MHSOAC
Mental Health Services
Oversight & Accountability Commission

MENTAL HEALTH SERVICES ACT · PROPOSITION 63 · CALIFORNIA
WELLNESS • RECOVERY • RESILIENCE

Research and Evaluation Committee Meeting

June 17, 2021
1:00 pm to 4:00 pm

Chair Itai Danovitch | Vice Chair Ken Berrick

Research and Evaluation Committee Meeting Agenda

Thursday, June 17, 2021
1:00 – 4:00 PM
MHSOAC: Zoom Teleconference
Note: The meeting audio will be recorded.
Link: https://zoom.us/j/91263059651?pwd=d2d0bkZWZGhoTmJDSW95SGhmQzF5Zz09

Call-in Number: 669-900-6833, 408-638-0968

Meeting ID: 912 6305 9651, **Password**: 353607

Meeting Purpose and Goals:

- Convene the Committee to advise the MHSOAC's Research and Evaluation Division and provide feedback on a child/youth/school mental health evaluation framework to drive transformational change and improve performance across public systems.

TIME	TOPIC	Agenda Item
1:00 PM	**Welcome** *Commissioners Dr. Itai Danovitch, Chair & Mr. Ken Berrick, Vice Chair* Welcome, opening remarks and review of the agenda.	
1:10 PM	**Action: Approval of Meeting Minutes** *Commissioner Dr. Itai Danovitch, Chair* The Research and Evaluation Committee will consider approval of the minutes from the February 24, 2021 meeting teleconference. • **Public comment** • **Vote**	**1**
1:20 PM	**Information: Summary of the Committee's Work** *Dr. Dawnté Early, Chief of Research and Evaluation* Dr. Early will summarize the Committee's work to date including the development of a child/youth/school mental health evaluation framework to support the Commission's research and evaluation activities.	**2**
1:40 PM	**Discussion to Guide the Commission's Proposed Evaluation Framework** *Facilitator: Chair, Co-Chair, Commission Staff* The Committee will discuss and provide feedback on a general evaluation framework developed by Commission staff that could be applied across the Commission's grants and initiatives for children, youth, and school mental health. Questions to guide the discussion will include, but are not limited to: 1. How can the objectives and structure of the evaluation framework be improved and be applicable to a range of programs and services?	**3**

	2. Equity considerations are foundational to the MHSA. How can the framework better reflect the centrality of equity to our evaluation work? • **Public Comment**	
2:40 PM	**Break**	
2:50 PM	**Information and Discussion to Guide Evaluation of the Mental Health Student Services Act (MHSSA)** *Cheryl Ward, Health Program Specialist* Summary of the objectives of the MHSSA legislation, the grants awarded, the learning collaborative, and data collection tool. *Facilitator: Chair, Co-Chair, Commission Staff* The MHSSA will be used as a case example for applying the general evaluation framework (Agenda Item 3). Questions to guide the Committee's discussion will include, but are not limited to: 1. What would be appropriate measures and a monitoring strategy for evaluating the MHSSA? 2. What are suggestions for ensuring that youth, families, and other stakeholders are meaningfully engaged in the evaluation of the MHSSA? • **Public comment**	**4**
3:50 PM	**Wrap-Up and Adjourn** *Commissioner Dr. Itai Danovitch, Chair*	

AGENDA ITEM 1

Action

June 17, 2021 Research and Evaluation Committee Meeting

Approval of Meeting Minutes

Summary: The Commission's Research and Evaluation Committee will review the minutes from the February 24, 2021 Committee teleconference meeting. Any edits to the minutes will be made and the minutes will be amended to reflect the changes and posted to the Commission Web site after the meeting.

Presenter: None.

Enclosures (1): February 24, 2021 Meeting Minutes.

Proposed Motion: The Committee approves the February 24, 2021 meeting minutes.

Research and Evaluation Committee Teleconference Meeting Minutes/Summary
Date: Wednesday, February 24, 2021 | Time: 1:00 p.m. – 4:00 p.m.

MHSOAC
1325 J Street, Suite 1700
Sacramento, CA 95814

Committee Members:	Staff:	Other Attendees:
Itai Danovitch, Chair Ken Berrick, Vice Chair Rikke Addis Sergio Aguilar-Gaxiola Robert Brook Victor Carrion Eleanor Castillo Sumi Jonathan Freedman Sharon Ishikawa Bridgette Lery Gustavo Loera April Ludwig Belinda Lyons-Newman Mari Radzik Ruth Shim Lonnie Snowden, Jr. Katherine Watkins	Toby Ewing Brian Sala Dawnte Early Ashley Mills Kai LeMasson Kayla Landry Sheron Wright	Jane Adcock Tiffany Carter Theresa Comstock Ellie Stabeck (phonetic) Mandy Taylor

Committee Member absent: Laysha Ostrow

Welcome

Commissioner Itai Danovitch, Committee Chair, called the meeting to order at approximately 1:00 p.m. and welcomed everyone. He reviewed the meeting protocols and meeting agenda.

Kai LeMasson, Ph.D., Senior Researcher, called the roll and confirmed the presence of a quorum.

Agenda Item 1: Action – Approval of Meeting Minutes

Chair Danovitch asked for a motion to approve the meeting minutes for the November 18, 2020, Research and Evaluation Committee meeting.

Vice Chair Berrick made a motion to approve the minutes as presented. The motion was seconded by Lonny Snowden.

Vote recorded with participating members as follows:

- Approve: Committee Members Danovitch, Berrick, Addis, Carrion, Castillo Sumi, Freedman, Ishikawa, Lery, Loera, Ludwig, Lyons-Newman, Radzik, Snowden, and Watkins
- Abstain: Committee Member Brook

Agenda Item 2: Information – Summary of Committee Member Feedback and Next Steps for Committee Work

Chair Danovitch discussed feedback received from individual Committee Members on priority areas to connect the work of the Committee. The California Association of Local Behavioral Health Boards and Commissions (CALBHB/C) submitted a letter suggesting specific performance measures for Mental Health Services Act (MHSA) initiatives, which was included in the meeting packet.

Chair Danovitch stated one of the areas initially addressed in the last meeting was whether to orient the work along a single, broad-based strategy around developing a guiding evaluation framework for all MHSA initiatives, creating a research agenda to assess the impact of the MHSA, and developing a strategy for evaluation of mental health status indicators at the California population level. Feedback received indicated that Committee Members endorsed essentially every option across the board; however, common themes emerged – caution against spending time addressing a high-level population of health indicators and grappling with problems known to be exceedingly difficult to solve, wariness about generating material that sits on the shelf, interest in practical, actionable, future-oriented work, and subdividing the meeting into smaller work groups to ensure that more voices are heard.

