the screener. With the help of Campus Clinic, the school was able to conduct a comprehensive planning process to establish screening goals, tools, and procedures that were effective and ethical. Through needs assessment and resource mapping, Campus Clinic helped secure funding, staffing, and data technology for screening while providing visible referral and linkage pathways to ensure every student got the care they needed in a timely manner. They also helped Feaster streamline the parental consent process and put procedures in place to ensure adherence with data privacy and confidentially laws. According to the Feaster team, stigma remains one of the biggest challenges to screening and school-based services. To overcome this barrier, Campus Clinic and Feaster prioritized relationship building during the planning phase, to gain trust and buy-in from school staff and families.

One staff member offered advice for other schools: "This program so far has been the "unicorn" program that we all wished we had a long time ago and every school should have

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something like it! If schools are not there yet – start small, challenge stigmas, educate all interest-holders, and build your networks."

West Sacramento Elkhorn Village Elementary: Multitudes Universal Neurodevelopmental Screening

On March 22, 2024, the Commission hosted a site visit at Elkhorn Village Elementary School in West Sacramento, CA, to learn about Multitudes, a platform developed by the University of California, San Francisco (UCSF) Dyslexia Center to screen students for learning challenges.

Research shows that low reading proficiency by third grade results in higher high school drop-out rates, higher risk of system involvement, loss in earnings and productivity. It also shows that early and accurate identification of learning difficulties and strengths combined with support can improve academic outcomes *and* brain health by decreasing anxiety, increasing resilience, and improving self-efficacy.

Under the California Senate Bill 114, beginning in the 2025-2025 academic school year and thereafter, all local educational agencies are required to assess kindergarten through third grade students annually for risk of reading difficulties, including dyslexia.

In 2020 the State allocated funding to the University of California, San Francisco (UCSF), Dyslexia Center, to create a digital platform for universal literacy screening and interventions students and pilot its application in California public schools. After years of research led by a coalition of scientists and educators across the US, the UCSF Dyslexia Center is delivering Multitudes, a state-of-the-art digital literacy screening platform in more than 70 schools, reaching more than 12,675 of California's school-aged children. Elkhorn Village Elementary is one of the schools piloting Multitudes in preparation of statewide mandates for universal literacy screening.

Screening Procedures

Multitudes is a platform based on the latest neuroscience to identify students who may be at risk for reading difficulties. The screening assessments are not considered diagnostic, but are used to identify students who may require additional testing and/or who may benefit from some additional support to prevent the development of significant learning delays.

The screening tool consists of brief, reliable, and valid assessments of pre-reading skills such as visual-spatial abilities, short term memory, phonemic awareness, vocabulary, and spoken language skills. Beginning in kindergarten, the screener is administered to all students individually who perform tasks guided by trained "proctors" using secure electronic devices. The screener is provided in both English and Spanish.

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Student scores are generated automatically via a dashboard to administrators to view class screening progress and individual results. The program also includes training modules for users to improve their ability to support children's growth.

Lessons Learned

While the Multitudes screener is different than mental health screening, much of the evidence around best practices for implementation holds true. For example, the UCSF team emphasized the importance of building partnerships and earning the trust of school staff, parents, and communities in order for the screener to be effective. One UCSF team member said the team "let[s] our partner districts and schools lead in how they prefer to communicate and work." They also reflected on the importance of developing screening tools and practices that are culturally and linguistically responsive. For example, by hiring staff who look like and come from the same communities as participant families they were able to increase participation and precision of the screener.

The Opportunity for Mental Health Screening

According to lead investigator of Multitudes, the big opportunity is to apply modern technology to research early signs of strength and weakness in emotions (i.e. emotion appraisal, regulation, and control) that are known precursors of mental health struggles. Building on the Multitudes screener infrastructure, the UCSF team's next step is to pilot research on similar "objective", task-based early screener for emotional and behavioral health. The vision is that evaluating early strengths and weaknesses in cognition *and* emotion through a "whole brain" early screener could lead to better interventions and precision-education approaches.

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Hemet Unified School District: Whole Child Universal Screener

On May 30, 2024, the Commission visited Hemet, CA to learn about the school-based universal Adolescent Whole Person Health Screener (WPHS).

Hemet is a small, urban town in Riverside County's striking San Jacinto Valley and is known for its diverse cultural heritage and a strong farming industry. Yet, like many small towns, the Hemet community faces economic challenges, and many families struggle to meet their basic needs.

A person's wellbeing is affected by the family environment, individual relationships, and the many systems a person is influenced by in their day-to-day life; when parents are struggling, it's natural that their children struggle too. For children and youth, such need gaps impact their physical and mental health, and in school, can lead to behavioral challenges or poor academic performance – often it's both.

Recognizing the impact such challenges were having on students' health, behavior, and learning, the Hemet Unified School District decided to go beyond providing academic services and begin supporting the wellbeing of a whole child and their family.

Screening Procedures

In 2020, Hemet USD partnered with Riverside University Health System (RUHS) and began administering the Adolescent Whole Person Health Screener (WPHS). Supported by Mental Health Student Services Act funds, this screening tool is designed to create a holistic representation of needs across six health domains: physical health, emotional health, resources and resilience, socioeconomics, ownership, and nutrition and lifestyle. Administered twice a year beginning in ninth grade, this brief, 30-question survey gives each student a score for each domain.

For any student showing risk in one or more domains, Hemet USD provides services directly to them and their families through the district's Transforming Our Partnerships to Support Students (TOPSS) program. The support offered through TOPSS is comprehensive, encompassing a range of on-site supports, resources, and linkages to intensive services, depending on the individual students' needs. In addition to providing individual or group mental/behavioral health services, support often includes clothing, food and household items for the whole family, childcare, on-site legal and financial counseling, and medical and dental care through a mobile clinic parked outside.

Outcomes and Impact

Screening and early intervention is changing the trajectory of student's lives.

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In the three years that Hemet USD administered the Adolescent WPHS and the TOPSS program, the percentage of students categorized as "high risk" has decreased as much as 50 percent in some domains, with the largest improvements occurring in students' emotional health. Although such improvements may be due to other factors, it's clear that Hemet USD is unique in its ability to improve students' functioning during a time when most districts are seeing sharp increases in students' mental health and academic challenges.

"A person who feels like they have control and ownership of their life are more likely to seek out new opportunities and create positive upward spirals in their outlook and trajectory," said Dr. Brandon Tran, Supervising Research Specialist at RUHS. "We've done some great work in helping a person find themselves, often coming from a place where they don't think that's possible."

A wall of testimonials from students decorated the room where the Commission heard personal stories from students and parents – many told with tears in their eyes – which reinforced the success of the program. One parent who is deaf noted that the screener allowed her son to get help, which included assistance in improving the communication between her and her hearing son.

One student who was flagged by the Adolescent WPHS and received services through TOPSS said "If I wasn't being supported, I would still be doing badly. I'm grateful I got to have a support system like that."

"I'm really grateful we have this program, and I wish it would start for everybody before it's too late," said one of the parent panelist. "In high school, they're already going in with big trauma."

Lessons Learned

Success requires meaningful collaboration and trust between many partners.

Creating and implementing the universal screener and TOPSS programs required consistent effort and dedication from Hemet USD and its partners in public health, behavioral health, social services, as well as teachers, students, and families.

Trust and Buy-in: An initial challenge for the TOPPS team was gaining trust and buy-in from parents. Stigma and misunderstandings about mental health is a persistent challenge according to administrators of the program, and many students and families aren't yet comfortable with schools playing a role in the mental health of their children. For this reason, gaining parent trust and consent has become a core component of the screening and TOPSS program, and outreach and transparency has been a key. Once families start seeing the benefits of screening, they become champions of the program themselves, according to the

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TOPPS team, and many parents now work as certified peers helping other families in the TOPSS program. Certified youth peers have also played an important role in gaining the trust of students.

Data sharing: While Hemet USD and its partners continue to refine the program, collecting, analyzing, and sharing data remains a challenge. Memorandums of understanding can be complicated and incomplete, according to administrators, and the lack of universal and integrated data systems makes it difficult to do the real-time, customized analysis and reporting that would serve the program well.

Appendix II: SUMHS Resources

Guidance Documents and Toolkits for Implementing SUMHS

Multiple guidance documents have been developed to support school and district teams in planning for and implementing SUMHS.

- The School Mental Health Collaborative's (SMHC) *Best Practices in Universal, Social, Emotional, and Behavioral Screening: An Implementation Guide*.
- The National Center for School Mental Health's (NCSMH) *School Mental Health Quality Guide: Screening*.
- The California Department of Education Project Cal-Well's practical brief on *Universal Social, Emotional, and Behavioral Screening for Monitoring and Early Intervention*.
- Ohio PBIS Network's *School-Wide Universal Screening for Behavioral and Mental Health Issues: Implementation Guidance*.
- The U.S. Substance Abuse and Mental Health Services Administration's (SAMHSA) *Ready, Set, Go, Review: Screening for Behavioral Health Risk in Schools* toolkit.
- The Center for Health and Health Care in Schools's Issue Brief *Screening and Assessing Immigrant and Refugee Youth in School-Based Mental Health Programs*.

Screening Tools

Resources providing available SUMHS tools for specific school and/or district populations (non-exhaustive).

- The NCSMH's School Health Assessment and Performance Evaluation (SHAPE) System Screening and Assessment Library is a searchable library of free or low-cost screening and assessment measures related to school mental health. After creating a free SHAPE

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System account, users can search by focus area, assessment purpose, student age, language, informant, and cost. One-page summaries, which include direct links to measures, administration instructions, and information about scoring and interpretation, are provided for each measure.

- The Mental Health, Social-Emotional, and Behavioral Screening and Evaluation Compendium (2nd Edition; Center for School-Based Mental Health Programs, Ohio Mental Health Network for School Success, 2022) provides information on select no-cost and at-cost screening and evaluation tools. Information includes a description of the tool, target population, informant, logistics for use, and sample technical properties.
- The Center for Health and Health Care in Schools, School-Based Health Alliance, and NCSMH (2021) brief on *Assessing Social Influencers of Health and Education* reviews screening and surveillance practices for social influences of health and education and provides an overview of several measures that may be used for each purpose.

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Fictional Examples of SUMHS Application

This appendix contains fictional examples of how schools at different grade levels for illustrative purposes.

Middle School: Screener and Selection

Over the last few years, Mountainside Unified School District has been working closely with its County Office of Education to build school-community behavioral health partnerships to implement a trauma-informed continuum of mental health supports, improve Positive Behavioral Interventions and Supports implementation, and increase mental health awareness within its diverse school community. A few middle schools in the district are also starting to build wellness centers as part of a grant funded initiative. The district team leading these school mental health efforts regularly reviews data and last year identified the need for a universal mental health screening system to monitor the impact of their school-wide interventions and support the early identification of student mental health needs.

The leadership team formed a workgroup co-led by an assistant superintendent, family liaison, and school psychologist, and agreed that a planning year would be very important to get input from the school community. The district had a negative past experience with a SUMHS that was required as part of a grant program, but it was poorly implemented and focused only on student "deficits" as identified by teachers, raising concerns about teacher bias and over pathologizing certain subgroups. The workgroup started by carefully reviewing validated universal mental health screening processes and screeners, and how these aligned with the goals of their mental health and wellness programming. The workgroup also conducted listening sessions with parents, teachers, and students. The listening sessions revealed that parents generally supported school mental health and SUMHS, but wanted to better understand what universal mental health screening would mean for their children. They wanted to be assured that the SUMHS would provide information about their children's strengths – not just searching for mental health problems. They also expressed concerns about family privacy being protected and that participating in SUMHS would be a choice. Educators generally felt SUMHS would support their classroom programing, but indicated that fitting in more professional development would be challenging with all of the other current initiatives. All groups expressed an interest in learning more about the UMHS.

