UNIVERSITY of CALIFORNIA, LOS ANGELES

CENTER for HEALTH SERVICES and SOCIETY

California State Evaluation and Learning Support (Cal SEALS) for SB 82 Triage Grants

Deliverable 3: Draft Summative Evaluation Plan

PREPARED FOR:
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1. Introduction

The Introduction gives a background for Child Crisis Intervention and School-County Collaborative Programs of SB-82/833 followed by separate Draft Plans for Child Crisis (Section 2) and School-County Programs (Section 3).

This Draft Summative Evaluation Plan for Child Crisis Intervention and School-County Collaborative Programs describes the plan for a statewide evaluation of the process and impact of SB-82/833 programs, and offers separate drafts of summative evaluation for Child Crisis Intervention and School- County Collaborative Programs. Throughout, we a balance of describing shared, broad components of programs while highlighting some differences in context, approach, population, and intervention goals. In addition, flexibility is built into the evaluation plan to explore options for study designs and data sources in collaboration with different program partners. Together guided by the experience of our county program partners, Community Advisory Board, and other multi-stakeholder public engagements (e.g., webinars), the evaluation plan will continue to be refined but remain anchored within the shared vision for improving statewide capacity for proactive and early interventions for children and their families in crisis, and for school-county partnerships including in prevention of crises. This shared vision includes four goals: 1) expand crisis prevention and treatment services; 2) improve child, youth, and family experience of care and clinical outcomes while reducing costs; 3) reduce hospitalization and inpatient days; and 4) reduce recidivism and law enforcement and expenditures.

For the Child Crisis Intervention and School-County Collaborative SB-82/833 programs, the primary objective is to increase access to and care coordination with crisis prevention and/or intervention services for children and adolescents and their parents/caregivers. Each site's interventions are tailored to their populations and services sectors, often building on existing relationships while stimulating new partnerships and services.

The **Child Crisis Intervention** project goals are to: 1) expand crisis prevention and treatment services; 2) improve child, youth, and family experience of care and clinical outcomes while reducing costs; 3) reduce hospitalization and inpatient days; and 4) reduce recidivism and law enforcement and expenditures.

The **School-County Collaborative** project goals are to: 1) improve school-county and community partnerships; 2) expand school-based prevention, early intervention, and access to crisis services; 3) improve engagement with parents and caregivers; and 4) reduce removal from school and community.

The broad goal of our evaluation is to both capture the statewide picture of the impact of these crisis intervention and school- county collaborative programs, as well as describe in-depth some of the particular interventions and the impacts these programs have had on children and adolescents, their families, communities, and the providers who care for them.

1.1 Community Partnered Approach to Evaluation Plan

The Draft Summative Evaluation Plan was developed using a community partnered approach (Jones & Wells, 2007) by partnering with county sites and the MHSOAC. This draft plan has been informed by: 1) goals of the legislation; 2) priorities as clarified by MHSOAC staff in meetings and calls; 3) review of the SB-82/833 proposals, including each county's background and stakeholder input; 4) discussions with experts in crisis intervention; 5) feedback with lead stakeholders for the evaluation; 6) review of evaluation plans with representatives of the programs at in-person meetings; 7) rapid reviews of the literature; 8) review of components of the plan with workgroups (Data Coordinator, School-County Collaborative); 9) review of drafts of the Evaluation Plan with MHSOAC staff and representatives of programs; and 10) reviews by experts in data sources (i.e., Client and Service Information [CSI] data) and University officials for data privacy and security, HIPAA compliance, human subjects protection, contracts, and purchasing. Additional input will be invited through online posting of the draft plan and webinars, as in our first webinar attended by 52 stakeholders.

1.1.1 Evaluation Plan for Stakeholder Engagement

Our stakeholder approach is informed by Community Partnered Participatory Research (CPPR) (Jones & Wells, 2007), with a focus on consumers, families, community stakeholders and providers. CPPR emphasizes two-way knowledge exchange, co-leadership/partnership, trust, and respect. The work structure includes a council or advisory group comprised of stakeholder representatives and a set of workgroups to provide input and assist in developing plans in priority areas. The stages consist of "vision" or planning, "valley" or main work, and "victory" or products and dissemination. Activities using this approach include:

- **Stakeholder Advisory Board** for Child and School-County Collaborative Programs: We have had initiation participation of 3 lead stakeholders Richard Van Horn, Karen Hart, Felica Jones) and have at their suggestion invited participants from other areas involved with child and/or school-county partnership programs. The first formal convening is scheduled for April, 2020. Following CPPR principles, this Board will be co-chaired by a stakeholder leader, followed by a rotation of members.
- **Evaluation Information**: We have initiated a **newsletter** and a **public website** for participating programs to obtain relevant information. The newsletters are disseminated on a quarterly basis. The public website will be updated as information emerges throughout the evaluation period.
- **Workgroups**: Staff of funded programs are involved in **workgroups** (Data Coordinator, Adult/TAY, and/or School-County). This provides regular input on aspects of evaluation, as well as opportunities to learn of stakeholder involvement in program activities. These workgroups have been meeting regularly, initially monthly, and now quarterly.
- **Stakeholder webinars:** We are hosting 2-3 webinars a year together with UC Davis and their focus on the SB82 Adult/TAY programs. The first webinar, hosted 11/25/2019, discussed literature reviews on child crisis interventions, school-county partnerships and Adult/TAY programs. There were 52 registered participants, mostly from California with two from Montana. This webinar also

included an overview of the SB-82/833 program from the MHSOAC. Stakeholders are invited to ask questions or post comments through an online portal. The next webinars will review the Draft Summative Evaluation Plan, to obtain comments to finalize the plan. This we anticipate being co-hosted by stakeholder leaders from the Advisory Boards.

- **MHSOAC-hosted in-person meetings:** There are quarterly hosted meetings for all SB-82/833 grant-funded programs, including the evaluation teams and for some meetings, lead stakeholders in person or by phone to inform all programs about stakeholder views (van Horn, Jones, Hart). Following CPPR principles noted above, in breakout workgroups, program staff have been invited to respond to evaluation issues such as data sources, outcomes, approaches to intervention, similarities and differences across sites, and issues, such as programs comparison types that are meaningful. This has led to clarification of options for evaluation, as well as individual follow-up discussions with particular programs. MHSOAC staff have participated in some of these sessions.
- **Evaluation of Stakeholder Input**: The process of stakeholder input will be documented and included as a key evaluation feature through qualitative description, using meeting notes, proposals, interviews, feedback from webinars and other sources.

As examples of input, at one of our MHSOAC-led meetings, the use of hospitalization as an indicator of impact, was viewed as complex by county participants. For some, increase in hospitalization for children in crisis, particularly in areas without child beds, was viewed a favorable outcome to protect children and facilitate entry into care despite goals of the legislation to reduce hospitalization. This led to a change from "decrease in hospitalizations" as an outcome to "decrease in unnecessary" hospitalizations. Similarly, there were issues discussed with reducing law enforcement time in the field. Programs provided anecdotes suggesting that their efforts may actually increase law enforcement time in the field due to law enforcement training to respond to children in crises. For some, this was viewed be a favorable outcome because training law enforcement would improve the chances of direct referral to outpatient or other alternatives to hospitalization. Views differed across programs, reinforcing the importance of context as well as program design and goals, informing the selection of the conceptual model for our Formative Evaluation (Consolidated Framework for Implementation Research, CFIR which emphasizes "outer" factors such as community context as well as "inner" factors such as individual need or program design). Similarly, context remains and important issue for the draft Summative Evaluation.

Background Literature: We note that the main literature reviews for the Child Crisis Intervention and School-County Partnership programs, are available in Deliverable 2. A brief summary is included in Appendix A.

The following Sections provide an overview of the Summative Evaluation Plans for Child Crisis Intervention and School-County Partnerships.

2. Draft Summative Evaluation Plan for Child Crisis Intervention Programs

The Draft Summative Evaluation Plan for Child Crisis Intervention Programs section of this document opens with an overview of Child Crisis Intervention Programs descriptions, followed by specific aims and a description of the Child Crisis Intervention Programs Logic Model, followed by the Methods for each main Aim subsection.

2.1 Child Crisis Intervention Programs

2.1.1 Overview

The programs serving children and adolescents across the Child Crisis Intervention Programs vary widely and include: school-based prevention and early intervention programs, school-based crisis triage, mobile crisis teams, triage personnel based in EDs, expansion of adult crisis programs tailored for children, and expanded collaborations with agencies to help youth in crisis. Some programs are contracted-out to non-profit agencies while others build upon directly operated services. Access to crisis-related resources, such as crisis stabilization units, emergency child psychiatric evaluations, and inpatient psychiatric beds for children and adolescents vary across the county programs.

Child Crisis Intervention vary across counties by the number of SB-82/833 funded programs (1-3) and funding amount (Table 1), an important context for evaluation. Two counties (Humboldt and Placer) received funding for all three types SB-82/833 funded programs (Adult/TAY, Child, and School-County), with funding of $6.5-$7.1M. Six counties (Berkeley City, Calaveras, Los Angeles, Sacramento, Stanislaus, and Yolo) received funding for Adult/TAY and child crisis services (Keith, Crosson, O'Malley, Cromp, & Taylor, 2017), with total funding $416K to $31.3M. Three counties (Riverside, San Luis Obispo, and Santa Barbara) have funding for child crisis (funding ranging $208K to $13.8M).

Table 1: SB-82/833 Child Crisis Intervention Programs, by County and Total Funding.

GRANTEE	CHILD	SCHOOL	ADULT/TAY	TOTAL SB-82/833
Berkeley City	X		X	$830,933.03
Calaveras	X		X	$578,633.52
Humboldt	X	X	X	$6,497,015.57
Los Angeles	X		X	$31,313,440.35
Placer	X	X	X	$7,129,412.75
Riverside	X			$1,436,318.53
Sacramento	X		X	$4,521,763.78
San Luis Obispo	X			$371,233.73
Santa Barbara	X			$882,415.63
Stanislaus	X		X	$1,315,448.37
Yolo	X		X	$415,830.00

2.1.2 Child Crisis Intervention Program Characteristics by County

Of the 11 Child Crisis Intervention Programs, 6 programs (Humboldt, Riverside, San Luis Obispo, Santa Barbara, Stanislaus, and Yolo) augment existing crisis intervention services, two programs provide mental health services in schools (Berkeley City in one high school, Sacramento in three middle schools, both have one mental health team). Three programs (Calaveras, Los Angeles, and Placer) focus on new programs, two for new mobile crisis teams (one in a police department). The end date for funding for these programs is November 30, 2021. Appendix B describes Child Crisis Intervention Programs.

2.2 Draft Evaluation Plan Overview

The Draft Evaluation Plan for Child Crisis Intervention Programs is influenced by several features including: 1) stakeholder feedback, 2) the actual programs proposed and program modifications over time, 3) a conceptual framework for considering intervention effects on indicators, including those prioritized in the legislation and Request for Proposals (RFP), and 4) additional outcomes prioritized by programs, stakeholders, and the scientific literature.

Within this context, we propose using a **mixed methods approach**, to leverage qualitative data described in the Formative/Process Evaluation (Deliverable 4) to enrich findings from the quantitative data analyses. For example, barriers and facilitators to implementation, assessed in the Formative/Process Evaluation, will offer potential explanations for quantitative findings related to patterns in service use.

2.3 Child Crisis Intervention Logic Model

The Child Crisis Intervention Program Evaluation Logic Model is presented in Figure 1. Levels of intervention are categorized at the system-, program-, and client-levels. Monitoring program changes will be captured by qualitative data gathered from the bi-annual interviews described in Deliverable 4.

As shown in the figure, the SB82/833 goals are to: 1) expand crisis prevention and treatment services; 2) improve child, youth, and family experience of care and clinical outcomes while reducing costs; 3) reduce hospitalization and inpatient days; and 4) reduce recidivism and law enforcement and expenditures. Program mechanisms are illustrated at system, program and client-levels. At the system-level, expansion of crisis intervention services and care coordination is stimulated through strengthening existing crisis-community agency partnerships and new partnerships. At the program-level, based on program feedback, SB-82/833 funds foster greater team integration. At client- and family-levels, implementation of personalized crisis interventions with linkage to behavioral health services promote change in client outcomes.

Outcomes are conceptualized to align with the target mechanisms of change, including number of memoranda of understanding (MOUs) (system-level), interdisciplinary team meetings (program-level), and contacts across care sectors (client-level). At the program level, indicators of team integration may include a breadth of

disciplines (i.e., law enforcement, teachers), improved team communication, and task shifting (e.g., law enforcement adapting protocol for child crisis intervention to be more trauma-informed).

Proximal outcomes are immediate or very short-term outcomes directly related to the delivery of care processes for the crisis intervention. Following a standard quality of care framework (Donabedian, Wheeler, & Wyszewianski, 1982), care processes include technical and interpersonal care processes. Technical care processes are components of the crisis intervention, which may vary by program, such as referral source, reason for referral, site of care, assessment, safety plan, triage plan, and linkage to behavioral health services. The extent to which the intervention is personalized will be explored by examining reason for referral and types of crisis services provided. The interpersonal care process is assessed by experience of the client and/or family of care received, where satisfaction data are available.

Distal outcomes (i.e., 3 months, 6 months) are reduction in crisis-related ED visits and unnecessary psychiatric hospitalizations and improvement in partner agency-related outcomes such as family preservation or placement stability, improved school outcomes, and reduction in unnecessary involvement of law enforcement (i.e., during mental health crises, number of juvenile arrests and detainments).

Findings from Aim 2 will guide selection of counties and programs for case studies (Aim 3).