Chair Danovitch stated the Committee will get more granular and will prioritize work on specific research and evaluation projects, rather than broad-based assessment-type strategies. Work groups will be organized based on areas of expertise or selected topic of interest to help better leverage existing initiatives and maximize the ability to ask and answer effective questions that drive toward goals.

Agenda Item 3: Information and Discussion to Guide the Commission's Evaluation and Research

• Brief Presentation on the Commission's Priority Areas to Facilitate Committee Discussion

Chair Danovitch asked Dr. Early to present a summary of the Commission's existing initiatives that closely align with the seven population-level outcomes.

Dr. Dawnté Early, Chief of Research and Evaluation Division, provided an overview, with a slide presentation, of the work of the Research and Evaluation Division – school mental health, criminal justice involvement, unemployment, suicide prevention, triage crises services, and disparities – to facilitate Committee discussion. She noted that more information on these initiatives and the feedback received are included in the appendices in the meeting packet. She noted that all work of this Committee is guided by the Commission's Five-Year Strategic Plan, specifically Strategic Goal 2: to advance data and analytics that will better describe desired

outcomes; how resources and programs are attempting to improve those outcomes; and, elevate opportunities to transform and connect programs to improve results.

Dr. Early invited a number of Committee Members and staff to give their perspectives on initiatives to aid the discussion during today's breakout session.

Dr. Early reviewed the three breakout group options:

- Group 1: Triage Crisis Services and Criminal Justice Involvement, facilitated by Chair Danovitch and Kai LeMasson.
- Group 2: Suicide Prevention and Unemployment, facilitated by Brian Sala and Ashley Mills.
- Group 3: Reducing Disparities and Outcomes and School Mental Health, facilitated by Dr. Early.

Discussion

Committee Member Brook stated his understanding that the main purpose of this Committee was to evaluate the effectiveness of the MHSA and to make the MHSA more effective. Most of this presentation was about trying to establish the efficacy of mental health services and what is known about it, which is a different issue and not relevant. He asked if the discussion is about applying something that is known in a way that works or about trying to develop new information about something new that will make a difference in mental health care.

Chair Danovitch stated the Committee is in a position of building a plane while flying it at the same time, rather than evaluating the MHSA in a backward-looking way. Given constrained resources, the Committee has been focused on how to move forward to ensure that the current system is responsive to information and is utilizing research and evaluation questions to inform existing and new interventions. He offered to talk more about Dr. Brook's concerns offline.

Committee Member Watkins asked if the Committee will evaluate the MHSA or the treatments that the MHSA supports.

Chair Danovitch stated this Committee is not evaluating the MHSA. The Committee is seeking to answer questions in order to tailor services and supports for communities that have historically been left out.

Committee Member Lyons-Newman asked if this Committee will evaluate the impact of the MHSA's vision for transformation of the system and to what extent the system has transformed as a result of the MHSA.

Brian Sala, Ph.D., Deputy Director, stated much of the presentation highlighted that the MHSA is embedded in a large system. Historically, the data has not been in place to even attempt to evaluate the MHSA in a meaningful way because of the lack of whole-person awareness. The data infrastructure is still being built to have a robust understanding of where the MHSA is within the larger system to allow for meaningful conversations about best practices within services and about the impact the MHSA is having on the system as a whole.

Public Comment

Mandy Taylor, Outreach and Advocacy Coordinator, California LGBTQ Health and Human Services Network, stated they respectfully disagreed with Committee Member Brook's

assessment. The speaker stated much of the current data only demonstrates evidence-based practices for white, straight, and able-bodied communities. It is important to capture the data of all communities. The speaker stated they were excited to see an intentional decision is being made as a state and as a Commission to embark in collecting research that is more mindful about what works for all Californians.

Theresa Comstock, Executive Director, CALBHB/C, reminded everyone about the letter and Performance Outcome Data Issue Brief, which was included in the meeting packet. The speaker stated they are excited on behalf of their 59 boards and commissions that the MHSOAC is working on performance outcome measures. The speaker stated every community collects and reports on performance in a different way. It is important to identify measures in common. Recommendations cannot be made on MHSA plans and updates without performance information on local programs.

10 Minute Break

- ## Workgroup Breakout Discussion

Chair Danovitch stated the Committee and members of the public will break out into groups for in-depth discussion. Questions to guide the discussion will include:

1. What measures or outcomes are most important to monitor and drive improvement in performance?
2. What types of evaluation will expose disparities in outcomes and drive reduction of disparities?
3. What evaluation frameworks should be used to standardize evaluations and improve their quality and utility?
4. How do we facilitate impactful research by others in each domain?

Chair Danovitch dismissed everyone to their chosen breakout group.

Agenda Item 4: Report Out and Further Committee Deliberation

Chair Danovitch reconvened the full Committee and asked the breakout groups to provide a brief summary of their discussion and feedback.

Group 1 – Triage Crisis Services and Criminal Justice Involvement:

- Not much is known about what happens in the mental health system relative to service delivery and quality control.
- The mental health system is sometimes indifferent, and the service delivery is not as expected.
- Each individual present knows something that will help the equation.
- Much information exists but the keepers of the information are not necessarily sharing their information. There needs to be a realistic conversation about that between the Commission and state departments.

- It is important to develop a framework to capture and share all the information from stakeholders.
- Consider characterizing the variability within full-service partnership (FSP) services and within triage crisis services so that there can be some effort to link differences in outcomes to the interventions that are delivered by FSPs since not all FSPs are the same.
  - There is a need to learn when interventions work and when they do not in order to enhance performance.

<u>Group 2 – Suicide Prevention and Unemployment</u>:

- Equity issues and ensuring that tracking data or surveillance data being collected needs to take the diversity of California's population into account so that something meaningful can be said beyond just what is happening at the whole population level. Disparities need to be infused in all efforts.

Suicide Prevention

- A need for better understanding at the community level of outcomes relating to suicide deaths and suicidality or other measures that are correlated with suicide or related to suicide.
- Provide better accessibility to state data on suicide deaths and suicide death rates as well as Office of Statewide Health Planning and Development (OSHPD) data on emergency room admissions.
- Relate community-level outcomes to the investments being made in programs.

Unemployment

- The Commission is working to pair data from the Employment Development Department (EDD) and individuals involved in the public mental health system to track the income in employment for those individuals through that data.
- The Department of Rehabilitation should also be involved in tracking data.
- Individual Placement and Support is an evidence-based practice that must track data.