The workgroup wrote an article describing the SUMHS practices in the monthly school newsletter, posted information on the school website, and invited interested parents, educators, and students to join their workgroup. The workgroup also met with students from mental health clubs at the middle and high schools. After a year of planning, UMHS screener selection, and co-designing a SUMHS process, the workgroup decided to pilot a UMHS in the

spring at three middle schools and train the leadership teams there on a process that could be scaled to all middle and high schools the following school year.

Elementary School, COST Team

Mr. Xu is a school social worker at Morning Light Elementary School. This Title 1 school serves approximately 300 students in grades K-6 who identify as white (25%), Hispanic/Latino (45%), Black (15%), Asian American (8%), or another racial/ethnic group (7%). The Coordination of Student Services Team (COST) manages universal screening administration and follow-up as one component of their comprehensive approach to school mental health.

Mr. Xu is a member of the COST team and is responsible for coordinating the SUMHS process. Mr. Xu participates in ongoing district-led professional development and quarterly meetings to monitor and improve SUMHS processes across the district. At Morning Light Elementary School, the COST team meets three times per year with teachers in each grade level. During these meetings, teachers are provided time to complete a screener for each of the students in their class using a secure spreadsheet, which takes less than 20 minutes. Results are then reviewed by Mr. Xu, who indicates which students are scoring in the "at-risk" range and solicits additional information about student needs from teachers and school records.

The COST team provides recommendations for follow-up with identified students based on reviewing multiple data sources and pre-established decision rules about available interventions to meet a range of needs. The majority of students identified at-risk are referred to Tier 2 and classroom-based interventions that are matched to their specific needs (e.g., Check-in Check-out, Hawken et al., 2020; classroom-based social-emotional learning (SEL) activities; or to counselor-led groups). The COST team contacts parents and meets individually with some students. The COST team is pleased with their progress in implementing school-wide support with SUMHS and other data indicating that over 80percent of students are responding to their school-wide efforts.

High School – Strengths -Based

Sunset High School is in a district that has been building out its MTSS to focus on students' complete mental health and well-being through a continuum of interventions that supports social-emotional strengths, as well as intervention to prevent and/or address psychological problems or diagnoses. The district has been partnering with researchers investigating strength-based approaches to SUMHS. Twice per year, students are administered two brief screeners, one focused on behavioral and emotional risk and another focused on social-emotional strengths, which they complete during their second period within a two-week screening window.

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After the screening window, the team's data manager works with their partners at the local university to score the screeners and use research-based norms to create priority groups for follow-up. Students are then sorted into these priority groups based on their total risk and total strengths scores. The highest priority groups for follow-up include students whose scores indicate a high-level of emotional and behavioral risk and low levels of social-emotional strengths as well as students who report average levels of risk but low strengths. The team shares these findings with the school counselors, who follow up individually with priority individuals who are also on their advising caseload.

[Adapted from Moore et al. (2015), also available on the Covitality website.]

Highschool – Internalizing Behavior

Emilio is a ninth grade student enrolled at Sunnyside High School. He does well in school academically, participates in class and has two close friends that he spends most of his time with in and out of school. His school district serves almost 5,000 students in grades 7-12 across two high schools and three middle schools. The school district has been building its multi-tiered system of support, including a continuum of academic and social-emotional/behavioral supports and resources, since just before the COVID-19 pandemic. Over the last year, school and district leadership developed a plan to implement SUMHS to inform decision-making within their MTSS. This year, they're piloting their SUMHS process in Emilio's high school.

During new student enrollment, Emilio's mother receives an opt-out consent form for SUMHS as part of the enrollment packet. In mid-October, Emilio's English teacher begins class with an overview of a screener that students are asked to complete. The teacher explains that this screener will help the school to remove barriers to learning and to follow up with students who may benefit from additional support. Emilio opens the screener on his Chromebook and responds to 20 questions, taking him about two minutes.

All ninth grade students at Emilio's school were invited to complete the screener that day. Following the screener administration, the school wellness team met to review a software-generated report that indicates students with normal, elevated, and extremely elevated risk of having behavioral or emotional needs. Emilio was one of the ninth graders who scored in the extremely elevated risk range. His counselor meets with him to talk about how he's doing. Emilio shares that he's been feeling very worried about everything he's managing at school and home, and is having a hard time focusing in class. Emilio is invited to participate in a 6-week small group skill-building session to bolster his coping skills and the counselor follows up with his mother for her consent.

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The screening results indicated that many other ninth graders at Emilio's school were feeling stressed and anxious. The school wellness team collaborates with district and community partners to organize a series of workshops for all ninth graders to support their transition to the new school year. The wellness team also starts developing some lessons to infuse into the eighth grade spring SEL curriculum and information to help parents support their child's transition to high school.

Appendix III: Landscape Analysis Activities and Methods

Through the California 2023-24 Budget Act, the Legislature directed the Mental health Services Oversight and Accountability Commission, in consultation with the Department of Health Care Services (DHCS), submit a report on universal mental health screening for youth, with attention on data, best practices, and costs for implementing screening in K-12 school settings.

In preparation for the report called on by the Legislature, the Commission contracted with researchers from the University of California, San Francisco, the University of California, Riverside, and WestED to conduct a Landscape Analysis of existing school-based universal mental health screening (SUMHS) practices, perceptions, and barriers in California's K-12 education systems.

The Commission and UC research team utilized the following strategies as part of the Landscape Analysis.

Literature Review

The UCR team led a review of the literature on SUMHS policies and practices in schools, including evidence to support SUMHS for mental health processes; 2) best practices in equitable UMHS; 3) commonly used SUMHS models, including those in California, other states, and/or countries, including information on who is doing the screening, what mental health needs they are screening for, and what happens with the results; 4) information published on guiding principles and standards for SUMHS in school settings, including legal considerations related to parental notification and the data security and privacy framework needed to ensure confidentiality of screening results; and 5) existing information on costs related to implementing SUMHS for children and youth. (The Literature Review Report and methodology is available at https://mhsoac.ca.gov/wp-content/uploads/MHSOAC_UMHS-Phase-1-Report-Lit-Review_Final.pdf)

Survey of California Schools and Follow-up Interviews

The UCSF team conducted a voluntary survey of public school/district representatives in California to (a) understand their current SUMHS practices, including which models and tools, if any, are being used and with whom, how results are used, implementation successes and challenges, and estimated associated costs; and (b) assess perceived barriers and opportunities for implementation among those who are and are not screening. The survey invitation was sent to the list of public school administrators available from the California Department of Education (CDE) website. The invitation was also sent by the CDE and the Commission to listservs and email lists of school administrators and mental health professionals throughout the State. Survey respondents received $10 gift cards for their time. Data were analyzed using simple summary statistics by those who were and were not screening, as well as those not sure if they were conducting UMHS. The final sample

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comprised 180 representatives from local education agencies (LEAs) conducting UMHS, 171 representatives from LEAs that were not conducting SUMHS and 55 representatives who were not sure if their LEAs were conducting SUMHS.

The UCSF team identified survey respondents who were and were not implementing SUMHS and contacted them via email to see if they were willing to participate in follow-up semi-structured interviews that asked more specifically about their screening practices and needed supports. UCSF contacted 48 individuals to invite them to participate in interviews. Three individuals declined/cancelled and 35 did not respond. The final sample consisted of four representatives from LEAs that were conducting UMHS and six from LEAs that were not conducting UMHS. Interview participants received a $30 gift card for their time. Interviews were recorded with permission and transcribed. Data were analyzed for common themes and pertinent quotes. The UCSF researchers received approval from the UCSF Institutional Review Board to conduct the survey and interviews (approval #23-40219). (Survey overview and data are provided in Appendix III)

Qualitative Analysis of Youth and Parent/Caregiver Listening Session Transcripts

The Commission held public online listening sessions with youth and parents/caregivers to understand their thoughts on schools conducting UMHS. The Commission facilitated three listening sessions with a total of 21 youth who were recruited from partner organizations that had youth advisory groups and afterschool youth-led clubs focused on mental health. Two parent/caregiver listening sessions were conducted with a total of 14 parents/caregivers who were recruited with the help of United Parents, a non-profit/community-based organization that advocates for, empowers, and supports parents/caregivers with children facing emotional, behavioral, mental health, and family challenges. Each listening session participant received a $30 gift card for their time. Listening sessions were recorded and transcribed. The research team summarized general themes and highlighted pertinent quotes from these discussions.

School Site Visits

The Commission facilitated four school site visits attended by stakeholders and Legislative staff to learn about existing SUMHS practices in disparate California communities. (Site visit summaries are provided in Appendix II)

Final Report

Project activities informed the development of two reports presented to the Legislature.

Phase 1 Report: Literature review summary. – Delivered March 1, 2024

Report available at https://mhsoac.ca.gov/wp-content/uploads/MHSOAC_UMHS-Phase-1-Report-Lit-Review_Final.pdf

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Phase 2 Report: Landscape analysis findings and policy recommendations – Anticipated delivery date December 2024

Appendix IV: SUMHS Statewide School Survey Technical Overview

Universal Mental Health Screening of Children and Youth in California Schools: A Landscape Analysis for the Mental Health Services Oversight and Accountability Commission

Submitted: July 23, 2024

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Survey Findings

Overview

To understand the current landscape of universal mental health screening (UMHS) in California schools, the UCSF research team conducted a voluntary survey of local education agencies (LEAs) in California from March to June 2024. The survey was developed by the UCSF, UCR, and WestEd research team with feedback from experts in UMHS, as well as Mental Health Services Oversight and Accountability Commission ("Commission") staff and their legislative partners. The survey was sent by email to all public school administrators in a publicly available list from the California Department of Education (CDE) and distributed by Commission staff and partner CDE representatives to listservs of LEA administrators and mental health professionals. Each survey respondent received a $10 gift card for their time. The survey methods were approved by the UCSF Institutional Review Board.

The following is a summary of the survey findings.[1] While the sample sizes are small and <u>not representative of schools or districts statewide</u>, they provide insights into the current landscape of UMHS screening in California.

Study Sample

LEA representatives from schools, school districts, and county offices of education throughout California completed the survey, which asked about experiences with UMHS implementation, including barriers and facilitators, for those who were and were not conducting UMHS. Because the survey was open to representatives from county, districts, and schools throughout California, there may be some overlap in responses, for example when a district representative completed a survey and school representatives from within that district also completed the survey. We present data from all respondents to depict the landscape of UMHS.

At the start of the survey, respondents were given the following definition of UMHS:

> " *'Universal mental health screening' refers to the systematic and proactive assessment of social, emotional, and/or behavioral strength and risk indicators among all students within a given educational setting (e.g., school, district), with the goal of informing universal programming and additional assessment or intervention for those with identified needs. Universal mental health screening is conducted so that student data are identifiable (e.g., by student name or other identifiers).*"

Based on this definition, respondents were asked whether, to their knowledge, their LEA had conducted UMHS in recent years. Out of 443 total respondents, 43% (n=192) reported that their LEAs had conducted UMHS, 43% (n=191) said their LEAs were not conducting UMHS, and 14% (n=60) were not sure.

