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Mental Health Services
Oversight & Accountability Commission

Commission Meeting
October 24, 2024
Presentations and Handouts

Agenda Item 5:	•Presentation:	Behavioral Health Transformation: Early Intervention and Full Service Partnerhips
	•Handout:	Position Letters
Agenda Item 10:	•Presentation:	Report to the Legislature on the Mental Health Student Services Act
	•Handout:	Draft Mental Health Student Services Act Evaluation Plan
	•Handout:	Evaluation of The Mental Health Student Services Act (MHSSA)

Behavioral Health Transformation

Transformational Change in Behavioral Health: Early Intervention and Full Service Partnerhips

Mental Health Services Oversight and Accountability Commission

Marlies Perez, BHT Project Executive
Department of Health Care Services

October 24, 2024

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

MENTAL HEALTH FOR ALL

Housekeeping

- You may type your comments into the chat box throughout the presentation.
- Once we reach the discussion portion of our meeting, please raise your hand to speak and we will go in the order of raised hands.
- This is our opportunity to hear from you! We would appreciate your open and honest feedback during this discussion.

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Meeting Agenda

Early Intervention

- Overview
- Early Intervention Evidence-Based Practices (EBPs) and Community-Defined Evidence Practices
- Coordinated Specialty Care for First Episode Psychosis (CSC for FEP)

Full-Service Partnership (FSP)

- Overview
- Levels of Care, Assertive Community Treatment (ACT)/Forensic ACT (FACT), Individual Placement and Support (IPS) Model of Supported Employment, High Fidelity Wraparound (HFW)

Q&A

Resources

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Behavioral Health Transformation Milestones

Below are high-level timeframes for several milestones that will inform requirements and resources. Additional updates on timelines and policy will follow throughout the project.

Started Spring 2024

Stakeholder Engagement

Stakeholder engagement including, **public listening sessions,** will be utilized through all milestones to inform policy creation.

Started Summer 2024

Bond BHCIP: Round 1 Launch Ready

Requests for Applications (RFA) for up to $3.3 billion in funding leveraging BHCIP.

Beginning Late 2024

Policy Manual and Integrated Plan Guidance

Policy Manual chapters and Integrated Plan guidance will be **released for public comment in phases**.

Summer 2026

Integrated Plan

New integrated plans, fiscal transparency, and data **reporting requirements** go-live in July 2026 (for next three-year cycle)

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Early Intervention

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Today's Objectives

1	Review Early Intervention Funding Requirements
2	Understand Required Early Intervention Components
3	Overview of Biennial List

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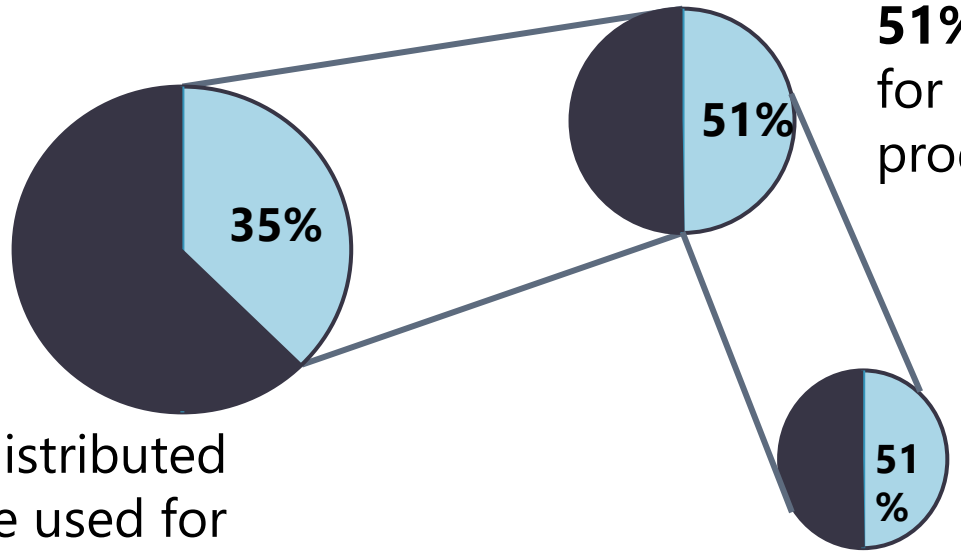
Early Intervention Legislative Funding Requirements



51% of BHSS funds must be used for **Early Intervention** services and programs

35% of the funds distributed to counties must be used for **Behavioral Health Services and Supports (BHSS)**

51% of Early Intervention funds must be used for **children and youth 25 years of age or younger**

Counties have the flexibility to transfer 7% of funds from BHSS into another funding category (FSP or Housing Interventions) for a maximum total shift of 14% into a single funding category.

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Behavioral Health Services and Supports

Per Welfare and Institutions Code (WIC) Section § 5892, Behavioral Health Services and Supports (BHSS) include the components below:

- ✓ **Early Intervention**
- ✓ Children's, Adult, and Older Adult Systems of Care
- ✓ Outreach and Engagement
- ✓ Workforce, Education, and Training
- ✓ Capital Facilities and Technological Needs
- ✓ Innovative behavioral health pilots and projects

Today's presentation will focus on Early Intervention.

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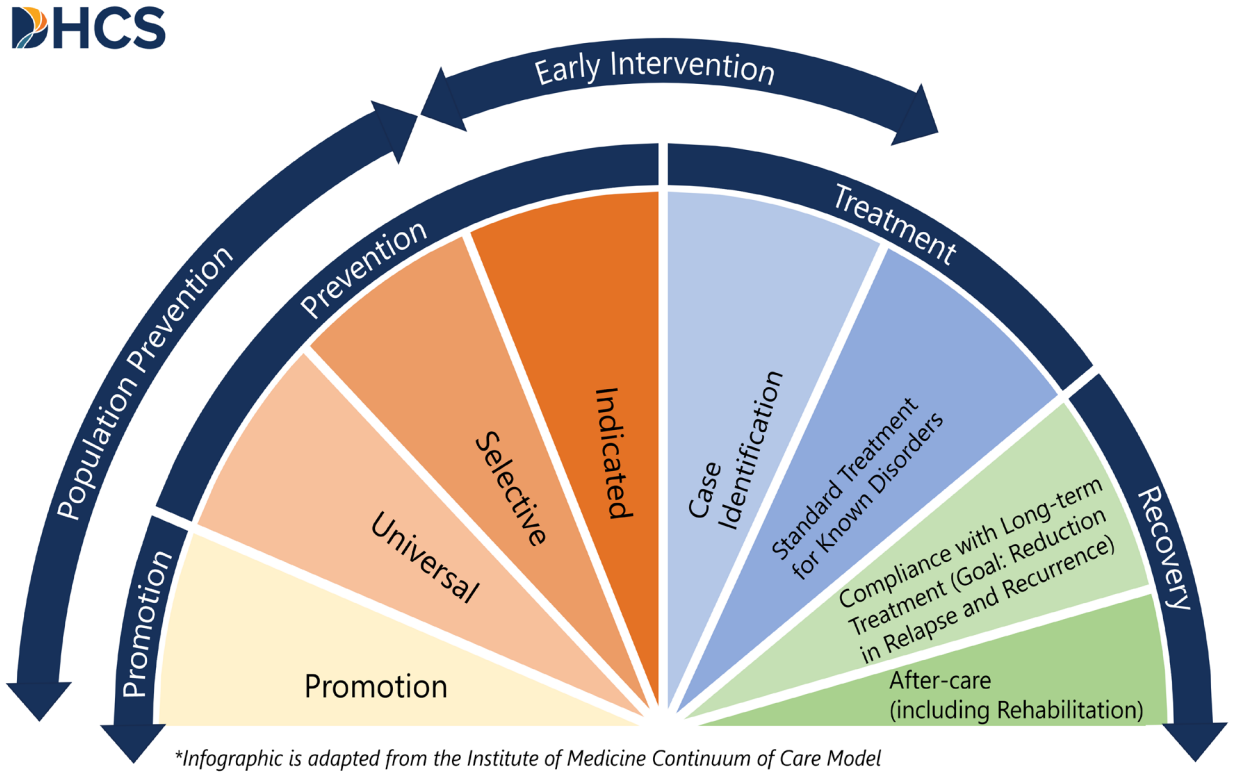
Defining Early Intervention, Target Populations

- WIC 5840(a)(1) defines Early intervention as those designed to prevent mental illnesses and substance use disorders from becoming severe and disabling.
- Early intervention would include indicated prevention case identification and early treatment and supports.
- Early intervention programs for children and youth are required to be designed to meet their social, emotional, developmental and behavioral needs (WIC § 5840(d)) along the continuum of care.



Infographic is adapted from the Institute of Medicine Continuum of Care Model

Early Intervention Funds for Children & Youth

The Behavioral Health Services Act strengthens prioritization of resources to serve children and youth with its dedicated allocation of Early Intervention funds.

51% of Early Intervention funds must be used for **children and youth 25 years of age or younger**

Early Intervention funds must **prioritize childhood trauma** through addressing the root causes of Adverse Childhood Experiences or other social determinants of health that contribute to early origins of mental health and substance use disorder, including strategies focused on:

- Youth experiencing homelessness
- Justice-involved youth
- Child welfare-involved youth with a history of trauma
- Other populations at risk of developing serious emotional disturbance or substance use disorders
- Children and youth in populations with identified disparities in behavioral health outcomes (WIC Sections 5840 and 5892)

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MHSA to BHSA: BHSS Early Intervention Aims

SB 326 requires that Early Intervention programs focus on reducing the likelihood of certain adverse outcomes (WIC § 5840(d)).

Suicide and **self harm**	Incarceration	School **suspension, expulsion, referral to an alternative or community school**, or failure to complete*	Unemployment	Prolonged suffering

Homelessness	**Overdose**	Removal of children from homes	**Mental illness in children and youth from social, emotional, developmental, and behavioral needs in early childhood**

Yellow represents additional goals for counties under the Behavioral Health Services Act

* Including early childhood 0 to 5 years of age, inclusive, TK-12, and higher education

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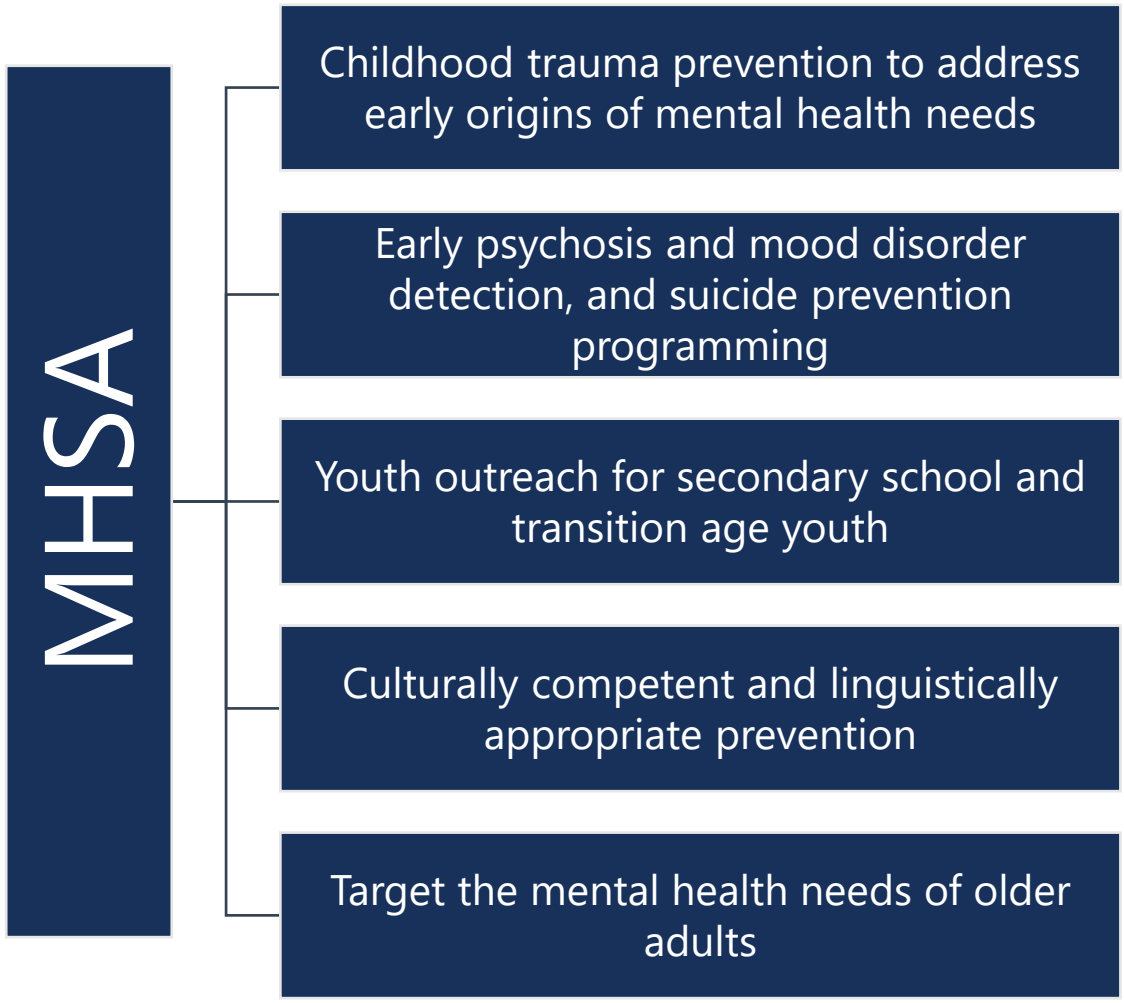
MHSA to Behavioral Health Services Act: Priorities for Use of Early Intervention Funds



Behavioral Health Services Act: Added Additional Priorities for County Early Intervention Programs:

- Target early childhood 0-5 years of age, including infant and childhood mental health consultation
- Advance equity and reduce disparities
- Programs that include community-defined evidence-based practices and mental health and substance use disorder treatment services similar to programs that have been effective and successful in the past
- Address the needs of individuals at high risk of crisis

Counties may add priorities for the use of their early intervention funds based on their community planning process.

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BHSA Early Intervention Program Components

BHSA requires that county Early Intervention programs be "designed to prevent mental illnesses and substance use disorders from becoming severe and disabling and to reduce disparities in behavioral health." WIC § 5840(a)(1)

BHSA requires that county Early Intervention programs include:

- Outreach
- Access and Linkage to Care
- Mental Health and Substance Use Disorder Treatment Services and Supports

The Early Intervention services provided should fall into one of these component categories.
*DHCS may include additional components (WIC § 5840(b)(4)).

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Outreach under Early Intervention

*"**Outreach** to families, employers, primary care health care providers, behavioral health urgent care, hospitals, inclusive of emergency departments, education, including early care and learning, T-12, and higher education, and others to recognize the early signs of potentially severe and disabling mental health illnesses and substance use disorders." WIC § 5840(b)(1)*

Outreach that may be funded under Early Intervention

- Outreach must be directed **toward priority populations[1], including older adults[2] and youth[3],** and outreach cannot be directed at an entire population.
- Outreach must have the goal of **identifying individuals** for **access and linkage to services and treatment and supports.**
- Outreach **must be able to connect individuals directly** to access and linkage programs or to mental health and substance use disorder treatment services and supports, should an individual wish to be connected to services.

1. WIC § 5892(d) 2. WIC § 5840.6(g) 3.WIC § 5840.6(e)

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Access and Linkage to Care

Early Intervention programs **must contain a component that focuses on access and linkage to medically necessary care** provided by county behavioral health programs as early in the onset of these conditions as practicable.