<u>Group 3 – Reducing Disparities and Outcomes and School Mental Health</u>:

- There is a need to understand the data received to ensure it can be relied upon.
- Design performance outcomes to align with MHSA goals.
- Use linkage rates and connection to services as potential outcomes.
- Focus not only on improvement but on who is not improving and why.
- Do not be constrained by available data but ask higher-level questions about the MHSA and how to measure improvements of the MHSA.
- Support legislation to create a data system that not only measures the MHSA but measures mental health services across different systems.

- When discussing disparities, it depends on the question asked. Define disparities by comparison groups.

Public Comment

Jane Adcock, Executive Officer, California Behavioral Health Planning Council, stated the Welfare and Institutions Code states the Council must approve any performance measure that is established.

Tiffany Carter, ACCESS California, a Program of Cal Voices, suggested more time for the discussions due to the richness of the topics.

Ellie Stabeck (phonetic), family member, asked about the boundaries of the MHSA in terms of evaluations and accountability and if the Commission must go through the departments of mental health.

Chair Danovitch stated it depends on what is being evaluated. The MHSA establishes and supports many types of programs and activities, and, within those programs and activities, there are requirements for evaluation.

Discussion

Committee Member Carrion stated the heterogeneity of assessments is a challenge; however, it is still possible to create groups. It is important to consider heterogeneous groups even within groups with disparities. Programs being evaluated can be more effective for some groups than others.

Chair Danovitch asked about upcoming events and next steps. Staff reported the following:

- A series of forums on Prevention and Early Intervention are scheduled for March 17th, March 24th, and April 5th. More information is posted on the website.
- Staff will gather all feedback received today to structure the focus of the next meeting.
- The next Research and Evaluation Committee meeting is scheduled for May of 2021.

Wrap-Up and Adjourn

Chair Danovitch asked Committee Members to send any additional suggestions and recommendations to staff. There being no further business, the meeting was adjourned at approximately 4:15 p.m.

AGENDA ITEM 2

Information

June 17, 2021 Research and Evaluation Committee Meeting

Summary of the Committee's Work

Summary: The Committee's work to date will be presented and summarized, including the development of a child/youth/school mental health evaluation framework to support the Commission's research and evaluation activities.

Background: Since convening in August 2020, the Research and Evaluation Committee has made strides in pinpointing its mission, priorities and tasks. The Committee has met three times—in August and November of 2020, and in February 2021—and received and incorporated feedback from members and public stakeholders. In addition, Commission staff have met individually with each Committee member to better understand their interests, and to identify how to best leverage each member's expertise to support the work of the Commission's Research and Evaluation Division. The following provides a chronological summary of Committee meetings and content:

1. August 24, 2020 Research and Evaluation Committee Meeting. The first introductory meeting provided an overview of the Mental Health Services Act (MHSA), the Commission's role, and the work of the Research and Evaluation Division that supports transparency and accountability in transforming California's mental health system. We discussed the charge of the Committee, as outlined in the charter.

2. November 18, 2020 Research and Evaluation Committee meeting. The second Committee meeting continued deliberations on how the Committee can best support the Commission's goal of transforming the mental health system. The Committee received a presentation from Applied Survey Research that summarized the Committee's strategic planning process and the Results-based Accountability Framework it produced. The presentation sparked a discussion that reflected the Commission's expansive approach to implementing the MHSA and the multiple opportunities to deploy evaluation to improve understanding, oversight, and outcomes.

The meeting included facilitated workgroup discussions with Committee members and stakeholders, the results of which were identification of key opportunities/priorities for the Committee's consideration in 2021:

- An evaluation framework for MHSA programs.
- A research agenda to evaluate the impact of the MHSA.
- A strategy for evaluating population-level mental health status.

3. February 24, 2021 Committee meeting. The February meeting continued our discussion of the three options via a staff presentation on current Research and Evaluation Division projects and through breakout sessions. We sought the Committee's expertise in guiding research and evaluation projects on school mental health, crisis services, suicide prevention, criminal justice involvement, unemployment, and disparities. The facilitated breakout groups allowed us to do a deeper dive into these research and evaluation activities. These conversations centered on identifying frameworks, measures and outcomes that will best monitor and drive improvement in performance, facilitate impactful research, and drive reduction of disparities.

After taking into consideration the information gathered from Committee members and stakeholders and linking them to the Commission's goals for Research and Evaluation, the Committee landed on prioritizing the development of a Child/Youth/School Mental Health Evaluation Framework. This decision was made based on several factors including that the framework aligns with: (1) Committee member interest in children, youth, and school mental health and developing an evaluation framework; and (2) The Commission's policy and grant work in school mental health and acquiring California Department of Education data this year.

Presenter: Dr. Dawnté Early, Chief of Research and Evaluation

Enclosures (0): None.

Handout (1): PowerPoint presentation

AGENDA ITEM 3

Discussion

June 17, 2021 Research and Evaluation Committee Meeting

Discussion of the Commission's Proposed Evaluation Framework

Summary: The Committee will discuss and provide feedback on a general evaluation framework developed by Commission staff that could be applied across the Commission's grants and initiatives for children, youth, and school mental health.

Background: See agenda Item 2.

Questions to guide the discussion of the framework include, but are not limited to:

1. How can the objectives and structure of the evaluation framework be improved and be applicable to a range of programs and services?
2. Equity considerations are foundational to the MHSA. How can the framework better reflect the centrality of equity to our evaluation work?
3. How can the framework ensure better alignment between program goals and clear, measurable outcomes?

Presenter/Facilitator: Chair, Co-Chair, Commission Staff

Enclosures (1): Evaluation Framework for Child/Youth/School Mental Health

Handout (0): None

EVALUATION FRAMEWORK FOR CHILDREN/YOUTH/SCHOOL MENTAL HEALTH

This document presents a general evaluation framework that could be applied across the Commission's initiatives, grants, and programs targeting school mental health, children, youth, and their families. The framework is a practical tool that summarizes essential elements of effective evaluation. This tool could be used for various purposes by the Commission, including:

- As a requirement in grant proposals for applicants to sketch out a logic model. This would get applicants to think about evaluation early in the grant process.
- For awarded grantees to track and monitor their performance for quality improvement and reporting to the Commission.
- For the Commission's Research and Evaluation Division to frame research questions for statewide evaluation and reporting.