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[1] Missing data are excluded from all percentage calculations.

Counties Represented

Among respondents who were at LEAs that had conducted UMHS, most respondents were from Santa Clara (8%), Los Angeles (8%), and Ventura (8%). For those at LEAs that had not or were not sure if they had conducted UMHS, most were from Los Angeles (12% and 17% respectively; Table 1).[2]

Table 1: 2024 UMHS Survey Respondents, Percentage of Total Respondents by County

County	Conducting UMHS (n=192)	Not Conducting UMHS (n=191)	Not Sure if Conducting UMHS (n=60)	All Respondents (n=443)
Los Angeles	8%	12%	17%	11%
Santa Clara	8%	6%	5%	7%
Stanislaus	4%	7%	8%	6%
Ventura	8%	2%	2%	5%
Marin	4%	5%	5%	5%
San Diego	4%	6%	0%	5%
Riverside	4%	3%	7%	4%
Orange	4%	5%	3%	4%
San Joaquin	4%	4%	3%	4%
Humboldt	3%	4%	8%	4%
San Bernardino	5%	2%	3%	3%
Imperial	4%	3%	3%	3%
Kings	5%	0%	0%	2%
Siskiyou	3%	1%	2%	2%
Sacramento	2%	2%	5%	2%
Contra Costa	2%	2%	5%	2%
Kern	2%	3%	3%	2%
Alameda	2%	2%	2%	2%
Lake	1%	2%	5%	2%
Monterey	1%	3%	2%	2%
Solano	2%	1%	3%	1%
Fresno	1%	3%	0%	2%
Mendocino	3%	1%	0%	2%
Tuolumne	2%	2%	0%	2%
San Francisco	1%	2%	0%	2%

[2] Surveys were received from ≥1 LEA in all but 3 counties; their county names are suppressed to protect confidentiality.

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County	Conducting UMHS (n=192)	Not Conducting UMHS (n=191)	Not Sure if Conducting UMHS (n=60)	All Respondents (n=443)
Other counties (representing <1% each of total sample)	13%	17%	9%	14%

Survey respondents were mainly from LEAs that served elementary school students (Table 2).

Table 2: 2024 UMHS Survey Respondents, by Grades Served *(Respondents could choose multiple options so percentages do not add up to 100%)*

What grade span does your school serve?	Conducting UMHS (n=188)	Not Conducting UMHS (n=188)	Not Sure if Conducting UMHS (n=60)	All Respondents (n=436)
Alternative or continuation	18% (33)	21% (40)	17% (10)	19% (83)
Elementary	51% (95)	54% (102)	55% (33)	53% (230)
Middle/intermediate/junior high	47% (89)	41% (77)	33% (20)	43% (186)
High school	38% (71)	38% (72)	33% (20)	37% (163)
Other	6% (12)	10% (19)	7% (4)	8% (35)

Over half of the respondents in all groups worked in school districts and one-third worked in traditional public schools (Table 3).

Table 3: 2024 UMHS Survey Respondents, by Type of Educational Agency *(Respondents could choose multiple options)*

In which type of educational agency do you work?	Conducting UMHS (n=187)	Not Conducting UMHS (n=187)	Not Sure if Conducting UMHS (n=60)	All Respondents (n=434)
County Office of Education	12% (23)	14% (27)	12% (7)	13% (57)
School district	57% (107)	53% (99)	53% (32)	55% (238)
Traditional public school	32% (60)	29% (54)	32% (19)	31% (133)
Single-site charter school	6% (12)	9% (17)	5% (3)	7% (32)
Multi-site charter school	5% (9)	6% (12)	5% (3)	6% (24)
Other	1% (1)	5% (9)	10% (6)	4% (16)

As shown below, respondents in all groups were mostly from urban counties (Table 4).[3]

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[3] Counties were classified as urban, rural or suburban based on the California State Association of Counties classifications. Accessed on June 30, 2024 from: https://www.counties.org/sites/main/files/file-attachments/2020-june3-countycaucusesinfographic-4-final.pdf.

Table 4: 2024 UMHS Survey Respondents, by LEA County Urbanicity

	Conducting UMHS (n=192)	Not Conducting UMHS (n=191)	Not Sure if Conducting UMHS (n=60)	All Respondents (n=443)
Urban	53% (101)	52% (100)	53% (32)	53% (233)
Rural	25% (48)	27% (52)	30% (18)	27% (118)
Suburban	22% (43)	20% (39)	17% (10)	21% (92)

Almost half of respondents reported their primary role as administrators, and about one-fifth were school counselors (Table 5).

Table 5: 2024 UMHS Survey Respondents, by Primary Role

What is your primary role?	Conducting UMHS (n=191)	Not Conducting UMHS (n=190)	Not Sure if Conducting UMHS (n=60)	All Respondents (n=441)
Administrator	48% (91)	50% (95)	25% (15)	46% (201)
Teacher in grade 4 or below	5% (10)	1% (2)	0% (0)	3% (12)
Teacher in grade 5 or above	1% (1)	1% (1)	5% (3)	1% (5)
Special education teacher	1% (1)	1% (1)	2% (1)	1% (3)
Prevention staff, nurse, or health aide	0% (0)	1% (2)	3% (2)	1% (4)
School counselor	18% (34)	21% (40)	18% (11)	19% (85)
School psychologist	4% (8)	4% (8)	7% (4)	5% (20)
School social worker	6% (11)	6% (11)	10% (6)	6% (28)
Paraprofessional, teacher assistant, or instructional aide	0% (0)	1% (1)	0% (0)	0% (1)
Other (e.g., School-based mental health specialist, mental health clinician)	18% (35)	15% (29)	30% (18)	19% (82)

LEA Mental Health Resources across All Respondents

Over one-half of the LEAs that were and were not conducting UMHS were using the California Healthy Kids Survey to identify students' mental health needs (Table 6). About one-quarter of representatives from all groups said they were using district/school-developed surveys. *Note: This question asked all respondents about surveys used. These surveys were not necessarily the tools used for UMHS, which was asked in a different question only of respondents whose LEAs were conducting UMHS.*

Table 6: 2024 UMHS Survey, Surveys Currently Used to Identify Students' Mental Health Needs *(Respondents could choose multiple options)*

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Are you using any of the following surveys to identify students' mental health needs?	Conducting UMHS (n=158)	Not Conducting UMHS (n=173)	Not Sure if Conducting UMHS (n=46)	All Respondents (n=377)
California Healthy Kids Survey	59% (93)	55% (96)	37% (17)	55% (206)
CoVitality	6% (9)	2% (3)	0% (0)	3% (12)
Kelvin	15% (24)	8% (13)	7% (3)	11% (40)
Panorama	26% (41)	16% (28)	4% (2)	19% (71)
District/school-developed survey	27% (42)	24% (41)	20% (9)	24% (92)
Other	15% (24)	16% (27)	11% (5)	15% (56)
Do not know	8% (13)	8% (14)	35% (16)	11% (43)
No surveys used	5% (8)	17% (29)	15% (7)	12% (44)

Among all respondents, most (92%) agreed that implementing UMHS in California schools would benefit the community (Table 7). However, less than half (41%) agreed that their LEAs currently had sufficient resources to support students' mental health needs. This differed across LEAs that were and were not conducting UMHS, as seen in the table below.

Table 7: 2024 UMHS Survey, Perceptions of UMHS and Available Resources to Support Students' Needs

Participants who responded "Agree" or "Strongly Agree" to the following statements:	Conducting UMHS (n=158)	Not Conducting UMHS (n=171-174)	Not Sure if Conducting UMHS (n=44-45)	All Respondents (n=377)
Implementing universal screening in all California schools would benefit students, staff, and school communities.	94% (149)	90% (156)	96% (43)	92% (348)
Our school has sufficient resources to support students' mental health needs.	56% (89)	29% (50)	32% (14)	41% (153)

When asked whether their LEAs had organizations they could refer students to for mental health services in the community, most respondents said they did but availability was limited, with a higher percentage of LEAs that did not conduct UMHS reporting this than schools that were (Table 8).

Table 8: 2024 UMHS Survey, Availability of Community-Based Mental Health Services

Does your district or school have organizations you can refer students to for mental health services in the community (off-campus)?	Conducting UMHS (n=158)	Not Conducting UMHS (n=173)	Not Sure if Conducting UMHS (n=45)	All Respondents (n=376)
Yes, and they have availability to meet students' needs	25% (40)	13% (23)	22% (10)	19% (73)
Yes, but availability is limited	65% (103)	83% (143)	62% (28)	73% (274)

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No	3% (5)	3% (6)	9% (4)	4% (15)
Not sure	6% (10)	1% (1)	7% (3)	4% (14)

LEAs Conducting UMHS Screening

Among the survey respondents from LEAs that had conducted UMHS, most reported they had conducted UMHS in the current 2023-24 school year (79%), with 11% reporting that they conducted UMHS in the 2022-23 school year, 4% in 2021-22 or earlier, and 6% were not sure when they conducted UMHS. Most respondents reported using Local Control Funding Formula (52%) and/or grant/foundation (27%) funds to support their UMHS programs, while 17% reported they used "other" funds and 19% reported they did not use any funds (data not shown in tables).

Why LEAs Implement UMHS

When asked why they decided to conduct UMHS, most responses related to conducting screenings as part of their MTSS, using data to identify students in need, and a desire to provide early intervention, as well as conducting screenings as part of a district-led initiative. For example:

- *"To ensure the mental health needs of students were being addressed post pandemic."*
- *"To inform our practices and provide data so we can implement supports and activities within our MTSS."*
- *"To use data to identify students who need more assistance."*
- *"To better direct and support mental health resources."*
- *"[Because] we know kids are falling through the cracks and we want to find ways to ensure we are supporting all students."*
- *"High number of students dealing with mental health and we need to figure out resources."*
- *"One important factor is that students with internalizing symptoms are sometimes missed within the school environment as managing students with externalizing behaviors is more prevalent due to challenges these behaviors present in the learning environment. It also increases staff awareness of student needs."*

How LEAs Implement UMHS

Among those who reported conducting UMHS, most reported that students complete the screening tool (70%); 39% reported that teachers complete the tool, 11% parents/caregivers, and 16% mental health professionals (data not shown in tables). Three-quarters of respondents reported that their schools screened for behavioral/emotional challenges (78%) and/or strengths (75%), as seen in the table below (Table 9).

Table 9: 2024 UMHS Survey, Screening Tool Focus Areas *(Respondents could choose multiple options)*

Which of the following did you screen for?	N=172
Behavioral or emotional challenges (e.g., acting out, stress, anxiety, depression)	78% (135)
Emotional or behavioral strengths or well-being (e.g., SEL, resiliency, school connectedness, belonging)	75% (129)
Social skills (e.g., communication, cooperation, responsibility)	56% (96)

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Other (e.g., academics, suicide risk, school engagement/climate)	7% (12)

Half of the survey respondents that were conducting UMHS were at LEAs that screened all students, while the second largest group were those at LEAs that screened specific grade levels (Table 10).