Figure 1: Child Crisis Intervention Logic Model

Overarching Goal: *To increase access to and care coordination with crisis prevention and intervention services for children and adolescents.*

SB-82/833 School-County Collaborative Program Evaluation

Contextual Factors:
County-Level – Urban/Rural, Poverty, % Racial/Ethnic Minority, Resources, Type
Program-Level – Type

Project Goals	Target Mechanisms	Outcomes	Model Programs
1. Expand crisis prevention and treatment services 2. Improve experience outcomes while reducing costs 3. Reduce unnecessary hospitalizations and inpatient days 4. Reduce recidivism and law enforcement expenditures	1. Develop MOUs between crisis services and other community agencies (e.g., school, DCFS, juvenile justice, primary care) *[System-Level]* 2. Team Integration *[Program-Level]* 3. Implement personalized crisis intervention programs (Mobile teams, crisis stabilization units, mental health triage in ED) *[Client-Level]*	1. Increase community-agency partnerships Number of MOUs, Contracts across sectors, Interdisciplinary team meetings *[System-Level]* 2. Improve communication, staff mixing, task shifting *[Program-Level]* 3. Implement crisis services • Technical Care *- Referred sources, Assessment, Primary reason for referral, Triage Plan, Safety Plan, Linkage to behavioral health services (contact service intensity, duration of care)* • Interpersonal Care *- Positive family/client experience [Client-Level]* 4. Reduce crisis-related ED visits *[System-/Client-Levels]* 5. Reduce unnecessary psychiatric hospitalizations *[System-/Client-Levels]* 6. Improve partner agency related outcomes Increase family preservation or placement stability - Increase school outcomes - Decrease law enforcement involvement - Decrease for mental health crises - Decrease # of juvenile arrests and detentions *[Client-Level]*	1. Case Studies 2. Longitudinal Cohort Studies (if feasible)

2.4 Specific Aims and Evaluation Questions

The Child Crisis Intervention Draft Summative Evaluation Plan has three aims, with each aim informing the subsequent aim. To standardize the evaluation across programs, the main study time period is 12 months, from 07/01/2020 to 06/30/2021, to increase the likelihood that all programs during the study period will be operating at steady-state. The overarching goal for the Child Crisis Intervention Programs is to reduce the negative impact of child mental health crises through prevention, early intervention, and linkage to behavioral health care when clinically indicated. These programs span a continuum of crisis-related care and vary by target population, site, and delivery of care. The specific aims followed by example questions are:

Aim 1: To describe the client characteristics and delivery of SB-82/833-funded services for the Child Crisis Intervention and School-County Collaborative Programs, and examine variation in shared contextual characteristics.

Question 1: What are the sociodemographic and clinical characteristics of the children and youth receiving crisis intervention care?

Question 2: What is the breadth of SB-82 funded child programs (e.g. mobile crisis teams, ED visit triage, school-based mental health services) provided and how do they vary by geographic region, urban vs. rural counties, and program reach (e.g., countywide vs. specific community-centered)?

Question 3: What proportion of children have recommended follow-up care, and what are the characteristics of children who are more likely to connect with outpatient mental health care?

Question 4: Among children receiving recommended outpatient mental health care, what services do they receive and how long do they stay in care? What child characteristics are associated with having care/remaining in care?

Question 5: What program characteristics (e.g. new vs. augmented program) are associated with improved follow-up in terms of recommended care following a crisis intervention?

Question 6: What proportion of children receiving crisis intervention services, are frequent users or crisis or other mental health services, and what are the characteristics of frequent users?

Question 7: If data are available, how satisfied are parents and youth with their crisis care and how does their experience relate to likelihood of follow-up on recommended care, adjusting for clinical severity?

Aim 2: To evaluate impact of SB-82/833-funded Child and School-County Collaborative Programs on clinical and service use outcomes.

Question 1: If outcome data are available: Among children who receive crisis intervention and short term (e.g., 3 months) recommended mental health care, is there improvement in target symptoms and/or functioning?

Question 2: Among programs that reach children youth county-wide, are ED visits and hospitalizations reduced during implementation periods, compared to periods prior to SB-82?

Question 3: If child level data are linkable to other county agency data: What

proportion of children who receive any crisis intervention services have histories of child welfare involvement, school failure or contact with the juvenile justice system? What proportion of children who receive crisis intervention services experience removal from home, school failure or have contact with the juvenile justice system? Are these outcomes more likely for children who did not start or continue in recommended mental health care?

2.5 Approach by Aims

To address the three Aims, the Draft Summative Evaluation Plan proposes a mixed methods approach, combining quantitative and qualitative data. The approach described below focuses on quantitative data, as the qualitative data approach is discussed in the Formative/Process Evaluation Plan. For each aim we clarify sub aims and hypotheses, and describe the approach or methods

2.5.1 Aim 1: *To describe the client characteristics and service delivery of SB-82/833-funded Child Crisis Intervention Programs and examine variation by shared contextual characteristics.*

Sub aims are:

1.1 To examine variation by State region (Superior, Central, Bay Area, Southern, Los Angeles). [Exploratory.]

1.2 To examine variation by county sociodemographic characteristics (e.g., rural/urban, income).
distribution, racial/ethnic diversity).

H1.2.1 Children and youth from urban counties will be more likely to contact recommended follow-up services after crisis intervention than children from rural counties.

H1.2.2 Children receiving SB-82/833-funded crisis intervention services in counties with greater racial/ethnic diversity are more likely to receive care compared to children who receive services in less racial/ethnic diverse counties (i.e., indicator of aligning with community).

1.3 To examine variation by program characteristics.

H1.3.1 Programs augmenting existing crisis intervention services will be more likely to serve more children and youth, have more partnerships, and provide a wider range of follow-up care services after crisis intervention than new crisis intervention programs.

H1.3.2 Programs with greater funding per proposed number of staff will serve more children and youth and provide more services than programs with less funding per proposed number of staff.

Methods

<u>Study Population</u>

The study population is children and youth with at least one encounter with an SB-82/833-funded crisis intervention program. An encounter could be an individual seen

directly by SB-82/833 staff (either part-time or full-time) for SB-82/833 services, or identified by SB-82/833 staff and referred to external services.

Study Time Period

The main study period is July 1, 2020 through June 30, 2021, with July 2021 through December 2021 as a possible extension especially given delays in start-up. If funding for the programs is extended beyond November 30, 2021, an additional six months could be added to the study period. Prior to the study period, we propose a pilot (i.e., "ramp-up") during which data collection procedures and data security and transfer processes will be developed, tested, and finalized. The rationale for the index start date is to: 1) increase the likelihood that programs will be at steady state, making comparisons by program type feasible; 2) allow for a minimum of a 3-month time period prior to index start date to pilot and refine data collection procedures; and 3) maintain unmeasured or external statewide threats to validity constant across programs. Grant periods, conservative estimates of initiation of program delivery, and a pilot data collection/transfer period are shown in Figure 2, with Los Angeles County having a start-up delay, to be confirmed.

Figure 2. Grant periods, conservative estimates of initiation of program delivery, and a pilot data collection/ transfer period.

	Grant Periods	Program Delivery Initiation (Estimate)	Proposed Pilot Period	Proposed Study Period
Berkeley City	10/18-09/21	09/19	02/20-06/20	07/20-09/21
Humboldt	10/18-09/21	10/18	02/20-06/20	07/20-09/21
Los Angeles	10/18-09/21	01/20	02/20-06/20	07/20-09/21
Placer	10/18-09/21	07/19	02/20-06/20	07/20-09/21
Riverside	10/18-09/21	10/18	02/20-06/20	07/20-09/21
Sacramento	10/18-09/21	06/20	02/20-06/20	07/20-09/21
San Luis Obispo	10/18-09/21	10/18	02/20-06/20	07/20-09/21
Santa Barbara	10/18-09/21	06/19	02/20-06/20	07/20-09/21
Stanislaus	10/18-09/21	07/19	02/20-06/20	07/20-09/21
Yolo	10/18-09/21	10/18	02/20-06/20	07/20-09/21

The start date of an encounter will be date of first contact with an SB-82/833 funded program. The end date will be defined as no contact with any referred services for at least 30 days after most recent contact. We anticipate that the study time period for any follow-up care recommended after crisis intervention will be 3 months. If a child is hospitalized for a primary mental health problem during the child's episode of care (i.e., encounter), this will be noted for potential cross-validation of data sources with program partners.

Study Design

The study design for Aim 1 is a repeated cross-sectional observational study. Inclusion criteria will be children and youth ages 0 through 21.0 years at encounter start date with at least one contact with SB- 82/833-funded crisis intervention during study time period. There will be no additional exclusion criteria as we assume that programs

will be responsive to all calls for crisis intervention or all calls for mental health team support from program main site (i.e., ED, police department, schools).

Preparation for Data Collection and Transfer

February 1, 2020 through June 30, 2020 was our selected pilot period for data collection procedures and data security and transfer processes to be developed, tested, and finalized. As described previously, key lessons learned from interviews, the CSI survey, and workgroup and in-person meetings will continue to inform policies and procedures for data collection and security.

At this juncture, we recognize that there may be delays owing to COVID-19 infrastructure changes, to be determined with our program partners. We have actively been working on our data transfer policies and procedures and reviewing issues with partners in data workgroup meetings and interviews. In addition, we recognize that the COVID-19 epidemic context may be a major external factor affecting demand for or supply of crisis services, or mechanisms such as telehealth. We will be working with our county and stakeholder partners to identify potential impacts of this context on services and responses, and as feasible determining features of crisis programs in relation to changes in policy/programs for COVID-19. This will include through both qualitative data and evaluation of county and other data sources.

The two scenarios for data collection are as follows:

1. For data bases such as EHR, CSI, or another database that captures data elements that the county/entity can extract in accordance with their internal data security protocols, those records will be uploaded through a secure process for clients served by SB-82/833 programs (Box Health). Ability to flag SB-82/833 encounters and activities is currently being explored.

2. For other forms of data or where there are not existing electronic data systems, the evaluation team will use an online survey tool for programs to enter and transfer data (REDCap), using a secure portal. This web-based system will create a dataset consisting of data elements exclusively for SB-82/833 clients and program activities.

During the last three months of the pilot period (April 1, 2020 through June 30, 2020, potentially extended with COVID-19), we will use a partnered approach to pre-test data collection and data transfer procedures, to facilitate tailoring to counties/programs and any modifications to procedures/information.

Data Collection and Transfer

Upon completion of the pilot period, the study time period will launch on the index start date of July 1, 2020 (or later if delayed with COVID-19). Whether a county/entity is using scenario 1 or 2, described above, or both, data will be transferred on a monthly basis with a 4-week lag to ensure that grantees have sufficient time to prepare data for transfer.

Data Sources

1. **Grantee proposals** to the MHSOAC for SB-82/833 funding will be used as a qualitative data source to provide information about general program characteristics and existing county resources.
2. **Qualitative interviews** will be conducted every 6 months with programs and stakeholder groups to clarity program characteristics and progress, lessons learned and perceived impacts. Procedures for these interviews are described in detail in Deliverable 4.
3. **Quarterly staffing reports** are summaries of changes in staff reported by grantees to the MHSOAC quarterly. This data source will provide information on new hires and staffing changes.
4. **Program Activity Log** (Appendix C) or extraction from **Existing Data Infrastructure** (i.e., tracking logs or other database) will capture program-level activities such as creation of MOUs, staff trainings, outreach, parent, and child activities.
5. **Client Contact Log** (Appendix D) or the extraction from **Existing Data Infrastructure** (i.e., EHR, County CSI, or other database) will capture client-level data such as demographics, client history, new crisis encounters, and follow-up visits.
6. **Supplemental data sources** from other care sectors (i.e., juvenile justice, hospital/ED data, schools, child welfare) will be considered. Because many of these sources are not available or not linkable with client-level data, an alternative source of data may be State data (e.g., State CSI data, State Medicaid data). We are currently exploring the feasibility of linking this data to client-level data, as discussed in the Early Lessons Learned section. Options may include: 1) Counties/entities link data at the county level to State data; 2) UCLA receives data with identifiers and probabilistically links to supplemental data sources; or 3) UCLA receives aggregate county-level data and links to State data.

To further enrich findings or processes and impacts, qualitative data (from proposals and interviews) will provide a more descriptive evaluation approach on implementation, progress, lessons learned, and key impressions of impacts, with themes sorted by key program characteristics (e.g., region, urban/rural, extent of crisis intervention resources, target population served, main type of program).

Anticipated Data Challenges and Options

- Some programs may record some of the data elements in service logs and progress notes on children who are not "opened as a case" in the county mental health agency. In these instances, the entry in EHR, CSI, or other databases will not exist. For this reason, we have provided an option to request all programs to use the web-based system or ensure data extractions cover all possible SB-82/833 cases. The options provide flexibility to the programs on which data sources they use to report the requested data elements.

- In addition, not all data elements apply to all programs; these data will be categorized as missing because they are not applicable. There is also wide variation in size of crisis intervention programs, thus data may be stratified by size

of program to improve comparability across programs. Some children entering the study will have a prior history of use of SB-82/833-funded services and repeated use will be underestimated for the total time the program was implemented. An option is to work with county program data coordinators to explore if they have capacity to "look back" during a 6-month time prior to index start date to differentiate whether or not the crisis encounter is new.

- There are particular issues in data availability for children and adolescents. Some datasets, such as juvenile justice records or child welfare administrative data may have limited accessibility. For example, child welfare administrative data requires a court order to link at the individual level. Though we have had some experience with this in the past, accessibility to this data is still improbable. Certain data such as addiction data or data from child interviews, which require parental consent, may become accessible with more restricted access. The evaluation team has expertise in these technical limitations, which will be integrated along with available data into the Summative Evaluation Plan.

Study Variables

The expected study variables (derived from data elements) and data sources are summarized in Appendix E. Operational definitions in Program Activity and Client Contact Codebooks are likely to be further refined during piloting of data collection and transfer procedures.

Analyses

Program Description and Evolution

We will integrate all sources of data to develop analysis plans for programs by county/entity, considering the evolution of goals and modifications to programs that have taken place since the proposal. This will involve a synthesis of the analysis of proposals, qualitative interviews, and quarterly staffing reports as well as available documentation on stakeholder involvement in monthly workgroups, quarterly in-person meetings, and meetings of the advisory board. This will also involve a synthesis of data from the Program Activity Log (or extraction from existing data infrastructure). Service delivery of SB-82/833 will be described by relevant clusters such as primary location and reach, program type, main care processes, priority areas, staffing, maturation, total funding, and estimated funding per staffing (see Table 2). All analytical decisions will be based on consensus among the evaluation team, workgroups, and stakeholders in relation to the goals of the legislation, stated evaluation goals, and recommendations from the literature. Ultimately, these analyses will be informed by the Formative/Process Evaluation, namely considering features of implementation in relation to outcomes as well as to inform grouping of programs

Aim 1 Contributions: The main contribution of Aim 1 is the description of the clients served and services delivered by program and by shared program characteristics. These data will be interpreted using mixed methods as described here and in Deliverable 4. In addition, findings from Aim 1 will inform the selection of programs, study design, and data sources for Aim 2.

2.5.2 Aim 2: *To evaluate the impact of funded SB-82/833 Child Programs on clinical and service use outcomes.*

Methods

Study Population

In Aim 2, we will evaluate program impact within three categories: 1) grants which are augmenting existing mental health crisis intervention services; 2) grants which are developing new mental health crisis intervention services; and 3) Child grants supporting crisis intervention services in a school setting. Findings from Aim 1 will be used to inform the approach for Aim 2. Preliminary categorization was informed by proposals and baseline qualitative interviews resulting in the following groupings:

1) Augmenting – Humboldt County, Riverside County, San Luis Obispo County, Santa Barbara County, Stanislaus County, and Yolo County

2) New – Calaveras County and Placer County (Los Angeles County – to be finalized)

3) School-Based – Berkeley City and Sacramento County

Within the augmenting and new categories, the level of reach varies. Some counties are implementing their program countywide while others are concentrating SB-82/833 service delivery in one or more regions, such as a city or one geographic region. Our study design will differ depending on categorization and level of reach. For example, for SB-82/833 programs that provide countywide services, a pretest-posttest study design using existing countywide data on service use and outcomes may be appropriate.