The proposed evaluation framework is informed by and includes elements of the following: (1) The Donabedian model for evaluating quality in health care (structure, process, and outcomes)[1]; (2) Results-Based Accountability (RBA)[2]; (3) the CDC's program evaluation framework in public health;[3] (4) RAND's evaluation framework for PEI[4,5]; and (5) PCORI's implementation and dissemination framework.[6] A hybrid framework was created to be accessible to different stakeholders and reflect the values of the MHSA. For example, some stakeholders use a structure, process, and outcomes framework for evaluation. Other stakeholders prefer a results-oriented framework such as RBA which begins with what is trying to be achieved (the result or indicator) and works backward. The Commission's proposed framework also addresses gaps in any one framework and emphasizes the importance of stakeholder engagement, having evaluation standards, and the rapid dissemination of lessons learned.

Committee members were asked to review the framework and provide guidance and feedback, as well as specific suggestions for key research questions, performance indicators and addressing equity and the social determinants of health in the framework.

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[1] Donabedian, A. (1988). "The quality of care: How can it be assessed?". *JAMA*. **260** (12): 1743–8.

[2] Friedman, Mark (2009). *Trying hard is not good enough.* BookSurge Publishing.

[3] Centers for Disease Control and Prevention. Framework for program evaluation in public health. MMWR 1999;48(No. RR-11):1-42.

[4] Watkins, K. E., Burnam, M. A., Okeke, E. N., and Setodji, C. M. (2012). *Evaluating the impact of prevention and early Intervention activities on the mental health of California's population*. Santa Monica, CA: RAND Corporation. https://www.rand.org/pubs/technical_reports/TR1316.html.

[5] Eberhart, N. K., Cerully, J. L., Shearer, A. L., Berry, S. H., Burnam, M. A. and Ebener, P. A. (2017). Evaluation approaches for mental health prevention and early intervention programs. Santa Monica, CA: RAND Corporation. https://www.rand.org/pubs/research_reports/RR1882.html.

[6] Esposito, D., Heeringa, J., Bradley, K., Croake, S., and Kimmey, L. (2015*). PCORI Dissemination and Implementation Framework.* Princeton, NJ: Mathematica Policy Research.

EVALUATION FRAMEWORK FOR CHILDREN/YOUTH/SCHOOL MENTAL HEALTH

KEY OBJECTIVES

1. To advance equity in outcomes through the development and application of clear, specific, and measurable evaluation goals and research questions.

2. To support improvements in programs, policies and practices by implementing and establishing an effective and culturally appropriate monitoring system that is feasible and minimizes burden for counties, providers and consumers.

3. To enhance public confidence in evaluation findings by establishing and utilizing sound metrics, methodology, and resources.

4. To produce actionable research findings that communities can use by ensuring robust community engagement at key stages of all evaluation activities.

Results Whole Population: Positive mental health, wellbeing, and school success for ALL children and youth. Client Population: Early detection and treatment to foster recovery and resilience.				
Stakeholder Engagement is Central				
Broader Context Existing systems, resources & unmet needs	**Structure** What is the structure of the program or services?	**Formative/Process** Is it feasible, appropriate, and acceptable to target populations? How much is being done? How well is it being done (and why)?	**Short-Term Outcomes** Does it make a difference and for whom?	**Long-Term Outcomes** Are there public health benefits?
Infrastructure Capacity Partnerships Resource mapping Needs assessment/ gaps Individual/family risk factors School/community context Cultural barriers Access (e.g., transportation)	Description of Program/services Logic model SMART goals Target population Capacities and resources Cultural/linguistic responsiveness Flexibility	Feasibility Community acceptance Outreach and Engagement Implementation barriers and facilitators # of activities or services # served and their characteristics	Improved mental health and school outcomes Improved family wellbeing and resilience Reduction in disparities Increased connectedness	High school graduation College admission and retention Reduced system involvement Employment Housing Quality of life
Standards for Evaluation: Utility, Feasibility, Ethical, and Accurate				
Dissemination and Lessons Learned				

Evaluation Framework Definitions/Explanation:

- *Whole population*: All preK-12 students (General population of children and youth).
- *Client population*: The population of children and youth receiving mental health services and/or those who are system involved.
- *Stakeholder engagement is central*: Stakeholders are meaningfully engaged in developing programs and conducting evaluation activities. Stakeholders should include representatives of the populations of interest (students and their families) and others involved in decision making. Stakeholders should be engaged in the identification of evaluation goals, selection of metrics and data sources, and interpretation of findings.
- *Broader context (Column 1)*: Describes the existing system and the continuum or services and supports in the school or community. Identifies the resources available and what gaps in services or needs exist in relation to the social determinants of health and risk factors, particularly in unserved or underserved communities.
- *Structure (Column 2)*: Establishes goals that are specific, measurable, attainable, relevant, and time-bound (SMART). Describes the program or services to be implemented, program activities, the logic model, the target population, and how it will be delivered using developed capacities and resources.
- *Formative/process (Column 3)*: Describes the implementation and delivery of the program/services including number served and their characteristics. Documents the quality of implementation including fidelity, use of best practices, program reach, and client responsiveness.
- *Short-term outcomes (Column 4)*: Describes the short-term outcomes achieved.
- *Long-term outcomes (Column 5)*: Describes the long-term public health benefits achieved.
- *Standards for evaluation*: (1) Utility: The evaluation should serve the information needs of intended users; (2) Feasibility: The evaluation should be practical, prudent and efficient; producing valuable information to justify expended resources; (3) Ethical: The evaluation should be conducted ethically and with concern for the welfare/wellbeing of those involved and those impacted by the results; and (4) Accurate: The evaluation should be based on valid and reliable sources of information, appropriate and systematic quantitative/qualitative analyses, and justified conclusions.
- *Dissemination and lessons learned*: Interim findings and evaluation reports should be disseminated to intended users so that they can be used in a timely fashion to inform decision making. This process should begin at the earliest stages of stakeholder engagement and continue throughout the evaluation.

AGENDA ITEM 4

Information and Discussion

June 17, 2021 Research and Evaluation Committee Meeting

Evaluation of the Mental Health Student Services Act (MHSSA)

Summary: The Mental Health Student Services Act (MHSSA) will be presented including a description of MHSSA objectives, grants awarded, the learning collaborative, and the current data collection tool. The MHSSA will be used as a case example for applying the general evaluation framework presented in Agenda Item 3. Specifically, the Committee will discuss developing an evaluation plan for MHSSA grant programs.

Background: The Mental Health Student Services Act (MHSSA) is a competitive grant program established to fund partnerships between county behavioral health departments and local education entities for the purpose of increasing access to mental health services in locations that are easily accessible to students and their families. The grants awarded are used to provide support services that include, at a minimum, services provided on school campuses, suicide prevention services, drop-out prevention services, placement assistance and service plans for students in need of ongoing services, and outreach to high-risk youth, including foster youth, youth who identify as LGBTQ, and youth who have been expelled or suspended from school.