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Table 10: 2024 UMHS Survey, Which Students Are Screened

Which students were screened? Indicate the largest relevant group.	N=174
All students in the school(s)	50% (87)
All students in a specific grade level(s)	29% (50)
All students in a class	2% (3)
Students nominated or referred by staff	9% (15)
Other	7% (12)
Not sure	4% (7)

The survey asked whether identifiable student data was collected during school screenings, and, while 83% of respondents said that it was, 8% said that they were not collecting identifiable student data and 9% were not sure (data not shown in tables). Furthermore, as seen in the table below, LEAs used a variety of tools to conduct UMHS, but notably 30% were using tools that, while still informative and valuable, are potentially not identifiable and 18% were using district/school developed tools (Table 11).

Table 11: 2024 UMHS Survey, Screening Tools Used *(Respondents could choose multiple options)*

Which tool(s) were used in your universal mental health screening process? *Please note, we are not endorsing any of these tools.*	N=168
District/school-developed screener	18% (31)
Social, Academic, Emotional Behavior Risk Screener (SAEBRS)	11% (18)
Student Risk Screening Scale (SRSS)	11% (18)
BASC-3 Behavioral and Emotional Screening System (BASC-3 BESS)	7% (11)
SSIS Social-Emotional Learning Edition (SSIS SEL)	7% (11)
Strengths and Difficulties Questionnaire (SDQ)	5% (8)
Devereux Student Strengths Assessment (DESSA)	6 (4%)
Behavior Intervention Monitoring Assessment System (BIMAS-2)	2% (3)
Other (write-in responses included: Panorama, Covitality, Kelvin, Heads Up Check Up, California Healthy Kids Survey)	30% (51)
Not sure	24% (41)

Respondents shared what happens once students are identified to have mental health needs through the UMHS process, including referring students to a mental health professional in the school (53%) and/or to a problem-solving team (38%; Table 12).

Table 12: 2024 UMHS Survey, Next Steps after Students Are Identified as Having Mental Health Needs *(Respondents could choose multiple options)*

What happens when a student is identified to have mental health needs through the universal mental health screening process?	N=167

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Students are referred to a mental health professional within the school (e.g., school psychologist)	53% (89)
Students are referred to problem-solving team (e.g., COST, Care, Student Success Team)	38% (64)
Our school team has a written protocol to link students to services depending on level of need	37% (61)
Students' parent/guardians are alerted and advised to seek further assessment	29% (49)
Students are referred to a mental health professional/clinic outside the school	27% (45)
Students are referred to a school-based group program	23% (38)
Other	7% (11)
Not sure	8% (14)

Challenges with UMHS Implementation

Respondents were asked to select the challenges they faced when implementing UMHS from a list of potential challenges. Lack of external resources to refer students requiring follow-up (44%) and lack of school resources to refer students requiring follow-up (38%) were the most frequently reported challenges (Table 13). One respondent elaborated on the challenges:

> *"Universal mental health screening tools are useful and can be helpful. Many years ago, we were utilizing them and they were helpful to identify students early and offer support early. Some of the charter schools use them as well and this can help the school identify needs. The problem though is that with funding cuts to mental health supports in schools, we are limited with the support that can be offered to students. Having screeners could potentially create an influx of need that the school mental health staff is unable to support with the limited resources and also the limited community partners to refer for additional support. We lack the infrastructure to mandate screening in schools."*

Table 13: 2024 UMHS Survey, Challenges Faced with UMHS *(Respondents could choose multiple options)*

What challenges do you face with your universal mental health screening efforts?	N=165
Lack of external (community) resources to refer students requiring follow-up	44% (72)
Lack of internal (school) resources to refer students requiring follow-up	38% (62)
Survey/assessment fatigue	31% (51)
Time taken away from classroom instruction	25% (42)
Concerns related to equity/cultural responsiveness	22% (37)
Accessing data after screening is conducted	16% (26)
Ethical/legal concerns, e.g., legal responsibility to serve students identified with needs	15% (25)
Lack of staff to conduct screening	15% (24)
Lack of knowledge about how to implement (e.g., which tools to use, resources needed, etc.)	12% (19)
Cost to conduct screening	8% (13)

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What challenges do you face with your universal mental health screening efforts?	N=165
Other	15% (25)
No challenges	10% (17)

Ethical Challenges

Survey respondents shared the following thoughts on their concerns related to the ethical challenges of screening:

- *"We end up with more need identified than capacity to meet the need, which feels unethical. We are working to increase our resources through grant funding so that more resources are available for identified students."*
- *"Ensuring all students who have identified as high/moderate risk are met with and supported in a timely manner. The concerns also are the legality piece; offering it multiple times in a school year, running out of support/resources for these students, staff buy in (refusing to administer)."*
- *"The length of time to have students considered and referred is taking too long and when the student does not qualify for a specific program there needs to be another service available to meet the student's needs."*
- *"We reach out to parents and inform them that their child requires mental health counseling, parents do not follow through with obtaining counseling for their child, so we feel ethically obligated to take on that student as a client even though our caseloads are at max capacity."*

Screening Concerns

When asked whether concerns from different groups limited their screening efforts, more than half (55%) of respondents said that none of those groups (students, school staff, leadership, or parents/caregivers) expressed concerns that limited screening efforts, though some respondents reported that they did:

- 24% indicated that concerns from school staff limited screening efforts, such as insufficient time to dedicate to screening and not supporting the screener used.
- 20% indicated that concerns from students limit efforts, such as survey fatigue and lack of interest.
- 13% noted parent/caregivers' concerns, such as questions being invasive and equity/cultural concerns.
- 8% noted concerns from school and/or district leadership, such as having sufficient community resources and staff to conduct screening.

Facilitators of UMHS Implementation

Respondents also selected the factors that support UMHS implementation in their schools. The most common factor selected was having adequate school staff to handle referral needs (Table 14).

Table 14: 2024 UMHS Survey, Factors that Facilitate UMHS *(Respondents could choose multiple options)*

What factors help your universal mental health screening efforts succeed?	N=161
Adequate school staff to handle referral needs	58% (93)

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What factors help your universal mental health screening efforts succeed?	N=161
Ongoing communication about screening and related mental health initiatives	53% (86)
Dedicated time during the school day to conduct screenings	48% (77)
Adequate community referral sources	46% (74)
Clear roles and responsibilities across staff involved in screening efforts	42% (67)
Clear identified student needs	40% (64)
Alignment with school mission and district priorities	38% (61)
Adequate funding	35% (57)
Availability of trainings on how to conduct the screenings	25% (41)
Other	4% (6)
None of the above	4% (6)

Centering Equity in UMHS

Given the importance of centering equity in UMHS efforts, respondents were asked to indicate which strategies they used to center equity in their UMHS processes. Most respondents indicated that they were implementing several strategies (60%, n=94), as evidenced by their selection of two or more options from the list of strategies. One-quarter selected one of the listed strategies (26%) and 15% reported they were not implementing any of the listed strategies. As seen in the table below, half were focusing on culturally responsive school-wide supports (51%) and over one-third reported analyzing disaggregated data, using tools in the primary languages of students and families, and involving diverse voices in decisions made about the screening process (Table 15).

Table 15: 2024 UMHS Survey, Strategies Used to Center Equity in UMHS *(Respondents could choose multiple options)*

What strategies are you using to center equity in your UMHS process?	N=158
Focus on culturally responsive school-wide supports	51% (80)
Analyze disaggregated data to identify and address disparities	39% (62)
Screening tools are provided in the primary language of students/families	34% (54)
Decisions made about the screening process include diverse staff, student, and family voices	34% (54)
Staff involved in screening processes are representative of the broader school community	28% (44)
Other	3% (5)
None of the above	15% (23)

Success of UMHS

When asked, overall, if they felt their UMHS efforts were successful in identifying students who needed additional mental health supports and why, most respondents felt that it was successful. Yet, some

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shared mixed feedback, reinforcing the need to ensure that UMHS efforts are well-planned, well-resourced, and use an equity-focused approach. For example:

- *"Yes, we were able to identify trends amongst the student body to better direct resource, and intervene for individual student needs."*
- *"Certainly. It has helped us identify student mental health needs, allow us to monitor student progress and measure as well as evaluate small group interventions. We have strong parent and administrator support at this point."*
- *"Yes, a mental health questionnaire helps to identify students struggling with mental health problems. Once identify they are able to be referred to appropriate services."*
- *"Yes. The universal screening has helped us identify areas needing improvement for individual students, small groups of students, whole classes and whole schools. It helps us be more proactive in addressing student needs."*
- *"Yes, there were some students identified who are very good at 'masking' at school. We were able to identify some challenges they were facing and provide them with support."*
- *"Our universal mental health screening efforts have been hugely successful in identifying students who need additional mental health supports, because it offers us equitable data for all students -- not just the ones acting out. We've been able to implement early intervention strategies with students who may have otherwise "flown under the radar.""*
- *"While it is successful, the lack of outside resources creates difficulty, and the great need outweighs the amount of time one counselor has to serve all students. Often my requests for a student to receive counseling are not followed through due to the lack of time and personnel to service students."*
- "*Not really, kids were unclear about questions, and the kids who had 'problems' were often resolved before we got the data."*
- *"No, because we did not have the proper system in place to use the information after the screenings."*

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LEAs That Were Not or Were Not Sure If They Were Conducting UMHS

Among respondents who reported that their LEAs did not conduct UMHS or were not sure if they were conducting UMHS, few planned to conduct UMHS in the near future (Table 16).

Table 16: 2024 UMHS Survey, Future Plans to Conduct UMHS

Has your site ever seriously considered conducting universal mental health screening?	Not Conducting UMHS (n=181)	Not Sure if Conducting UMHS (n=50)
Yes, we are planning to	19% (35)	8% (4)
Yes, but we are not planning to conduct anytime in the near future	29% (52)	14% (7)
No	17% (30)	6% (3)
Not sure	35% (64)	72% (36)

How LEAs Identify Youth with Potential Mental Health Needs

When asked what they are currently doing to identify students who need mental health supports, most respondents indicated that “school staff refer students to community partners”, “school mental health staff screen individual students who are referred to them,” or “identified students’ needs are discussed at school committee meetings” (Table 17).

Table 17: 2024 UMHS Survey, Methods to Identify Students with Mental Health Needs *(Respondents could choose multiple options)*

What are you currently doing to identify students who need mental health support?	Not Conducting UMHS (n=175)	Not Sure if Conducting UMHS (n=46)
School mental health staff screen individual students who are referred to them	79% (139)	67% (31)
School staff refer students to community partners	70% (123)	57% (26)
Identified students’ needs are discussed at school committee meetings (e.g., COST, SST, etc.)	79% (139)	57% (26)
Other	19% (34)	13% (6)
Not sure	2% (3)	9% (4)
We are not currently identifying students	1% (2)	4% (2)

Overall, only 18% of participants from LEAs that were not conducting UMHS said that current approaches to identifying students with mental health needs adequately meet the needs of their school community, while 73% felt they “somewhat” met their needs. The percentage that felt they had adequate approaches was slightly higher in LEAs that were not sure if they conducted UMHS (Table 18).

Table 18: 2024 UMHS Survey, Adequacy of Approaches to Identify Students with Mental Health Needs

Do your current approaches to identifying students with mental health needs adequately meet the needs of your school community?	Not Conducting UMHS (n=176)	Not Sure if Conducting UMHS (n=46)
Yes	18% (32)	24% (11)
Somewhat	73% (129)	59% (27)
No	9% (15)	17% (8)

Challenges to UMHS Implementation

Similar to LEAs that were conducting UMHS, most survey respondents from LEAs that were not or were not sure if they were conducting UMHS noted lack of resources to refer students to as a factor that limits UMHS, however over half also noted not having staff to conduct screenings, ethical/legal concerns, lack of knowledge about how to do it, and costs as other concerns (Table 19).