Time Period for Aim 2

The study time period for Aim 2 is as described in Aim 1, including the proposed pilot period (with any modifications due to delayed start-up or data retrieval with COVID-19 impacts).

Design for Aim 2

The design evaluating impact for augmenting and new programs that are implementing SB-82/833-funded services countywide will be a one group pretest-posttest design for each county/entity if client-level data prior to implementation is available. This design will allow us to examine the added effect of the SB-82/833 grant on individual- and county-level outcomes. The specific outcomes examined will likely differ between augmenting and new programs. However, this design does not account for the influence of other secular trends that may impact outcomes for a given county. Other quasi-experimental options also exist with potential comparison groups being: 1) matched counties without SB-82/833 funding; 2) the other type of SB-82/833 programs, in other words, comparing augmenting programs to new programs; and 3) non-SB-82/833 clients within a given county/entity.

The study design for augmenting programs or new programs that are concentrating SB-82/833-funded services in one or more regions within the county, and for school-based programs will be a one group pretest- posttest design if relevant county-level data prior to implementation of the programs can be disaggregated for the served region(s) to create a baseline. If disaggregation is not possible, other design options will be considered such as a case study or a different quasi-experimental design (e.g., posttest only comparison group design). Potential comparison groups in this case would be: 1) matched region(s) within the county without SB-82/833 funding; 2) the other types of SB-82/833 programs, specifically comparing augmenting programs to new programs, augmenting programs to school-based programs, and new programs to school- based programs; and 3) non-SB-82/833 clients within a given region.

Data Collection, Transfer, Data Sources and Variables

See above description for Aim 1.

For Aim 2, in addition to examine potential impact, we are actively exploring other data sources at county- and state-level. For example, data from the Office of Statewide Health Planning and Development (OSHPD) can provide ED encounters by county and hospital and the American Community Survey (Bromley et al., 2018) can provide county population and economic characteristics. However, it is important to note that there are known limitations such as some agencies requiring provision of identifiable data in order to link, or only providing aggregate deidentified data. Limitations such as this may require more reliance on qualitative data or de-identified county- level data when available. The main potential additional datasets relevant to Aim 2 include: 1) hospitalization and ED visit data; 2) behavioral health services use, including other systems, (i.e., Medi-Cal claims); 3) police records (i.e., time in the field); 4) contact with criminal justice settings (i.e., arrests, detainment, probation camp, field probation); and 5) school outcomes (i.e., reduced school disciplinary actions, improved attendance, academic achievement).

Qualitative Analyses

Using the same sources of qualitative data as for Aim 1 (e.g., stakeholder interviews), we will also address Aim 2 by generating "stories" of program impacts from the perspective of different stakeholders (Bromley et al., 2018). These "stories" will be used to complement quantitative results and triangulate findings in line with a mixed methods approach. Detailed analysis methods for qualitative data are discussed in the Formative/Process Evaluation.

Quantitative Analyses

Study analytic design options, will depend largely on which outcomes are available, at what level (individual, aggregate), for which programs, the quality of data within and across counties. For more limited data, the approach to impact will be largely descriptive versus a more rigorous analytical approach that considers changes pre-post implementation or with different features of implementation, across different programs,

or in consideration of other temporal trends through the use of contextual variables as covariates.

If descriptive, we will summarize outcomes achieved and describe changes within counties using chi- square tests of proportions for categorical variables and Student's T-tests for continuous variables, for example. Analyses will include stratification by shared program and individual characteristics. If the more rigorous analytical approach is feasible, this will allow adjusting for confounding propensity score matching and other higher-level analyses. This will address potential missingness of data, such as using imputation.

County Data Options

Comparisons of counties with funded programs to the comparison groups described previously will likely be based on aggregated data at the county- (for countywide implementers) or region-level (for concentrated implementers). We note that using aggregated data limits statistical power for comparisons. If data are not available directly from counties, there may be limitations to the quality of data available from State sources. These may include limitations in completeness/accuracy and time frame for obtaining data in relation to service delivery. At a minimum, we will describe limitations; however, we also will use analytic strategies to permit outcome comparisons and increase certainty of interpretation, as feasible.

Pre-post analyses of outcomes are likely more powerful if there are longer periods prior to implementation to establish baselines, understand trends, and examine how outcomes differed after implementation. We will explore feasibility of obtaining pre-award data at the county-level, either from the counties themselves or drawn from State data. Pre-post comparisons of alternative models are common for analyses of policy changes (e.g., Prospective Payment System as implemented, (Draper et al., 1990; Ettner et al., 2016; Wells, Hosek, & Marquis, 1992). However, comparison groups in policy initiatives, and in this evaluation, may differ in underlying characteristics, measured factors or unmeasured factors, and at the level of individuals and programs or counties. For example, it is possible that counties with more organized approaches or higher levels of crises may have been more likely to be funded; and individuals receiving services may differ in risk for poor outcomes even from "similar" or matched individuals who have not received crisis intervention services. This type of selection bias is typical in studies where randomization is not possible, as in real-world policies and programs. Nonetheless, using a non-equivalent comparison group and pre-post data would strengthen our design and minimize many threats to validity.

State Data Options

One possibility for evaluating the impact of SB-82/833 is to examine statewide data. Many barriers exist to obtaining such data, but if possible, important questions could be answered. One possibility is to obtain the CSI dataset, which contains service records for both Medi-Cal and non-Medi-Cal mental health services delivered in California as a whole. If there is a common client identifier, we would then obtain records from each SB-82/833 county and link those records with the CSI data, thus identifying those who received services funded by SB-82/833. This would allow us to compare outcomes

of individuals receiving SB-82/833 care with matched individuals not receiving such care. A study by Cordell and Snowden (2017), used this methodology to determine that Children's Full Service Partnerships, funded by the Mental Health Services Act, decreased negative trajectories for those children receiving such services.

Other statewide data could also be used to evaluate the impact of SB-82/833 if the data can be obtained. Obtaining statewide Medi-Cal data, linked with county SB-82/833 data, would allow us to look at the impact of SB-82/833 services on further service use, including the use of ED services and psychiatric services, both inpatient and outpatient. Even if linking of data is not possible, statewide data could provide a benchmark for comparison with outcomes tracked by the Counties of their use of SB-82/833 funds.

Juvenile justice system data for the state could help us to evaluate the impact of SB-82/833 service use on subsequent juvenile justice involvement. Similarly, Department of Child and Family Services (DCFS) data could be used to evaluate the impact of SB-82/833 service use on the involvement in the child welfare system. Many barriers to obtaining these data exist, including willingness of agencies to share the data, linkages to client data from other sources, cost of obtaining the data, and resources to clean and analyze large data sets.

Anticipated Challenges and Options

Whether using county data, State data, or both, the main challenge in estimation of the causal effect of SB-82/833 programs is the selection of counties/programs through a policy process without a designated control group or random assignment. When randomization is not possible or assignment choices have already been made naturalistically, it is still possible to consider inference for causal effects from non-randomized comparisons using (1) confounding adjustments, (2) propensity score matching, or (3) other methods, such as instrumental-variable techniques (Imbens & Rubin, 2015; Rosenbaum, 2002). We will use Neyman-Rubin's potential outcomes framework (Rubin, 1980, 1990, 2005) to define causal effects of programs as described and parameterized in Aim 2 analyses. To adjust for effects of confounding variables such as county context or infrastructure of services, we will model either treatment assignment (program goals/implementation) or the outcome, or both, and estimate average program effects and average program effects for those served or treated (Berzuini, Dawid, & Bernardinell, 2012; Morgan & Winship, 2015) using the CAUSALTRT Procedure in the SAS System V9.4.

Propensity score matching is a quasi-experimental statistical method for reducing selection bias (D'Agostino Jr, 1998; Rosenbaum & Rubin, 1983, 1984). The propensity score method can be viewed as a way to apply the stratification method that reduces the dimension of the number of stratifying cells (or categories) from potentially many to a modest number, such as five, with outcomes between groups defined by treatment status compared within cells (categories) defined by common propensity to be in one or the other group conditional on a potentially large set of covariates. The propensity model itself may be fitted using a straightforward technique such as logistic regression. Strengthening the foundation for inference from observational data in this way is readily accessible. We will also explore other methods: 1) difference-in- difference (DID) technique originated in the field of econometrics (Ashenfelter & Card, 1985; Donald &

Lang, 2007) and 2) regression discontinuity design (RD) framework (DiNardo & Lee, 2004; Imbens & Lemieux, 2008; Thistlethwaite & Campbell, 1960). We will examine which of above methods are the best-fit actual data and explore alternative robust methods. In addition, propensity score matching may be used with a difference-in-difference analysis (Stuart et al., 2014; Wing, Simon, & Bello-Gomez, 2018).

Where feasible, we will use other techniques to improve validity of analyses, such as: 1) imputing missing data, 2) control for covariates that are derived from the Logic Model (in addition to propensity score matching), and 3) conducting sensitivity analyses for main analyses under alternative assumptions. Models will be tailored to the form of the measure (e.g., logistic for binary outcomes, linear for continuous) and outcomes may be transformed for distributional characteristics (e.g., logarithmic transformation). Level of aggregation of data may vary, depending on the data sources available, from individual to program (such as school) or county (e.g., for comparisons with and without SB-82/833, if data from non-SB-82/833 counties/schools are available). A key strategy overall is to examine robustness of findings using different approaches for drawing inference, whether quantitative and qualitative analyses or alternative forms of quantitative analysis, an approach commonly referred to as "triangulation" (Ohlsson & Kendler, 2019).

Regarding analytic strategies for identifying intervention effects, options include having: 1) pre-post analyses of intervention programs only (individual or aggregate); 2) pre-post or post only analyses against a benchmark (e.g., from the literature or from available data from the state or other counties); 3) comparison of pre-post (or post only) data for SB-82/833 and non-intervention counties (or among different groupings of intervention programs), with either individual-level data, or aggregate data (again, which may depend on the impact indicator and data source).

We are currently outlining options for statistical power/precision for analyses based on various assumptions. An example of a preliminary power analysis is included in Appendix F.

Aim 2 Contributions

The analyses for Aim 2 will describe how different crisis intervention programs for children affect services use, including outcomes such as hospitalizations and ED visits (when available), partner agency-related outcomes (when feasible), and subsequent engagement of at- risk clients in outpatient mental health or other services (i.e., prevention, early intervention). At a minimum, the evaluation will provide a descriptive analysis for the state across programs, using triangulation of qualitative and quantitative analyses to describe impacts in main programmatic areas.

2.5.3 Aim 3: *To identify potential explanations for the variation in implementation and impact of programs findings using case studies from purposively selected programs and longitudinal cohort data analyses for a subset of counties.*

Methods

Study Population and Design

Findings from Aim 2 will inform the approach for Aim 3. Case studies of select Child Crisis Intervention Programs may be of interest for individual or small clusters of county/entity analyses, using a mixed methods approach similar to above. This may allow detailed description and analysis of outcomes for a given unique program, or allow a more detailed analysis of a broader set of outcomes. The case study method will also provide an opportunity to incorporate data that may be unique to a given program.

In select counties/entities with the ability to provide and/or link to a broader range of data sets (e.g., ED visits, hospitalization, school outcomes, indicators of child welfare or juvenile justice involvement), we will explore the feasibility of conducting a longitudinal cohort analysis on children and youth served in the program. For example, a goal may be to explore a longitudinal cohort study based either on the uniqueness of a program or on the ability to link and/or provide data that can be linked across sectors with pre-post SB-82/833 comparison. Another design option could be to track client outcomes over a specified episode of care (i.e., 3, 6 months) starting at the index start date for when the child received care (i.e., prevention, early intervention, crisis intervention). Another feature may be to expand qualitative data from providers, administrators, partners, or clients/family members on program impacts.

Data Sources and Study Variables

See information for Aim 1.

Analyses

Analyses for Aim 3 will include qualitative data on program features for case study sites. In addition, main analyses of quantitative data would feature sub-analyses for particular programs, or program clusters, focusing on particular populations of clients. For example, some counties may have more extensive, individually-linked data that gives a broader picture of outcomes. For program-county partnerships, it is possible that analyses of program data from each county may help explain what is accomplished from each type of collaboration, that in combination with qualitative data, provides an overall picture of what can be achieved through such partnership (see mixed methods discussion in the Formative/Process Evaluation).

As noted in Aim 2, some of the more definitive impact analyses, such as pre-post comparisons with control for key covariates, or a focus on certain outcomes such as criminal justice involvement, may be possible in some counties/programs only. In this case, though with more limited precision, analyses as described for Aim 2 would be focused on some groups of counties/programs with more available data, even if for more exploratory or descriptive purposes. (See Aim 2 methods).

Aim 3 Contributions: The Aim 3 "case study" approach will highlight the impacts of exemplar programs or clusters of programs, as a complement to the main impact analysis, either for clusters of interest or where more detailed data on impact are possible only for some programs, as exploratory analyses.

3. School-County Collaborative Program Descriptions

3.1 Overview

Overall, the programs serving children and adolescents across the School- County Collaborative Programs include school-based prevention and early intervention programs, school-based crisis triage, and increased collaboration with county and other community agencies to help youth in crisis. There are different models that the programs focus on, including some who offer whole-school approaches in specific districts or countywide, while others focus on crisis triage and referral to existing services across the county. There are also differences across programs in terms of having additional SB-82 programs in the county for adult/TAY and children compared to counties with only a School-County Collaborative Program (See Table 1).

Table 1: SB-82/833 School-County Collaborative Programs, by County and Total Funding.

GRANTEE	SCHOOL	CHILD	ADULT/TAY	TOTAL SB-82/833 FUNDING
CAHELP	X			$5,293,367.35
Humboldt	X	X	X	$6,497,015.57
Placer	X	X	X	$7,129,412.75
Tulare	X			$5,293,367.34

3.1.1 School-County Collaborative Program Characteristics by County

The program characteristics and funding for the School-County Collaborative Programs are summarized in Appendix G. Three School-County Collaborative Programs (CAHELP, Placer, and Tulare) are emphasizing prevention and early intervention services in schools, and the fourth program (Humboldt) is emphasizing school-based crisis intervention services. Two programs (CAHELP and Placer) are using a multi- tiered system of support based on the Positive Behavioral Interventions and Supports (PBIS) framework. Three programs provide crisis treatment (Humboldt, Placer, and Tulare) while the fourth program (CAHELP) refers clients to County partners for treatment. One program (Placer) is serving eight schools in one city (Roseville) within the county compared to the other three programs (CAHELP, Humboldt, and Tulare), which are serving schools in all or most districts across the county. All four School-County Collaborative Programs received the same amount of funding, $5.3M, with the end date for these programs being November 30, 2022.