- Access and linkage to care includes, but is not limited to:
  - Scaling of and referral to:
    - Early Psychosis Intervention (EPI) Plus Program
    - Coordinated Specialty Care
    - Other similar EBPs and CDEPs for early psychosis and mood disorder detection and intervention programs
  - Activities with a primary focus on screening, assessment, referral
  - Telephone help lines
  - Mobile response

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Mental Health and Substance Use Disorder Treatment Services and Supports

- This component includes mental health and substance use disorder treatment services and supports **that are effective in preventing mental health illnesses and substance use disorders from becoming severe**, and that have been successful in reducing the duration of untreated serious mental health illnesses and substance use disorders and assisting people in quickly regaining productive lives.
- This component must include services that are demonstrated t**o be effective at meeting the cultural and linguistic needs of diverse communities**.
- May include **services to address first episode psychosis and services that prevent, respond, or treat** a behavioral health crisis or activities that decrease the impacts of suicide.

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Stigma and Discrimination Reduction

Required Programs within the MHSA PEI Component	Required Components for Behavioral Health Services Act Early Intervention Program		
	Outreach to recognize early signs of severe MH or SUDs	Access and linkage to care provided by county BH	MH & SUD treatment services/EBPs & CDEPs for Early Intervention
Prevention			
Early intervention		X	X
Outreach to recognize early signs of severe MH	X		
Access and linkage to treatment		X	
Stigma and discrimination reduction			

- **Stigma and Discrimination Reduction programs align with population-based prevention activities, which will be funded by other funding sources (including SAMHSA Block Grants, CDPH Behavioral Health Services Act funding, other prevention dollars).**
- CDPH will provide guidance on the Behavioral Health Services Act population-based prevention funding. DHCS is working collaboratively with CDPH on the guidance.
- Stigma and discrimination reduction activities aim to reduce negative feelings, attitudes, beliefs, perceptions, stereotypes and/or discrimination related to being diagnosed with a mental illness or seeking mental health services.

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Early Intervention Evidence Based Practices and Community-Defined Evidence Practices Biennial List

Biennial List Purpose

DHCS will develop a non-exhaustive list of Early Intervention EBPs and CDEPs biennially, in consultation with the BHSOAC, counties, and stakeholders.

DHCS proposes that the biennial EBP and CDEP list will be a reference tool for counties to determine which practices to implement locally.

This non-exhaustive list will include suggested EBPs and/or CDEPs that a county may implement.

If a county is demonstrating gaps in services or is struggling to meet performance measures, DHCS may require a county to implement a particular EBP or CDEP from the biennial list.[1]

1. WIC § 5840 (c)(5)

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Sources for Evidence-Based and Community-Defined Evidence Practices

DHCS will leverage the following sources to identify EBPs and CDEPs:

- Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Medicaid Section 1115 Demonstration
- The Children and Youth Behavioral Health Initiative (CYBHI)
- Family First Prevention Services Act (FFPSA)
- Early intervention EBP's identified by the Prevention and Youth Branch (ex: UCLA, National Registry of Evidence-based Programs and Practices, Blueprints Programs, Athena Forum, programs implemented through SUBG)
- Community-Defined Evidence Practices identified through the California Reducing Disparities Project (CRDP)
- Evidence-Based Practices Resource Center developed by the Substance Abuse and Mental Health Services Administration
- The Cognitive-Behavioral Interventions for Substance Use (CBI-SU) curriculum designed by the University of Cincinnati
- California Evidence-Based Clearinghouse for Child Welfare (CEBC)

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Considerations for Inclusion in Biennial EBP and CDEP List

EBPs: Levels of evidence (Well-Supported, Supported, Promising, Emerging).

CDEPs: Strong level of efficacy within specific communities based on their perceived positive outcomes.

Cultural evidence.

Populations served.

Risk and protective factors.

Program type (Universal, Selective, Indicated, Tiered).

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Full-Service Partnership (FSP)

Today's Objectives

1	Understand Full-Service Partnership (FSP) core components
2	Discuss FSP levels of care design

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FSP Overview

Behavioral Health Services Act FSP Funding Requirements

» 35% of the funds distributed to counties **must be used for Full-Service Partnership (FSP) Programs**

» Per WIC § 5887(a)(2), counties with a population of less than 200,000 may request an exemption from certain components of the required 35% allocation of Behavioral Health Services Act funds for Full-Service Partnership (*Note: exemption process under development*)

» Counties have the flexibility to move 7% of funds to/from Full-Service Partnerships into another category (Housing Interventions or Behavioral Health Services Supports) for a maximum total shift of 14%.

SB326 on FSP Programs

Focus of today's presentation.

Per WIC § 5887, each county shall administer a full-service partnership program that includes the following services:

(a)(1) **Mental health services, supportive services, and substance use disorder treatment services.**
(2) **Assertive Community Treatment and Forensic Assertive Community Treatment fidelity, Individual Placement and Support model of Supported Employment, high fidelity wraparound**, or other evidence-based services and treatment models, as specified by the State Department of Health Care Services.
(3) **Assertive field-based initiation for substance use disorder treatment services**, including the provision of medications for addiction treatment, as specified by the State Department of Health Care Services.
(4) **Outpatient behavioral health services**, either clinic or field based, necessary for the ongoing evaluation and stabilization of an enrolled individual.
(5) **Ongoing engagement services** necessary to maintain enrolled individuals in their treatment plan inclusive of clinical and nonclinical services, including services to support maintaining housing.
(6) **Other evidence-based services and treatment models**, as specified by the State Department of Health Care Services
(7) **Service planning**
(8) **Housing interventions** pursuant to Section 5830.
(e) Full-service partnership programs shall have an **established standard of care with levels based on an individual's acuity and criteria for step-down** into the least intensive level of care, as specified by the State Department of Health Care Services, in consultation with the Behavioral Health Services Oversight and Accountability Commission, counties, providers, and other stakeholders.

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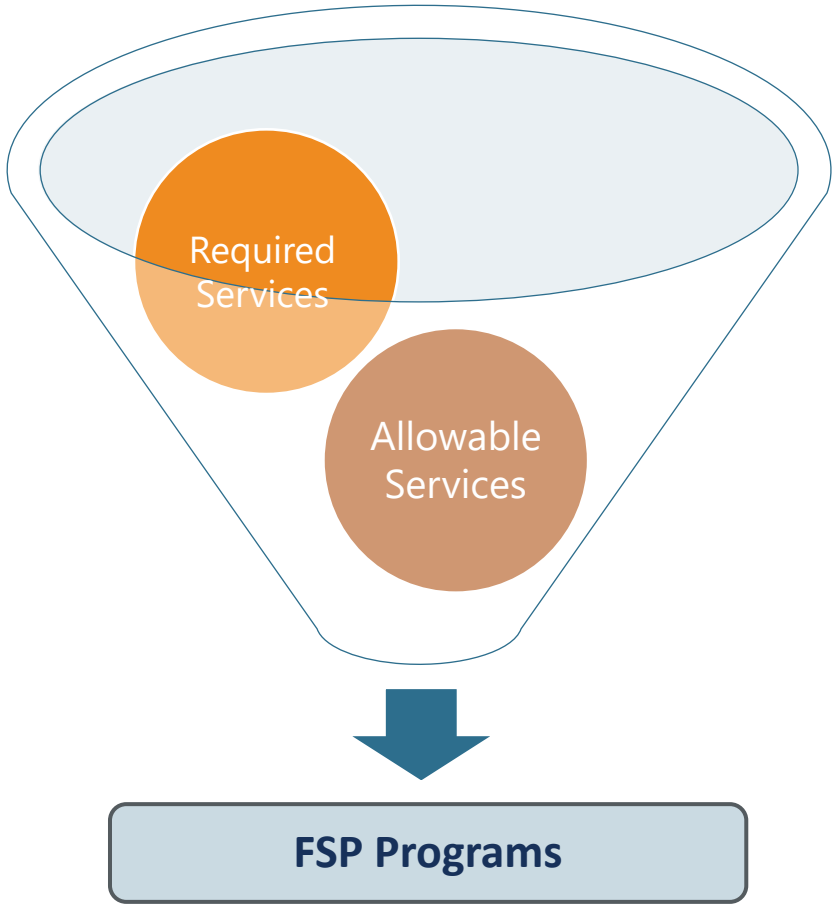
FSP Continuum

FSP programs are comprised of required and allowable services. FSP programs must make required services available as a condition of receiving Behavioral Health Services Act funding. Allowable services are additional services that may be offered and can be paid for using Behavioral Health Services Act FSP funds.



Required Services

- Required services are outlined in statute and must be included in FSP programs:
  - Mental health services, supportive services, and SUD services
  - Assertive field-based initiation for SUD
  - Outpatient behavioral health services for evaluation and stabilization
  - Ongoing engagement services
  - Service Planning
  - ACT/FACT** or FSP ICM
  - HFW**
  - Individual Placement and Support (IPS) model of Supported Employment**

Allowable Services

- Allowable services may be included in addition to, or in conjunction with, required services. They include, but are not limited to:
  - Housing Interventions*
  - Primary SUD FSPs
  - Additional EBPs
  - Outreach and engagement
  - Other non-clinical services

*Housing Interventions pursuant to WIC Section 5830 must be funded through Housing Interventions funding.
**Services eligible for small county exemption requests.

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Relationship to Medi-Cal EBP Policy Design

- This presentation includes an overview of how required EBPs – ACT/FACT, IPS, and HFW – will function within FSP.
- FSP EBPs will mirror the Medi-Cal EBP benefits being developed through BH-CONNECT.
- Under BH-CONNECT, DHCS is partnering with a Center of Excellence to provide support related to fidelity monitoring, training, and technical assistance for FSP EBPs.
- FSP programs will also be expected to meet initial certification and subsequent fidelity monitoring standards as provided for in forthcoming Medi-Cal guidance.

Note: Preliminary EBP policy design presented for the purposes of BHSA are subject to final approval of Medi-Cal policy guidance.

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FSP EBP and Fidelity Timing

- Counties will be required to **implement** FSP EBPs – **ACT/FACT, IPS, HFW** – beginning July 1, 2026.
- Counties will also be required to implement **FSP-ICM and Assertive Field-Based SUD** by July 1, 2026.
- Counties will have **18-months** to complete a **fidelity review** for all EBPs (by December 31, 2027).
  - Fidelity reviews will be led by a **Center of Excellence (COE),** which will also provide **training and technical assistance** leading up to and following the fidelity review.
- Following the first fidelity review, counties will have **18 months** (by June 30, 2029) to come into compliance and demonstrate they are delivering FSP EBPs to **fidelity**.
  - The COE will continue providing training and TA as counties move toward delivering FSP EBPs to fidelity.
  - Additional fidelity reviews by the COE over this 18-month period will confirm whether the county is delivering FSP EBPs to fidelity.

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Exemptions

FSP Exemptions for Small Counties

Per statute, small counties may request an exemption from FSP program requirements.*

WIC § 5887(a)(2):

(a) Each county shall establish and administer a full service partnership program that includes the following services:

(2) Assertive Community Treatment and Forensic Assertive Community Treatment fidelity, Individual Placement and Support model of Supported Employment, high fidelity wraparound**, or other evidence-based services and treatment models, as specified by the State Department of Health Care Services. **Counties with a population of less than 200,000 may request an exemption from these requirements. Exemption requests shall be subject to approval by the State Department of Health Care Services.** The State Department of Health Care Services shall collaborate with the California State Association of Counties and the County Behavioral Health Directors Association of California on **reasonable criteria for those requests and a timely and efficient exemption process.**

For the FY 2026 Integrated Plan, all small counties will be exempt from:

- **Meeting fidelity requirements for ACT/FACT**, but must still provide FSP ICM; and,
- **Meeting the fidelity requirements for the IPS model of Supported Employment and/or HFW**

Note: DHCS believes that there are very few circumstances where exemptions from the IPS model of Supported Employment and/or HFW would be warranted given the flexibility of the models and ability of individual practitioners to deliver IPS and HFW).

**Note:* This exemption does not apply to Field-Based SUD or FSP ICM*

***Note:* Counties will still be required to offer HFW through Medi-Cal under EPSDT*

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Criteria for 2029 FSP Exemptions for Small Counties

- Starting in 2029, the following exemption criteria would apply:
- Counties may cite **one or more of the following criteria** when requesting an exemption to ACT/FACT and/or the fidelity requirements for IPS and/or HFW:
  - Limited **workforce**, including providers
  - Limited **need** (e.g., small number of individuals in or eligible for the program to support the required staffing for fidelity)
  - **Other considerations** subject to evidence requirements and DHCS review
- Requests for exemptions must include:
  - **Documentation** demonstrating that one or more of the criteria for exemption are met (e.g., workforce data, county demographic data, etc.)
  - For exemption requests from IPS and HFW fidelity, counties must include a description of how they will **modify EBP requirements** (e.g., substitute LPN for RN requirements) and **plans to move toward meeting FSP EBP fidelity requirements**.

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FSP Levels of Care

Adult FSP Levels of Care

- To meet new BHT requirements, DHCS has begun developing a **straw model for the Adult FSP standards of care** with levels based on an individual's acuity and criteria for step down.
- Since ACT is a required service and an evidence-based practice (EBP) for those with the highest acuity, **we propose that ACT be the highest level of care** for an adult in the FSP program.
- **DHCS proposes developing a standardized step-down level from ACT, using known terminology, FSP Intensive Case Management (ICM),** which will capture individuals who may not meet ACT eligibility criteria, but still have significant behavioral health needs and can benefit from FSP supports. Many of California's current FSP programs include more than one level of care; this Behavioral Health Services Act policy will improve standardization across the state.
- WIC § 5892(k)(8)(A) defines adult and older adults as those 26 and older. For the purposes of FSP programs, **the Adult FSP is for those 26 and older as well as Transitional Age Youth or younger, if determined to be clinically and developmentally appropriate.**

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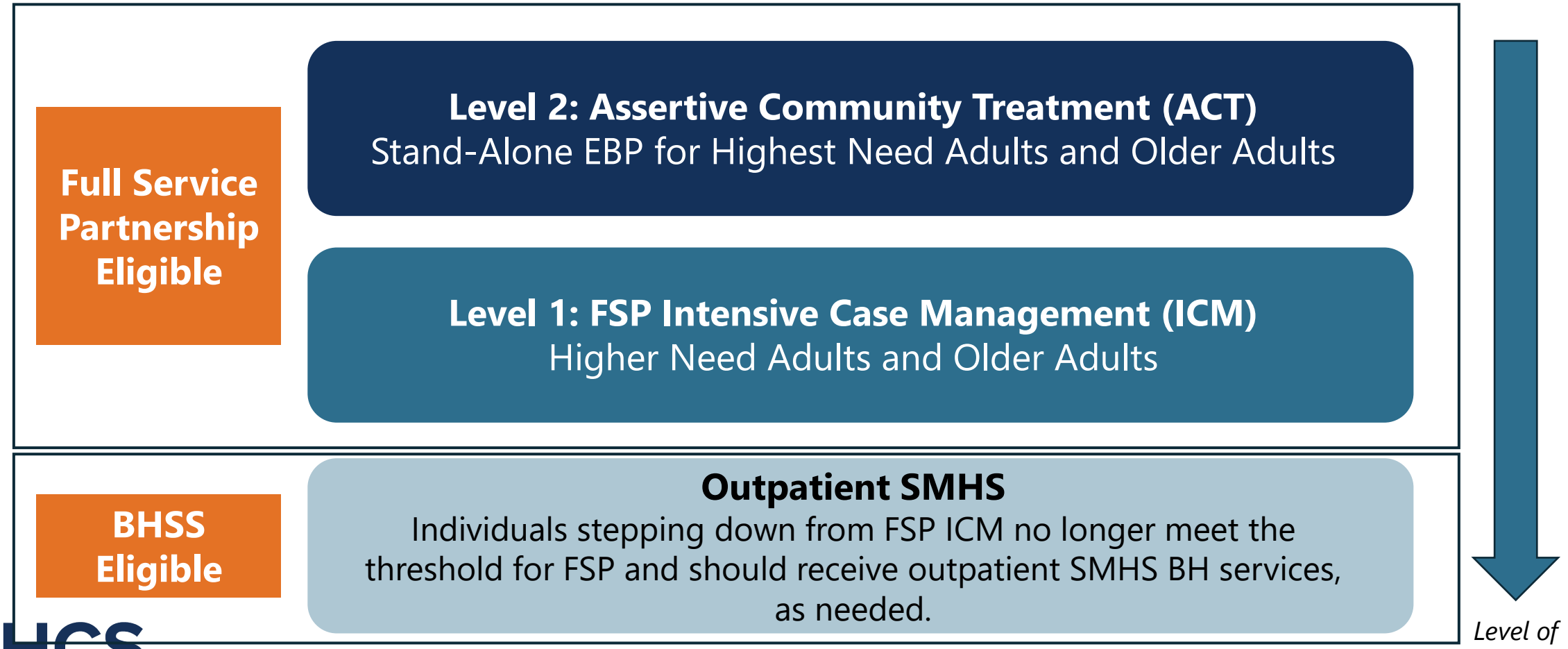
Adult FSP Levels of Care Framework

The framework includes two levels of coordinated care for adults and older adults with ACT as the highest level and a step-down level from ACT, that we are calling FSP Intensive Case Management (ICM).