In 2020, the Commission awarded MHSSA grants to 18 school-county mental health partnerships across California. The Commission also funds an additional four school-county mental health partnerships through the Triage Grant program.

The MHSSA requires that the Commission develop metrics and a system to measure and publicly report on the performance outcomes of services provided using the grants. The Commission is expected to provide a status report to the fiscal and policy committees of the Legislature on the progress of implementation no later than March 1, 2022. The report shall address, at a minimum, the following:

- Successful strategies.
- Identified needs for additional services.
- Lessons learned.
- Numbers of, and demographic information for, the school age children and youth served.
- Available data on outcomes, including, but not limited to, linkages to ongoing services and success in meeting program goals.

Questions to guide the discussion of the MHSSA evaluation, include, but are not limited to:

1. What would be appropriate measures and a monitoring strategy for evaluating the MHSSA?
   - Specifically, what would be appropriate process and outcomes measures, given the heterogeneity of MHSSA program goals and services?
2. How can the Commission balance standardizing the evaluation to tell a statewide story while also allowing grantees to tailor their goals, aims, activities, and metrics to the local context?
3. What are suggestions for ensuring that youth, families, and other stakeholders are meaningfully engaged in the evaluation of the MHSSA?
   - How can stakeholder engagement be maintained across the evaluation process?

Presenter: Cheryl Ward, Health Program Specialist

Facilitator: Char, Co-chair, Commission Staff

Enclosures (3): 1) Mental Health Student Services Act (MHSSA); 2) MHSSA Background Summary; and 3) Evaluation Framework Case Example: MHSSA.

Handout (2): 1) MHSSA Data Reporting Tool; and 2) PowerPoint presentation.

MENTAL HEALTH STUDENT SERVICES ACT

WELFARE AND INSTITUTIONS CODE - WIC

DIVISION 5. COMMUNITY MENTAL HEALTH SERVICES [5000 - 5952]

(Division 5 repealed and added by Stats. 1967, Ch. 1667.)

PART 4. THE CHILDREN'S MENTAL HEALTH SERVICES ACT [5850 - 5886]

(Part 4 repealed and added by Stats. 1992, Ch. 1229, Sec. 2.)

CHAPTER 3. Mental Health Student Services Act [5886- 5886.]

(Chapter 3 added by Stats. 2019, Ch. 51, Sec. 67.)

5886.

(a) The Mental Health Student Services Act is hereby established as a mental health partnership competitive grant program for the purpose of establishing mental health partnerships between a county's mental health or behavioral health departments and school districts, charter schools, and the county office of education within the county.

(b) The Mental Health Services Oversight and Accountability Commission shall award grants to county mental health or behavioral health departments to fund partnerships between educational and county mental health entities.

(1) County, city, or multicounty mental health or behavioral health departments, or a consortium of those entities, including multicounty partnerships, may, in partnership with one or more school districts and at least one of the following educational entities located within the county, apply for a grant to fund activities of the partnership:

(A) The county office of education.

(B) A charter school.

(2) An educational entity may be designated as the lead agency at the request of the county, city, or multicounty department, or consortium, and authorized to submit the application. The county, city, or multicounty department, or consortium, shall be the grantee and receive any grant funds awarded pursuant to this section even if an educational entity is designated as the lead agency and submits the application pursuant to this paragraph.

(c) The commission shall establish criteria for the grant program, including the allocation of grant funds pursuant to this section, and shall require that applicants comply with, at a minimum, all of the following requirements:

(1) That all school districts, charter schools, and the county office of education have been invited to participate in the partnership, to the extent possible.

(2) That applicants include with their application a plan developed and approved in collaboration with participating educational entity partners and that include a letter of intent, a memorandum of understanding, or other evidence of support or approval by the governing boards of all partners.

(3) That plans address all of the following goals:

(A) Preventing mental illnesses from becoming severe and disabling.

(B) Improving timely access to services for underserved populations.

(C) Providing outreach to families, employers, primary care health care providers, and others to recognize the early signs of potentially severe and disabling mental illnesses.

(D) Reducing the stigma associated with the diagnosis of a mental illness or seeking mental health services.

(E) Reducing discrimination against people with mental illness.

(F) Preventing negative outcomes in the targeted population, including, but not limited to:

(i) Suicide and attempted suicide.

(ii) Incarceration.

(iii) School failure or dropout.

(iv) Unemployment.

(v) Prolonged suffering.

(vi) Homelessness.

(vii) Removal of children from their homes.

(viii) Involuntary mental health detentions.

(4) That the plan includes a description of the following:

(A) The need for mental health services for children and youth, including campus-based mental health services, as well as potential gaps in local service connections.

(B) The proposed use of funds, which shall include, at a minimum, that funds will be used to provide personnel or peer support.

(C) How the funds will be used to facilitate linkage and access to ongoing and sustained services, including, but not limited to, objectives and anticipated outcomes.

(D) The partnership's ability to do all of the following:

(i) Obtain federal Medicaid or other reimbursement, including Early and Periodic Screening, Diagnostic, and Treatment funds, when applicable, or to leverage other funds, when feasible.

(ii) Collect information on the health insurance carrier for each child or youth, with the permission of the child or youth's parent, to allow the partnership to seek reimbursement for mental health services provided to children and youth, where applicable.

(iii) Engage a health care service plan or a health insurer in the mental health partnership, when applicable, and to the extent mutually agreed to by the partnership and the plan or insurer.

(iv) Administer an effective service program and the degree to which mental health providers and educational entities will support and collaborate to accomplish the goals of the effort.

(v) Connect children and youth to a source of ongoing mental health services, including, but not limited to, through Medi-Cal, specialty mental health plans, county mental health programs, or private health coverage.

(vi) Continue to provide services and activities under this program after grant funding has been expended.

(d) Grants awarded pursuant to this section shall be used to provide support services that include, at a minimum, all of the following:

(1) Services provided on school campuses, to the extent practicable.

(2) Suicide prevention services.

(3) Drop-out prevention services.

(4) Outreach to high-risk youth and young adults, including, but not limited to, foster youth, youth who identify as lesbian, gay, bisexual, transgender, or queer, and youth who have been expelled or suspended from school.

(5) Placement assistance and development of a service plan that can be sustained over time for students in need of ongoing services.

(e) Funding may also be used to provide other prevention, early intervention, and direct services, including, but not limited to, hiring qualified mental health personnel, professional development for school staff on trauma-informed and evidence-based mental health practices, and other strategies that respond to the mental health needs of children and youth, as determined by the commission.

(f) The commission shall determine the amount of grants and shall take into consideration the level of need and the number of school age youth in participating educational entities when determining grant amounts.