3.2 Evaluation Plan Overview

The School-County Collaborative Programs Evaluation Plan, similar to the Child Program Evaluation Plan, has been designed with the following processes: 1) extensive stakeholder feedback as outlined in the previous Introduction section, 2) review of programs' proposals and subsequent modifications, 3) a community-partnered conceptual framework for considering the broad range of activities and effects on indicators, including priorities from the MHSA legislation and RFP, and 4) additional

outcomes prioritized by programs, stakeholders, and the scientific literature, including implementation science frameworks.

Within this context, we propose using a mixed methods approach, which will leverage qualitative data described in the Formative/Process Evaluation Plan (Deliverable 4) to enrich findings from the quantitative data analyses. For example, barriers and facilitators to implementation, assessed in the Formative/Process Evaluation Plan, will provide potential explanations for quantitative data findings related to patterns in service use. Changes at the client-, program-, and system-level (details specified in logic model), will capture features of program maturation that were stimulated by SB-82/833 funding that cannot be easily quantified but an important proximal outcome (e.g., building new and strengthening existing community-agency partnerships).

3.3 Logic Model

The overarching goal for the School-County Collaborative Programs is to expand collaboration between school and county resources to increase prevention, early intervention, crisis intervention, and linkage to behavioral health care when clinically indicated. Through these expanded services, the longer-term goal is to eventually improve school functioning for students such as less overall out-of-school discipline.

The School-County Collaborative Program Evaluation Logic Model aligns with these overall goals and is summarized in Figure 3. Level of intervention is categorized at the county, school, and child/family levels. The **project goals** are to: 1) improve school-county and community partnerships; 2) expand school-based prevention, early intervention, and access to crisis services; 3) improve engagement with parents and caregivers; and 4) improve school functioning for students. **Target mechanisms** to meet these goals are: 1) develop MOUs between schools/districts, county agencies, and other community organizations; 2) linkage of school supports and referrals for student crisis, mental health service, and parent/caregiver referrals; and 3) implement school prevention and early intervention trainings and services for students and families.

Outcomes are conceptualized to align broadly with the target mechanisms of change. In response to strengthening school partnerships with county and community agencies, indicators of positive outcomes include the number of activities and meetings across school, county, and community agencies. At the school level, positive outcomes of linkage between school supports and crisis referrals may include number of students and parents/caregivers referred for services. **Proximal outcomes** related to the implementation of prevention programs are conceptualized at the staff and student/family levels. Number of participants at staff trainings for prevention and/or early intervention will be measured. At the student/family level, outcomes include positive family/client well-being and number of students who access prevention, early intervention, and crisis services in school and linkage to behavioral health services. The main **distal outcomes**, which require additional time to assess change, are reduction in school disciplinary actions and improved school outcomes, which will be measured primarily at the school level. We will explore ways to use publicly available

data sources to measure these school outcomes (see Appendix E for details of example data sources). Finally, we will also use a case study methodology to characterize each site, measuring how services and programs are tailored to meet the unique needs within each county.

Figure 3: School-County Collaborative Logic Model

SB-82/833 School-County Collaborative Program Evaluation

Contextual Factors:

County-Level – Urban/Rural, Poverty, % Racial/Ethnic Minority, Resources, Type
Program-Level – Type

Project Goals	Target Mechanisms	Outcomes	Model Programs
1. Improve school-county and community partnerships 2. Expand school-based prevention, early intervention, and access to crisis services 3. Improve engagement with parents and caregivers 4. Improve school functioning	1. Develop MOUs between schools/ districts, county agencies, and other community organizations 2. Linkage of school supports and referrals for student crisis mental health services, and parent/caregiver referrals *[School-Level]* 3. Implement school prevention and early intervention trainings and services *[Child-/Family-Level]*	1. Increase school-county community agency partnerships (Number of activities/meetings, Contracts across sectors, Interdisciplinary team meetings) *[County-Level]* 2. Improve communication, staff mixing, task shifting to improve linkage to services *[Program-Level]* 3. Increase implementation of prevention interventions - Staff training: prevention, early intervention - Student/Family: positive family/client wellbeing, students with increased access to all tiers of supports in school - Linkage to behavioral health services: contact, service intensity, duration of care *[School-/Student-Levels]* 4. Improve access to crisis response and stabilizations *[Student-Level]* 5. Reduce school discipline and improve school outcomes *[School-/Student-Levels]*	1. Improved site-specific services by county contextual factors (Case Studies)

3.4 Evaluation Questions

The School-County Collaborative Program Summative Evaluation Plan addresses five main evaluation questions, linked to outcomes as described in the above logic model. Together, quantitative and qualitative findings will be used to answer the following questions:

1. How has SB-82 funding stimulated new, and strengthened existing, school partnerships with county and community agencies to better serve children in crisis? (Outcome 1)

2. Has SB-82 funds improved linkages from schools to county services for children and families in crisis? (Outcome 2)

3. Does SB-82 funding lead to a greater number of educators trained in school-based prevention strategies and more students and caregivers receiving prevention and early intervention supports and crisis services when needed in schools? (Outcome 3, 4)

4. How has SB-82 funding resulted in better school functioning for youth? (Outcome 5)

5. Among the School-County Collaborative Programs, how are services tailored to the unique needs of each community and school population served? (Case Studies)

3.5 Approach

The following section describes the overall time period for the pilot phase and evaluation data sources and approach for the entire statewide evaluation for Adult/TAY, Child, and School-Community Collaborative Programs. Then for each evaluation question, we will describe the sample population, design, data sources, analysis, and anticipated contributions and challenges.

Overall Evaluation Time Period

The evaluation time period is July 1, 2020 through June 30, 2021, with July 2021 through June 2022 as a possible extension of the evaluation for the School-County Collaboration programs. Prior to the onset of the study time period, we propose a pilot period during which data collection procedures and data security and transfer processes will be developed, tested, and finalized (April-June 2020). Grant periods, conservative estimates of initiation of program delivery, and a pilot data collection/transfer period are shown in Figure 4.

Figure 4. Grant periods, conservative estimates of initiation of program delivery, and a pilot data collection/ transfer period.

	Grant Periods	Program Delivery Initiation (Estimate)	Proposed Pilot Period	Proposed Study Period
CAHELP	10/18-09/22	10/18	02/20-06/20	07/20-09/21
Humboldt	10/18-09/22	10/18	02/20-06/20	07/20-09/21
Placer	10/18-09/22	08/19	02/20-06/20	07/20-09/21
Tulare	10/18-09/22	10/18	02/20-06/20	07/20-09/21

Several factors guided the rationale for setting the index start date at July 1, 2020, including: 1) increased likelihood that all four programs will be at steady state, making comparisons more feasible and appropriate, 2) improved data integrity by allowing for a minimum of a 3-month time period prior to index start date to pilot and further refine data collection and transfer procedures. However, we understand that this timeline and our expectations of services (especially prevention interventions) may need to be adjusted given the COVID-19 crisis and school closures.

For client level encounters (whether formal or informal), the start date will be the date of first contact with staff from an SB- 82/833-funded program. The end date will be defined as no contact with any referred services for at least 30 days after most recent contact with any referred services. We anticipate that the study time period for any follow-up care recommended during the early, acute, or crisis intervention will be 3 months. If a child is hospitalized for a primary mental health problem during the episode of care, this will be noted during the preliminary data analyses and a decision point using program partner input to ensure good face validity will be developed.

Methods

Study Population

For the School-County Collaborative Programs, the study populations include several types: students who receive direct services (prevention/early intervention, triage/linkage, treatment, crisis management), classrooms/schools that receive prevention services, teachers and other staff who receive trainings, parents/caregivers who receive education and/or triage/linkage, and community members/agencies.

- ***Students***. The student study population consists of pre-school children through high school students who have at least one encounter with an SB-82/833-funded School-County Collaborative program staff member. An encounter can include two main types of interactions: 1) students can be seen by an SB-82/833 staff who provides crisis services or mental health support/treatment or 2) students can be seen by an SB-82/833 staff for triage and linkage, and then referred to external services, such as Department of Behavioral Health.
- ***Classrooms/Schools.*** The classroom/school population consists of groups of students at the classroom- or school-level who receive SB-82/833 prevention or early intervention services.
- ***Teachers/Staff.*** The teacher and school staff population consists of any school personnel on a campus (principal, teachers, school nurse, school psychologist, etc.) who receives an SB-82/833 training.

- ***Parents/Caregivers.*** The parent/caregiver population consists of any parent or caregiver who receives SB-82/833 services. This population will be distinguished between those parents/caregivers of general education students and those of at-risk students (defined as children in foster care, special education, etc.).
- ***Community members.*** SB-82 staff may also provide training or other supports to community members or agency staff.
- ***SB*-82 staff.** For the qualitative interviews, SB-82 staff will be the population participating in the evaluation, describing the impact of their SB-82 programs on communities, districts/schools, families, and youth.

Study Design

The study design is a repeated cross-sectional observational study. Inclusion criteria will be any study population participant (student, classrooms/schools, teacher/staff, parent/caregiver, community member) with at least one contact with an SB-82/833-funded School-County Collaborative program staff during the study time period (July 1, 2020 through June 30,2021). There will be no additional exclusion criteria as the programs are designed to be broad.

Data Sources

1. Grantees submitted **proposals** to the MHSOAC to receive SB-82/833 funding. The proposals are being used as a qualitative data source to provide information about general program characteristics and existing county resources.
2. **Qualitative interviews** are being conducted every 6 months with different stakeholder groups to provide clarity from grant proposals on general program characteristics and new and existing county resources. Procedures for these interviews are described in detail in the Formative/Process Evaluation Plan (Deliverable 4).
3. **Quarterly staffing reports** are summaries of changes in staff reported by the grantees to the MHSOAC on a quarterly basis. This data source will provide information on new hires and staffing changes.
4. The web-based **Program Activity Log** (Appendix C) developed in partnership with SB-82 School-County Collaborative stakeholders to capture program-level activities such as new county and community partnerships, staff trainings, outreach activities, family activities, parent activities, and child activities.
5. The web-based **Client Contact Log** (Appendix D) developed in partnership with SB-82 School-County Collaborative stakeholders to capture client-level data such as demographics, client history, new encounters, and follow-up visits for formal and informal client contacts that would otherwise not be captured in an EHR or other administrative database that can be accessed for this evaluation.
6. **Supplemental public data sources** We will explore possible use of public use data sources for this evaluation. Because many of these sources are only available at the school- or district-level, these secondary data sources will only be used with schools that participate in whole-school or whole-district programming. Another potential limitation of these public data sources is that there may be a lag in obtaining the most current data.

7. **Supplemental site data sources** will be obtained from sites that are collecting site-specific data, which may include whole-school assessments and evaluations of prevention efforts.

Analyses

We will present the analysis plan by evaluation question, and describe the challenges and options and contributions of each analysis. This evaluation will use a mixed methods approach to describe and evaluate the impact of School-County Collaborative Programs on specified outcomes. Given that each of the four counties/entities is implementing their program in a unique way (e.g., countywide reach v. concentrated reach), our study design will differ depending on each county's approach.

For outcomes reported in the Program Activity and Client Contact Logs (Appendices C and D), one study design option is a single time series design using the July 1, 2020 to June 30, 2021 study time period as well as the proposed extended study time period from July 2021 to June 30, 2022 to examine how outcomes change over time. If it is feasible to establish baselines for selected outcomes, we will consider a one group pretest-posttest design. This design will allow us to examine the added effect of the SB-82/833 grant on selected individual- and county-level outcomes. If baselines cannot be feasibly established in a given county/entity, another option would be to compare selected outcomes to county- or state-level benchmarks.

For distal school outcomes (e.g., attendance, discipline), for which some data may be available publicly, a study design option is a pretest-posttest comparison group design. Potential comparison groups would be: 1) matched region(s) within the county without SB-82/833 services; or 2) comparing either across CAHELP, Humboldt, Placer, and Tulare programs or across programs with shared characteristics (e.g., comparing CAHELP and Placer, which are both using a PBIS approach).

Question 1. How has SB-82 funding stimulated new, and strengthened existing, school partnerships with county and community agencies to better serve children in crisis?

Outcome. This evaluation question will address Outcome 1: to increase school-county-community agency partnerships. We will examine this outcome in terms of number and strength of partnerships and will explore the impact of this outcome in qualitative interviews.

Hypothesis. We hypothesize that county characteristics and pre-existing school-county mental health collaborations will influence the program's capacity to provide a broad range of prevention to crisis intervention services on school campuses.

Measures. We will primarily use data from the Program Activity Log, which has a section on partnerships and relationships that describes the SB-82/833 program interactions with other county agencies and the types of activities that are shared. Our qualitative interviews will also ask about key impacts of partnerships and how these relationships affected the services available for children in crisis.

Population. County and community agencies

Question 2. Has SB-82 funds improved linkages from schools to county services for children and families in crisis?

Outcome. This question addresses Outcome 2: to improve communication, staff mixing, and task shifting to improve linkages to services.

Hypothesis. Those programs that have strong networks with county agencies and community organizations especially pre-dating SB-82 funding, with MOU's and shared case coordination and referral infrastructures will demonstrate an increase in linkages of children to needed care.

Measures. Data from the Program Activity Log will be used, including sections on partnerships and relationships that describes the SB-82 program interactions with other county agencies and the types of activities that are shared. We will also use the Client Contact Log, which contains information about referral of students in crisis to outside agencies and resources.

Population. Students, County and community agencies

Question 3. Does SB-82 funding lead to a greater number of educators trained in school-based prevention strategies and more students and caregivers receiving prevention and early intervention supports and crisis services when needed in schools?

Outcome. This question addresses Outcomes 3 and 4: to increase implementation of prevention interventions and to improve access to crisis response and stabilization.

Hypothesis. We hypothesize that over time we will see an increase in 1) trainings of educators in prevention models both at the classroom and schoolwide levels, 2) classroom and school level implementation of prevention approaches, 3) parent prevention and early interventions, and 4) student prevention, early intervention, and access to crisis services if needed.

Measures. Data from the Program Activity Log will be used, including sections on Staff Training (e.g. number of staff trained, type of training), Child Activity (e.g. number attending and type of Universal Prevention), and Parent Activity (e.g. number and type of Targeted Strategies for parents of at-risk children). We will also use the Client Contact Log, which contains information about individual students accessing services (e.g. Reason for crisis service visit).