ACT Service Components

FSP ACT programs must mirror the service components outlined in the Medi-Cal benefit and be made available to non-Medi-Cal members who receive FSP and are clinically eligible for the highest level of care. FSP funding can be used to cover additional non-clinical supports that are not covered by Medi-Cal, as needed.

- ✓ Assessment
- ✓ Crisis Intervention
- ✓ Employment and Education Support Services
- ✓ Medication Support Services
- ✓ Peer Support Services
- ✓ Psychosocial Rehabilitation
- ✓ Referral and Linkages
- ✓ Therapy
- ✓ Treatment and Planning

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Forensic ACT Requirements

- FACT is ACT tailored to Justice-involved individuals.
- Counties may adapt their FACT model based on local resources and needs (e.g., more populous counties may have dedicated FACT team, smaller more rural counties may integrate FACT within their ACT teams)
- ACT teams meet the FSP requirement to include FACT if:
  - Counties have dedicated FACT teams; **OR**
  - At least one ACT team member has lived experience; **OR**
  - All ACT team members complete FACT training.

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Overview: Intensive Case Management (ICM)

- ICM is a service that is well known and documented in the literature.
- ICM includes a **comprehensive set of community-based services** for individuals with significant behavioral health conditions.
- Compared to standard care, ICM has been shown to improve general **functioning, employment and housing outcomes, and reduce length of hospital stays**.
- ICM does not have set fidelity criteria like ACT but generally **combines the principles of case management** (assessment, planning, linkages) with **low staff to client ratios**, **assertive outreach**, and **direct service delivery**.

Sources:
1. Dieterich M, Irving CB, Bergman H, Khokhar MA, Park B, Marshall M. Intensive case management for severe mental illness. Cochrane Database of Systematic Reviews. 2017, DOI: 10.1002/14651858.CD007906.pub32
2. Schaedle, R.W., Epstein, I. Specifying Intensive Case Management: A Multiple Perspective Approach. *Ment Health Serv Res* 2, 2000. https://doi.org/10.1023/A:1010157121606
3. Meyer, P., and Morrissey, J. A Comparison of Assertive Community Treatment and Intensive Case Management for Patients in Rural Areas. Psychiatric Services. (2007). https://doi.org/10.1176/ps.2007.58.1.121

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Who Might FSP ICM Serve?

- Individuals receiving FSP ICM may include **members who were receiving ACT and have been clinically determined to be ready for a step-down** level of care
- Individuals may also enter an FSP program **needing a moderate to significant level of support** but do not meet the qualifications for ACT
- Individuals living with **co-occurring SMI/SUD** are eligible to receive FSP ICM
- Individuals ages 18-26 or younger who are **not connected to children's services**, if determined to be clinically and developmentally appropriate

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FSP ICM Service Components

FSP ICM participants may need some or all of the same services components as ACT.

- ✓ Assessment
- ✓ Crisis Intervention
- ✓ Employment and Education Support Services
- ✓ Medication Support Services
- ✓ Peer Support Services
- ✓ Psychosocial Rehabilitation
- ✓ Referral and Linkages
- ✓ Therapy
- ✓ Treatment and Planning
- ✓ Housing supports

Note: *This list is not exhaustive. Additional services may be provided on an as needed basis.*

A Note on Permanent Supportive Housing:
Pairing intensive behavioral health services like ACT and FSP ICM with permanent housing is a recommended best practice for achieving long-term housing stability.

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FSP Levels of Care for Children/Youth

- DHCS will require HFW for children/youth as an EBP, so that it is delivered with fidelity in each county.
- HFW subject matter experts/research do not support defining multiple levels of care in this scenario, given that HFW service design enables flexibility to adjust the level of intensity according to an individual's needs.
- SB 326 does not prohibit counties from establishing FSP programs for children/youth that include multiple levels of care based on intensity of mental health or SUD needs. However, DHCS will not require counties to develop multiple, dedicated levels of care for FSP for children/youth.

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Overview: High Fidelity Wraparound (HFW)

HFW is a **team-based** and **family-centered evidence-based practice** that includes an **"anything necessary"** approach to care for children/youth living with the **most intensive mental health or behavioral challenges**. HFW is regarded as an **alternative to out-of-home placement for children with complex needs,** by providing intensive services in the family's home and community.

» HFW centers family voice and decision-making in developing a care plan to reach desired family outcomes by providing a structured, creative, and individualized set of strategies that result in plans/services that are effective and relevant to the child, youth, and family.

» HFW is delivered by a **HFW Facilitator**, who leads a team through a prescribed process, which is both flexible and responsive to child and family-identified strengths and needs.

» At its core, high fidelity is defined as **adherence to the four phases of the HFW model:**

Phase 1: Engagement and Team Preparation	Phase 2: Plan Development	Phase 3: Implementation	Phase 4: Transition

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HFW Service Components

HFW must mirror the service components outlined in forthcoming Medi-Cal guidance.

Basic HFW Medi-Cal service bundle includes:

- ✓ HFW Facilitation and Coordination
- ✓ Child and Adolescent Needs Survey (CANS) Administration
- ✓ Individualized Care Planning, including Safety and Crisis Planning
- ✓ Caregiver Peer Support

Additional services (as needed) through Medi-Cal, e.g.:

- ✓ Therapy
- ✓ Youth Peer Support
- ✓ 24/7 Support (mobile crisis)
- ✓ Intensive home-based services
- ✓ Caregiver Respite

Flexible Funds are a **vital component of HFW,** and inclusive of anything deemed necessary by the HFW team, **that are <u>not</u> Medi-Cal billable**.

HFW facilitation occurs within the context of a <u>Child and Family Team</u> (CFT) and HFW Providers must refer to other services part of the intervention, including FSP services that may be particularly beneficial for Transitional Aged Youth (TAY), such as housing supports and the IPS model of supported employment.

All eligible children/youth will receive the basic HFW Medi-Cal bundle, but not all will need to receive every additional service.

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Individual Placement and Support (IPS) Supported Employment

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Overview: Individual Placement and Support (IPS)

Over 60% of clients with severe mental illness want to work, but less than 20% are employed.[1] The IPS model of supported employment is an evidence-based intervention that engages people with severe mental illness in finding and maintaining *competitive* employment or education *of their own choice*.

- The IPS model uses a strength-based approach to support individuals living with serious mental illness[1] **find and maintain employment**, which plays a crucial role in their **recovery and integration into the community**.
- Supported Employment can be **integrated into other FSP services** such as ACT, HFW and CSC for FEP, to offer a comprehensive approach to recovery that addresses both clinical and functional needs.
- BHT Supported Employment programs will align with the evidence-based IPS model and **mirror the Medi-Cal benefit** being developed through BH-CONNECT[2].
- Compared to traditional vocational rehabilitation approaches, IPS has demonstrated **higher rates of competitive employment for individuals with behavioral health disorders**.[3]

[1] IPS Employment Center, 2024
[2] Under BH-CONNECT, Supported Employment will be available at county option in the SMHS **and** DMC/DMC-ODS delivery systems
[3] Recent research has also demonstrated the effectiveness of the IPS model in supporting individuals living with SUD gain employment (Marsden et. al, 2024)

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*The information included in this presentation may be pre-decisional, draft, and subject to change.

IPS Principles

- IPS is an important part of **psychosocial rehabilitation**, providing structure, purpose, and social connection to reduce isolation and combat stigma for individuals with SMI.
- The evidence-based model is designed to help individuals with serious mental illness **find and maintain jobs as part of their recovery and is based on 8 core principles**[1,2]**.**

IPS Core Principles

- Zero Exclusion
- Competitive Employment
- Rapid Job Search
- Systematic Job Development
- Integrated Services
- Benefits Planning
- Time-Unlimited Supports
- Worker Preferences

[1] IPS Employment Center, 2024

[2] There are other evidence-based models of Supported Employment for individuals with I/DD to get and keep competitive integrated employment in the community.

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Assertive Field-Based Initiation for Substance Use Disorder (SUD)

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Working Definition

Assertive field-based initiation for substance use disorder treatment services

Outreach, engagement and initiation of treatment for substance use (e.g., alcohol misuse, stimulant misuse, opioid use) disorder **particularly medications for addiction treatment (MAT) in any low-barrier setting**, such as on the street, in homeless encampments, drop-in centers, in hospital emergency departments (ED) **to reach people wherever they are**.

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*The information included in this presentation may be pre-decisional, draft, and subject to change.

Assertive Field-Based Initiation for SUD Treatment Services Requirements

Counties will be required to **strengthen**, **expand existing**, and/or **stand-up** the following three services/models:

1. **Conduct ongoing, data-informed targeted outreach** to BHSA eligible individuals with SUD needs
   - May be performed by Mobile Field-Based teams (below) or delivered via other models
2. **Mobile Field-Based Programs**
   - Mobile teams that conduct **field-based** outreach and provide or facilitate **access to MAT,** and other treatment. Services are for populations at higher risk of overdose and provided in locations with higher rates of overdose and need (e.g., outreach/medicine programs)
3. **Open-Access Clinics**
   - A "**walk-in**" service delivery model with **low-barrier MAT access** (e.g., telehealth models, Bridge Clinics) that can connect individuals to **other supports**

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Assertive Field-Based Initiation for SUD Treatment Services Requirements

The key goals of these requirements is to **increase access** to MAT and directly provide or facilitate **rapid access** to all FDA approved MAT**.**

- **Rapid MAT access** means:
  - County field-based programs are **expected** to work towards ensuring **same day MAT access**
  - To help meet this standard, field-based programs can **have MAT prescribers on staff or refer** to buprenorphine providers, Federally Qualified Health Centers (FQHCs), Indian Health Clinics, and Narcotic Treatment Programs (NTPs)
  - Counties can utilize **telehealth models** to ensure access to MAT

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FSP Integration With SUD

Expectations for the Behavioral Health Services Act

1. Counties must conduct assertive field-based initiation; and
2. FSP teams must be capable of supporting individuals living with co-occurring mental health and substance use conditions.

NOTE: *SB 326 does not prohibit counties from establishing FSP programs for individuals with primary SUD diagnoses (i.e., without co-occurring significant mental health needs), however, counties are not required to develop new, dedicated Levels of Care specific to SUD, or FSPs that are exclusively for SUD (apart from implementing new, field-based initiation of SUD care requirements). DMC-ODS is intended to cover a comprehensive continuum of care for SUD.*

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Resources

Behavioral Health Transformation Website and Monthly Newsletter

Explore the Behavioral Health Transformation website to discover additional information and access resources.

Please sign up on the DHCS website to receive monthly Behavioral Health Transformation updates.

Public Listening Sessions

Attend public listening sessions to provide feedback on Behavioral Health Transformation-related topics.
Registration links will be posted on the Behavioral Health Transformation website, along with recordings, once available.

Questions and Feedback

Please send any other questions or feedback about Behavioral Health Transformation to BHTInfo@dhcs.ca.gov.

Questions?

Thank You

For Questions

BHTinfo@dhcs.ca.gov

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DEPARTMENT OF PEDIATRICS
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TORRANCE, CALIFORNIA 90509

Oct 14, 2024

Importance of early intervention in trauma.

Dear MHSOAC Team,

I am grateful for the work of the commission addressing the full spectrum of children's mental health issues. As California and the US overall continues to experience the impacts of climate change including excessive heat, wildfires and the complex health and mental health impact I wish to urge the commission consider the salience of early risk identification and intervention. There is now increasing evidence that by identifying children's mental health risk after various types of trauma (disasters(including climate change), active shooter, community and family violence that early intervention can result in an earlier return to resilience, less collateral impacts(school failure, attendance/ADA impacts) and be more cost effective. Kids return to positive mental health sooner benefiting themselves, their families and their communities and at increased efficiency using the currently available mental health workforce more efficiency.

In our work in Sonoma County after COVID, wildfires and floods, we found that using the "stepped triage to care" model resulted in many children(50-70%) being sufficiently improved after just the first step of the intervention(TF-CBT in this case). This helped the kids get back to wellness sooner and allowed the mental health provider to see twice as many kids in the same time frame. We hope the commission will consider to support early trauma intervention and specifically the "stepped triage to care" model we developed with Sonoma County Office of Education and that we are now providing nationally through the HRSA Pediatric Pandemic Network.
Happy to address any questions as the commission considers these ideas moving our state ahead.

Sincerely,

Very Respectfully,

Merritt Schreiber, Ph.D.
Department of Pediatrics
Harbor-UCLA Medical Center
The Lundquist Research Institute
Professor of Clinical Pediatrics
David Geffen School of Medicine at UCLA

FIRST 5 SACRAMENTO | CELEBRATING 25 YEARS

Putting Kids First

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Mental Health Services Oversight & Accountability Commission Meeting
October 24, 2024

Written Comment on Agenda Item 5: Transformational Change in Behavioral Health: Early Intervention & Full Service Partnerships

Hello Chair Madrigal-Weiss and Commissioners,

With the implementation of Prop. 1, as your Commission prepares to transition to the Behavioral Health Services Oversight and Accountability Commission and begins consulting with CDPH in July 2026 on population-based prevention, we urge you to prioritize the mental well-being of young children ages 0 to 5, a priority population per the statute.

Over its 25-year history, First 5 has demonstrated the effectiveness of prevention and early intervention services in the prenatal through pre-school stages of life. Unfortunately, public systems tend to mandate treatment services but not prevention services despite the overwhelming evidence of cost savings when we invest in prevention. Here, the Mental Health Services Act dollars, and you as the stewards of those funds, have a unique role to play.

Ninety percent of brain growth happens by the time a child turns five; because of the rapid pace of development in this phase, the physical, cognitive, social and emotional dimensions of well-being are inextricably woven together. This leaves young children particularly vulnerable to environmental adversity, including toxic stress, which can damage the architecture of the rapidly developing brain and significantly increase the likelihood of concurrent and subsequent mental health issues. We know that people in marginalized groups experience greater environmental adversity and are exposed to more stressors, meaning that there are inherent equity issues in early childhood mental health.

The powerful influence of relationships with caregivers in early childhood, both disruptive and reparative, means that “early childhood mental health” can be understood as “early relational health”. The Harvard Center for the Developing Child sums it up this way: “The emotional and behavioral needs of infants, toddlers, and preschoolers are best met through coordinated services that focus on their full environment of relationships” (National Scientific Council on the Developing Child, 2008/2012). Bolstering the quality of early relationships provides a buffering effect on the influence of environmental stressors, protecting children's mental health.

Given the rapid and foundational brain growth in early childhood and the importance of early relational health, we recommend to you the following systemic changes to the behavioral health system:

- Expand the evidence-based behavioral and developmental screening program for 0 - 5-year-olds, Help Me Grow, statewide to move toward truly universal screening, connect families to assessment and treatment, and address developmental and behavioral health issues as they arise.