(g) The commission may establish incentives to provide matching funds by awarding additional grant funds to partnerships that do so.

(h) Partnerships currently receiving grants from the Investment in Mental Health Wellness Act of 2013 (Part 3.8 (commencing with Section 5848.5)) are eligible to receive a grant under this section for the expansion of services funded by that grant or for the inclusion of additional educational entity partners within the mental health partnership.

(i) Grants awarded pursuant to this section may be used to supplement, but not supplant, existing financial and resource commitments of the county, city, or multi-county mental health or behavioral health departments, or a consortium of those entities, or educational entities that receive a grant.

(j) (1) The commission shall develop metrics and a system to measure and publicly report on the performance outcomes of services provided using the grants.

(2) (A) The commission shall provide a status report to the fiscal and policy committees of the Legislature on the progress of implementation of this section no later than March 1, 2022. The report shall address, at a minimum, all of the following:

(i) Successful strategies.

(ii) Identified needs for additional services.

(iii) Lessons learned.

(iv) Numbers of, and demographic information for, the school age children and youth served.

(v) Available data on outcomes, including, but not limited to, linkages to ongoing services and success in meeting the goals identified in paragraph (3) of subdivision (c).

(B) A report to be submitted pursuant to this paragraph shall be submitted in compliance with Section 9795 of the Government Code.

(k) This section does not require the use of funds included in the minimum funding obligation under Section 8 of Article XVI of the California Constitution for the partnerships established by this section.

(l) The commission may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis in order to implement this section. Contracts entered into or amended pursuant to this subdivision are exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, and Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and shall be exempt from the review or approval of any division of the Department of General Services.

(m) This section shall be implemented only to the extent moneys are appropriated in the annual Budget Act or another statute for purposes of this section.

(Added by Stats. 2019, Ch. 51, Sec. 67. (SB 75) Effective July 1, 2019.)

MHSSA Background Summary

The Mental Health Services Oversight & Accountability Commission (MHSOAC) administers the Senate Bill 82 Investment in Mental Health Wellness Act which provides local assistance funds to expand mental health crisis services. The Commission recognizes that the effects of mental health crises are evident on school campuses and that reaching pupils in the school setting is practical for a first point of contact for mental, behavioral, and substance use disorder services for youth. Schools provide an opportunity for early identification and early intervention to address behavioral health issues that can undermine learning and health development.

Improved access to mental health services is foundational to supporting children and youth develop into healthy resilient adults. Comprehensive models and integrated services that are tailored to individual and family needs, have the best chance of improving health and academic outcomes. The Mental Health Services Act is intended to foster stronger school-community mental health partnerships that can leverage resources to help students succeed by authorizing counties and local educational agencies to enter into partnerships to create programs that include targeted interventions for pupils with identified social-emotional, behavioral, and academic needs. School-community mental health partnerships offer an opportunity to reach children and youth in an environment where they are comfortable and that is accessible.

The MHSOAC makes Triage funding available to counties through a competitive grant process to expand access to services for children and youth. In 2017, the MHSOAC released SB 82 funds, with 50 percent of those funds dedicated to children and youth aged 21 and under. Additionally, the MHSOAC set aside approximately $20 million for four School-County Collaboration Triage grants with the aim of 1) providing school-based crisis intervention services for children experiencing or at risk of experiencing a mental health crisis and their families/caregivers, and 2) supporting the development of partnerships between behavioral health departments and educational entities.

Under that funding program Humboldt County, Placer County, Tulare County Office of Education, and California Association of Health and Education Linked Professions Joint Powers Authority in San Bernardino was awarded $5.3 million over four years. The four School-County partnership programs are supporting strategies to 1) build and strengthen partnerships between education and community mental health, 2) support school-based and community-based strategies to improve access to care, and 3) enhance crisis services that are responsive to the needs of children and youth, all with particular recognition of the educational needs of children and youth.

In addition to the four School-County partnership grantees, the MHSOAC awarded Triage contracts to counties to operate school-based Triage programs in Berkeley, Humboldt, Riverside, Sacramento, and San Luis Obispo.

As a result of the high-level of response to the school-county collaboration RFA and the implementation of school-based programs through the Triage RFA, the Legislature passed and the Governor signed the 2019 Budget Bill, Senate Bill 75, which included the Mental Health Student Services Act (MHSSA) to establish mental health partnerships between County Mental Health or Behavioral Health Departments and educational entities.

Categories of Funding:

During planning sessions, stakeholders raised concerns that communities with existing partnerships may have an advantage in responding to a Request for Application (RFA) compared to those with no existing partnership. In response to those concerns, in November 2019 the Commission approved the outline of the RFA which would make available $75 million in funding from four fiscal years, setting aside $5 million for implementation and evaluation, with program funding available in two categories: 1) funding for counties with existing school mental health partnerships ($45 million) and 2) funding for counties developing new or emerging partnerships ($30 million).

20 counties applied for Category 1 funding, 10 of which were awarded grants in April 2020. 18 counties applied for Category 2 funding and 8 additional grants will be awarded at the Commission's August 2020 meeting.

Grant Awards Breakdown:

The following table includes the 38 county partnerships that applied for the MHSSA grants, including 18 which were awarded and 20 which were not awarded:

Applicant County Name	Size	Category	Awarded (18)	Not Awarded (20)
Amador	Small	2		X
Calaveras	Small	2	X	
Contra Costa	Large	2		X
Fresno	Large	1	X	
Glenn	Small	1		X
Humboldt	Small	1	X	
Imperial	Small	2		X
Kern	Large	1	X	
Lake	Small	1		X
Los Angeles	Large	1		X
Madera	Small	2	X	
Marin	Medium	1		X
Mariposa	Small	1		X
Mendocino	Small	1	X	
Monterey	Medium	1		X
Nevada	Small	2		X
Orange	Large	1	X	
Placer	Medium	1	X	
Riverside	Large	2		X
Sacramento	Large	1		X
San Bernardino	Large	1		X
San Diego	Large	1		X
San Francisco	Large	1		X

San Luis Obispo	Medium	1	X	
San Mateo	Large	2	X	
Santa Barbara	Medium	2	X	
Santa Clara	Large	2	X	
Santa Cruz	Medium	2		X
Shasta	Small	2		X
Solano	Medium	1	X	
Sonoma	Medium	2		X
Sutter-Yuba	Small	2		X
Tehama	Small	2	X	
Trinity-Modoc	Small	2	X	
Tulare	Medium	1	X	
Tuolumne	Small	2		X
Ventura	Large	1	X	
Yolo	Medium	2	X	