Populations. Students, Teachers/Staff, Parents/Caregivers.

Analyses of Questions 1-3

The quantitative data sources will be limited to our Program Activity and Client Contact Logs (Appendices C and D). Study design options, including possible comparisons, were described in the Study Design section above, and the approach to analyses will differ depending on the option selected.

Further, the analytical approach may differ across different types of outcomes (for those where data are more available at the individual level, or not, for example). As we determine the level, scope, type, and quality of data available within and across counties, we will further clarify whether the approach to quantitative analyses is largely descriptive (e.g., summarizing outcomes achieved, describing changes within counties, etc.), versus a more rigorous analytical approach (e.g., adjusting for confounding, propensity score matching) that considers other temporal trends through the use of contextual variables as covariates in models. The analytical approach chosen will also address potential missingness of data, such as using imputation or sensitivity analyses. In any case, the goal of quantitative analyses will be to complement qualitative findings in order to tell a story of SB-82/833 impact, highlighting stakeholder perspectives.

Anticipated Challenges and Options

In a quasi-experimental design, the main challenge in estimation of the effect of SB-82/833 programs is the selection of counties/programs through a naturalistic policy process without a designated control group or random assignment. When randomization is not possible or assignment choices have already been made naturalistically, it is still possible to consider inference for causal effects from non-randomized comparisons. These options would be considered to address threats to validity such as selection bias.

Contributions

As a key aim for the School-County Collaborative Summative Evaluation Plan, the analyses for Questions 1-3 will reveal how school-county partnerships are enacted and affect shared outreach, crisis prevention, linkage between school supports and crisis referrals, and access to appropriate treatment services. While we are as yet uncertain of the final study design, at a minimum, the evaluation will provide a descriptive analysis that is integrative for the state across programs, using triangulation of qualitative and quantitative analyses to describe impacts in the main programmatic areas.

Question 4. How has SB-82 funding resulted in better school functioning for youth?

Outcome. This question addresses Outcome 5: to reduce school discipline and improve school outcomes

Hypothesis. In those sites that have public use data available and implement SB-82 services schoolwide, we hypothesize that we will see improvements in school outcomes such as attendance, school climate, and school connectedness.

Measures. Data from the California Department of Education contains public data on California's students, schools, and districts. This includes data on enrollment, academic performance, student poverty, expulsion and suspension, absenteeism, truancy, graduation, and dropout. The DataQuest tool allows access to a wide variety of reports on the outcomes listed. Different outcomes are available at different levels, including state-, county-, district-, school-, and Special Education Local Plan Area (SELPA)-levels.

The California Healthy Kids Survey (CHKS) is a modular, anonymous assessment of students in grades 5 and above. CHKS focuses on several different domains important for guiding school and student improvement (e.g., student connectedness, school climate, school safety, physical and mental well-being, and student supports). A Core Module is required of all participating districts, and additional modules are available in alternate years. CHKS data is available at the school-level by request. We are able to identify districts who have recently participated in CHKS, but this does not necessarily mean that they will continue to collect CHKS data in future years, nor does it mean that additional districts cannot resume participation in the survey at a later date. Below is a summary of CHKS data collection at SB-82/833 school districts.

Population. Schools/Districts

- CAHELP is working with 15 districts (in some cases, these are not full districts) in San Bernardino County. Of those, 12 districts participated in CHKS in 2017-18 and/or 2018-2019.
- Humboldt is working with 31 districts in the county. Of those, 21 districts participated in CHKS in 2017- 18 and/or 2018-2019.
- Placer is working with 2 districts in the county. Both of these districts participated in CHKS in 2017-18 and/or 2018-2019.
- Tulare is working with 1 school in each of the 48 districts in their county. Of those, 35 districts participated in CHKS in 2017-18 and/or 2018-2019.

Analysis of Question 4

We will be primarily descriptive, comparing trends over time and subanalyses of specific populations of interest (by race/ethnicity, age, gender).

Question 5. Among the School-County Collaborative Programs, how are services tailored to the unique needs of each community and school population served?

Outcome. This question addresses Outcomes 6: to improve site-specific services by county taking into account county-specific contextual factors and needs

Hypothesis. We hypothesize that each of the four School-County Collaborative Programs will deliver unique services to meet the needs of specific high-risk populations that they serve (e.g. Native communities, rural populations).

Measures. Supplemental Site Data Sources (as available), Qualitative Interviews

Analysis for Question 5

We will use a case study approach for each of the four School-County Collaborative Programs, using mixed-methods. This may allow detailed description and analysis of outcomes for each unique program, and potentially allow a more detailed analysis of a broader set of outcomes. The case study method will also provide an opportunity to incorporate supplemental data that may be unique to a county/entity and that has not been gathered through other sources. We will explore the feasibility of conducting a longitudinal cohort analysis on a subset of children and youth served in the programs. Another feature may be to expand qualitative information from providers, administrators, partners in intervention to provide a more detailed overview of program impacts.

Depending on the data available within and across counties/programs, some of the overall goals of evaluation for SB-82/833 may be more fully realized in analyses of particular programs that have broader data (e.g., data on school climate). For this reason, some of the broader evaluation goals may be met by overall analyses of main outcomes (Outcomes 1-5) and some may be met by examples where data are more available for Outcome 6.

Contributions

This "case study" approach will highlight the impacts of exemplar programs or clusters of programs. Case studies may also complement the main analysis by providing more detail for particular examples. In addition, it may offer an alternative to a more limited analysis of all counties if there are challenges in data completeness.

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Appendix A

Brief Summary of the Child and School-Community Literature Reviews

This draft plan for evaluating client and project outcomes from the SB-82/833 child- and school- focused projects is based, in part, on our review of the relevant literature on child-focused crisis intervention and school-community partnerships. Our review found that crisis intervention services should either intervene with or make appropriate referrals for a continuum of clinical needs ranging from anger and low frustration tolerance, anxiety, depression, and suicidality at the child-level, multiple psychosocial stressors at the parent- and family-level, and risk for disrupted foster care placements at the system-level. Intensive in-home community-based services are effective for helping children in crisis. A common goal for crisis services is to avert hospitalizations. Effective programs tend to support both child and family through intensive services.
One exception is an approach referred to as "critical incident debriefing". The literature suggests that there is no evidence to support the effectiveness of this strategy for child crisis intervention services, and there is evidence that it may be deleterious.

For the child/school age groups, crises can frequently center on a suicidal youth. One intervention to help suicidal youth, Dialectic Behavior Therapy, has been shown to be the most effective treatment for suicidal youth to date. Interventions in EDs can help stabilize youth and families and link them to care. Research suggests that linkage alone is not effective if the youth is not linked to evidence-based care, such as Dialectic Behavior Therapy or Cognitive Behavioral Therapy.

Our literature review found that schools are effective sites for preventive interventions. Universal programs instituted in schools to improve school climate and increase social and emotional learning of students appear to prevent subsequent behavioral and emotional problems. Interventions within schools that are delivered either universally or to at-risk students, appear effective in preventing disruptive, anxiety, PTSD, and depressive disorders.

School-community partnerships appear to be integral in addressing the needs of the whole child and family in crisis, recognizing that many children cannot be successful academically unless their social context and unmet physical and emotional needs are addressed. The scant literature that does exist suggests that these partnerships are fundamental to establishing healthy development of children, especially those living in under-resourced communities.

Along with our review of the literature on crisis interventions and school-community partnerships, we examined the literature on implementation of programs, such as crisis interventions, in community settings. Our Draft Evaluation Plan is guided by conceptual frameworks in implementation science, including Proctor's distinction between evidence-based practices and their implementation in practice, and between implementation processes and outcomes (Proctor, Powell, & McMillen, 2013; Proctor et al., 2011). Chambers, Glasgow, and Stange's (2013) Dynamic Sustainability framework emphasizing adaption to context, and Reach Effectiveness-Adoption Implementation

Maintenance (RE-AIM) (Chambers, Glasgow, & Stange, 2013; Glasgow, McKay, Piette, & Reynolds, 2001), informing intervention implementation outcome choices along a continuum from reach, efficacy to adoption, implementation, and maintenance. In addition, our stakeholder engagement process is informed by theory and methods from Community Partnered Participatory Research (Jones & Wells, 2007), as well as by the literature on mental health disparities and attention to equity (Kataoka, Novins, & Santiago, 2010), mental health needs of vulnerable child population (homeless, foster care, juvenile justice) (Barnert et al., 2015; Kataoka et al., 2001; McMillen et al., 2005; Zima, Wells, & Freeman, 1994), crisis and trauma-informed practices (Kataoka, Langley, Wong, Baweja, & Stein, 2012; Kataoka et al., 2009), clinical outcomes for children in publicly-funded care (Ashwood et al., 2018; Zima, Marti, Lee, & Pourat, 2019) and effectiveness of school-based mental health programs (Bussing, Zima, & Belin, 1998; Kataoka et al., 2012; Kataoka et al., 2003; Kataoka et al., 2001). Lastly, the flexibility built into the summative evaluation provides an opportunity to use findings from our Formative/Process Evaluation Plan (Deliverable 4) to inform choices made in the draft summative evaluation.

Appendix B

Child Crisis Intervention Program Descriptions

	Program Characteristics					Funding		
	Type*	Care Processes**	Priority Features	Staffing	Status	Phase 1***	Funding Amount	Grant Period
Berkeley City	School-Based	Crisis Intervention Linkage	Providing crisis intervention services, follow-ups, and peer support at Berkeley High School.	1 Crisis Counselor	In progress	No	Requested: $980,891.87 Received: $216,098.53	Execution through 11/30/2021
Calaveras	New	Prevention Crisis Intervention Linkage	New crisis and outreach team to provide crisis intervention services where needed, link services to clients, and provide community outreach.	1 Children's Triage Case Manager 1 Peer Support Specialist	In progress	Yes	Requested: $519,371.00 Received: $366,562.87	Execution through 11/30/2021
Humboldt	Augment	Crisis Intervention	Expanding and enhancing an existing crisis support system by adding staff to continue safely diverting hospitalizations using an emergency response team.	1 Supervising Mental Health Clinician 2 Mental Health Clinicians 2 Mental Health Case Managers	In progress	No	Requested: $726,446.00 Received: $512,712.74	Execution through 11/30/2021

Los Angeles	TBD	Crisis Intervention	Utilization of ACCESS hotline to provide immediate intervention at crisis sites to assist children and caregivers in de-escalating behaviors that impact life functioning.	8 Mental Health Clinician Supervisors 18 Mental Health Clinicians 25 Case Workers 14 Community Workers 11 Clinical Psychologists 2 Mental Health Psychiatrists 1 Supervising Psychiatrist 1 Mental Health Clinical Program Manager 1 Health Program Analyst 1 Administrative Support	Planning stages	Yes	Requested: $29,825.232.00 Received: $13,755,073.37	Execution through 11/30/2021
Placer	New	Crisis Intervention Crisis Stabilization Linkage	The Family Mobile Crisis Team, co-located at the police station, will mobilize to de-escalate crises and subsequently link the clients to services.	1 Client Services Program Supervisor 1 Client Services Practitioner 1 Parent/Family Partner 1 Youth Advocate 1 Police Department Liaison/ Administrator	In progress	Yes	Requested: $1,468,049.00 Received: $1,036,123.02	Execution through 11/30/2021

Riverside	Augment	Crisis Intervention Crisis Stabilization Linkage	Develop and refine youth triage crisis services by expanding the capacity of existing RUHS-BH community-based crisis intervention response with the addition of youth-focused teams to assess individual needs and additional supports and follow-up if a referral is made.	1 Behavioral Health Services Supervisor 3 Clinical Therapists 5 Peer Support Specialists 1 Office Assistant	In progress	Yes	Requested: $2,035,073.00 Received: $1,436,318.53	Execution through 11/30/2021
Sacramento	School-Based	Prevention Crisis Intervention	Three 2-person Safe Zone Squad teams, consisting of a Youth Advocate/Mental Health Worker and a Mental Health Counselor will have designated and consistent office hours at all 3 targeted middle school campuses to support walk-in crisis needs, including providing mental health screenings at first or second suspension and restorative mediation.	3 Safe Zone Coaches/Mental Health Counselors 3 Youth Advocates/ Mental Health Workers 1 Program Coordinator	Planning stages	Yes	Requested: $2,386,811.00 Received: $1,684,568.99	Execution through 11/30/2021

San Luis Obispo	Augment	Crisis Intervention Crisis Stabilization	SLO Crisis and Connections will add triage personnel to the existing mobile crisis response system who have specific training, knowledge, and experience working with youth, families, and the youth system of care in order to better support and manage field-based crises.	1 Lead Triage Clinician 1 Associate Triage Clinician 2 Triage Specialists	In progress	No	Requested: $620,665.00 Received: $371,233.73	Execution through 11/30/2021
Santa Barbara	New	Crisis Intervention Crisis Stabilization Linkage	Children's Crisis Triage Teams will locate to hospitals to provide treatment in the ED and divert hospitalizations while connecting clients to needed services. The team will be available to respond to crises in the community as well.	2 Mental Health Practitioners 2 Peer Recovery Assistants	In progress	Yes	Requested: $4,042,502.00 Received: $882,415.63	Execution through 11/30/2021
Stanislaus	Augment	Crisis Intervention	Address the averted population needs by providing support and linkage for youth and children that are assessed for 5150, but do not meet the level of care for hospitalization.	1 Working Program Manager/ Clinician 2 Navigators 1 Core Program Director 1 Clinical Supervisor	In progress	No	Requested: $598,099.00 Received: $422,127.70	Execution through 11/30/2021

Yolo	Augment	Crisis Intervention Crisis Stabilization	Augment existing services and create linkages, which will serve to get C&Y access to services, provide stabilization, and avoid unnecessary hospitalization or incarceration.	1 Clinician	In progress	Yes	Requested: $294,579.00 Received: $207,921.35	Execution through 11/30/2021

*_Type_ will be defined as: **1) New** = grant targets development of new mental health crisis intervention services; **2) Augment** = grant augments existing mental health crisis intervention services; **3) School-Based** = child grant supports crisis intervention services in a school setting

Main Care Processes will be defined as: 1) Prevention** = strategies and services to promote mental health care and prevent crises among youth (e.g., community trainings, outreach, outside agency partnerships); **2) Crisis Intervention** = immediate services provided for youth at the time of crisis (e.g., mobile crisis support teams, crisis assessments); **3) Crisis Stabilization** = services provided to meet the needs of youth post-crisis (e.g., follow-up visits, safety planning); **4) Linkage** = connecting youth with mental health care services (e.g., linkage to ongoing services, referrals)