Currently, 30 of California's 58 counties have some form of the program, almost all supported with First 5 funds which is a rapidly declining funding stream. Replacing this piecemeal approach with a statewide program would greatly strengthen it.

- Continue to focus on perinatal mood disorders, supporting universal screening for birthing people and innovating low-barrier treatment programs such as the home-visiting model Moving Beyond Depression. Perinatal mood disorders go undetected in approximately 50% of cases and can have profound effects on child mental wellness.

- Expand the number of providers trained in dyadic / family treatment therapies that address infant and early childhood mental health; evidence-based approaches include Child-Parent Psychotherapy (CPP), Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Parent-Child Interaction Therapy (PCIT), and Child Parent Relationship Therapy (CPRT).

In closing, we urge you to focus on birth to 5-year-olds and their families in order to provide true prevention of mental health challenges and support mental wellness.

In partnership and support,

Julie Gallelo, Executive Director
First 5 Sacramento

National Scientific Council on the Developing Child. (2008/2012). *Establishing a Level Foundation for Life: Mental Health Begins in Early Childhood: Working Paper No. 6*. Updated Edition. Retrieved from www.developingchild.harvard.edu.

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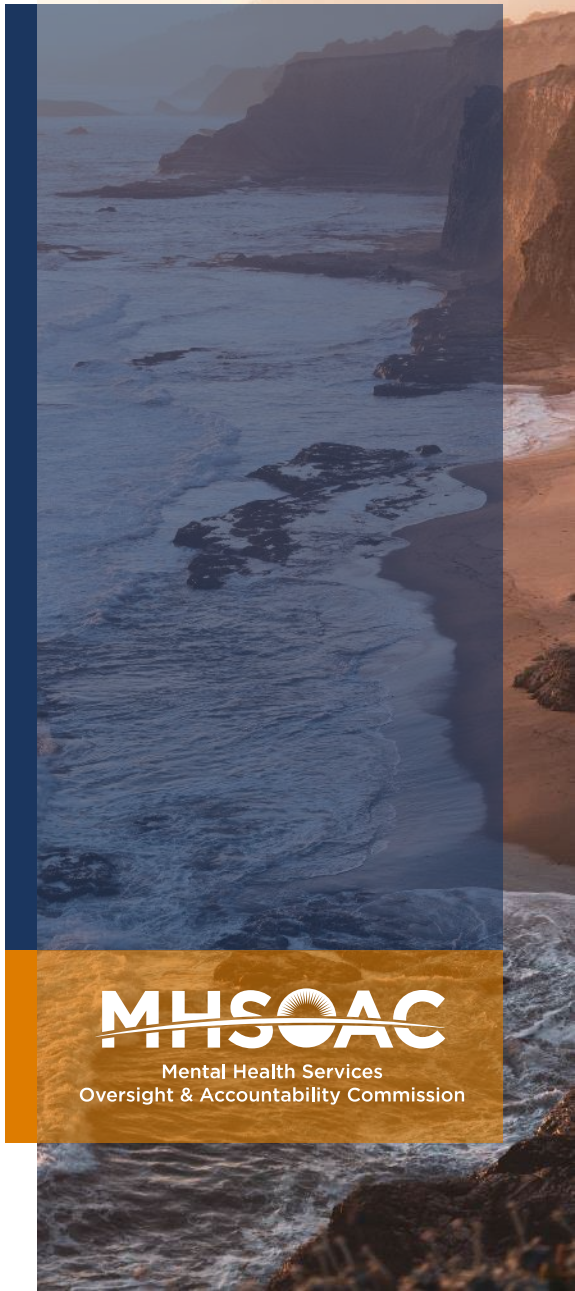
Report to the Legislature on the Mental Health Student Services Act

Dr. Melissa Martin-Mollard, Chief of Research and Evaluation

October 24, 2024

Mental Health Student Services Act

- $255 million investment, prioritizing highest needs K-12 school districts and schools.
- Reaches approximately 45% of school districts and almost 1 in 4 schools.
- Services are tailored to meet local needs.



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Report to the Legislature on the Mental Health Student Services Act

by the Mental Health Services Oversight and Accountability Commission

Submitted to the Fiscal and Policy Committees of the Legislature

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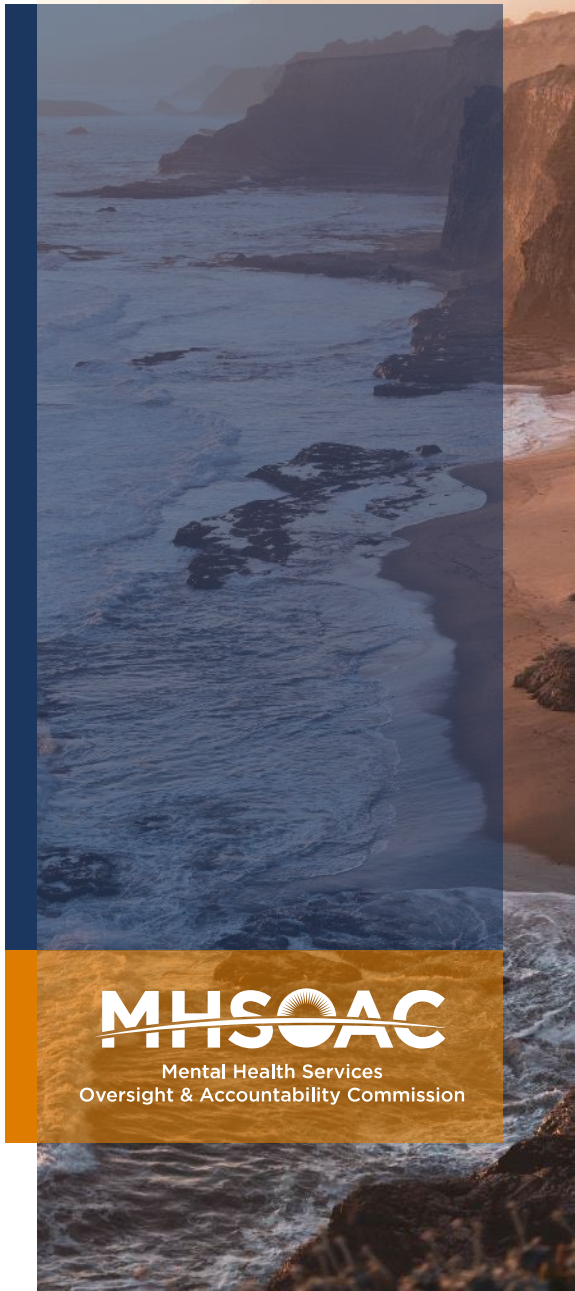
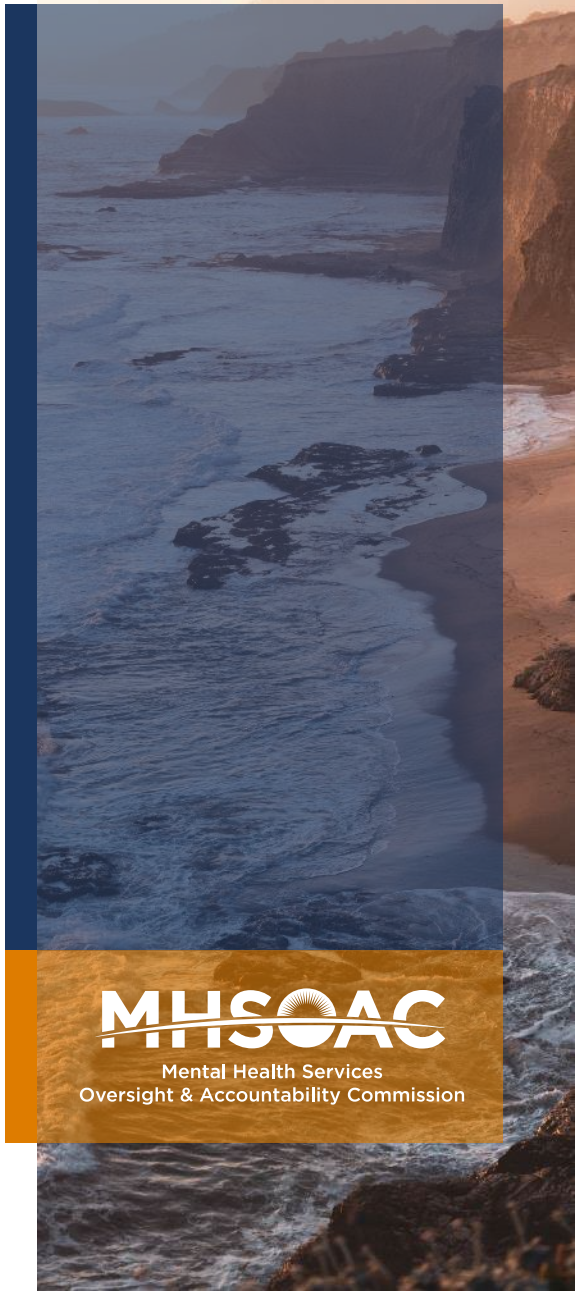


Lessons Learned

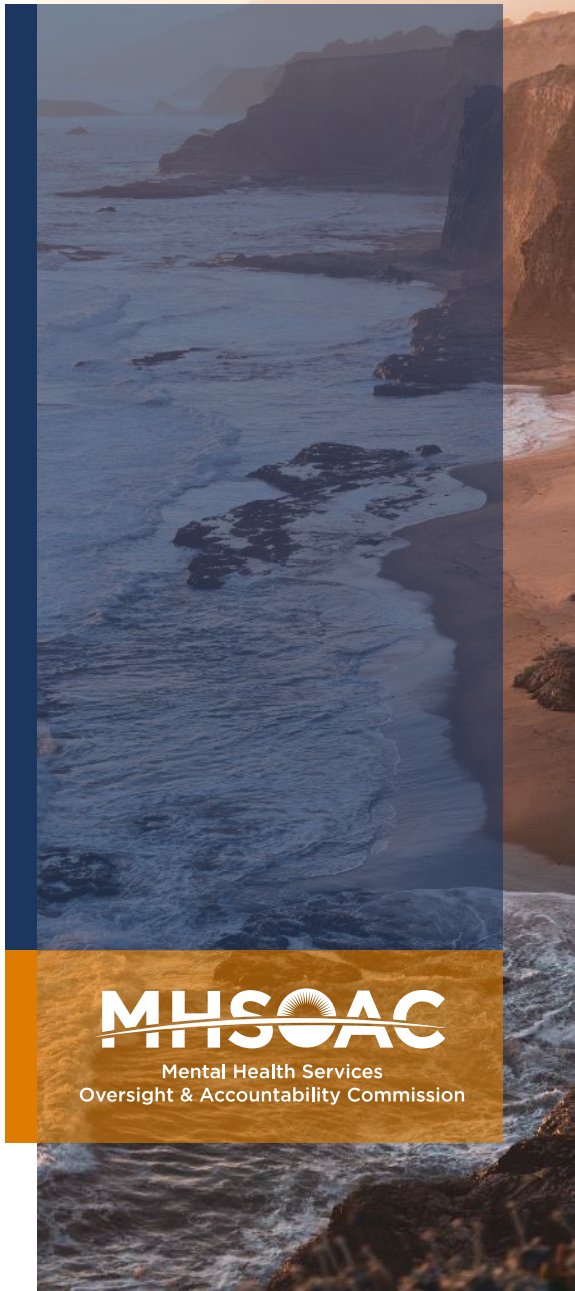
1. Local MHSSA activities and services are **heterogenous and tailored** to meet local needs and gaps in services.
2. MHSSA partners have **built and strengthened partnerships** but need additional guidance to support local success.
3. The **need** for school mental health services often **exceeds** local capacity.
4. **School mental health standards** are needed in California to drive quality improvement.
5. **Alignment** of California's school mental health initiatives is important for local success.



Recommendations

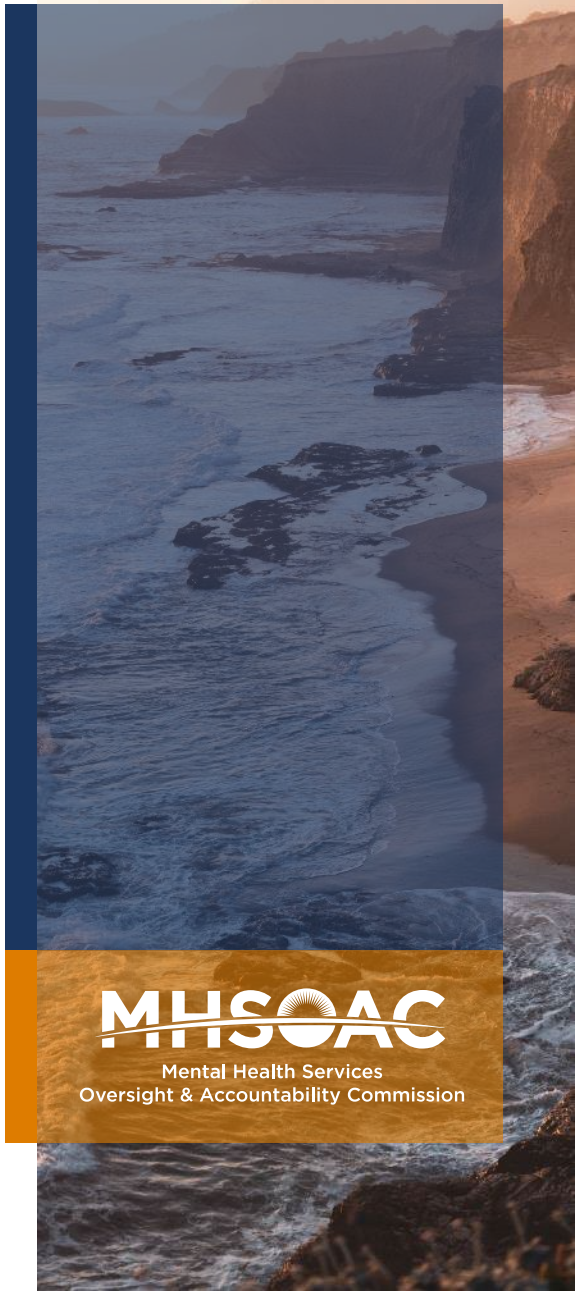
The State should:

- Establish a **leadership** structure for youth behavioral health to coordinate and align school mental health initiatives and develop a strategy for building sustainable, comprehensive school mental health systems in every K-12 school in California.
- Make additional **investments** that are adequate, consistent, aligned, and incentivized to achieve desired outcomes.
- Develop an **accountability** structure including school mental health standards and metrics that show progress toward established goals.