Description of MHSSA Grant Programs:

County	Size	Partnership Type	Partners	Program Goals	Specifically…
Calaveras	Small	New	County COE 4 SDs Charter	◦Continuum for student mental health services on elementary campuses that will have three tiers ◦Staff and operate Mental Health Wellness Centers on elementary school campuses ◦Wellness Center staff will link students appropriate services	◦Students will receive individual assessment and treatment as needed ◦Services to students may include crisis support, brief mental health assessments, outreach and engagement, linkage/navigation to community services, therapy (includes DBT), activities/skills training to emphasize self-care, and mental health awareness
Fresno	Large	Existing	County Sup of Schools 32 SDs	◦Expand prevention and early intervention services for youth aged 0-22 throughout Fresno County ◦Focus on prevention and early intervention, and connect youth with needed therapeutic services through existing All 4 Youth Hubs ◦Construction and facilities improvements to develop four new, school-adjacent Wellness Centers	◦Provide accessible information and host trainings to increase student, family, school staff, and community knowledge about trauma and mental health ◦Provide mental health prevention and intervention services in accessible locations ◦Promote mental health for all and reduce stigma around mental health to increase the likelihood of accessing services ◦Provide strategies and training for comprehensive self-care for families, students, and school staff
Humboldt	Small	Existing	County COE All 32 SDs All Charters	◦Provide school-based mental health intervention and support to students, in crisis or at risk of crisis ◦Increase access to mental health services by providing intervention and services in locations easily accessible to students and their families	◦Identify students in need of support ◦Determine and provide an appropriate, limited duration intervention or interventions ◦Determine if intervention was successful ◦If successful, slowly discontinue intervention and continue to monitor student, or if necessary, assist student in accessing more intensive, longer term services and supports

Kern	Large	Existing	County Sup of Schools 5 SDs	◦Implement Multi-tiered System of Support mental health approach designed to increase access to mental health services by establishing new mentoring programs, offering school-based after-hours mental health services, and improving the cross-agency continuum of care	◦Screen foster and homeless youth for ACEs ◦Pilot a universal screening tool for all students ◦Pilot a screening tool to assess PreK-3rd grade ◦Ensure that Check In/Check Out rapid response intervention to support academics, behavior and social and emotional health is implementing with fidelity ◦Screen students using a Biopsychosocial Assessment in addition to the PHQ9, GAD 7 and Columbia Suicide Rating Scale ◦Provide school-based therapeutic services for youth and families (during school and after-hours) ◦Substance abuse counseling and case management services ◦Peer-to-peer mentoring as well as AmeriCorps Mentoring for foster and homeless youth
Madera	Small	New	County COE 10 SDs 3 Charters	◦Navigation and case management services for students and families ◦Additional capacity to assist with new interventions before calling school resource officers or law enforcement to conduct an assessment for a 5150 hold	◦Increase access to behavioral health services in locations easily accessible to students and their families ◦Emphasize preventive and early intervention services that maximize the healthy development of children and minimize the long-term need for public resources ◦Provide case management services to children and families with multiple needs ◦Enhance crisis services that are responsive to the needs of children and youth ◦Facilitate linkages and access to a continuum of ongoing and sustained services for students with identified social-emotional, behavioral and academic needs ◦Identify gaps in services to targeted populations

Mendocino	Small	Existing	County COE SELPA 7 SDs 3 Charters	◦Bolster and expand existing services to Mendocino County students and their families ◦Includes linking and strengthening existing mental health services to better meet student's mental health needs, and enhance awareness, prevention and early intervention	◦Outreach and engagement to students and families ◦Screening for mental health concerns and assessing student needs and strengths ◦Brief treatment and intervention ◦Coordinating services and resources outside the school and help students access community resources and mental health services ◦Follow-up with students, families, and community providers ◦Crisis intervention ◦Providing support and collateral services to teachers in responding to students' mental health concerns ◦Identifying needs of family members and providing referrals and linkages to services and community resources ◦Providing group mental health services to students

Orange	Large	Existing	County COE 29 SDs 1 Charter	◦Implement an educational-health partnership approach to improve collaboration between the educational and behavioral health systems to provide and coordinate mental health services and linkages, as well as train school staff on mental health topics	◦Conduct needs assessments with districts in their region to customize needed services and trainings for students, parents, and school staff ◦Develop communication pathways, monitor activities and needs and adjust activities based on evolving district needs surrounding mental health services and trainings ◦Identify regional resources and serve as the “regional expert” of mental health services ◦Coordinate and/or provide education and training for teachers, students, parents, and families on mental health issues ◦Coordinate and support student wellness team members in a regional collaborative ◦Provide care coordination to facilitate access to mental health resources and trainings for parents and caregivers of at-risk students, including serving as a liaison with districts to educate parents and students at high risk about mental health resources and trainings, and coordinate partnerships with community agencies ◦Facilitate targeted outreach and improved access to services for at-risk students ◦Coordinate and provide targeted outreach and linkage to students identified as high risk ◦Coordinate and provide intensified outreach and linkage to services for students who are identified as being in crisis ◦Provide and coordinate professional development in districts for teachers on mental health topics ◦Facilitate and coordinate trainer of trainer opportunities for district and school staff

Placer	Medium	Existing	County COE SELPA 4 SDs	◦Wellness Centers (4) will not only be a program, but also a physical space on campus where staff will be co-located ◦It will be a mental health resource and provider site where students and their families can access prevention, early intervention, intensive, and crisis mental health services and referrals ◦It is also where school staff can access the program for training, consultation and increased mental health literacy.	◦Assist students and families with linkage to community-based referrals ◦Help families initially access services and support the ongoing use of services ◦Provide mental health education to school staff ◦Partner with teachers to infuse social emotional learning and mental health content into their curricula ◦Engage parents and families to reduce complicating factors that impact mental wellbeing, such as food and housing insecurity, access to health care, and employment ◦Staff will also merge into the community for family and student support, including providing trainings for families in places where they live and work, and will blend into the school community providing presentations in classrooms and responding to mental health needs throughout the campus.
San Luis Obispo	Medium	Existing	County COE 6 SDs	◦Expand the partnership to provide the other six middle schools with the Program ◦Build collaborative teams with the goal of increasing access to mental health services, reducing risk, and increasing protective factors	◦On-campus prevention, screening, early intervention, counseling, and referral ◦On-campus youth development activities and engagement, including stigma reduction activities and education ◦Mental health assessments and treatments ◦Bilingual case management services to families
San Mateo	Large	New	County COE 12 SDs	◦Training and coaching to implement one of three selected evidence-based Social Emotional Learning (SEL) curricula that will be delivered universally in schools to prevent, and provide for early identification of, mental health challenges ◦Close identified equity gaps	◦Work closely with teachers at school sites to identify students with various challenges (e.g., homelessness, experiences in the foster system, depression due to sexual identity issues, etc.) ◦Perform crisis intervention and/or brief intervention therapy (individual and/or group) on a scheduled or drop-in basis ◦Provide guidance regarding use of the universal screening tool ◦Assist with the delivery of