***_Phase 1_ identifies whether or not sites received SB-82/833 funding during the first round of funding.

Appendix C

Program Activity Log

Record ID	Variable	Text	Response Options
2	name	First name of person filling out this form:	text, Required, Identifier
3	date	Date of Activity **Please manually choose a date. Do NOT use the "Today" button.*	text (date_mdy), Required
4	type	Type of Activity	Radio, Required 1, New Partnership/Relationship Established 2, Staff Training (Defined as any activity for staff that takes place in your SB-82/833 setting) 3, Parent/Caregiver Activity (Defined as any activity for parents/caregivers that takes place in your SB-82/833 setting) 4, Child Activity (Defined as any activity for children that takes place in your SB-82/833 setting) 5, Family Activity (Defined as any activity for parents/caregivers and children together that takes place in the scope of your SB-82/833 setting) 6, Outreach Activity (Defined as any activity that takes place outside of your SB-82/833 setting [e.g., health fairs, city council meetings]) 7, Standing Meetings (Defined as any activity that occurs on a regular basis to discuss SB-82/833-related matters)
5	ptnr Show the field ONLY if: [type] = '1'	With whom was this relationship created?	Radio 1, County Office of Education 2, Department of Behavioral/Mental Health 3, Police Department/Other Law Enforcement Agency 4, Emergency Department 5, Outside Evaluator 6, Other (e.g., External Agency)
6	ptnr_oth	Please specify 'Other':	text

	Show the field ONLY if: [ptnr] = '6'		
7	ptnr_act Show the field ONLY if: [type] = '1'	What type of activity is agreed upon in this new relationship? Please select all that apply:	Checkbox 1, Coordination among Organizations only 2, Case Coordination and Referral for Clients 3, Technical Assistance 4, MOU Created 5, Other
8	ptnr_act_oth Show the field ONLY if: [ptnr_act(5)] = '1'	Please specify 'Other':	text
9	ptnr_covid Show the field ONLY if: [type] = '1'	Was this relationship developed in response to COVID-19?	Radio 1, Yes 2, No
10	ptnr_covidyes Show the field ONLY if: [ptnr_covid] = '1'	Please describe:	text
11	staff_format Show the field ONLY if: [type] = '2'	Section Header: What is the format of this activity?	Radio 1, Live 2, Online Live 3, Online Asynchronous 4, Other
12	staff_format_oth Show the field ONLY if: [staff_format] = '4'	Please specify 'Other':	text
13	staff Show the field ONLY if: [type] = '2'	Who was this staff training led by? Please select all that apply:	Checkbox 1, SB-82/833 Program Lead or Other Staff 2, SB-82/833 Clinical Supervisor or Other Clinician 3, SB-82/833 Site or Agency Staff 4, SB-82/833 Peer or Parent Partners 5, Other
14	staff_oth Show the field ONLY if: [staff(5)] = '1'	Please specify 'Other':	text

15	staff_attend Show the field ONLY if: [type] = '2'	Who attended the training? Please select all that apply:	Checkbox 1, Administrators 2, SB-82/833 Program Staff 3, Partner Agency Staff (e.g., teachers, nurses) 4, Lay Health Workers 5, Other
16	staff_attend_oth Show the field ONLY if: [staff_attend(5)] = '1'	Please specify 'Other':	text
17	staff_topic Show the field ONLY if: [type] = '2'	What was the staff training topic(s) discussed? Please select all that apply:	Checkbox 1, Universal Prevention strategies to implement with youth (i.e., Social-Emotional Learning, Trauma-Informed Practices, bullying, prevention, Mindfulness) 2, Universal Prevention strategies to implement with parents/caregivers 3, Universal Prevention strategies for self-care 4, Crisis Intervention (i.e., suicide prevention/post-intervention, threat assessment, de-escalation, crisis management and triage, Psychological First Aid) 5, Parent/Caregiver Engagement 6, Other
18	staff_topic_oth Show the field ONLY if: [staff_topic(6)] = '1'	Please specify 'Other':	text
19	staff_quantity Show the field ONLY if: [type] = '2'	How many attended this training?	text (number)
20	staff_covid Show the field ONLY if: [type] = '2'	Was this training in response to COVID-19?	Radio 1, Yes 2, No
21	staff_covidyes Show the field ONLY if: [staff_covid] = '1'	Please describe:	text

22	par_format Show the field ONLY if: [type] = '3'	Section Header: What is the format of this activity? Please select all that apply:	Checkbox 1, Online Resource 2, Print Resource 3, In-Person Meeting 4, Live Online Meeting 5, Online Asynchronous 6, Other
23	par_format_oth Show the field ONLY if: [par_format(6)] = '1'	Please specify 'Other':	text
24	par_lead Show the field ONLY if: [type] = '3'	Who was the event leader(s)? Please select all that apply:	Checkbox 1, SB-82/833 Program Lead or Other SB-82/833 Staff 2, Clinical Supervisor or Other Clinician 3, Site or Agency Staff 4, Peer or Parent Partners 5, Other
25	par_lead_oth Show the field ONLY if: [par_lead(5)] = '1'	Please specify 'Other':	text
26	par_topic Show the field ONLY if: [type] = '3'	What was the topic(s) discussed? Please select all that apply:	Checkbox 1, Universal Prevention strategies for general population parents 2, Targeted Strategies for parents of at-risk children 3, Crisis Intervention (i.e., suicide prevention/post-intervention, Psychological First Aid) 4, Parenting Skills 5, Other
27	par_topic_oth Show the field ONLY if: [par_topic(5)] = '1'	Please specify 'Other':	text
28	par_target Show the field ONLY if: [type] = '3'	Who was the target population?	Radio 1, Parents/Caregivers 2, Parents/Caregivers of at-risk children and adolescents

			3, Other
29	par_target_oth Show the field ONLY if: [par_target] = '3'	Please specify 'Other':	text
30	par_quantity Show the field ONLY if: [type] = '3'	How many attendees or contacts?	text (number)
31	par_covid Show the field ONLY if: [type] = '3'	Was this event in response to COVID-19?	Radio 1, Yes 2, No
32	par_covidyes Show the field ONLY if: [par_covid] = '1'	Please describe:	text
33	child_format Show the field ONLY if: [type] = '4'	Section Header: What is the format of this activity?	Checkbox 1, Online Resource 2, Print Resource 3, In-Person Meeting 4, Live Online Meeting 5, Online Asynchronous 6, Other
34	child_format_oth Show the field ONLY if: [child_format(6)] = '1'	Please specify 'Other':	text
35	child_lead Show the field ONLY if: [type] = '4'	Who was the event leader? Please select all that apply:	Checkbox 1, SB-82/833 Program Lead or Other SB-82/833 Staff 2, Clinical Supervisor or Other Clinician 3, Site or Agency Staff 4, Peer or Parent Partners 5, Other
36	child_lead_oth Show the field ONLY if: [child_lead(5)] = '1'	Please specify 'Other':	text

37	child_topic Show the field ONLY if: [type] = '4'	What was the topic(s) discussed? Please select all that apply:	Checkbox 1, Universal Prevention strategies to implement with youth (i.e., Social-Emotional Learning, Trauma-Informed Practices, bullying, prevention, Mindfulness) 2, Crisis Intervention (i.e., suicide prevention/post-intervention, Psychological First Aid) 3, Other
38	child_topic_oth Show the field ONLY if: [child_topic(3)] = '1'	Please specify 'Other':	text
39	child_target Show the field ONLY if: [type] = '4'	Who was the target population?	Radio 1, Children/Adolescents 2, At-risk Children/Adolescents 3, Other
40	child_target_oth Show the field ONLY if: [child_target] = '3'	Please specify 'Other':	text
41	child_quantity Show the field ONLY if: [type] = '4'	How many attendees or contacts?	text (number)
42	child_covid Show the field ONLY if: [type] = '4'	Was this event in response to COVID-19?	Radio 1, Yes 2, No
43	child_covidyes Show the field ONLY if: [child_covid] = '1'	Please describe:	text
44	family_format Show the field ONLY if: [type] = '5'	Section Header: What is the format of this activity?	Checkbox 1, Online Resource 2, Print Resource 3, In-Person Meeting 4, Live Online Meeting 5, Online Asynchronous 6, Other

45	family_format_oth Show the field ONLY if: [family_format(6)] = '1'	Please specify 'Other':	text
46	family_lead Show the field ONLY if: [type] = '5'	Who was the event leader(s)? Please select all that apply:	Checkbox 1, SB-82/833 Program Lead or Other SB-82/833 Staff 2, Clinical Supervisor or Other Clinician 3, Site or Agency Staff 4, Peer or Parent Partners 5, Other
47	family_lead_oth Show the field ONLY if: [family_lead(5)] = '1'	Please specify 'Other':	text
48	family_topic Show the field ONLY if: [type] = '5'	What was the topic(s) discussed? Please select all that apply:	Checkbox 1, Universal Prevention strategies for general population parents 2, Targeted Strategies for parents of at-risk children 3, Crisis Intervention (i.e., suicide prevention/post-intervention, Psychological First Aid) 4, Parenting Skills 5, Other
49	family_topic_oth Show the field ONLY if: [family_topic(5)] = '1'	Please specify 'Other':	text
50	family_target Show the field ONLY if: [type] = '5'	Who was the target population?	Radio 1, Parents/Caregivers 2, Parents/Caregivers of at-risk children and adolescents 3, Other
51	family_target_oth Show the field ONLY if: [family_target] = '3'	Please specify 'Other':	Text

52	family_quantity Show the field ONLY if: [type] = '5'	How many attendees or contacts?	text (number)
53	family_covid Show the field ONLY if: [type] = '5'	Was this event in response to COVID-19?	Radio 1, Yes 2, No
54	family_covidyes Show the field ONLY if: [family_covid] = '1'	Please describe:	text
55	outreach_format Show the field ONLY if: [type] = '6'	Section Header: What was the format of this activity? Please select all that apply:	Checkbox 1, Online Resource 2, Print Resource 3, In-Person Meeting 4, Live Online Meeting 5, Online Asynchronous 6, Other
56	outreach_format_oth Show the field ONLY if: [outreach_format(6)] = '1'	Please specify 'Other':	text
57	outreach Show the field ONLY if: [type] = '6'	Please specify the type of outreach activity.	Radio 1, Public Health/Educational Activity (e.g., health fairs, city council meeting) 2, Sharing information about SB-82/833 services in the community 3, Other
58	outreach_oth Show the field ONLY if: [outreach] = '3'	Please specify 'Other':	text
59	outreach_topic Show the field ONLY if: [type] = '6'	What was the topic(s) of this activity? Please select all that apply:	Checkbox 1, Public Health/Educational Activity (e.g., health fairs, city council meeting) 2, Community Engagement

			3, SB-82/833 Staff Attending an External Task Force or Board Meeting 4, Other
60	outreach_topic_oth Show the field ONLY if: [outreach_topic(4)] = '1'	Please specify 'Other':	text
61	outreach_target Show the field ONLY if: [type] = '6'	Who was the target population?	Radio 1, Parents/Caregivers 2, Children/Adolescents 3, Community Organizations 4, Community Leaders/Policy Makers 5, Other
62	outreach_target_oth Show the field ONLY if: [outreach_target] = '5'	Please specify 'Other':	text
63	outreach_quantity Show the field ONLY if: [type] = '6'	How many attendees or contacts?	text (number)
64	outreach_covid Show the field ONLY if: [type] = '6'	Was this activity in response to COVID-19?	Radio 1, Yes 2, No
65	outreach_covidyes Show the field ONLY if: [outreach_covid] = '1'	Please describe:	text
66	meeting_format Show the field ONLY if: [type] = '7'	Section Header: What is the format of this activity?	Radio 1, In-Person Meeting 2, Live Online Meeting 3, Other
67	meeting_format_oth Show the field ONLY if: [meeting_format] = '3'	Please specify 'Other':	text

68	meeting Show the field ONLY if: [type] = '7'	Please specify the type of standing meeting activity.	Radio 1, Stakeholder Participation 2, Multidisciplinary Team Meeting 3, Other
69	meeting_oth Show the field ONLY if: [meeting] = '3'	Please specify 'Other':	text
70	meeting_frequency Show the field ONLY if: [type] = '7'	How often do these meetings take place?	Radio 1, Daily 2, Weekly 3, Quarterly 4, Annually 5, Other
71	meeting_frequency_oth Show the field ONLY if: [meeting_frequency] = '5'	Please specify 'Other':	text
72	meeting_topic Show the field ONLY if: [type] = '7'	What was the topic(s) discussed? Please select all that apply:	Checkbox 1, Identifying a child in need of SB-82/833 services 2, Staff updates 3, Community updates 4, Other
73	meeting_topic_oth Show the field ONLY if: [meeting_topic(4)] = '1'	Please specify 'Other':	text
74	meeting_quantity Show the field ONLY if: [type] = '7'	How many attendees or contacts?	text (number)
75	meeting_covid Show the field ONLY if: [type] = '7'	Were these meetings established in response to COVID-19?	Radio 1, Yes 2, No
76	meeting_covidyes	Please describe:	text

	Show the field ONLY if: [meeting_covid] = '1'		
77	program_activity_log_ complete	Section Header: *Form Status* Complete?	Dropdown 0, Incomplete 1, Unverified 2, Complete

Appendix D

Client Contact Log

Record ID	Variable	Text	Response Options
2	name	First name of person filling out this form:	text, Required, Identifier
3	sb82_id	SB-82/833 Unique Identifier *Unique ID created for each SB-82/833 client. Using an ID created from identifiable characteristics allows staff to find an existing ID in case of repeat contacts. (Example: DOB + 3 letters of last name.)*	text
4	anon_id	Record/Case Number *This ID would be an existing ID used by the program site.*	text
5	date	Date of Contact	text (date_mdy), Required
6	new_fu	Is this a new encounter or a follow-up? **Note: Please select Option 2 "First Follow-up within the Study Time Period" if your client has not had an encounter recorded during the study time period.*	Radio, Required 1, New Encounter 2, First Follow-up within the Study Time Period 3, Follow-up
7	dob Show the field ONLY if: [new_fu] = '1' or [new_fu] = '2'	**Section Header: *Demographics*** Year of Birth	text (number, Min: 1900, Max: 2020), Identifier
8	mob Show the field ONLY if: [new_fu] = '1' or [new_fu] = '2'	Month of Birth	dropdown 1, 01 2, 02 3, 03 4, 04 5, 05 6, 06 7, 07