Table 19: 2024 UMHS Survey, Factors Limiting UMHS *(Respondents could choose multiple options)*

What factors may limit screening efforts?	Not Conducting UMHS (n=178)	Not Sure if Conducting UMHS (n=48)
Concerns related to equity/cultural responsiveness	46% (82)	46% (22)
Cost to conduct screenings	54% (97)	48% (23)
Ethical/legal concerns, e.g., legal responsibility to serve students who are identified	61% (108)	50% (24)
Lack of staff to conduct screening	60% (106)	40% (19)
Lack of internal (school) resources to refer students requiring follow-up	66% (117)	48% (23)
Lack of external (community) resources to refer students requiring follow-up	57% (101)	35% (17)
Lack of knowledge about how to do it (e.g., which tools to use, what resources are needed, etc.)	58% (104)	50% (24)
Survey/assessment fatigue	31% (56)	33% (16)
Other	6% (10)	2% (1)
Not sure	3% (6)	13% (6)
None of the above	0 (0%)	0 (0%)

Screening Concerns

Respondents were asked about whether concerns from various groups would limit screening efforts. More than half of respondents selected from the provided list that concerns were related to parents/community members, such as questions about sensitive topics like gender identity, privacy, lack of information/knowledge, and fear of stigma associated with a child being flagged; or school

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staff, such as lack of resources and availability, capacity to conduct screenings, and extra workload. Less than half noted concerns were related to school and/or district leadership, such as the capacity to respond and follow-through, legal and financial liability, lack of resources; and parent/caregiver concerns about survey questions, or students, such as confidentiality, survey fatigue, and worrying about what families/friends may think (Table 20).

Table 20: 2024 UMHS Survey, Interest Holder Concerns Limiting UMHS *(Respondents could choose multiple options)*

Would concerns from any of the following groups limit screening efforts and, if so, what specific concerns?	Not Conducting UMHS (n=142)	Not Sure if Conducting UMHS (n=40)
Students	40% (57)	35% (14)
Parents/community members	58% (82)	57% (23)
School staff	59% (84)	40% (16)
School and/or district leadership	46% (66)	40% (16)
Other	6% (9)	3% (1)
None of the above	17% (24)	33% (13)

Support for UMHS

Survey respondents noted high levels of potential support from these groups for conducting UMHS in their school communities, with lower levels of perceived support from parents/guardians and school board members than school mental health staff, administrators, and students (Table 21).

Table 21: 2024 UMHS Survey, Interest Holders' Support of UMHS

How much do you agree or disagree that the following groups would support conducting universal mental health screening in your school community? (Percent responding "agree" or "strongly agree")	Not Conducting UMHS (n=171-173)	Not Sure if Conducting UMHS (n=43-44)
School mental health staff (e.g., school psychologists or social workers)	93% (159)	95% (42)
School administrators	85% (147)	91% (39)
Students	84% (144)	91% (39)
Teachers and other school staff	83% (143)	84% (37)
Parents/guardians	76% (131)	74% (32)
School board	71% (122)	74% (32)

What LEAs Need to Implement UMHS

When asked what their LEAs need to conduct UMHS, the most common responses that respondents who were from LEAs that were not conducting UMHS selected were "additional staff to handle referral needs" and "information about measures/tools to use," as seen in the table below (Table 22).

Table 22: 2024 UMHS Survey, Needed Supports to Implement UMHS *(Respondents could choose multiple options)*

What would you need to conduct universal mental health screening?	Not Conducting UMHS (n=183)	Not Sure if Conducting UMHS (n=50)
Additional school staff to handle referral needs	64% (118)	52% (26)
Information on measures/tools to use	63% (116)	46% (23)
Dedicated time during school day to conduct screenings	57% (105)	50% (25)
Clear roles and responsibilities across staff	55% (101)	56% (28)
Additional funds	51% (93)	48% (24)
Identification of community referral sources to refer students with identified needs	41% (75)	36% (18)
Information on costs	38% (70)	24% (12)
Other	10% (18)	4% (2)
Not sure	3% (6)	24 (12)
None of the above	1% (2)	0% (0)

When asked which resources participants think would be helpful in implementing UMHS, more than half selected "technical assistance on how to develop and use an UMHS process" and "direction from district leadership" (Table 23). More respondents from LEAs that were not conducting UMHS selected "state-level policy providing standards" or "state-level policy requiring it" would be helpful than those who were not sure if they were conducting UMHS.

Table 23: 2024 UMHS Survey, Helpful Resources to Implement UMHS *(Respondents could choose multiple options)*

Would any of the following resources be helpful in implementing universal mental health screening?	Not Conducting UMHS (n=182)	Not Sure if Conducting UMHS (n=50)
Technical assistance on how to develop and use a universal screening process	65% (119)	64% (32)
Direction from district leadership	55% (101)	54% (27)
State-level policy requiring it	43% (78)	26% (13)
State-level policy providing standards	43% (78)	26% (13)
Other	8% (15)	0 (0%)
Not sure	7% (12)	22% (11)
None of the above	2% (3)	2% (1)

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Youth and Parent/Caregiver Listening Sessions: Summary of Perspectives on Universal Mental Health Screening

Overview

The Mental Health Services Oversight and Accountability Commission (the Commission) prioritizes community engagement to inform the design and implementation of all initiatives. In order to better understand the perspectives of youth and parents/caregivers on universal mental health screening (UMHS), the Commission conducted listening sessions with groups of youth and parents/caregivers. These listening sessions were held with each group independently (i.e., youth listening sessions and parent/caregiver listening sessions were conducted separately). Three sessions were conducted with youth throughout California and two with parents/caregivers in May 2024. Youth were recruited from partner organizations that had youth advisory groups and afterschool youth-led clubs that were focused on mental health. Parents/caregivers were recruited with the help of United Parents, a non-profit/community-based organization that advocates for, empowers, and supports parents with children facing emotional, behavioral, mental health, and family challenges. Twenty-one youth and 14 parents/caregivers participated in the listening sessions. Listening sessions were recorded, transcribed, and analyzed for common themes and pertinent quotes.

In each session, participants were asked to respond dialogically to a semi-structured set of questions. These questions covered several topics related to UMHS. Participants were first asked to reflect on the current state of youth mental health, including contributing factors to mental health challenges, consequences of an insufficient support system, and the role of schools in identifying and connecting youth to mental health supports. Next, participants provided input on how the schools in their communities identify students with mental health concerns. In this stage of the listening sessions, participants provided their own definitions or examples of UMHS, which were considered alongside the Commission's definition. Each group was then asked what they felt the benefits of screenings might be and how their respective group (youth/students or parents/caregivers) would respond to schools conducting UMHS. For the remainder of the listening sessions, questions diverged between the two groups. Youth were asked about which school staff should be involved in UMHS, their experiences with school staff after they were screened, and how UMHS might improve outcomes for marginalized groups. Parents/caregivers were asked what potential challenges schools interested in conducting UMHS may face.

These listening sessions resulted in numerous important insights into how youth and parents/caregivers conceptualize UMHS amid the current school and cultural climates surrounding mental health. Below, we summarize the results of these listening sessions. Specifically, we present participants' articulations of both (1) barriers/concerns and (2) facilitators/helpful practices in the landscape of mental health and UMHS in California schools. Additionally, we address the similarities and distinctions between the perspectives of youth and parents/caregivers that manifested during the listening sessions.

Sources of Youth Mental Health Struggle in Schools

Respondents felt that youth mental health challenges are the result of multiple factors. These factors are multidimensional and often the direct result of school climate, which makes it difficult for schools

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to address them effectively. Students discussed how home and family life, community wellbeing, and peer groups all exert significant influence on their mental health. Additionally, external and/or educational pressures, such as the difficulties balancing academic, co-curricular, and personal responsibilities, contribute significantly to youth burnout, anxiety, and depression.

As respondents shared, life circumstances and school circumstances all have the potential to place youth at risk for mental health challenges. Across youth and parent/caregiver listening sessions, participants agreed that the stigmas surrounding mental health and support seeking behavior fundamentally hinder help-seeking behavior and the delivery of appropriate interventions that could improve students' wellbeing. As two youth participants discussed:

- *"I think despite mental health being something more commonly talked about nowadays, it's still really scary to open up. So lots of people still won't feel comfortable or feel like they're able to open up and go ask an adult for help because it's seen as something like attention craving or like, "oh, my problems aren't as big as others." So I feel like that is really diminishing."*
- *"I think it's really going to be dependent on the person and if they're willing to open up or not, because lots of people don't like the idea of people knowing their personal business; [it's] a sign of weakness."*

Despite increased political and educational efforts to destigmatize mental health, it is clear from these youths' testimony that asking for help is still a significant barrier for young people who may want support, including support from school staff such as counselors, psychologists, and educators. Some participants identified that schools are taking direct approaches to removing this barrier by creating a positive culture and climate around mental health support, but these schools' efforts are mediated by a lack of available resources, staffing, and/or prioritization to transform culture and climate into actionable support/intervention plans, including UMHS. We now turn to participants' identification of challenges in the UMHS process.

Challenges to Effective Implementation of UMHS to Address Mental Health

In the face of endemic mental health struggle, parents/caregivers and youth alike felt that UMHS must overcome significant hurdles to be as effective as possible. Parents/caregivers often felt as though student needs were not being met by schools, or were only met once those needs were significantly impacting their children's education and quality of life. Parents/caregivers felt as though they needed to take the lead to advocate for proactive identification of their children's needs and for school mental health supports. Additionally, although the parent/caregiver participants had favorable views of UMHS, they noted that resistance to UMHS exists among many parent communities. Parent/caregiver participants identified community concerns about their children being stigmatized:

> *I've been on state discussions and I know that the kids are ready and will embrace this. The parents will not. It is a measurement, a judgment, and something that they feel that would label their child. I know specific subcultures in our community where just even bringing it up is insulting. And so it is going to take several years of just refining and describing as you did to us today, what a mental health screening tool will do. And it has to assure confidentiality and all these other things.*

This response demonstrates the challenge parents and schools face in establishing trust and buy in among their students' families. While youth participants tended to agree with parents/caregivers that UMHS will be embraced by students, they identified some issues on their side. For example, some youth associate universal screening as a diagnostic or punitive measure and feel that schools are frequently vague about the purpose of screening and how screening data are used. Also, the youth noted that teacher messaging can impact how seriously students take these surveys, and teachers may not feel that UMHS is important or believe it takes up valuable class time. Youth also expressed concerns over anonymity and confidentiality, and disclosed that these concerns may lead to them not answering screeners truthfully or seriously. As one respondent discusses:

> *I feel like people tend to lie because they get scared that their parents are going to find out because some parents don't really believe in mental health, so their parents don't really want them to get the help they need because they find it useless. And I feel like also they tend to lie because they just feel scared I guess. And they just don't want to be called out in a way; they don't want to be truthful with themselves because they don't want to feel like there's something wrong with them.*

UMHS can only be an effective way to identify at risk youth and connect them with appropriate resources insofar as the responses to screeners are valid. If youth cannot trust their campus to maintain their privacy, or if they do not feel comfortable with the support offered by school counselors or psychologists, screening data may not accurately reflect the landscape of student needs. In the next section, we discuss listening session participants' ideas for the ways in which schools can improve mental health services to better capitalize on UMHS's potential and help students.