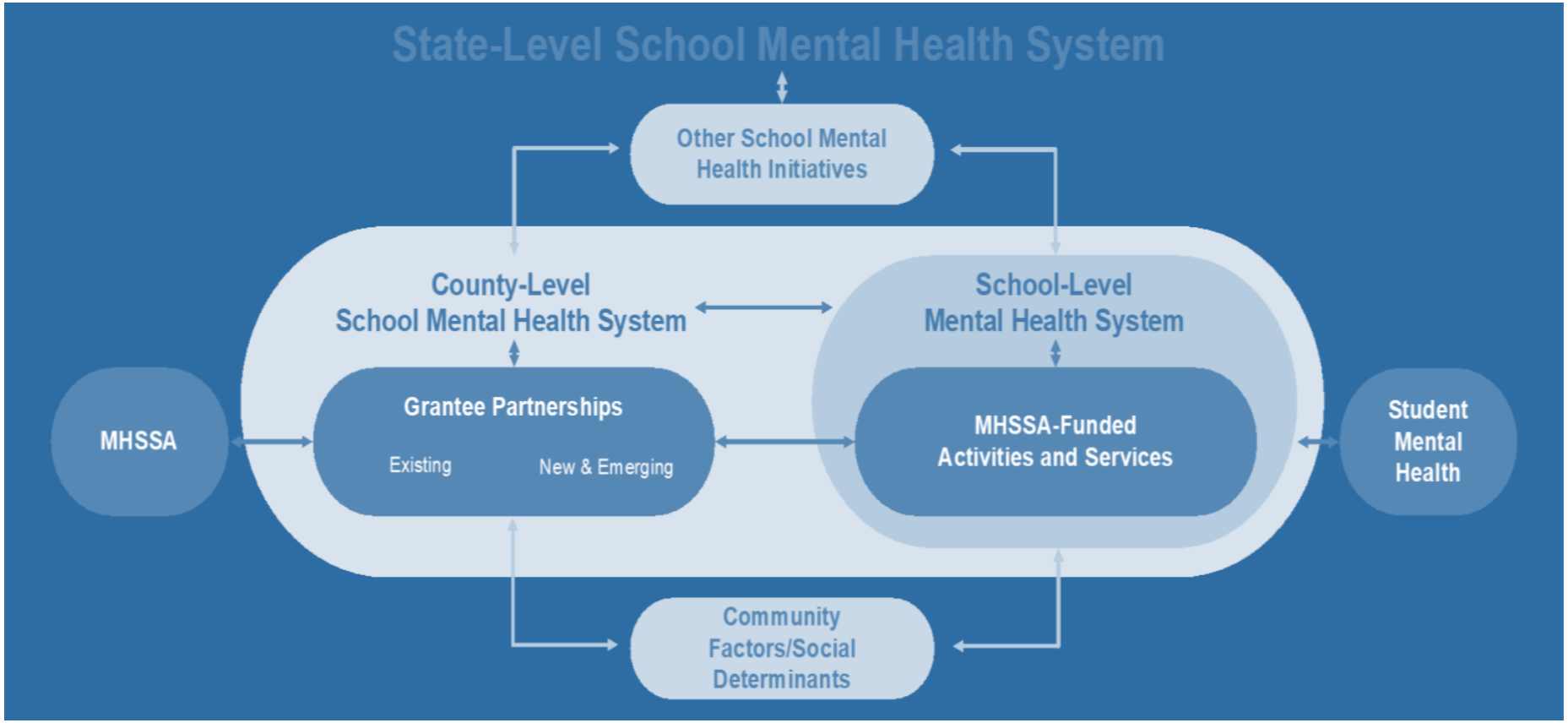


Next Steps: WestEd Evaluation

- WestEd completed planning phase of evaluation
  - Extensive document review
  - Community engagement
  - Listening sessions with grantees
  - Youth Advisory Board
  - Collaboration with Commission staff



Next Steps: WestEd Evaluation



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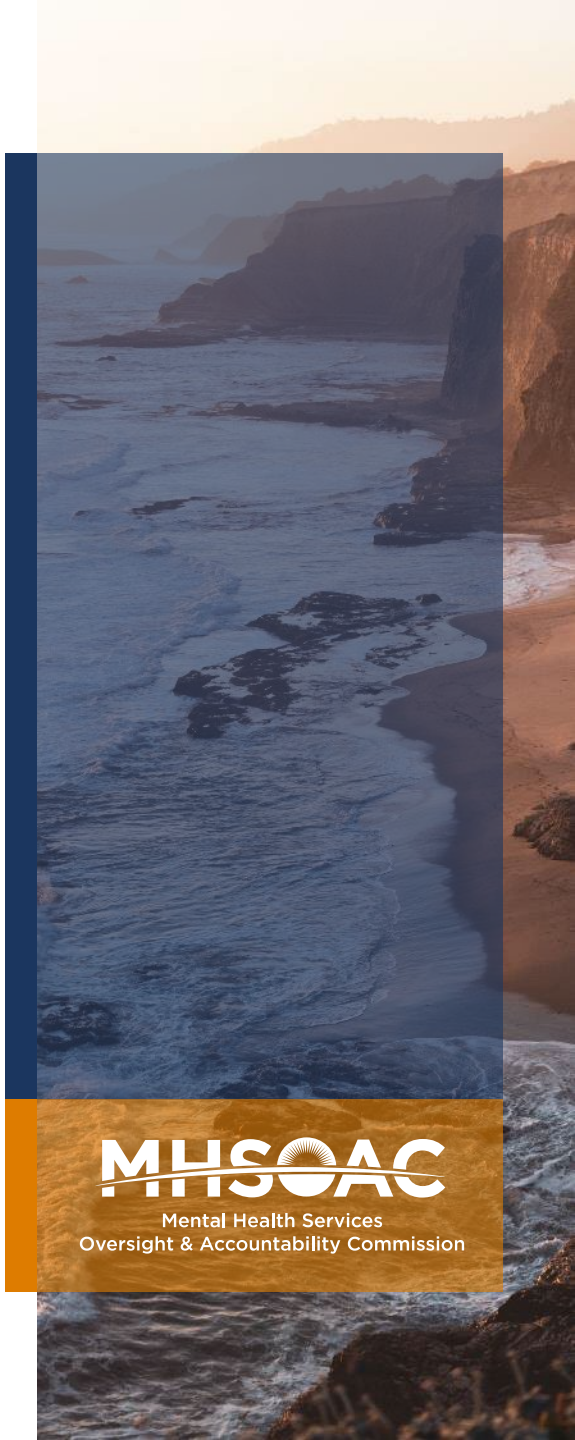
Next Steps: WestEd Evaluation

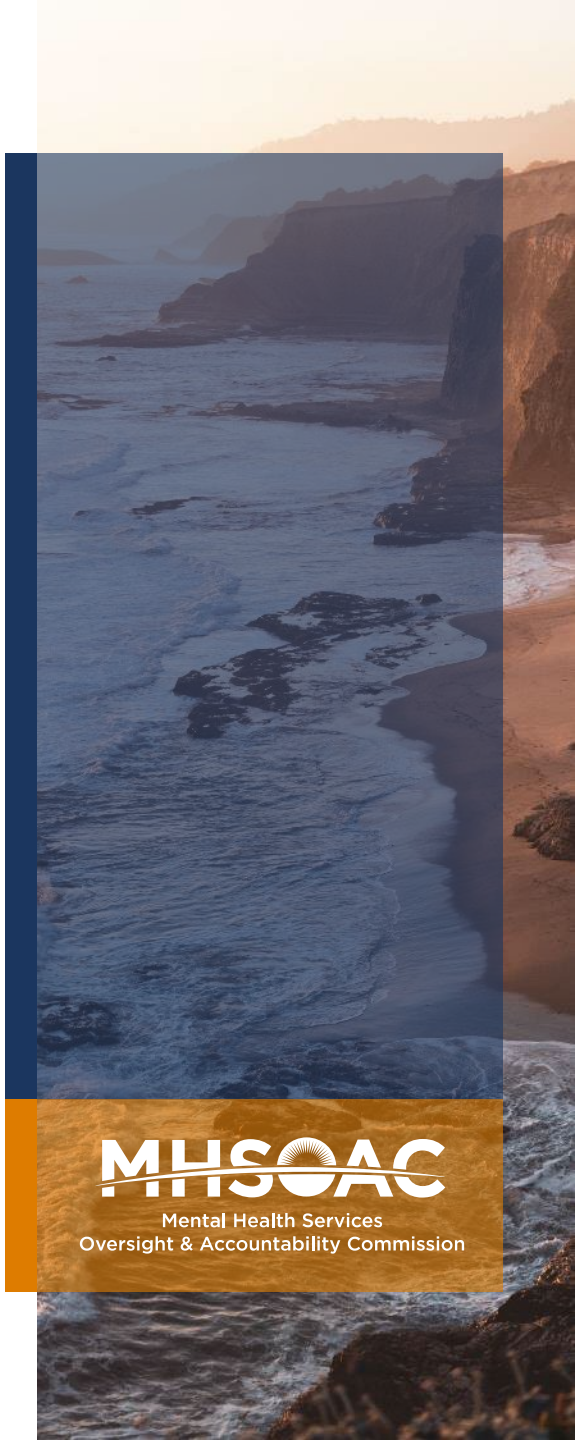
- **1.** Community Engagement
- **2.** Contextual Descriptive Analyses
- **3.** Process and Systems Change Evaluation
- **4.** Grantee Partnership Case Study
- **5.** Implementation and Impact School Case Study
- **6.** Dissemination and Strategic Communication



Proposed Motions

1) That the Commission approve the biennial progress report to the legislature on the Mental Health Students Service Act (MHSSA)

2) That the Commission approve a contract for up to $4 million for WestEd to begin Phase 2 of the MHSSA evaluation.



THANK YOU

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WestEd
WestEd.org

The Mental Health Student Services Act (MHSSA) Evaluation Plan

Prepared by WestEd
Submitted October 1, 2024

Draft

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WestEd is a nonpartisan, nonprofit organization that aims to improve the lives of children and adults at all ages of learning and development. We do this by addressing challenges in education and human development, reducing opportunity gaps, and helping build communities where all can thrive. WestEd staff conduct and apply research, provide technical assistance, and support professional learning. We work with early learning educators, classroom teachers, local and state leaders, and policymakers at all levels of government. For more information, visit WestEd.org.

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Executive Summary

The MHSSA Evaluation has been designed to measure how this early and substantial statewide investment has impacted interagency collaboration and transformational systems change to ultimately support schools in becoming centers of wellbeing and healing. The Evaluation has been codesigned by WestEd, the Mental Health Services Oversight & Accountability Commission (the Commission) and a broad group of community partners to ensure that the Evaluation reflects diverse community perspectives.

This technical report describes the plan for implementing the Mental Health Student Services Act (MHSSA) Evaluation based on a planning process that WestEd facilitated from June 2023 to October 2024. The report includes an introduction that describes the history and context of the MHSSA, and an overview of the multidisciplinary body of research and WestEd's community engagement findings that informed the MHSSA Evaluation Plan. The report then describes the MHSSA Evaluation Framework, which delineates the mechanisms of change underlying the intent and goals of the MHSSA, research questions, and a logic model depicting the relationships between inputs, activities, outputs, and outcomes of the MHSSA. Finally, the report details the MHSSA Evaluation Plan, including plans for sampling and recruitment, measures, methods, analysis, and reporting and dissemination. Included in this section is a description of community engagement and, when applicable, of technical assistance opportunities specific to all components of the MHSSA Evaluation Plan.

Through its participatory design, the MHSSA Evaluation will

- center the experiences and wisdom of those who are closest to school mental health systems, particularly those of youth;
- lift up community strengths;
- foster collaborative problem-solving with key partners and interest holders;
- facilitate authentic partnerships with youth to gather and make sense of data and meaningfully contribute to systems change within their communities; and
- encourage self-reflection and learning throughout all stages of the evaluation—individually and collectively.

The evaluation will be implemented November 2024–February 2027 and consists of four evaluation components:

1. Contextual Descriptive Analyses

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2. Process and Systems Change Evaluation
3. Grantee Partnership County Case Study
4. Implementation and Impact School Case Study

Table 1 provides an overview of the MHSSA Evaluation research questions, the components of the MHSSA Evaluation that will answer each research question, and the associated data sources.

Table 1. MHSSA Research Questions Addressed by Evaluation Component with Associated Data Sources

Research Question	Evaluation Component				Data Source
	1	2	3	4	
1. Who was involved in the MHSSA-funded partnerships?		X			Grantee Survey
2. What were the facilitators and/or barriers related to leadership teaming and collaboration?			X		Grantee Partnership Planning Process (G3P)
3. What were the facilitators and/or barriers related to the implementation of school mental health systems change at each level (county, district, school)?			X	X	G3P, MHSSA Implementation Liaison Interview
4. What was the relationship between MHSSA grantee partnerships and the county-level school mental health system?		X	X	X	Grantee Survey, Grantee Sensemaking Sessions, G3P, MHSSA Implementation Liaison Interview

5. What was the relationship between MHSSA-funded activities and services and the school-level mental health system?				X	MHSSA Implementation Liaison Interview, School Staff Focus Group (FG), School Mental Health Staff FG
6. What was the relationship between the county-level and the school-level mental health system?		X	X	X	Grantee Survey, Grantee Sensemaking Sessions, G3P, MHSSA Implementation Liaison Interview
7. How did the MHSSA grantee partnerships support the implementation of MHSSA-funded activities and services?			X	X	G3P, MHSSA Implementation Liaison Interview
8. What activities and services were implemented using MHSSA funding?		X		X	Grantee Survey, Grant Monitoring Data, MHSSA Implementation Liaison Interview
9. How were MHSSA-funded activities and services selected, designed, and implemented to close the equity gap?			X	X	G3P, MHSSA Implementation Liaison Interview, School Site Staff FG, School Mental and Behavioral Health Professional FG
10. What were the facilitators and/or barriers to implementing MHSSA-funded activities and services?				X	MHSSA Implementation Liaison Interview, School Site Staff FG, School Mental and Behavioral Health Professional FG

11. What were the mental health strengths and needs of young people and their school communities?	X	X	X	X	Grantee Survey, Grantee Sensemaking Sessions, California Healthy Kids Survey (CHKS), California Longitudinal Pupil Achievement Data System (CALPADS), US Census, California Open Data Portal, Project Implicit, G3P, School Site Staff FG, School Mental and Behavioral Health Professional FG, Student FG, Parent FG
12. How did community factors serve as facilitators and/or barriers to school mental health systems change at each level (county, district, school)?			X	X	CHKS, US Census, California Open Data Portal, Project Implicit, G3P, School Site Staff FG, School Mental and Behavioral Health Professional FG, Student FG, Parent FG
13. How did other school mental health initiatives serve as facilitators and/or barriers to the implementation of school mental health systems change at each level (county, district, school)?		X	X	X	Grantee Survey, Grantee Sensemaking Sessions, G3P, MHSSA Implementation Liaison Interview, School Site Staff FG, School Mental and Behavioral Health Professional FG
14. How did improvements in the school-level mental health system support students' mental health needs and for whom?			X	X	Grantee Survey, CHKS, CALPADS, G3P, Student FG, Parent FG

The MHSSA Evaluation Plan situates the MHSSA within California's larger school mental health landscape and builds on the understanding that mental health is inextricably linked to school success. The MHSSA Evaluation has been designed to capture how school communities across the state are reimagining school mental health systems in which students thrive and have access to effective mental health supports and services.

Introduction

Now more than ever, there is a nationwide focus on the urgency of addressing the mental health needs of young people. This complex challenge requires reimagining and transforming the systems that support the mental health and wellbeing of young people, their families, and the communities in which they learn and live (Office of the Surgeon General, 2021; United States Department of Health and Human Services, 2024). California has been a national leader responding to the call for school mental health systems change that leverages the strengths and resources of school communities.

History and Context of the MHSSA Evaluation

In August 2022, Governor Newsom and First Partner Jennifer Siebel Newsom launched the Master Plan for Kids' Mental Health—a 5-year initiative to address the significant mental health needs of students (California for All, 2023). This plan describes a fundamental overhaul of California's mental health system—boosting coverage options, service availability, and public awareness so that all children and youth are routinely assessed, supported, and served. As a key component of the governor's plan, the state allocated $4.7 billion to create the statewide Children and Youth Behavioral Health Initiative, designed and implemented by the California Health and Human Services agency with education agencies, other state agencies, and community partners.

Communities across California have also leveraged other statewide school mental health initiatives to support young people and their families. For example, the Student Behavioral Health Incentive Program supports the goals of California's Advancing and Innovating Medi-Cal (CalAIM) initiative and provides new investments in behavioral services, infrastructure, information technology and data exchange, and workforce capacity for school-based and school-affiliated behavioral health providers. In 2021, California invested $3 billion in the California Community Schools Partnership Program, which has since been extended to 2031. In 2022, the state also expanded the California Collaborative for Educational Excellence's Community Engagement Initiative, which builds the capacity of local education agencies (LEAs) for transformational community engagement. Further, in 2021, California appropriated $50 million to continue support for school- and districtwide implementation of services and practices within a multi-tiered system of support (MTSS) through the Scaling Up MTSS Statewide Partner Entity grant, which includes a focus on social and emotional learning; trauma-informed practices; and culturally relevant, affirming, and sustaining practices.