			8, 08 9, 09 10, 10 11, 11 12, 12
9	gender Show the field ONLY if: [new_fu] = '1' or [new_fu] = '2'	Gender	Radio 1, Female 2, Male 3, Non-Binary 4, Transgender Male 5, Transgender Female 6, Unknown/Not Reported
10	sexorientation Show the field ONLY if: [new_fu] = '1' or [new_fu] = '2'	Sexual Orientation	Radio 1, Gay 2, Lesbian 3, Bisexual 4, Questioning 5, Straight 6, Other 7, Unknown/Not Reported
11	sexorientation_oth Show the field ONLY if: [sexorientation] = '6'	Please specify "Other":	text
12	ethnicity Show the field ONLY if: [new_fu] = '1' or [new_fu] = '2'	Is the client of Hispanic or Latinx ethnicity? *CSI Variable Name: C-09.0*	Radio 1, Yes 2, No 3, Unknown/Not Reported
13	race Show the field ONLY if: [new_fu] = '1' or [new_fu] = '2'	Race *CSI Variable Name: C-10.0*	Radio 1, White or Caucasian 2, Black or African American 3, American Indian or Alaska Native

			4, Filipino 5, Chinese 6, Cambodian 7, Hmong 8, Japanese 9, Korean 10, Other Pacific Islander 11, Samoan 12, Asian Indian 13, Other Asian 14, Native Hawaiian 15, Guamanian 16, Mien 17, Laotian 18, Vietnamese 19, Other 20, Unknown/Not Reported
14	livsit Show the field ONLY if: [new_fu] = '1' or [new_fu] = '2'	Living Situation (Where has the client spent most nights in last 30 days?) Please select all that apply:	Checkbox 1, Lives in home/apartment 2, Lives in shared housing (doubled up with others) due to loss of housing, financial hardship 3, Lives in a motel/hotel 4, Lives in a shelter 5, Lives unsheltered (car, park, campground, temporary trailer, abandoned building) 6, Identified by school as homeless
15	ins Show the field ONLY if: [new_fu] = '1' or [new_fu] = '2'	Health Insurance	Radio 1, Public 2, Private 3, None 4, Unknown/Not Reported

16	past_help Show the field ONLY if: [new_fu] = '1' or [new_fu] = '2'	**Section Header: *Client History*** Prior to this visit, has the client seen a mental health professional for problems with emotions, behaviors, or use of alcohol or drugs within the last year?	Radio 1, Yes 2, No 3, Unknown/Not Reported
17	past_help3 Show the field ONLY if: [past_help] = '1'	Has the client seen a mental health professional for problems with emotions, behaviors, or use of alcohol or drugs in the last 3 months?	Radio 1, Yes 2, No 3, Unknown/Not Reported
18	past_fsp Show the field ONLY if: [new_fu] = '1' or [new_fu] = '2'	Prior to this visit, has the client been involved in Full Service Partnership (FSP) services?	Radio 1, Yes 2, No 3, Unknown/Not Reported
19	past_fsp3 Show the field ONLY if: [past_fsp] = '1'	Has the client been involved in FSP services within the last 3 months?	Radio 1, Yes 2, No 3, Unknown/Not Reported
20	past_outpt Show the field ONLY if: [new_fu] = '1' or [new_fu] = '2'	Prior to this visit, has the client been in outpatient services within the last year?	Radio 1, Yes 2, No 3, Unknown/Not Reported
21	past_outpt3 Show the field ONLY if: [past_outpt] = '1'	Has the client been in outpatient services within the last 3 months?	Radio 1, Yes 2, No 3, Unknown/Not Reported
22	past_hosp Show the field ONLY if: [new_fu] = '1' or [new_fu] = '2'	Prior to this visit, has the client been hospitalized in a psychiatric hospital within the last year?	Radio 1, Yes 2, No 3, Unknown/Not Reported

23	past_hosp3 Show the field ONLY if: [past_hosp] = '1'	Has the client been hospitalized in a psychiatric hospital within the last 3 months?	Radio 1, Yes 2, No 3, Unknown/Not Reported
24	past_er Show the field ONLY if: [new_fu] = '1' or [new_fu] = '2'	Prior to this visit, has the client gone to the emergency room for psychiatric reasons within the last year?	Radio 1, Yes 2, No 3, Unknown/Not Reported
25	past_er3 Show the field ONLY if: [past_er] = '1'	Has the client gone to the emergency room for psychiatric reasons within the last 3 months?	Radio 1, Yes 2, No 3, Unknown/Not Reported
26	past_home Show the field ONLY if: [new_fu] = '1' or [new_fu] = '2'	Prior to this visit, has the client lived in a foster home, group home, or residential facility within the last year?	Radio 1, Yes 2, No 3, Unknown/Not Reported
27	past_home3 Show the field ONLY if: [past_home] = '1'	Has the client lived in a foster home, group home, or residential facility within the last 3 months?	Radio 1, Yes 2, No 3, Unknown/Not Reported
28	past_law Show the field ONLY if: [new_fu] = '1' or [new_fu] = '2'	Prior to this visit, has the client been detained in juvenile hall or been on probation within the last year?	Radio 1, Yes 2, No 3, Unknown/Not Reported
29	past_law3 Show the field ONLY if: [past_law] = '1'	Has the client been detained in juvenile hall or been on probation within the last 3 months?	Radio 1, Yes 2, No 3, Unknown/Not Reported

30	past_speced Show the field ONLY if: [new_fu] = '1' or [new_fu] = '2'	Prior to this visit, has the client received special education services (from an IEP) within the last year?	Radio 1, Yes 2, No 3, Unknown/Not Reported
31	past_speced3 Show the field ONLY if: [past_speced] = '1'	Has the client received special education services (from an IEP) within the last 3 months?	Radio 1, Yes 2, No 3, Unknown/Not Reported
32	past_school Show the field ONLY if: [new_fu] = '1' or [new_fu] = '2'	Prior to this visit, has the client been suspended or expelled from school within the last year?	Radio 1, Yes 2, No 3, Unknown/Not Reported
33	past_school3 Show the field ONLY if: [past_school] = '1'	Has the client been suspended or expelled from school within the last 3 months?	Radio 1, Yes 2, No 3, Unknown/Not Reported
34	reason Show the field ONLY if: [new_fu] = '1'	**Section Header: *Current Encounter*** What is the primary reason for this SB-82/833 service visit?	Radio 1, Risk of self-injury 2, Risk of injury to others 3, Serious concerns regarding safety of child 4, Running away/Elopement 5, Change in behavior/mood (e.g., anxiety, depression) 6, Family needs resources 7, Grief/Loss issues 8, Problems in school (e.g., school refusal, withdrawal) 9, Other (please specify)
35	reason_oth	Please specify 'Other':	text

	Show the field ONLY if: [reason] = '9'		
36	reason_other Show the field ONLY if: [new_fu] = '1'	What are the other reasons for this SB-82/833 service visit? Please select all that apply:	Checkbox 1, Risk of self-injury 2, Risk of injury to others 3, Serious concerns regarding safety of child 4, Running away/Elopement 5, Change in behavior/mood (e.g., anxiety/depression) 6, Family needs resources 7, Grief/Loss issues 8, Problems in school (e.g., school refusal, withdrawal) 9, Other (please specify) 10, None
37	reason_other_oth Show the field ONLY if: [reason_other(9)] = '1'	Please specify 'Other':	text
38	refby Show the field ONLY if: [new_fu] = '1'	Did the client self-refer?	Radio 1, Yes 2, No 3, Unknown/Not Reported
39	refby_who Show the field ONLY if: [refby] = '2'	Who referred the client to your SB-82/833 service?	Radio 1, Emergency Department 2, School Staff 3, Parent/Caregiver 4, Primary Care Provider 5, Law Enforcement 6, Mental Health Provider 7, Other
40	refby_who_oth	Please specify 'Other':	text

	Show the field ONLY if: [refby_who] = '7'		
41	er_time Show the field ONLY if: [refby_who] = '1'	Length of time in ED during crisis (In Hours)	text (number)
42	diagnosis Show the field ONLY if: [new_fu] = '1'	Was a diagnosis given from this encounter?	Radio 1, Yes 2, No
43	diagnosis1 Show the field ONLY if: [diagnosis] = '1'	Primary Diagnosis *Please use DSM-V or ICD-10 codes, or 'NA'*	text
44	diagnosis2 Show the field ONLY if: [diagnosis] = '1'	Secondary Diagnosis *Please use DSM-V or ICD-10 codes, or 'NA'*	text
45	diagnosis3 Show the field ONLY if: [diagnosis] = '1'	Tertiary Diagnosis *Please use DSM-V or ICD-10 codes, or 'NA'*	text
46	service Show the field ONLY if: [new_fu] = '1'	What did you provide during this encounter?	Checkbox 1, Assessment 2, Individual Psychotherapy (CBT, DBT, Other) 3, Group Therapy 4, Safety Plan 5, Linkage/Referral 6, Parent or Primary Caregiver Psychoeducation or Parenting Supports 7, Family Therapy 8, Parent or Primary Caregiver Mental Health Referral 9, Other
47	service_oth	Please specify 'Other':	text

	Show the field ONLY if: [service(8)] = '1'		
48	hold Show the field ONLY if: [new_fu] = '1'	Was the client placed on a 5150 or 5585 hold during this encounter?	Radio] 1, Yes 2, No
49	mhrefer Show the field ONLY if: [new_fu] = '1'	Was the client referred to mental health services?	Radio 1, Yes 2, No
50	mhrefer1_16 Show the field ONLY if: [mhrefer] = '1'	To what mental health services was the client referred?	Checkbox 1, School Behavioral/Educational Services 2, Crisis Service (Mobile, County Services, etc.) 3, HMO/Managed Care MH Outpatient Services 4, County MH Outpatient Services 5, Private Practice MH Outpatient Services 6, Partial Hospitalization 7, Intensive Outpatient 8, Inpatient Hospitalization 9, Parent/Family Services (Family Therapy) 10, Parenting Support (Parent Training) 11, Other
51	mhrefer_oth Show the field ONLY if: [mhrefer1_16(11)] = '1'	Please specify 'Other':	text
52	othrefer Show the field ONLY if: [new_fu] = '1'	Was the client referred to other non-mental health services?	Radio 1, Yes 2, No

53	othrefer1_6 Show the field ONLY if: [othrefer] = '1'	To what other non-mental health services was the client referred?	Checkbox 1, CPS/Department of Social Services/Child Welfare 2, Law Enforcement/Probation 3, Primary Care Physician 4, School/Special Education 5, Spiritual Support Centers 6, Family Resources (e.g., Food Bank, Vocational Info) 7, Regional Centers, other Disability Services 8, Other
54	othrefer_oth Show the field ONLY if: [othrefer1_6(8)] = '1'	Please specify 'Other':	text
55	dmh Show the field ONLY if: [new_fu] = '1'	Is this encounter also opened in your county's DMH/DBH?	Radio 1, Yes 2, No 3, Unknown/Not Reported
56	mhrefer_fu Show the field ONLY if: [new_fu] = '2' or [new_fu] = '3'	Section Header: *Follow-up Visit* At the time of the last visit, was the client referred to mental health services?	Radio 1, Yes 2, No
57	mhrefer_fu1_16 Show the field ONLY if: [mhrefer_fu] = '1'	To what mental health services was the client referred? Please select all that apply:	checkbox 1, School Behavioral/Educational Services 2, Crisis Service (Mobile, County Services, etc.) 3, HMO/Managed Care MH Outpatient Services 4, County MH Outpatient Services

			5, Private Practice MH Outpatient Services 6, Partial Hospitalization 7, Intensive Outpatient 8, Inpatient Hospitalization 9, Parent/Family Services (Family Therapy) 10, Parenting Support (Parent Training) 11, Other
58	mhref_fu_oth Show the field ONLY if: [mhrefer_fu1_16(11)] = '1'	Please specify 'Other':	text
59	mhrcomplete1 Show the field ONLY if: [mhrefer_fu1_16(1)] = '1'	Did the client make contact with the School Behavioral/Educational Services?	Radio 1, Yes 2, No 3, Unknown/Not Reported
60	mhrcomplete2 Show the field ONLY if: [mhrefer_fu1_16(2)] = '1'	Did the client make contact with Crisis Services?	Radio 1, Yes 2, No 3, Unknown/Not Reported
61	mhrcomplete3 Show the field ONLY if: [mhrefer_fu1_16(3)] = '1'	Did the client make contact with the HMO/Managed Care MH Outpatient Services?	Radio 1, Yes 2, No 3, Unknown/Not Reported
62	mhrcomplete4 Show the field ONLY if: [mhrefer_fu1_16(4)] = '1'	Did the client make contact with the County MH Outpatient Services?	Radio 1, Yes 2, No 3, Unknown/Not Reported

63	mhrcomplete5 Show the field ONLY if: [mhrefer_fu1_16(5)] = '1'	Did the client make contact with the Private Practice MH Outpatient Services?	Radio 1, Yes 2, No 3, Unknown/Not Reported
64	mhrcomplete6 Show the field ONLY if: [mhrefer_fu1_16(6)] = '1'	Did the client make contact with the Partial Hospitalization referral?	Radio 1, Yes 2, No 3, Unknown/Not Reported
65	mhrcomplete7 Show the field ONLY if: [mhrefer_fu1_16(7)] = '1'	Did the client make contact with the Intensive Outpatient referral?	Radio 1, Yes 2, No 3, Unknown/Not Reported
66	mhrcomplete8 Show the field ONLY if: [mhrefer_fu1_16(8)] = '1'	Did the client make contact with the Inpatient Hospitalization referral?	Radio 1, Yes 2, No 3, Unknown/Not Reported
67	mhrcomplete9 Show the field ONLY if: [mhrefer_fu1_16(9)] = '1'	Did the client make contact with the Parent/Family Resources or Services?	Radio 1, Yes 2, No 3, Unknown/Not Reported
68	mhrcomplete10 Show the field ONLY if: [mhrefer_fu1_16(10)] = '1'	Did the client make contact with the Parenting Support referral?	Radio 1, Yes 2, No 3, Unknown/Not Reported
69	mhrcomplete11 Show the field ONLY if: [mhrefer_fu1_16(11)] = '1'	Did the client make contact with the 'Other' referral?	Radio 1, Yes 2, No 3, Unknown/Not Reported

70	othrefer_fu Show the field ONLY if: [new_fu] = '2' or [new_fu] = '3'	At the time of the last visit, was the client referred to other non-mental health services?	Radio 1, Yes 2, No
71	othrefer_fu1_6 Show the field ONLY if: [othrefer_fu] = '1'	To what non-mental health services was the client referred to?	checkbox 1, CPS/Department of Social Services/Child Welfare 2, Law Enforcement/Probation 3, Primary Care Physician 4, School/Special Education 5, Spiritual Support Centers 6, Family Resources (e.g., Food Bank, Vocational Info) 7, Regional Centers, other Disability Services 8, Other
72	mhref_fu_oth_2 Show the field ONLY if: [othrefer_fu1_6(8)] = '1'	Please specify 'Other':	text
73	othcomplete1 Show the field ONLY if: [othrefer_fu1_6(1)] = '1'	Did the client make contact with the CPS/Department of Social Services/Child Welfare?	Radio 1, Yes 2, No 3, Unknown/Not Reported
74	othcomplete2 Show the field ONLY if: [othrefer_fu1_6(2)] = '1'	Did the client make contact with the Law Enforcement/Probation?	Radio 1, Yes 2, No 3, Unknown/Not Reported
75	othcomplete3 Show the field ONLY if: [othrefer_fu1_6(3)] = '1'	Did the client make contact with their Primary Care Physician?	Radio 1, Yes 2, No 3, Unknown/Not Reported