Facilitators and Helpful Practices

Despite the challenges discussed above, UMHS was broadly supported by both youth and parents/caregivers in the listening sessions. Many participants felt that even if screening is not implemented with the same integrity across contexts, having a system in place to identify both individual and collective mental health needs early contributes positively to youth wellbeing above and beyond other referral methods. This was especially true for parents who were involved in educational/community activities around mental health. These participants - and many students - noted that school investment in normalizing struggle and destigmatizing support seeking behaviors, particularly as early as possible in a student's education, established trust among youth and families for UMHS, which in turn opens channels for staff to offer support to identified students.

As evidence, parent/caregiver participants often noted the impact of schools' efforts to educate parents and community partners about the importance of students' mental/emotional wellbeing. One explained, *"This is a way for us to come in and tailor these resources and approach your family, your children, with a more proactive approach. So there needs to be an educational component to it so that it breaks down that stigma."*

The educational component that this parent/caregiver identifies is an important step in getting parents/caregivers involved and invested in screening; coalition building between schools and families can demystify UMHS processes and democratize student mental health support.

Respondents' recommendations to improve UMHS and its impact in matching youth with appropriate supports include tangible action items for practitioners, administrators, and policymakers:

- Hire additional counselors and training them in culturally sustaining capacities.
- Provide robust education to students regarding UMHS measures and give them multiple modes for screener completion.
- Establish transparency about UMHS implementation to address stigma among families and community members.

Youth believe in the important role their schools play in supporting their mental wellbeing, particularly when they may not be able to access external resources. As one explained, *"My school offers really amazing counselors and things like that. And for me it saved my life. It was amazing and I got the help that I needed and I think that a lot of people have been helped too, and I just think it's really important and great to do."*

Yet, many remain skeptical - about their privacy, about how their parents/caregivers will respond to their screening data, and about placing their trust in school officials. To combat youth hesitancy and improve UMHS outcomes, listening session respondents offered the following points.

Youth believe that counselors and psychologists should be primarily responsible for UMHS, as they are trained in mental health issues. However, school mental health staff need to introduce themselves to and build relationships with students as early and as often as possible to establish trust. Transparency around follow-up and the use of screening data, including students' privacy rights and when parents/caregivers are contacted, is also crucial. Additionally, students need to understand why they are being screened. Rather than feeling as though they are having screening done to them, students should feel as though screening is being conducted by staff who stand with them and have their best interests at heart.

One parent/caregiver, in discussing how they talk with their child about their needs, described this with distinct clarity:

> *"She's still struggling like, 'oh, I have autism, something's wrong with me. What is wrong?' I'm like, 'nothing's wrong. Just so we can better identify what you need. If [timed test taking] doesn't work for you, then it doesn't work for you. We need to identify that first, then we can better help you.' So I think that kind of goes with this universal screening thing. People might be afraid, 'what is this going to look like for me?' So be very transparent, this is what this test or questionnaire is trying to do for all of us."*

Distinctions and Connections between Youth and Parents/Caregivers

Youth tend to consider UMHS in a more immediate capacity, since they are or would be directly affected by these practices at their schools. The listening sessions revealed their significant experiential knowledge about how mental health initiatives struggle or succeed in school contexts. They also articulate a clear desire for safety and wellbeing in school, and call on adult decision makers to take UMHS seriously. Parents tend to think outward into their communities and how district politics and cultural climates influence the way mental health programming occurs in schools. Additionally, they are concerned with how their students, particularly students with disabilities, might

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interact with school mental health networks and discussed the importance of appropriate planning and resources to maximize the impact of UMHS programs.

Although these differences in viewpoint are certainly important, parent/caregiver and youth listening sessions indicated broad alignment about contributing factors to youth mental health issues and critical issues in screening. Both sets of participants want broader, more personal access to school mental health professionals for students. Both groups highlight the importance of peer relationships on students' mindsets, suggesting that while peers may push some youth toward social, emotional, and behavioral risk, encouraging a positive, open mental health climate can make peers a powerful source of support and encouragement for youth. Most importantly, they tend to support the implementation of UMHS as an effective method for both (1) identifying individual students in need of more targeted intervention and (2) gauging the overall mental wellbeing of the student population in a given school setting.

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School Staff Interviews: Summary of Findings

Overview

In June 2024, the UCSF research team identified a small sample of local education agency (LEA) representatives to conduct semi-structured interviews with to learn more about their experiences with universal mental health screening (UMHS). Individuals were identified from the sample of respondents to the UMHS Survey based on whether they were or were not implementing UMHS. Some survey respondents also indicated in the survey that they would be willing to participate in follow-up interviews. The research team aimed to identify representatives from LEAs that were in different parts of California. Of the 48 total individuals contacted to participate in interviews, 35 did not respond and three declined or cancelled. Interviews were conducted over Zoom with four representatives from four LEAs that had conducted UMHS and eight representatives from six LEAs that had not (two of the latter interviews had two participants). Interviews were recorded, transcribed, and analyzed for common themes and pertinent quotes.

Interviewees held a diverse range of roles related to mental health in their LEAs, including program coordinators, school psychologists, counselors, social workers, administrators, and specialists focused on student support services, family engagement, and equity. Their years of experience in these roles ranged from six months to over 20 years.

The following is a summary of the interview findings. While the sample size is small and <u>not representative of schools or districts statewide</u>, the findings provide insights into the current landscape of UMHS screening in California.

Implementing UMHS

Those working in LEAs that conduct UMHS defined it as a tool administered to all students to identify strengths, needs, and risk factors through student self-report and teacher ratings. They described using formal screening tools, such as the Student Risk Screening Scale (SRSS), Devereux Student Strengths Assessment, or custom surveys, administered 2-3 times per year. The screenings were often integrated into their multi-tiered system of supports (MTSS) frameworks. Participants described detailed protocols for reviewing screening data in school teams, matching students to appropriate Tier 2 and 3 interventions, notifying parents/guardians, and monitoring progress over time. The representatives from LEAs that were conducting UMHS used general education, special education, and grant funds to support screenings. Costs included those related to purchasing screening tools, creating data systems, and staff time for administration and follow-up. When asked about their screening implementation, one interviewee shared:

> *We go through all the results of the screenings and look for if there are places where someone might be in need of individual services or if more tier two small groups can be implemented. Also, if we're seeing sort of a trend across the board, then working on what we can bring into the classrooms in a more tier one universal response. …I would say it starts with us [school psychologist and mental health counselor] and then the moderate and severe or moderate and high scoring - that's what they call it on the SRSS - we have what we call a mental health team. That's our superintendent, our two principals, our family resource center director. We have a mindfulness… program. Anyone who would be involved with mental health for students and*

families in the community, we come together about once a month. And so we at that point would bring those results and either just talk about trends or if there's specific families that are in need of things, we can collaborate on that. We also have a small rural health clinic that provides behavioral health and so sometimes referrals go there…

Benefits of UMHS

Those who work in LEAs that conduct UMHS described the benefits as including raising awareness, identifying students with internalizing concerns, informing allocation of resources, and monitoring intervention effectiveness over time. Screening helped identify students with significant unmet mental health needs, leading to increased access to services. Screening data also informed school- and district-level prevention and early intervention efforts. As one interviewee shared:

I think a real pro for universal screening is that it provides our people with a common language. They have an understanding of what mental health needs can look like or what they can be because of the language that's in screeners and so on. And it provides more understanding even at our parent level when we're communicating to our parents that, 'Hey, we're doing this not to identify that your kid is, there's something wrong with your kid, but to figure out how we can support your family, support you guys as a whole.' …. Honestly, knowledge is power. And when we do the screening, sometimes it's very surprising. Oh my gosh, I had no idea that that child felt that way. And so it's been super impactful in that way. It's allowed our staff, not just our teachers, but also our classified staff to build more meaningful relationships with our students because they know which kids need an intentional, deliberate check-in. They know which kids are just trying to fly low under the radar. Sometimes we learn things about family circumstances or what's going on inside and outside of school that we would've had no other way to know that. So I think it's had a huge impact in that way for all of our school community. One of the things we're really working hard to do is to remove the stigma of mental health challenges, because families will often decline services because that stigma is there. Nope, that would never be my child. Nope. They are not struggling with those kinds of things. Or just culturally, maybe receiving professional support isn't a part of what their culture supports. And so we have to be mindful of that too. But just bringing awareness.

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Challenges of UMHS

Those who did not conduct UMHS emphasized the limited capacity to respond to identified needs, concerns about student privacy and parental consent, and the potential for screening to overload already strained mental health resources. The lack of dedicated funding for mental health services was a significant barrier to implementing UMHS. Participants noted that short-term grants needed to be increased to build sustainable systems. Among those who were not conducting UMHS, they typically relied on teacher or parent/guardian referrals to identify students in need. Follow-up often involved connecting students to school counselors or community providers on a case-by-case basis. They also noted that the lack of UMHS made it difficult to accurately assess student needs and evaluate the impact of services. Referral-based approaches were seen as less equitable and proactive.

Participants who were and were not conducting UMHS shared the following thoughts on the challenges of UMHS:

- "*I think [a benefit of UMHS is] equity. So if you have bad behavior, you might get referred. If someone knows you really well, you might get referred. But I think there's a lot of missed potential to help students, especially historically marginalized student groups... So right now, I see people are getting mental health, but it's not really clear what they're getting or is it working and when it's there, how are we allocating resources intentionally and being effective and intentional with what we're doing."*
- *"I think we always have to be aware of our own biases, both our own personal biases as well as maybe our team members' biases the way we see our community, those biases because almost any screening tool that you use has some room for biases to sneak in."*
- *"As a person who's worked in schools for a long time, I think the staff or logistical focused reasons are that we do not have enough mental health professionals or the systems or facilities to address what I believe would be the result of the universal screener. We did in our district try… and even that with the list of students that was generated, it was quite a lot of students. And then we have one counselor who's at a middle school with 600 students. So if I get a list in one day of 150 students who may be at risk of something is very challenging to feel that I can get to them in time or to triage that communicate to parents because they're minors who may not have the facilities to supervise as many students who, especially if they were at an immediate risk. So there are a lot of, I call those logistical, even fiscal considerations because I know there's money that's available for mental health professionals, but even when we have grant funds and money, we don't even always have enough people to hire enough candidates who would be willing to work in a school setting who are trained clinical professionals."*
- *"I think my two big takeaways would be one, there is no tool that I have seen that is really, I would say, yes, let's do that. And two, if I magically have that tool tomorrow, do I have the infrastructure and the human beings to deal with it? I do not."*
- *"There's a fear around unmasking the real need and what it's really truly going to look like. I think people really already know what it is, but just to see it in data form."*
- *"And one of the challenges is if you do the screener and you don't have a system in place, system support and resources in place to address the needs that might come up, I don't know what you say, like a double slap in the face, or that's like a kid discloses, and then if the system's not there and you don't catch that, it's a huge disservice to the kid and the family."*
- *"…I feel like many of our teachers do not feel adequately trained to address the issues that come up. And so two things. One is they may be reluctant to do it because they don't know what to do when the information comes out… So that if we don't have a system in place of them being trained and knowing what to do when the information comes out and how to interact with that child to not trigger them and best support them, then yeah, there's a high risk of us not catching the information of being able to respond to it in a timely manner or even at all."*
- *"I would say one of the biggest hurdles would be misconception around mental health. People just not wanting to admit that there's a need. As far as the screener, I think the second biggest challenge we may face is the staffing and capacity to be able to do it with fidelity. Just dependent upon, if it's something that teachers are able to facilitate within a classroom, then they're going to, oh, it's one more thing taking away from my instructional time. Or if we had to have counselors, psychologists, therapists doing that screening, I could see that because of our rural title, we live up to it. And it's difficult to find staff to be able to do that. So I think that may be another hurdle."*
- *"The stigma around it with the community, our families here. And then additionally the capacity to address needs that may come up when you screen. And then what if you don't have folks to be able to provide services or support the capacity on the other side of that."*

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Recommendations and Summary

Those who work in LEAs that conduct UMHS recommended the importance of securing buy-in from district leaders and school staff, investing in high-quality screening tools and data systems, providing clear guidance and training for staff, partnering with families and community providers, and monitoring implementation fidelity and outcomes over time. Those who do not conduct UMHS emphasized the need for state and district mandates and funding to support UMHS, technical assistance for implementation, and greater investment in school-based mental health staffing to ensure adequate follow-up services.