Led by the Mental Health Services Oversight and Accountability Commission (the Commission), the Mental Health Student Services Act (MHSSA) is one of California's historic investments to deliver timely, equitable, and quality mental health services

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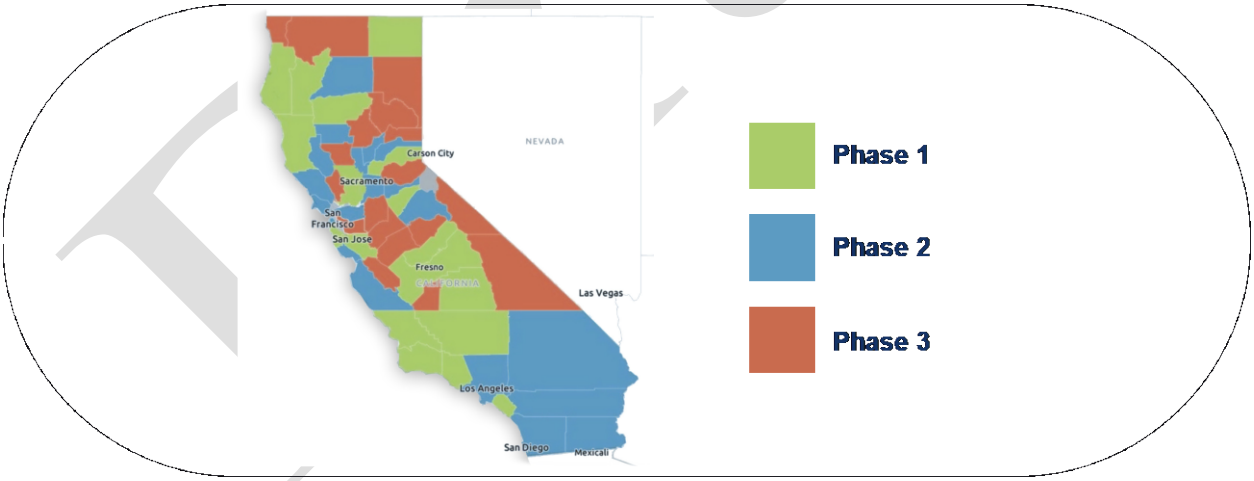
within school communities. The MHSSA was enacted in 2019 to provide financial support to counties in addressing student mental health needs related to COVID-19. Since its launch, the MHSSA vision has expanded to center schools as a core component of the community behavioral health system. To accomplish this, the MHSSA provided funding to incentivize change through local partnerships between county behavioral health departments and local education agencies (LEAs). In addition, the legislation offered flexibility in how funds are used to meet the diverse and immediate needs of counties across the state. MHSSA funding has been distributed across four phases. Phase 4 funding was announced in August 2024 and will provide $25 million to partnerships focused on the following priorities: (a) Marginalized and Vulnerable Youth, (b) Universal Screening, (c) Sustainability, and (d) "Other Priorities" to address unique needs within a county. The focus of the current statewide evaluation is on Phases 1–3.

Funding Phases 1 Through 3

In 2019, Senate Bill 75 established the MHSSA and provided $40 million in one-time and $10 million in ongoing funding to establish partnerships between county behavioral health departments and LEAs focused on school mental health systems change. To date, the Commission has provided MHSSA funds to support school mental health partnerships to 57 grantees for a total investment of $255 million. See Figure 1 for a map of the grantees by phase.

Figure 1. Grantees by Phase



For Phase 1, launched in 2020, awarded funding to a total of 18 grantees. The funding for these 4-year grants totaled $74,849,047. Grantees in this first phase included Calaveras, Fresno, Humboldt, Kern, Madera, Mendocino, Orange, Placer, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Solano, Tehama, Trinity-Modoc, Tulare, Ventura, and Yolo. Ten grantees received Category 1 (existing partnerships) funding, and eight grantees received Category 2 (new or emerging partnerships) funding. Of these Phase 1 grantees, five counties are urban, seven suburban, and six rural (the California State Association of Counties).

In response to a great deal of interest in the program, the Budget Act of 2021 allocated additional funding for applicants who applied but did not receive a grant during the initial phase. During this second phase, the Commission funded 19 new grantees in 2021 with a total of $77,553,078. Grantees that received Phase 2 funding included Amador, Contra Costa, Glenn, Imperial, Lake, Los Angeles, Marin, Monterey, Nevada, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, Santa Cruz, Shasta, Sonoma, Sutter-Yuba, and Tuolumne. Nine grantees received Category 1 (existing partnerships) funding, and 10 grantees received Category 2 (new or emerging partnerships) funding. Of these Phase 2 grantees, seven counties are urban, six are suburban, and six are rural.

In addition, the federal American Rescue Plan Act provided additional funds through the State Fiscal Recovery Fund. In 2022, the Commission funded 20 Phase 3 grantees with a total of $54,910,420. These grantees included Alameda, Berkeley City, Butte, Colusa, Del Norte, El Dorado, Inyo, Kings, Lassen, Mariposa, Merced, Mono, Napa, Plumas, San Benito, San Joaquin, Sierra, Siskiyou, Stanislaus, and Tri-City. For Phase 3, grantees were not asked to report if they had existing (Category 1) or new or emerging partnerships (Category 2). Of these Phase 3 grantees, 4 counties are urban, 4 are suburban, and 12 are rural.

To extend the work being done across the state, the Commission awarded $47,687,455 that had not been distributed to 41 grantees that had applied for it during the prior application phases. Due to this additional funding and extensions, all but 15 grantees' Phase 1-3 programs will end in 2026, with the majority ending on December 31, 2026.[1]

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[1] San Mateo's program end date is September 2024, and Orange, San Luis Obispo, Santa Clara, Solano, Trinity-Modoc, Tulare, Lake, Marin, Monterey, Nevada, Sacramento, Santa Cruz, Sonoma, and Tuolumne end in summer or fall 2025.

The MHSSA has had a broad reach, funding over 2,000 schools throughout the state, including 842 elementary schools, 304 middle schools, 425 high schools, and 564 combined schools.[2] Table 2 below details the number of MHSSA-funded schools by grade level and funding phase.

Table 2. Funded Schools by Phase

	Elementary Schools	Middle Schools	High Schools	Combined Schools	Total Schools
Phase 1 Grantees	288 (39.8%)	100 (13.8%)	150 (20.7%)	186 (25.7%)	724
Phase 2 Grantees	338 (43.4%)	120 (15.4%)	161 (20.6%)	161 (20.6%)	780
Phase 3 Grantees	216 (34.2%)	84 (13.3%)	114 (18.1%)	217 (34.4%)	631

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[2] Findings summarized in Table 2 were generated from a Commission file containing a list of schools funded by the MHSSA. The original file contained information about county name, district name, school name, and county-district-school (CDS) code. To create a more complete understanding of the school profile, the file was matched with raw data from the CDE's California school directory (https://www.cde.ca.gov/schooldirectory/). The school data was matched using the CDS code, which is the unique ID for each school. The combined files ultimately utilized the following information: CDS code, county name, district name, school name, school type, EIL name, and grades offered.

Using this information, WestEd categorized each school into the following categories: elementary school, middle school, high school, and combined schools. The categories served as a proxy for student ages. "Elementary school" included schools that served the ranges of PK–5, "middle school" included schools that served Grades 6–8, and "high school" included schools that served Grades 9–12. Schools that served a greater range of grades (e.g., K–8, 6–12) were categorized as "combined schools."

For a complete overview of grantee specific information, please see the Grantee Table document. This includes the phase of funding, grantee size, funding amount, program end date, and school level served by each grantee.

Activities and Services

Each MHSSA grantee has implemented a unique project plan based on local needs, priorities, and constraints. Grantee-specific project plans, as outlined in grant applications, Program Development Phase Plans, and MHSSA Grant Summaries, detail the activities and services each MHSSA-funded partnership planned to implement. County annual fiscal reports and hiring reports provide additional details on the roles and classifications of hired MHSSA personnel. These details offer a granular view of the distribution of funds across staff coordinating and/or implementing activities and services at the county, district, or school levels.

To inform the MHSSA Evaluation Plan, WestEd staff conducted a thematic analysis (Braun & Clarke, 2012) of the MHSSA Grant Summaries submitted to the Commission. This review provided a snapshot of a continuum of statewide MHSSA-funded activities and services (i.e., Tier I, Tier II, and Tier III), as well as information about grantees' proposed plans for implementation. Additionally, WestEd staff coded county-specific contextual information, target populations, and proposed MHSSA staff roles.

Contextual variables. Specific circumstances and elements shaped how grantees tailored their support and implement services. The majority of grantees (71.9%) identified specific populations they planned to support with their MHSSA funding. Regarding school level, 28.1 percent of grantees indicated a focus on high school, 15.8 percent on middle school, 12.3 percent on elementary school, and 5.3 percent on early childhood. Of the grantees, 19.3 percent specified that their services and activities would focus on underserved and/or high-need students, followed by foster care (12.3%) and LGBTQ+ (12.3%) youth. The majority of named MHSSA staff positions included mental health professionals, program managers and coordinators (a total of 33.3%), and care and systems navigators (a total of 26.3%). Finally, in terms of specific settings for accessing MHSSA services beyond schools, 22.8 percent of grantees proposed wellness centers, followed by various locations identified by only one or two grantees. Noteworthy settings specified included a school-based residential program, adult education site, and juvenile detention facility.

Implementation support. An MTSS framework was the most common implementation framework explicitly identified by grantees. Aligned with the MHSSA's focus on incentivizing change through partnerships, 79 percent of grantees included language about their partnerships and/or collaboration, and about half explicitly identified a specific team facilitating the implementation of MHSSA-funded activities and services. Staff training and professional development were noted in nearly half of the grant summaries, followed by numerous other examples of implementation supports for systems capacity building and sustainability. This included communication capacity, systems coaching/consultation, leveraging of various funding streams, procedure and protocol development. The most common types of data use included mental health screening (both universal and targeted, 45.6%), individual assessment (31.6%), and progress monitoring (17.5%).

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Tier I, Tier II, and Tier III. Proposed activities and services were focused across all three tiers. Specifically, 80.7 percent of grantees proposed Tier I activities and services, 68.4 percent Tier II activities and services, and 98.3 percent Tier III activities and services. At Tier I, mental health awareness and literacy promotion and training activities (63.2%) were the most common, followed by mental health and wellness training/skill-building programs that were not further specified (31.6%), and suicide prevention (26.3%). At Tier II, the most common activities and services were unspecified groups (35.1%) and peer-to-peer support/mentoring (19.3%). At Tier III, the most reported activities and services were individual counseling, therapy, and/or supports (86%) and comprehensive case management, including systems navigation, referral, and outreach/engagement (57.9%). Finally, 45.6 percent of grantees proposed crisis intervention services. Table 3 provides a summary of identified MHSSA Tier I, Tier, II, and Tier III services and activities as well as implementation supports across the three phases of grantees.

Table 3. Services, Activities, and Supports by Phase

	Tier I	Tier II	Tier III	Implementation Supports
Phase 1 (n = 18)	77.8% (14)	77.8% (14)	100% (18)	94.4% (17)
Phase 2 (n = 18)	88.9% (16)	61.1% (11)	94.4% (17)	88.9% (16)
Phase 3 (n = 21)	76.2% (16)	66.7% (14)	100% (21)	100% (21)

Grantees in Phases 2 and 3 followed a similar pattern of being most likely to report Tier III supports, followed by Tier I and then Tier II. Phase 1 grantees were equally likely to mention Tier I and Tier II supports. Every Phase 3 grantee discussed how they planned to support MHSSA implementation, as did the majority of Phase 1 and Phase 2 grantees.

Theoretical and Methodological Foundations

The MHSSA Evaluation Plan is informed by a multidisciplinary body of research literature. This research contextualizes the findings from WestEd's community engagement efforts and review of program documents and activities. The plan integrates insights from several research areas and methodologies:

- school mental health systems change
- developmental systems change evaluation and systems thinking
- case-centered research design
- implementation science
- antiracist participatory research

School Mental Health Systems Change

Schools are a natural setting for comprehensive mental health services. The MHSSA provides an opportunity for transforming systems through critical partnerships to create culturally responsive and sustainable conditions that support the mental health and wellbeing of California's diverse school communities.

Comprehensive school mental health systems build capacity among partners to support a full continuum of culturally responsive and sustainable interventions. Such interventions promote mental health and wellbeing while reducing the prevalence and severity of emotional and behavioral problems (Lazarus et al., 2021). School mental health systems are characterized as a cross-agency MTSS designed by and uniquely for a school community (Stephan et al., 2015; U.S. Department of Education, 2021; Weist et al., 2018).

Evolving from a public health approach, this multi-tiered implementation framework targets upstream determinants of mental health (Dopp & Lantz, 2020; Forman, 2015). Primary prevention (Tier 1) aims to address risk factors and promote protective factors, and secondary prevention (Tier II) and tertiary (Tier III) prevention aim to reduce the duration of mental health challenges (Forman, 2015; National Research Council and Institute of Medicine, 2009).

Developmental Evaluation and Systems Thinking

Developmental evaluation offers a framework to measure the impact of systems change initiatives, particularly in complex environments where linear evaluation approaches may not sufficiently account for context. This framework accounts for the complexity of school mental health systems change, which is driven by the unique context of each school, district, and county in which the MHSSA is implemented.

Systems thinking is at the core of this approach to evaluation, which asserts that the whole is greater than the sum of its parts. Complex systems are dynamic and change

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over time, and it is the role of the evaluator to examine the ways in which the key features of the system interact and measure the ways in which those interactions support systems change.

Developmental evaluation centers on key dynamics, or "parts" of a system, encompassing the following: understanding interrelationships; engaging with multiple perspectives; and reflecting on the definition, complexity, and challenges of assessing systems and the interventions within them (Patton, 2015). This dynamic framework informs how the MHSSA Evaluation is designed and, critically, keeps the focus on systems change and the relationships across all parts of the MHSSA and its implementation across the state (McGill et al., 2021).

Case-Centered Research Design

Case-centered research design is focused on one or more cases, which can be understood as complex social units. Throughout the research process, cases are examined within their entirety, thus maintaining the cohesiveness of the social unit (Roller & Lavrakas, 2015). WestEd will employ a collective case study design in the MHSSA Evaluation. Methodologists posit that the utility of a collective, or multiple case design, is the examination of the specifics of a single case to illuminate themes that are more broadly applicable (Stake, 1995). Within a statewide evaluation such as the MHSSA, the study of multiple cases facilitates the evaluation's understanding of a broader set of research questions.

Critical to this approach is acknowledging the limitations to external validity. Evaluators must be cautious in generalizing from a small group of cases to a broader group of cases that are made up of a different set of complex features (Roller & Lavrakas, 2015). The MHSSA will use a sampling approach that will result in selecting sample counties and schools with a diverse set of characteristics to mitigate some challenges to external validity. However, WestEd will articulate the limits to the evaluation's ability to generalize based on a small sample of cases.

Implementation Science

Implementation science provides a framework for understanding continuous improvement processes, where implementation variables influence intervention outcomes (Durlak & DuPre, 2008; Fixsen et al., 2005; Sanetti & Kratochwill, 2009). This understanding is critically important for scaling practices to achieve a socially meaningful impact (Horner et al., 2017; Kania et al., 2018). However, beyond changing the practices that have long maintained the status quo of how young people experience mental health supports and services, transformational change will also require what Blasé et al. (2015) describe as "changing hearts, minds, and behavior" among leaders, practitioners, and educators.