76	othcomplete4 Show the field ONLY if: [othrefer_fu1_6(4)] = '1'	Did the client make contact with their School/Special Education services?	Radio 1, Yes 2, No 3, Unknown/Not Reported
77	othcomplete5 Show the field ONLY if: [othrefer_fu1_6(5)] = '1'	Did the client make contact with a Spiritual Support Center?	Radio 1, Yes 2, No 3, Unknown/Not Reported
78	othcomplete7 Show the field ONLY if: [othrefer_fu1_6(6)] = '1'	Did the client make contact with Family Resources?	Radio 1, Yes 2, No 3, Unknown/Not Reported
79	othcomplete8 Show the field ONLY if: [othrefer_fu1_6(7)] = '1'	Did the client make contact with the Regional/County Centers referral?	Radio 1, Yes 2, No 3, Unknown/Not Reported
80	othcomplete6 Show the field ONLY if: [othrefer_fu1_6(8)] = '1'	Did the client make contact with the 'Other' referral?	Radio 1, Yes 2, No 3, Unknown/Not Reported
81	fu911 Show the field ONLY if: [new_fu] = '2' or [new_fu] = '3'	Has the client made any 911 calls since the last visit?	Radio 1, Yes 2, No 3, Unknown/Not Reported
82	fu911_quantity Show the field ONLY if: [fu911] = '1'	How many 911 calls were made?	text (number)

83	fulaw Show the field ONLY if: [new_fu] = '2' or [new_fu] = '3'	Has there been any transport by law enforcement since the last visit?	Radio 1, Yes 2, No 3, Unknown/Not Reported
84	fulaw_quantity Show the field ONLY if: [fulaw] = '1'	How many transports have there been?	text
85	fumobile Show the field ONLY if: [new_fu] = '2' or [new_fu] = '3'	Has there been any mobile crisis interventions since the last visit?	Radio 1, Yes 2, No 3, Unknown/Not Reported
86	fumobile_quantity Show the field ONLY if: [fumobile] = '1'	How many mobile crisis interventions have there been?	text
87	fuoutpt Show the field ONLY if: [new_fu] = '2' or [new_fu] = '3'	Has the client been in outpatient services (independent from any referrals) since the last visit?	Radio 1, Yes 2, No 3, Unknown/Not Reported
88	fuoutpt_time Show the field ONLY if: [fuoutpt] = '1'	How long was the client in outpatient services? (In Days)	text
89	fued Show the field ONLY if: [new_fu] = '2' or [new_fu] = '3'	Has the client gone to the emergency room for psychiatric reasons since the last visit?	Radio 1, Yes 2, No 3, Unknown/Not Reported
90	fued_time Show the field ONLY if: [fued] = '1'	How long was the client in the emergency room? (In Hours)	text

91	fuhosp Show the field ONLY if: [new_fu] = '2' or [new_fu] = '3'	Has the client been hospitalized for psychiatric reasons (independent from any referrals) since the last visit?	Radio 1, Yes 2, No 3, Unknown/Not Reported
92	fuhosp_time Show the field ONLY if: [fuhosp] = '1'	How long was the client hospitalized for? (In Days)	text
93	fuhome Show the field ONLY if: [new_fu] = '2' or [new_fu] = '3'	Did the client make a connection with a foster home, group home, or residential facility (independent from any referrals) since the last visit?	Radio 1, Yes 2, No 3, Unknown/Not Reported
94	fujustice Show the field ONLY if: [new_fu] = '2' or [new_fu] = '3'	Has there been justice involvement since the last visit?	Radio 1, Yes 2, No 3, Unknown/Not Reported
95	fuspeced Show the field ONLY if: [new_fu] = '2' or [new_fu] = '3'	Has the client engaged in special education services (independent from any referrals) since the last visit?	Radio 1, Yes 2, No 3, Unknown/Not Reported
96	fuschool Show the field ONLY if: [new_fu] = '2' or [new_fu] = '3'	Has the client been suspended or expelled from school since the last visit?	Radio 1, Yes 2, No 3, Unknown/Not Reported
97	client_contact_log_complete	**Section Header: *Form Status*** Complete?	Dropdown 0, Incomplete 1, Unverified 2, Complete

Appendix E

Study Variables and Data Sources

Domains	Study Variable Examples	Data Source Options
Contextual Factors		
State	Geographic region	ACS (Census Bureau)
County	Urban/rural	ACS (Census Bureau)
	Poverty	ACS (Census Bureau)
	% racial/ethnic minority	ACS (Census Bureau)
County Resources	Crisis stabilization unit(s)	Proposals, Interviews
	# hospitals	Proposals, Interviews, County Websites
	# ED's with on-site mental health support services	Proposals, Interviews
	# Inpatient psychiatric beds for children and adolescents (general hospital, free-standing psychiatric	Proposals, Interviews, County Websites
SB-82/833 Program-Level		
General Program Characteristics	Primary Location of Services (Mobile Response, ER-Based, School-Based)	Proposals, Interviews
	Staffing	Proposals, Interviews
	Prior SB-82/833 Funding	Proposals, Interviews
	Funding Amount	Proposals, Interviews, MHSOAC Websites
	Program Maturation	Interviews
	Main Care Processes (Prevention, Crisis Intervention, Crisis	Proposals, Interviews
	COVID-19 Policy Changes/ Services Offered	Interviews, Program Activity Log
Activities	MOUs Created	Program Activity Log
	New Hires	Interviews, Program Activity Log, Quarterly Staffing
	Staff Trainings	Program Activity Log
	Outreach Activities	Program Activity Log
	Parent/Caregiver Activities	Program Activity Log
	Family Activities	Program Activity Log
	Child Activities	Program Activity Log
	Standing Meetings	Program Activity Log
SB-82/833 Client-Level		
Demographics	Age	Client Contact Log,
	Gender	Client Contact Log,
	Sexual Orientation	Client Contact Log,
	Ethnicity	Client Contact Log,
	Race	Client Contact Log,

	Health Insurance	Client Contact Log,
Client History	Prior Seeking Professional	Client Contact Log,
	Prior Psychiatric	Client Contact Log,
	Prior Emergency Room Visit for Psychiatric Reasons	Client Contact Log, EHR/Other
	Prior Living Situation	Client Contact Log,
	Prior Contact with Law Enforcement	Client Contact Log, EHR/Other
	Prior Special Education	Client Contact Log,
	Prior School Discipline	Client Contact Log,
New Crisis Encounters	Number of New Crisis	Client Contact Log,
	Reason for Crisis Service	Client Contact Log,
	Referral Source	Client Contact Log,
	Diagnoses	Client Contact Log,
	Care Processes Provided in Crisis Service	Client Contact Log, EHR/Other
	5150/5585 Hold	Client Contact Log,
	Mental Health Service	Client Contact Log,
	Other Referral(s)	Client Contact Log,
	Case Opened in DMH	Client Contact Log,
Follow-up Visits	Number of Follow-up Visits	Client Contact Log,
	Completion of Mental Health Referral(s)	Client Contact Log, EHR/Other
	Completion of Other	Client Contact Log,
	911 Calls	Client Contact Log,
	Law Enforcement Transport	Client Contact Log,
	Mobile Crisis Interventions	Client Contact Log,
	Outpatient Services	Client Contact Log,
	ED Visits	Client Contact Log,
	Hospitalization for Psychiatric Reasons	Client Contact Log, EHR/Other
	Contact with Foster Homes, Group Homes, and/or	Client Contact Log, EHR/Other
	Justice Involvement	Client Contact Log,
	Special Education Services	Client Contact Log,
	School Discipline	Client Contact Log,

Appendix F

Options for Statistical Power Analyses

We are currently outlining options for statistical power/precision for analyses based on various assumptions. To illustrate this process, we describe a *preliminary* power analysis. It is important to note that this is included to share the *approach*; it is not a final power analysis. The illustration makes a number of assumptions: 1) there are about 150 (possibly 200) schools in areas served by the four School-County Collaborative Programs; 2) if data from comparison schools in non-SB-82/833 counties are available, we assume this would be at the school-level, for roughly 150 + 150 schools in a comparative, school-level analysis. For Child Crisis Intervention Programs, with eleven counties/programs we assumed conservatively that 1000- 1500 children would be served in a given year or period, with potentially a matched set of behavioral-health served children in non-SB-82/833 counties (if available) for 2000-3000 children in analyses. We assumed baseline rates of outcomes of interest among high-risk clients, such as hospitalization, school drop-out, and so forth, as at rates of 5, 10-20%; and that program impacts would potentially be in the range of a 10-20 percentage point improvement. We also assumed inter-temporal correlation (ITC) rates on measures of between 0.4 and 0.6. Using these assumptions, we estimated a range of precision levels for analyses. As might be expected, depending on the assumptions and availability of data, there is a very wide range of potential precision for observing impacts, with the highest precision from individual-level data, having comparison counties, and data on individuals within those comparison counties. Some available Phase 1 evaluation reports were used to help inform these assumptions based on the descriptive data. While we are only starting working through assumptions and modeling precision, the table below illustrates the approach. As shown in Table 6 below, for a binary outcome such as hospitalization, assuming 80% power, alpha=.05, and a 2-sided test for client-level analysis in a difference-in-differences framework (DID), the observable improvement over time between program and control clients would vary, depending on assumptions, from a low of .0285 (higher sample, 20% reference point) to a high of .0480 (smaller sample, 50% reference point). What this would mean, is for a baseline rate of 20% (e.g., prior hospitalization in a high risk sample), we would be able to observe about a 20 percentage change (e.g., from 20% to about 15-16%). Comparable analyses for school-level analyses (e.g., dropout rate), suggest observable standardized effect sizes (mean divided by standard deviation) are moderate (about .200). However, as noted, we are only beginning to explore assumptions, models, and potential precision, and much depends on type of data, data quality, and completeness in terms of either type of model or precision for a given analysis. In this regard, Table 6 below is more of a "best case scenario" with individual-level data with comparison counties, but also conservatively estimating sample size, which could be much larger (this may be a scenario for a large county in Aim 3 as a case example, or a cluster of counties). Other approaches (pre-post only within intervention counties) would have more limited power and likely be more for descriptive purposes.

Analysis Precision Levels Using Multiple Assumptions

For binary outcome variables assumed baseline proportions are equal in both groups Minimum detectable effect sizes (80% power, alpha=0.05, 2-sided test) for client level data analysis, testing for person level analysis of between group difference in change from baseline			
Total sample size	Inter-temporal	Assume reference p=.5	Assume reference p=.20
		Greater reduction from baseline in treatment vs	Greater reduction from baseline in treatment vs
2000	0.4	0.0480	0.0370
2000	0.5	0.0469	0.0362
2000	0.6	0.0448	0.0346
3000	0.4	0.0392	0.0304
3000	0.5	0.0383	0.0298

Appendix G

School-County Collaborative Program Descriptions

	Program Characteristics				Funding		
	Main Care Processes*	Priority Features	Staffing	Program Maturation	Phase 1**	Funding Amount	Grant Period
CAHELP	Health Promotion/ Prevention Early Intervention Acute Intervention	CAHELP will hire triage personnel to provide a multi-tiered system of triage services to children and youth on school sites who might be experiencing or are at risk for a mental health crisis. The CAHELP program will collaborate with 19 Local Education Agencies (LEAs) in San Bernardino County for the outreach component of their intervention. A number of schools within 4 of these LEAs (not whole districts) have been identified as ready for the universal screener component of their intervention.	1 Program Manager 4 Intervention Specialists 3 Community Services Assistants 1 Office Specialist II 1 Program Technician 1 Outreach Specialist 1 Intervention and Prevention Lead Specialist 1 Senior Fiscal Clerk	In progress	No	Requested: $7,500,000.00 Received: $5,293,367.35	Execution-11/30/2022
Humboldt	Acute Intervention Crisis Treatment	Humboldt Bridges to Success (HBS) will expand and enhance the existing crisis support system by funding staff. The Humboldt program will collaborate with all 31 school districts in Humboldt County.	1 Supervising Mental Health Clinician 1 Supervising K-12 Mental Health Coordinator 6 Mental Health Clinicians II 4 Family/Child Support Coaches 10 Case Managers	In progress	No	Requested: $7,500,00.00 Received: $5,293,367.35	Execution-11/30/2022

Placer	Health Promotion/ Prevention Early Intervention Acute Intervention Crisis Treatment	School-based Wellness Centers – will hire school-based mental health staff to provide a continuum of integrated mental health services in 8 schools servicing K-12 students. The Placer program will collaborate with 8 schools from 2 districts in Roseville, Placer County.	7 School Social Workers 8 Family/Youth/ Community Liaisons 1 Project Coordinator 1 Clinical Supervisor 1 Administrative Support/Assistant	In progress	Yes	Requested: $7,500,000.00 Received: $5,293,367.35	Execution-11/30/2022
Tulare	Health Promotion/ Prevention Acute Intervention Crisis Treatment	All districts supported and served by TCOE were offered a Triage Social Worker to provide collaborative social work services to a targeted school site within each respective district for a minimum of 1 day/week for 2 years (2 cycles of 2 years each). Participating schools are also using Mindful Schools as a universal prevention approach. The Tulare program will collaborate with 1 school from each of 24 school districts in Tulare County in each cycle (48 schools total) for the social worker component and the mindfulness component.	11 Triage Social Workers 1 Clinical Supervisor 1 Grant Coordinator 1 Peer Support Specialist 1 Parent Partner	In progress	No	Requested: $7,500,00.00 Received: $5,293,367.34	Execution-11/30/2022

*Main Care Processes will be defined as: **1) Health Promotion/Prevention** = universal and selected/indicated mechanisms (e.g., universal screenings, parent partner trainings, community

engagement) used to promote mental health and prevent crises in school settings; **2) Early Intervention** = involvement targeting early stages of crises (e.g., services for at-risk youth); **3) Acute Intervention** = immediate intervention services at the time of a crisis; **4) Crisis Treatment** = individualized, long-term strategies to treat a student following a crisis (e.g., linkage to ongoing services, referrals, safety plan)

** Phase 1 will identify whether or not sites received SB-82/833 funding during the first round of funding.