					supplemental SEL curricula, including Kit Grit and Wayfinder
Santa Barbara	Medium	New	County COE 20 SDs	◦Hire personnel to support mental health prevention, early intervention and crisis response activities, including coverage during the summer months, by providing direct services, making direct referrals to services and coordinating mental health training, educational opportunities and presentations to all stakeholders	◦Facilitate linkages to resources with warm hand-offs ◦Case management for students needing long-term services ◦Assist with community and on-campus mental health and wellness presentations ◦Crisis intervention support ◦Coordinate integration of PBIS/MTSS with mental health services ◦Support student re-entry after crisis intervention
Santa Clara	Large	New	County COE 31 SDs	◦Fill the gaps in existing prevention and early intervention mental health services in schools and provide strategies to support students during the Covid 19 crisis ◦Create Wellness Centers on school sites, increase the number of mental health professionals at school sites, and provide relevant professional learning to educators	◦Facilitate linkages and access to sustained services through the personnel hired ◦Tier 1 activities are prevention based and focus on all students, including homeless and foster youth, youth who identify as LGBTQ, and underserved youth. Included are Social Emotional Learning activities and Restorative Justice practices, age appropriate resources and information about mental health issues, parenting classes and support groups, and referrals for needed services. ◦Tier 2 activities are early intervention and focus on students struggling with specific behavioral, emotional, or social functioning needs and will include groups or one on one check-ins ◦Tier 3 activities are intervention for youth with the highest needs, and include short-term individual therapy, crisis assessment and triage and re-entry to school following suspension or expulsion
Solano	Medium	Existing	County COE 6 SDs	◦Enhance the efforts made to address critical gaps in school-based programming by significantly increasing the capacity of educators and school staff to identify and respond to mental health needs, and increasing timely access to mental health services for	°Training and Technical Assistance °Direct Services and Crisis Response °Pilot implementation of peer model that leveraged parent liaisons to provide support for families impacted by a child/youth experiencing a crisis and/or being at risk of drop-out

				students at risk of dropping out and/or high-risk youth ◦Significantly improve the crisis response provided to K-12 students in schools	°Universal screening of incoming kindergartener's
Tehama	Small	New	County COE 7 SDs	◦Use a Strategic Prevention Process for implementation of the TCSSC project ◦Universal screening, assessment, implementation of Social Emotional skills, and professional development will occur throughout the four years of the grant cycle ◦All schools participating in the collaborative will establish or update their facilities to develop a Social Emotional Wellness Center on campus	◦All children ages 0-5 in Tehama County will have an ASQ or ASQ-SE and transition meeting prior to entering Kindergarten ◦All grades K-3 and 4-6 will participate in Mind Up Curriculum to build Social Emotional wellness and self-regulatory skills ◦Universal screening will occur at LEA's and mental health partners using the CANS ◦Why Try curriculum implemented for grades 6-8 ◦Implement Botvin Life Skills for grades 9-12 ◦All schools and partners will participate in professional development on Trauma Informed Practices and Adverse Childhood Experiences (ACEs) ◦All schools will be trained in Applied Suicide Intervention Skills Training (ASIST) ◦Use of peer partners in schools through programs such as Club Live, STATUS, and Leadership to build a student network whose emphasis is on mental health wellness

Trinity-Modoc	Small	New	Trinity County Trinity COE Modoc COE 12 SDs 1 Charter	◦By providing personnel and peer support, this partnership will create linkages through the wellness liaisons between students, the triage team, community partners, and mental health providers	◦Social Worker/Clinicians will primarily provide direct services to students requiring mental health interventions ◦School Liaison/Counseling Technicians will provide students, parents, and staff with information and referrals to support students' success and will assist students with academic, attendance, and/or behavioral issues including implementing student disciplinary services and assisting parents and students in locating services (e.g. counseling, resource and intervention referrals) to increase student success ◦All services will be provided on school campuses to include, but not be limited to trauma "toxic stress" informed strategies, suicide prevention and crisis teams, drop-out prevention, placement assistance and service plans for students who need ongoing services
Tulare	Medium	Existing	County COE 4 SDs 1 Charter	◦Expand the current program and includes hiring additional Triage Social Workers to serve additional schools throughout Tulare County	◦Identify families in need of services and supports, including assessment, parenting support, family intervention services, linkage, and referrals to community services ◦Teach mindfulness to children and adolescents using the K-12 Mindful Schools Curriculum ◦Implement Coping and Support Training to target middle and high school-aged youth to build self-esteem, monitor and set goals, decision making and personal control ◦Collaborate with mental health prevention and early intervention programs that serve the region and provide targeted early intervention services

Ventura	Large	Existing	County COE 5 SDs 1 Charter	◦Wellness Centers (8) will reduce access barriers (e.g., transportation, cost, and stigma) and improve mental health and educational outcomes ◦Services provided through the Wellness Centers will specifically address suicide prevention, drop-out prevention, placement assistance and service planning for students in need of ongoing services, and outreach to high-risk youth	◦Provide mental health screenings and counseling ◦Provide mental health education and training ◦Coordinate early intervention services/short-term counseling ◦Support crisis intervention as indicated ◦Develop and implement the school-based communications program ◦Provide ongoing supervision and program management of Wellness Peers ◦Maintain service data to support program evaluation ◦Arrange brief interventions for alcohol and drug offenses ◦Refer students with more intensive mental health needs to the assigned clinician to provide linkages to care providers and a more complete evaluation and assessment
Yolo	Medium	New	County COE 5 SDs 1 Charter	◦Working alongside school personnel, project staff will increase access to the continuum of mental health services by providing prevention and intervention services in locations that are easily accessible to students and their families	◦Improve school climate on individual school campuses ◦Identify individual students in need of additional support ◦Establish and provide appropriate, limited duration intervention(s) on the school campus or appropriate locations chosen by the youth and families ◦Determine if the intervention(s) was successful ◦Assist with navigation and transition to informal community/cultural services and supports when appropriate for individual students and/or family ◦Assist the student and family in accessing more intensive, longer term services and supports

APPLYING THE GENERAL FRAMEWORK TO THE MENTAL HEALTH STUDENT SERVICES ACT (MHSSA)

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