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The statewide MHSSA Evaluation provides a unique opportunity to better understand behavioral health and education systems conditions as they relate to partnership capacity to effectively facilitate implementation of MHSSA-funded activities (i.e., who is doing what and how) and continuous improvement toward sustainable school mental health service delivery. In response to requirements stated under WIC Section 5886(k), the MHSSA Evaluation must build the capacity of MHSSA grantees for data-driven approaches informing continuous improvement toward effective and sustainable school mental health systems.

Antiracist Participatory Research

In the work to center equity, the MHSSA Evaluation Plan is guided by antiracist evaluation principles. WestEd's approach to antiracist evaluation centers critical self-reflection and learning; collaborative and equitable partnerships; and attention to cultural, historical, and political contexts throughout all stages of the evaluation (WestEd, 2021). This approach centers close collaboration with those who are most proximal to the program, the initiative, or the organization that is being evaluated.

The MHSSA Evaluation Plan integrates the perspectives and expertise of partners, including Commission staff, county behavioral health staff, county and LEA staff, youth, families and caregivers, subject matter experts, school staff, mental and behavioral health professionals, and evaluation partners. WestEd's antiracist community engagement model, which informed the development of the statewide MHSSA Evaluation Plan, consisted of four primary activities:

- **Relationship building.** Community engagement activities began with building relationships with several key partners and interest holders. These included the Commission Research and Evaluation Division (RED) team, the Community Engagement and Grants (CEG) team, the MHSSA Research and Evaluation Workgroup, Commission staff, MHSSA grantees, behavioral and mental health providers, school staff, families and caregivers, and youth. The goal was to foster relational trust, shared goals, and a unified vision for the MHSSA Evaluation.
- **Listening sessions.** The WestEd team met virtually with partners to learn about the shared and unique goals of the MHSSA for grantees and school-level implementers, the components of grantee partnerships, implementation strategies, and the outcomes that are meaningful and useful to different partner groups.
- **Sense making.** WestEd collected written feedback and met virtually with partners throughout the planning process to collect feedback on the emerging MHSSA Evaluation Plan. Partners have seen and responded to each major evaluation component.
- **Partnering with youth.** As part of the evaluation planning process, WestEd convened a group of 15 youth to make up a youth advisory group (YAG) that met monthly from February 2024 to September 2024. WestEd facilitators taught youth

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about evaluation and created interactive activities for youth to share their ideas, thoughts, and recommendations for the MHSSA Evaluation. Through these activities and discussions, WestEd learned about the MHSSA Evaluation outcomes most important to young people, their priorities for the evaluation, strategies to engage young people in schools, and how youth voice should be incorporated into the evaluation.

Methodological Constraints and Community Priorities

The MHSSA, together with the rest of California's historic investments in student mental health, promises transformational change within the state's school mental health system. However, the extent to which each statewide initiative drives systems change, builds upon other initiatives, and contributes to positive outcomes for students, families, and school communities has yet to be evaluated. There are several methodological constraints and, as previously highlighted, priorities that emerged from community engagement with partners and interest holders during the MHSSA Evaluation planning phase.

Each MHSSA grantee has taken a unique approach to funding supports that address student mental health needs and improve student wellbeing. This is because the MHSSA provides critically important flexibility for grantee partners to innovate. However, this flexibility introduces methodological challenges in evaluating the statewide implementation of a heterogeneous set of MHSSA-funded activities and services.

An additional challenge for this evaluation's design relates to the timeline of MHSSA implementation versus that of the MHSSA Evaluation. As previously noted, the statewide MHSSA Evaluation planning process occurred between June 2023 and October 2024. Meanwhile, MHSSA program implementation has been underway since the first phase of funding in 2020, and for some counties, funding ends as early as fall 2024. Therefore, the MHSSA Evaluation Plan accounts for varying start and end dates across the three phases of funding (see the Grantee Table document).

Table 4 reflects the program implementation timeline for each phase of MHSSA funding and the timeline for the evaluation planning and implementation periods.[3] This timeline presents constraints on the methods that can be used, particularly quantitative research methods that require a baseline comparison.

[3] All dates identified in this report are subject to change dependent upon WestEd's evaluation contract execution date.

Table 4. Grant Phases and Proposed Evaluation Timeline

	2020	2021	2022	2023	2024	2025	2026	2027
Grant Phase								
Phase 1	2020–2026							
Phase 2			2022–2026					
Phase 3				2023–2026				
Proposed Evaluation Timeline								
Planning				2023–2024				
Implementation					2024–2027			

One critical feature of any evaluation plan is its clear alignment with the evaluation framework, which includes conceptual and measurement models, research questions, and a logic model (Ravitch & Riggan, 2016). In developing the MHSSA Evaluation Framework, WestEd utilized an iterative process that began with developing a framework inclusive of those outputs and outcomes specified in Welfare and Institutions Code section 5886(k). This initial framework served as a starting point for conversations with community partners, leading to a series of revisions that now yield a framework that is more reflective of community needs and perspectives. Through this community engagement process, WestEd learned about the evaluation outputs and outcomes that various groups found to be meaningful and useful.

The WestEd team also engaged in a systematic metrics mapping process. This process helped to determine the feasibility of measuring each output and outcome specified in legislation. This process yielded an additional set of practical and methodological constraints that further informed the revision of the MHSSA Evaluation Framework and the broader MHSSA Evaluation Plan. To the greatest extent possible, WestEd has developed a plan that aligns with Welfare and Institutions Code section 5886(k) and with community needs and perspectives.

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The MHSSA Evaluation Framework

The MHSSA Evaluation Framework, the foundation of the statewide evaluation, encompasses

- the MHSSA Conceptual Model, which illustrates the mechanisms of change underlying the intent and goals of the MHSSA and represents the relationships between represented elements;
- the MHSSA Logic Model, which depicts the relationships between inputs, activities, outputs, and outcomes for MHSSA;
- research questions that align with the Conceptual Model; and
- measurement models that operationalize each element within the Conceptual Model.

The MHSSA Evaluation Framework is informed by a diverse body of literature, the distinctive characteristics of the California landscape, and findings from extensive engagement with a broad range of community partners and interest holders from across the state.

MHSSA Conceptual Model

The MHSSA Conceptual Model (Figure 2) illustrates the a priori, hypothesized mechanisms of change underlying the intent and goals of the MHSSA and represents the relationship between elements within the model. While acknowledging that additional elements and relationships might exist, this Conceptual Model provides the most direct and measurable framework to evaluate the implementation and impact of the MHSSA.

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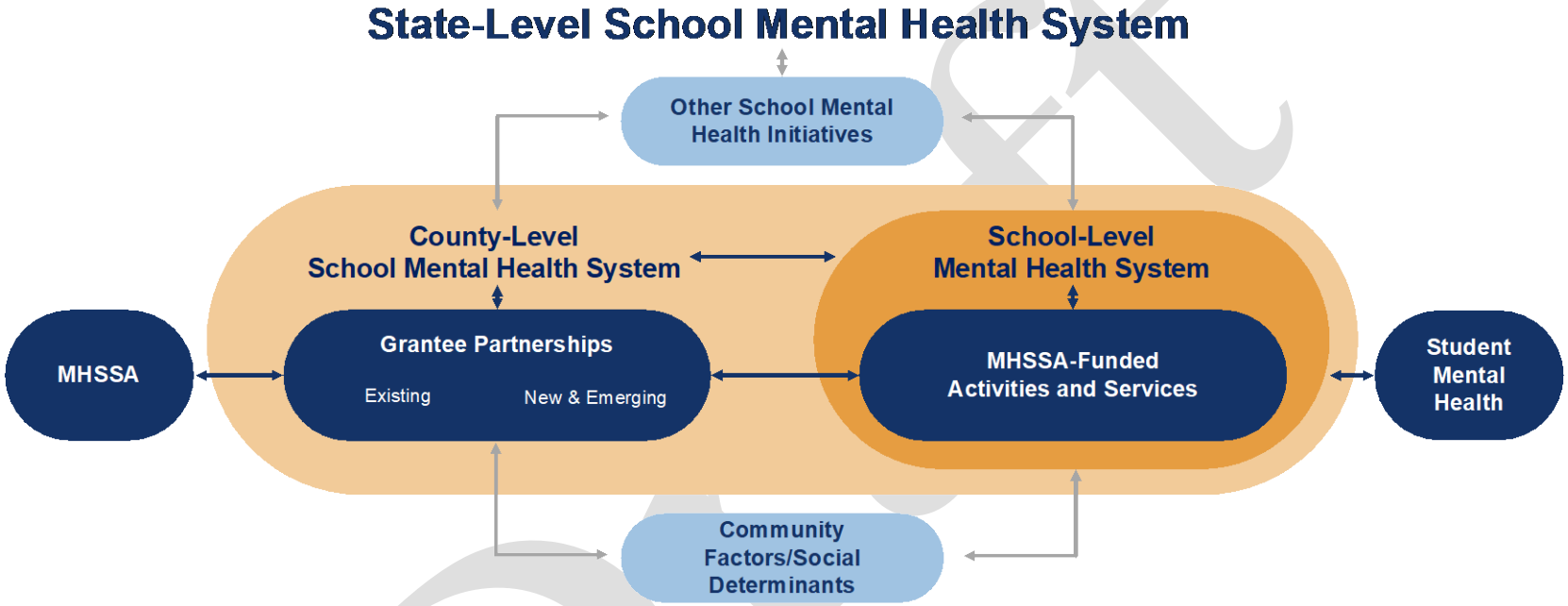
Figure 2. The MHSSA Conceptual Model



Note. Districts are represented both within grantee partnerships—as they collaborate with the county-level school mental health system—and within MHSSA-funded activities and services—as they provide leadership and support to school-level mental health systems.

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This evaluation does not attempt to isolate the MHSSA's unique effect on a series of distal outcomes. Instead, it focuses on two vital relationships: MHSSA grantee partnerships and the county-level school mental health systems, and MHSSA-funded activities and services and the school-level mental health system. The evaluation framework emphasizes the cumulative effect of school mental health systems change through MHSSA grantee partnerships and MHSSA-funded activities and services on schools and young people.

The Conceptual Model illustrates how the MHSSA supports establishing new and emerging partnerships, or leveraging existing partnerships, between county behavioral health departments and Local Education Agencies (LEAs). These partnership teams design MHSSA-funded activities and services that are implemented within county, district, and/or school communities.

This model takes a complex systems approach, depicting the interrelated and interactive parts of school mental health systems at the state, county, and school levels. The Conceptual Model uses bidirectional arrows to illustrate the feedback loops that reflect the nonlinear nature of the MHSSA mechanisms of change (Mayne, 2023).

The model's logic posits that effective grantee partnerships facilitate transformational change toward one cohesive county-level school mental health system. Similarly, the model assumes that the implementation of MHSSA-funded activities and services impacts and is impacted by transformational change toward one cohesive school-level mental health system. The model also depicts the bidirectional relationship between the county-level and school-level mental health system such that change within one system can facilitate change within the other system.

The Conceptual Model represents two key factors that influence the MHSSA's implementation and impact: community factors and other school mental health initiatives. Counties, districts, and schools throughout California are layering, blending, and braiding funds to meet the distinct mental health needs of the young people within their communities. Each MHSSA grantee contributes to this effort by funding school mental health activities and services to improve the mental health of select school communities within their county and to improve student wellbeing. The MHSSA functions as one of several inputs within this complex and contextually unique system. Its impact may be diminished or amplified depending on the system's overall response to these many inputs (McGill et al., 2021).

In California's vast and diverse landscape, it is critical that this evaluation considers the community context and the interplay between the MHSSA; other school mental health initiatives; and the federal, state, and local funding streams.

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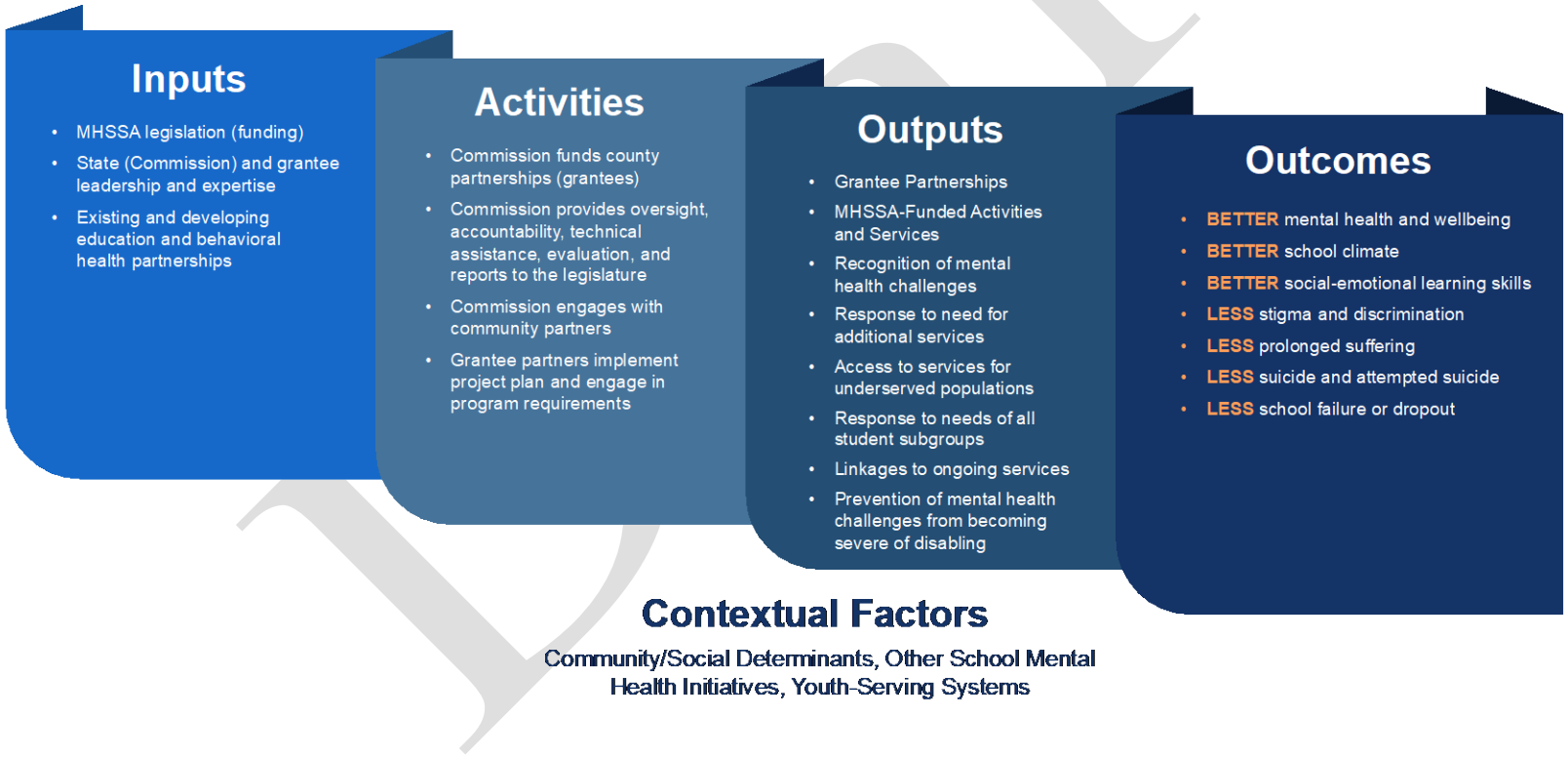
Logic Model

The MHSSA Logic Model (Figure 3) depicts the relationships between resources and inputs, activities, outputs, and outcomes, in alignment with the Conceptual Model, while also incorporating contextual factors, community and social determinants, other school mental health initiatives, and youth-serving systems.

Figure 3. The MHSSA Logic Model



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The MHSSA Logic Model identifies key inputs such as MHSSA legislation and funding, Commission and grantee leadership and expertise, and partnerships between education and behavioral health agencies. The activities that follow these inputs include the Commission funding grantee partnerships; providing ongoing oversight, accountability, technical assistance, and evaluation support; reporting to the legislature, and facilitating engagement with community partners. Finally, activities include the implementation of project plans by grantee partners.