- *"I think something that might be helpful… is just to have the various screeners reviewed and maybe compared and for different needs, which ones might be for different schools or if there's ways to help counties have sort of a universal screener for their whole county and all the districts so that we're kind of all in the same program. Something like that might be nice."*
- *"Honestly, I think if it's a district initiative, there just needs to be an expectation that it's not optional. This is really important. We have to build the why, right? We have to help staff to understand why it matters so much, how it's going to positively impact our kids and our families. And when we establish that, why it's really hard to dispute. And then from there, it's just setting the expectation and then holding people accountable when it's not being done. It is, 'no, we're all doing this. It's really important. Here's the data we're going to get from it,' and then some follow through."*
- *"But the biggest deal is… having the screening, but you don't have the tools or the systems to intervene. You have the knowledge... but you need to work on those interventions. The biggest deal is those tier two interventions and solid tier one schools are pretty good at tier three interventions because those are students who have stood out. But having those interventions across tier one and tier two in place so that you can identify them and put them in there with ease."*
- *"I think it all depends on the climate of where you are and what's happening and the leadership. And then students I think are cautious about, if it's not disseminated clearly, 'where's my data going? Who's going to look at this?' Yeah, it just seems to be about clarity, transparency, good leadership… And the other component is, is it accessible? So is it for our students and families that are different languages? Some of our students speak indigenous languages that aren't in written form, can they listen to the question in a preferred language? So it depends on what tool you also choose and how you ask those questions."*
- *"I feel like it's a question of resources. Right now in our middle schools, we don't have anyone who is a full-time therapist that can provide ongoing service to a student who's identified with needs. We're in line for that to change, but it's not a permanent solution. It's because one of our community partners happens to have funding to provide that. So we don't have an internalized resource, essentially money to pay for that to be an ongoing sustainable support in our middle schools. And the same thing with our elementary schools right now, we're putting together money that we're getting from the city and from various different places so that we can have the contracted supports in place. But, as we know, foundations can decide to use their money in different ways. The city could decide to use their money in different ways. So it's not necessarily sustainable until there is realistic funding to meet the need of mental health services at our schools. And we know that while students can be referred off campus, the supply off campus is also very taxed. It's hard to find. And we've found that students who get services on campus, it's more likely that they attend all the time and potentially more effective for that reason. But to me, it comes down to money to pay for the people*

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that are actually going to provide the service. And we have very limited of that money because it's grant funded for the most part."

- *"I think that goes back… having systems in place and having everyone trained and educated about what it is, what the purpose is, and what's going to happen after it happens. Because I think what happens, I think, especially with classroom teachers is if they're implementing this mental health screener and one of their students is identified, then they need to know what is going to happen after that and not feel like they are the owners of that next necessarily. And so I think it depends on how we purposefully, strategically set up a system in which we can realistically address whatever is found through the universal screening... it kind of doesn't make sense to do a universal screening if we know that we don't have everything in place to address the issues that come up. And so I think that to me is the larger issue, is having a strategic plan in place of how we're going to address even the issues that come up without a universal screener now."*
- *"I think there's a lot out there and it's new and there's funding for it. I think what would be helpful, honestly, if CDE just said, 'Here it is. Here, it's required.' Then we could just fall back on fact. 'This is the mandate' and in our world and our work, both [my colleague] and I, sometimes we have to do things that are hard for us personally, but it makes it little bit easier when we say, 'Oh, nope, it's a state mandate. We're sorry. Here's the CDE website.' So I think it'd be wonderful. I think it is what's best for all children, schools as a whole and communities. If we were to have something that were standardized across the board and mandated from the CDE and then time for training, implementation, stakeholder engagement, opportunity for public viewing and things like that, people are often worried about, 'what is this you're asking my child and wanting?' So I think having opportunity for the public and family to view whatever the tool is, I think would be super helpful too."*
- *"…Unless they make it a requirement, it's going to be pretty difficult for us overall to add one more thing just with the capacity that we have, and then to also be able to defend why we're doing it. Not that we don't believe in it, we do. It's just okay, because we've been talking about this on the other side of things since 2018, and we just cannot seem to pull the pieces together. And so unless it's kind of required and mandated, I don't know that it [will] ever be something that we actually pull the trigger on. You know what I mean?"*

Overall, LEAs implementing UMHS reported significant benefits in identifying students in need, targeting limited resources more effectively, and informing school- and district-level prevention efforts. However, they also faced challenges regarding staff capacity, parental concerns, and sustainable funding. LEAs not currently implementing UMHS recognized the potential value but cited a lack of resources, competing priorities, and logistical barriers as significant impediments. Both groups emphasized the importance of strong leadership, stakeholder buy-in, ongoing monitoring, and quality improvement in successfully implementing UMHS in schools.

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MISCELLANEOUS ENCLOSURES

November 21st, 2024 Commission Meeting

Enclosures (3):
(1) Evaluation Dashboard
(2) Innovation Dashboard
(3) Department of Health Care Services Revenue and Expenditure Reports Status Update

MHSOAC Evaluation Dashboard November 2024
(Updated November 11, 2024)

Summary of Updates

Contracts

New Contracts: 0

Total Contracts: 3

Funds Spent Since the October 2024 Commission Meeting

Contract Number	Amount
21MHSOAC023	$ 0.00
22MHSOAC025	$ 0.00
23MHSOAC018	$ 0.00
TOTAL	**$ 0.00**

The Regents of the University of California, San Francisco: Partnering to Build Success in Mental Health Research and Policy (21MHSOAC023)

MHSOAC Staff: Melissa Martin-Mallard

Active Dates: 07/01/21 - 06/30/27

Total Contract Amount: $7,544,350.00

Total Spent: $4,244,350

UCSF is providing onsite staff and technical assistance to the MHSOAC to support project planning, data linkages, and policy analysis.

Deliverable	Status	Due Date	Change
Quarterly Progress Reports	Complete	09/30/21	No
Quarterly Progress Reports	Complete	12/31/21	No
Quarterly Progress Reports	Complete	03/31/2022	No
Quarterly Progress Reports	Complete	06/30/2022	No
Quarterly Progress Reports	Complete	09/30/2022	No
Quarterly Progress Reports	Complete	12/31/2022	No
Quarterly Progress Reports	Complete	03/31/2023	No
Quarterly Progress Reports	Complete	06/30/2023	No
Quarterly Progress Reports	Complete	09/30/2023	No
Quarterly Progress Reports	Complete	12/31/2023	No
Quarterly Progress Reports	Complete	03/31/2024	No
Quarterly Progress Reports	Complete	06/1/2024	Yes
Quarterly Progress Reports	In Progress	9/30/2024	Yes
Quarterly Progress Reports	Not Started	12/31/2024	Yes
Quarterly Progress Reports	Not Started	3/21/2025	Yes
Quarterly Progress Reports	Not Started	6/30/2025	Yes
Quarterly Progress Reports	Not Started	9/30/205	Yes

Quarterly Progress Reports	Not Started	12/31/2025	Yes
Quarterly Progress Reports	Not Started	3/31/2026	Yes
Quarterly Progress Reports	Not Started	6/30/2026	Yes
Quarterly Progress Reports	Not Started	9/20/2026	Yes
Quarterly Progress Reports	Not Started	12/31/2026	Yes
Quarterly Progress Reports	Not Started	3/31/2027	Yes
Quarterly Progress Reports	Not Started	6/1/2027	Yes

WestEd: MHSSA Evaluation Planning (22MHSOAC025)

MHSOAC Staff: Kai LeMasson
Active Dates: 06/26/23 - 12/31/24
Total Contract Amount: $1,500,000.00
Total Spent: $1,100,000.00

This project will result in a plan for evaluating the Mental Health Student Services Act (MHSSA) partnerships, activities and services, and student outcomes. The MHSSA Evaluation Plan will be informed by community engagement and include an evaluation framework, research questions, viable school mental health metrics, and an analytic and methodological approach to evaluating the MHSSA.

Deliverable	Status	Due Date	Change
Project Management Plan	Complete	August 1, 2023	No
Community Engagement Plan	Complete	September 1, 2023	No
Community Engagement Plan Implementation (a, b and c)	Complete Complete In Progress	December 15, 2023 January 15, 2024 October 30, 2024	No
Evaluation Framework and Research Questions	Complete	December 15, 2023	No
School Mental Health Metrics	Complete	June 15, 2024	No
Evaluation Plan (draft and final)	In Progress	September 1, 2024 October 30, 2024	No
Consultation on Report to the California Legislature	Complete	March 1, 2024	No
Progress Reports (a, b, and c)	Complete Complete Complete	September 15, 2023 January 15, 2024 June 15, 2024	No

The Regents of the University of California, San Francisco: Universal Screening Project (23MHSOAC018)

MHSOAC Staff: Kali Patterson

Active Dates: 12/12/23 -12/31/24

Total Contract Amount: $160,000

Total Spent: $10,000

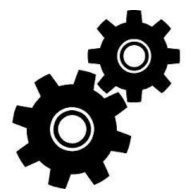
The project will support the Commission in conducting research on the subject of universal mental health screening for children and youth and conduct a landscape analysis to understand universal mental health screening policies and practices for children and youth in California. Doing so will allow the Commission, as part of its required legislative Report, to develop recommendations to improve universal screening of students in California schools.

Deliverable	Status	Due Date	Change
Survey Tool	Complete	02/01/2024	No
Literature Review Report	Complete	02/01/2024	No
Project Support and Consult			
a. Workplan	Complete	1/15/2024	No
b. Meetings and Interviews	Complete	1/15/2024	No
c. Analysis and Summary	Complete	4/30/2024	No
Landscape Analysis Report			
a. Draft Report	Complete	6/30/2024	No
b. Final Report	Complete	7/31/2024	No

Note. Invoices are pending payment.

INNOVATION DASHBOARD

November 2024



UNDER REVIEW	Final Proposals Received	Draft Proposals Received	**TOTALS**
Number of Projects	5	4	**9**
Participating Counties (unduplicated)	5	4	**9**
Dollars Requested	$41,884,983	$8,760,000	**$50,644,983**

PREVIOUS PROJECTS	Reviewed	Approved	Total INN Dollars Approved	Participating Counties
FY 2018-2019	54	54	$303,143,420	32 (54%)
FY 2019-2020	28	28	$62,258,683	19 (32%)
FY 2020-2021	35	33	$84,935,894	22 (37%)
FY 2021-2022	21	21	$50,997,068	19 (32%)
FY 2022-2023	31	31	$354,562,909	26 (44%)
FY 2023-2024	15	15	$197,481,034	13 (22%)

TO DATE	Reviewed	Approved	Total INN Dollars Approved	Participating Counties
2024-2025	3	3	$6,891,376	2

INNOVATION PROJECT DETAILS

FINAL PROPOSALS						
Status	County	Project Name	Funding Amount Requested	Project Duration	Draft Proposal Submitted to OAC	Final Project Submitted to OAC
Under Final Review	Nevada	BHSA Implementation Planning	$1,365,000	3 Years	9/4/2024	10/4/2024
Under Final Review	Shasta	Level Up Norcal: Supporting Community Driver Practices for Health Equity	$999,978	2 Years	7/25/2024	8/30/2024
Under Final Review	Alameda	Psychiatric Advance Directive (PADs) Phase 2 Multi County Collaborative	$3,070,005	3 Years	9/13/2024	10/10/2024
Under Final Review	Tri-City	Psychiatric Advance Directive (PADs) Phase 2 Multi County Collaborative	$1,500,000	4 Years	9/13/2024	10/10/2024
Under Final Review	Orange	Program Improvements for Valued Outpatient Treatment (PIVOT) Multi-County Collaborative	$34,950,000	5 Years	9/19/2024	10/31/2024

DRAFT PROPOSALS						
Status	County	Project Name	Funding Amount Requested	Project Duration	Draft Proposal Submitted to OAC	Final Project Submitted to OAC
Under Review	San Mateo	Peer Support for Peer Workers	$580,000	4 Years	10/1/2024	Pending
Under Review	San Mateo	Animal Care for Housing Stability & Wellness	$930,000	4 Years	10/1/2024	Pending
Under Review	San Mateo	allcove Half Moon Bay	$1,600,000	3.5 Years	10/1/2024	Pending
Under Review	San Mateo	PIVOT: Developing Capacity for Medi-Cal Billing	$5,650,000	5 Years	10/1/2024	Pending

APPROVED PROJECTS (FY 24-25)			
County		Funding Amount	Approval Date
Sierra	Semi-Statewide Enterprise Health Record Multi County Collaborative	$910,906	7/25/2024
Orange	Community Program Planning – Extension Request	$1,000,000	8/22/2024
Orange	Psychiatric Advance Directive (PADs) Phase 2 Multi County Collaborative	$4,980,470	8/22/2024

DHCS Status Chart of County RERs Received
November 21, 2024, Commission Meeting

Below is a Status Report from the Department of Health Care Services regarding County MHSA Annual Revenue and Expenditure Reports received and processed by Department staff, dated November 8, 2024. This Status Report covers FY 2021 -2022 through FY 2022-2023, all RERs prior to these fiscal years have been submitted by all counties.

The Department provides MHSOAC staff with weekly status updates of County RERs received, processed, and forwarded to the MHSOAC. Counties also are required to submit RERs directly to the MHSOAC. The Commission provides access to these for Reporting Years FY 2012-13 through FY 2022-2023 on the data reporting page at: https://mhsoac.ca.gov/county-plans/.

The Department also publishes County RERs on its website. Individual County RERs for reporting years FY 2006-07 through FY 2015-16 can be accessed at: http://www.dhcs.ca.gov/services/MH/Pages/Annual-Revenue-and-Expenditure-Reports-by-County.aspx. Additionally, County RERs for reporting years FY 2016-17 through FY 2021-22 can be accessed at the following webpage: http://www.dhcs.ca.gov/services/MH/Pages/Annual_MHSA_Revenue_and_Expenditure_Reports_by_County_FY_16-17.aspx.

DHCS also publishes yearly reports detailing funds subject to reversion to satisfy Welfare and Institutions Code (W&I), Section 5892.1 (b). These reports can be found at: https://www.dhcs.ca.gov/services/MH/Pages/MHSA-Fiscal-Oversight.aspx.

DCHS MHSA Annual Revenue and Expenditure Report Status Update

County	FY 21-22 Electronic Copy Submission	FY 21-22 Return to County	FY 21-22 Final Review Completion	FY 22-23 Electronic Copy Submission	FY 22-23 Return to County	FY 22-23 Final Review Completion
Alameda	1/31/2023	2/6/2023	2/7/2023	1/30/2024	1/31/2024	2/14/2024
Alpine	4/14/2023		4/17/2023	7/30/2024	8/6/2024	8/8/2024
Amador	1/31/2023	2/7/2023	2/17/2023	2/8/2024	2/8/2024; 2/14/24	2/16/2024
Berkeley City	1/31/2023	2/2/2023	2/7/2023	1/31/2024	2/2/2023	2/6/2024
Butte						
Calaveras	1/27/2023		2/7/2023	1/31/2024	2/2/2024	2/5/2024
Colusa	4/3/2023	4/4/2023	5/11/2023	3/15/2024	3/20/2024	4/2/2024
Contra Costa	1/30/2023		2/1/2023	2/13/2024	2/14/2024	2/15/2024
Del Norte	1/30/2023		2/7/2023	1/30/2024	1/31/2024; 2/1/24	2/5/2024
El Dorado	2/24/2023		2/28/2023	1/30/2024	1/30/2024	1/30/2024
Fresno	1/31/2023	2/2/2023	2/10/2023	1/29/2024	1/30/2024	2/1/2024
Glenn	12/14/2023	12/21/2023	2/16/2024			
Humboldt	1/31/2023		2/2/2023	1/30/2024	1/31/2024	2/2/2024
Imperial	1/20/2023	1/23/2023	2/1/2023	1/19/2024	1/24/2024; 1/30/24	2/7/2024
Inyo	5/19/2023		8/16/2023	5/28/2024	5/29/2024	9/4/2024
Kern	1/31/2023	2/1/2023	2/15/2023	2/2/2024	2/9/2024	2/23/2024
Kings	1/10/2023	1/19/2023	2/14/2023	2/8/2024	2/14/2024	2/16/2024
Lake	1/31/2023		2/1/2023	5/8/2024	5/8/2024	5/9/2024
Lassen	2/8/2023	2/9/2023	2/14/2023	2/29/2024	2/29/2024	3/5/2024
Los Angeles	1/31/2023	2/2/2023	2/17/2023	2/5/2024	2/6/2024	2/16/2024
Madera	2/8/2023	2/9/2023	2/14/2023	3/22/2024		3/29/2024

DHCS Status Chart of County RERs Received
November 21, 2024, Commission Meeting

County	FY 21-22 Electronic Copy Submission	FY 21-22 Return to County	FY 21-22 Final Review Completion	FY 22-23 Electronic Copy Submission	FY 22-23 Return to County	FY 22-23 Final Review Completion
Marin	1/30/2023	1/31/2023	2/3/2023	1/31/2024	2/2/2024	2/5/2024
Mariposa	4/19/2023	4/20/2023	4/21/2023	2/7/2024	2/15/2024	2/15/2024
Mendocino	1/31/2023		2/2/2023	1/31/2024	2/5/2024	2/15/2024
Merced	1/19/2023		1/23/2023	1/18/2024	1/19/2024	1/23/2024
Modoc	3/23/23	4/4/2023	4/5/2023	5/6/2024	5/8/2024	5/13/2024
Mono	1/31/2023		2/2/2023	1/31/2024	2/5/2024	
Monterey	1/31/2023	2/2/2023	2/2/2023	1/31/2024	2/1/2024	2/6/2024
Napa	1/31/2023	2/1/2023	2/13/2023	2/6/2024	2/9/2024	3/11/2024
Nevada	1/31/2023	2/1/2023	2/2/2023	1/31/2024	2/9/2024	2/14/2024
Orange	1/31/2023		2/1/2023	1/31/2024	2/7/2024	2/15/2024
Placer	1/31/2023	2/1/2023	2/14/2023	1/31/2024	n/a	2/7/2024
Plumas	2/14/2023	2/15/2023	2/21/2023	2/9/2024	2/9/2024	2/15/2024
Riverside	1/31/2023	2/1/2023	2/15/2023	2/1/2024	2/8/2024	2/21/2024
Sacramento	1/25/2023	1/26/2023	1/27/2023	1/31/2024	2/14/2024	2/23/2024
San Benito	5/10/2023	5/11/2023	5/25/2023	3/18/2024	3/18/2024	3/22/2024
San Bernardino	1/31/2023		2/6/2023	1/31/2024	2/12/2024	2/21/2024
San Diego	1/31/2023	1/31/2023	2/14/2023	1/30/2024	2/5/2024	2/14/2024
San Francisco	1/31/2023	2/1/2023	2/16/2023	1/31/2024	2/8/2024	
San Joaquin	1/31/2023		2/1/2023	2/22/2024	3/7/2024	3/27/2024
San Luis Obispo	12/30/2023	1/6/2023	1/19/2023	1/25/2024	2/8/2024	2/14/2024
San Mateo	3/6/2023	3/24/2023	4/3/2023	2/16/2024	2/22/2024	4/9/2024
Santa Barbara	12/23/2023	2/7/2023	2/15/2023	1/30/2024	2/9/2024	2/12/2024
Santa Clara	1/31/2023	1/31/2023	2/16/2023	2/1/2024	2/15/2024	2/22/2024
Santa Cruz	4/6/2023	4/14/2023		8/16/2024	8/21/2024	10/11/2024
Shasta	1/31/2023	2/2/2023	2/16/2023	1/30/2023	2/15/2024	2/21/2024

DHCS Status Chart of County RERs Received
November 21, 2024, Commission Meeting

County	FY 21-22 Electronic Copy Submission	FY 21-22 Return to County	FY 21-22 Final Review Completion	FY 22-23 Electronic Copy Submission	FY 22-23 Return to County	FY 22-23 Final Review Completion
Sierra	1/27/2023	1/30/2023	2/16/2023	12/18/2023	12/27/2023	1/15/2024
Siskiyou	2/6/2023	2/7/2023	2/9/2023	2/2/2024	2/15/2024	2/15/2024
Solano	1/31/2023	1/31/2023	2/15/2023	1/31/2024	2/15/2024	2/20/2024
Sonoma	1/31/2023	2/2/2023	3/6/2023	1/31/2024	2/7/2024	2/14/2024
Stanislaus	1/31/2023	2/2/2023	2/3/2023	1/31/2024	2/6/2024	2/9/2024
Sutter-Yuba	1/31/2023	2/2/2023	3/6/2023	3/29/2024		4/2/2024
Tehama						
Tri-City	1/25/2023	1/25/2023	2/16/2023	1/31/2024	2/6/2024	2/9/2024
Trinity	7/18/2023	7/24/2023	8/24/2023	5/21/2024	5/29/2024	6/10/2024
Tulare	1/31/2023	1/31/2023	2/15/2023	1/30/2024	2/20/2024	5/1/2024
Tuolumne	3/29/2023	3/30/2023	4/5/2023	3/1/2024	3/4/2024	3/7/2024
Ventura	1/30/2023	1/30/2023	1/31/2023	1/31/2024	2/15/2024	2/15/2024
Yolo	1/31/2023	2/2/203	3/15/2023	4/4/2024	4/5/2024	4/19/2024
Total	**57**	**42**	**57**	**56**	**53**	**56**