The outputs resulting from these activities are multifaceted: they include the formation or strengthening of grantee partnerships, whereby MHSSA partners collaboratively work with districts to support schools with implementing MHSSA-funded activities and services. Additional outputs, aligned with those in the Conceptual Model and Welfare and Institutions Code section 5886(k), encompass recognition of mental health challenges, response to the need for additional services, access to services for underserved populations, response to the needs of all student subgroups, linkages to ongoing services, and prevention of mental health challenges from becoming severe or disabling.

The outcomes listed in the Logic Model include improving mental health and wellbeing, improving school climate, reducing stigma and discrimination around mental health challenges, reducing prolonged suffering, increasing social–emotional learning skills, reducing suicide and attempted suicide, and reducing school failure or dropout.

Measurement Models and Research Questions

The measurement models (Figures 4-8) operationalize the elements of the MHSSA Conceptual Model, outlining the theoretical underpinnings of each element, anchoring them within their respective bodies of research. At the end of each measurement model section are the research questions aligned with the MHSSA Conceptual Model element, and together, these sections shape the MHSSA Evaluation Plan. All research questions, organized by conceptual model element, are presented in Table 5.

Table 5. MHSSA Research Questions

Conceptual Model Element	Research Question
Grantee Partnership	1. Who was involved in the MHSSA-funded partnerships?
	2. What were the facilitators and/or barriers related to leadership teaming and collaboration?

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County-Level and School-Level Mental Health System	3. What were the facilitators and/or barriers related to the implementation of school mental health systems change at each level (county, district, school)?
	4. What was the relationship between MHSSA grantee partnerships and the county-level school mental health system?
	5. What was the relationship between MHSSA-funded activities and services and the school-level mental health system?
	6. What was the relationship between the county-level and the school-level mental health system?
MHSSA-Funded Activities and Services	7. How did the MHSSA grantee partnerships support the implementation of MHSSA-funded activities and services?
	8. What activities and services were implemented using MHSSA funding?
	9. How were MHSSA-funded activities and services selected, designed, and implemented to close the equity gap?
	10. What were the facilitators and/or barriers to implementing MHSSA-funded activities and services?
Community Factors	11. What were the mental health strengths and needs of young people and their school communities?
	12. How did community factors serve as facilitators and/or barriers to school mental health systems change at each level (county, district, school)?
Other School Mental Health Initiatives	13. How did other school mental health initiatives serve as facilitators and/or barriers to the implementation of school mental health systems change at each level (county, district, school)?
Meaningful and Equitable Outcomes	14. How did improvements in the school-level mental health system support students' mental health needs and for whom?

Equity-Centered School Mental Health Systems

The MHSSA Conceptual Model represents the interrelated mechanisms of the school mental health system. It shows the bidirectional relationships at the county, district, and school levels within the larger state context. Sustainable implementation of a school mental health system requires partnerships that facilitate alignment and coordination of the school mental health service delivery system across these levels. A school mental health system is a continuum of tiered interventions within an MTSS framework that creates conditions to promote the mental health and wellbeing of everyone within a school community (Barrett et al., 2013; Hoover et al., 2019; U.S. Department of Education, 2021; Weist et al., 2018). Figure 4 depicts critical components of a school mental health system engaging in continuous improvement towards meaningful and equitable mental health outcomes. While the county- and school-level mental health systems each play a distinct but interconnected role in facilitating school mental health systems change, these critical components apply to all levels (county, district, school) of the school mental health system.

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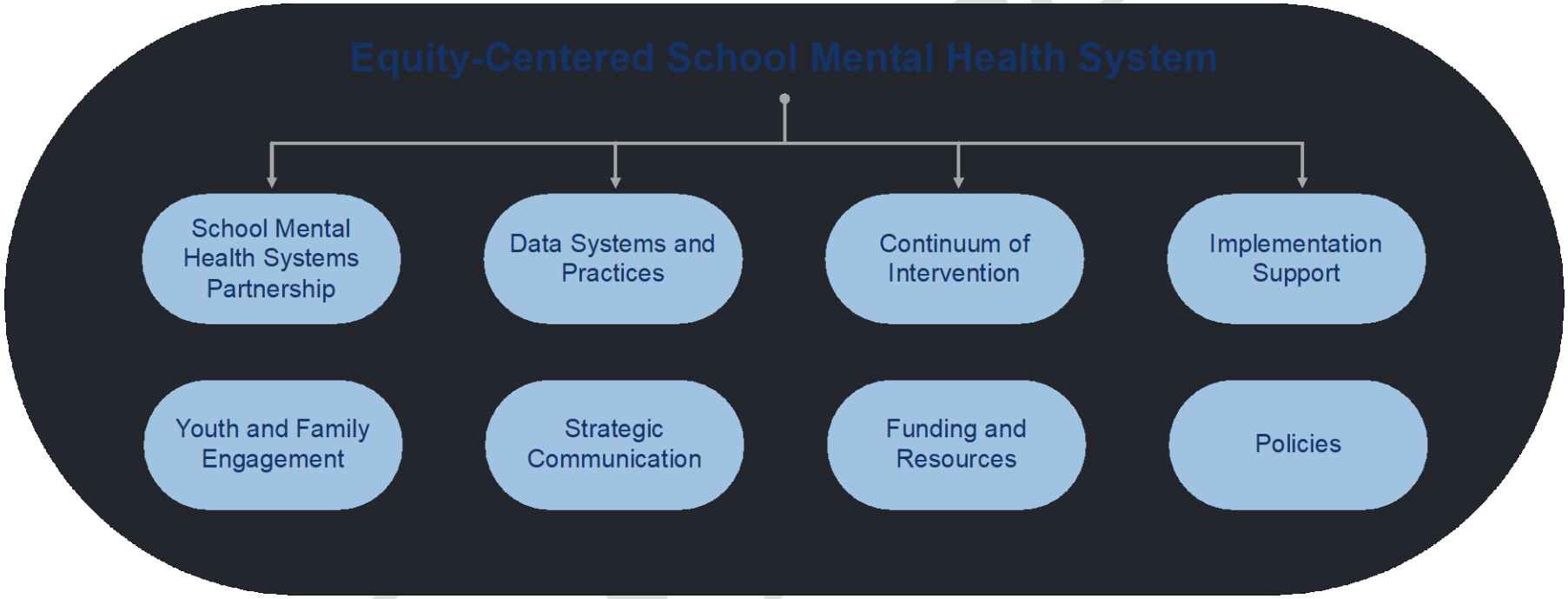
Figure 4. Measurement Model of Equity-Centered School Mental Health Systems



Equity-Centered School Mental Health System Research Questions

- What were the facilitators and/or barriers related to the implementation of school mental health systems change at each level (county, district, school)?
- What was the relationship between MHSSA grantee partnerships and the county-level school mental health system?
- What was the relationship between MHSSA-funded activities and services and the school-level mental health system?
- What was the relationship between the county-level and the school-level mental health system?

Grantee Partnerships

The vision guiding the MHSSA was to transform schools into centers of wellbeing that address students' unmet needs and improve their access to services. To that end, the MHSSA aims to foster stronger school–community mental health partnerships that can leverage resources to bolster student success. This goal is achieved by incentivizing counties and LEAs to establish partnerships that provide a comprehensive and integrated model of school mental health services.

School mental health systems bring together partners to align and coordinate supports and services (Barrett et al., 2017; CCSSO and NCSMH, 2021), thus expanding access to services for young people and their families. While MHSSA partnerships range from existing to new and emerging, they are the proximal result of the MHSSA and are an integral part of all subsequent MHSSA-funded activities and services implemented in schools and communities. Therefore, the MHSSA Evaluation focuses on measuring the strengthening or formation of partnerships.

The specific roles and responsibilities of school and behavioral health partners will vary by community and team. However, collaborative practices and teaming are critical at all levels of the service delivery system (state, county, district, and school) to ensure the ongoing implementation of a culturally responsive and sustainable school mental health system (Bohnenkamp et al., 2023; Eber et al., 2019; Malone et al., 2022).

Figure 5 illustrates the MHSSA partnerships, encompassing both those that are existing and those that are newly developed. People, teaming practices, and collaboration form the core components of each of these partnerships. The people component involves the leadership team's composition, roles, and participation—essentially, the "who." The teaming practices and procedures of cross-agency leadership teams (e.g., operating procedures; data-based decision-making informed by school, community, and student data; referral pathway protocols; data sharing; meeting agendas and action plans) are essential for implementing an integrated school mental health system (Weist, Garbatz, Lane, & Kincaid, 2017; Splett et al., 2017).

Finally, the collaboration component involves sharing knowledge and resources to accomplish more than either agency could do on its own (Mellin & Weist, 2011). It has been characterized by newly defined relationships and roles, interdependence, and collective ownership and accountability and through shifting beliefs, establishing a shared understanding, and addressing power disparities (Bronstein, 2003; Mellin & Weist, 2011; Splett et al., 2017).

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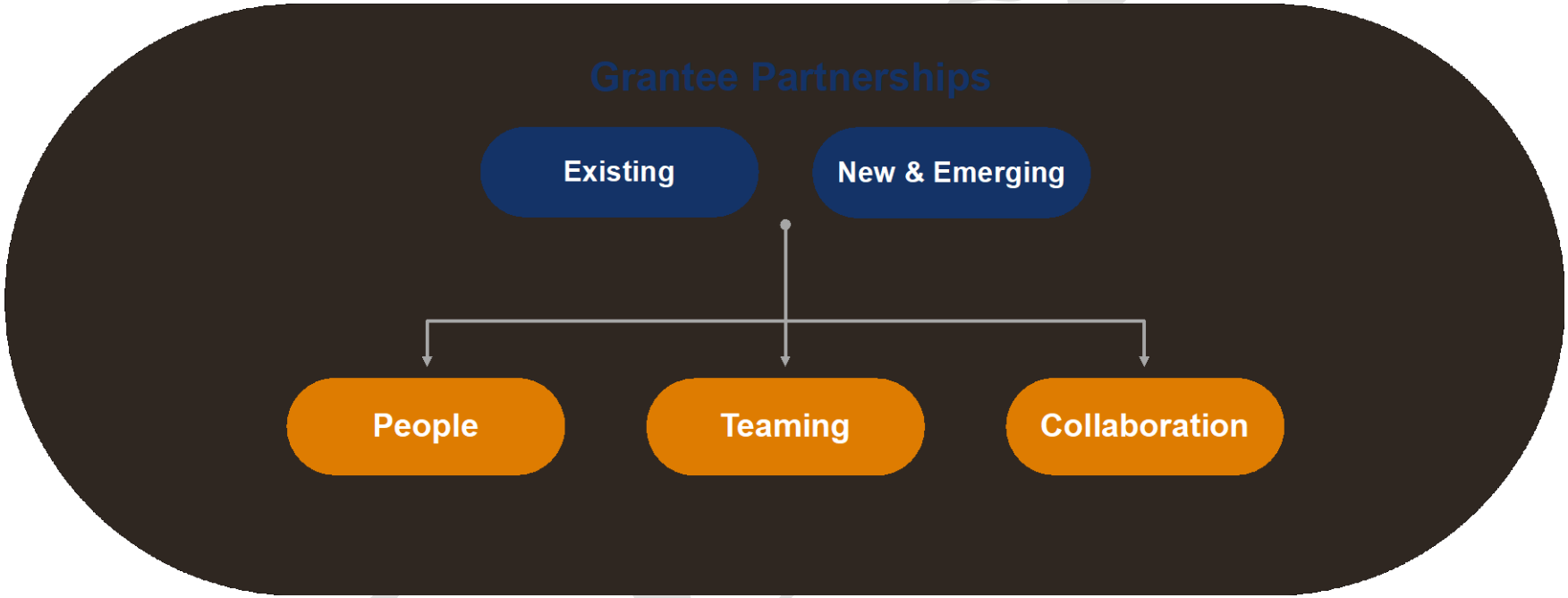
Figure 5. Measurement Model of Grantee Partnerships



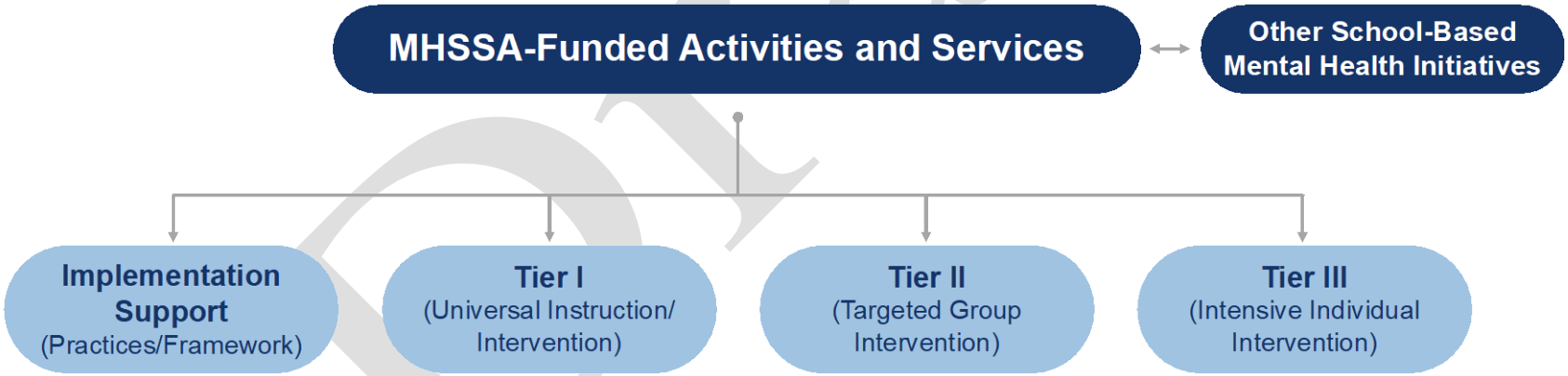
Grantee Partnership Research Questions

- Who was involved in the MHSSA-funded partnerships?
- What were the facilitators and/or barriers related to leadership, teaming, and collaboration?

MHSSA-Funded Activities and Services

The groupings of MHSSA-funded activities and services (Figure 6) are derived from a comprehensive review of all documents from grantees and the Commission, the Grant Summaries Review, and feedback collected from community engagement activities. As detailed previously, these activities and services have been organized into four main categories: implementation support, Tier I, Tier II, and Tier III. It is important to note that grantees often implement MHSSA-funded activities and services across multiple categories. Thus, MHSSA-funded activities and services will be reflected in nuanced classifications within the evaluation's analysis and reporting.

Figure 6. Measurement Model of MHSSA-Funded Activities and Services



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As previously stated, MHSSA-funded activities and services occur within a broader mental health landscape of state, county, and school levels. As such, other school mental health initiatives, and their associated funding streams, may have impacted the selection and implementation of MHSSA-funded activities and services. The relationship between MHSSA-funded activities and services and other school mental health initiatives is bidirectional. MHSSA-funded activities and services can also influence how schools, districts, or counties implement other mental health initiatives.

MHSSA-Funded Activities and Services Research Questions

- How did the MHSSA grantee partnerships support the implementation of MHSSA-funded activities and services?
- What activities and services were implemented using MHSSA funding?
- How were MHSSA-funded activities and services selected, designed, and implemented to close the equity gap?
- What were the facilitators and/or barriers to implementing MHSSA-funded activities and services?

Meaningful and Equitable Outputs and Outcomes

The statewide MHSSA Evaluation Plan provides an a priori theoretical map of the ways in which this initiative positively impacts school mental health systems change and students. Within the plan, the focus is on outputs and outcomes that are meaningful—that is, facilitate learning and continuous improvement to key partners and interest holders—and that center equity and aim to close the equity gap.

The outputs and outcomes listed in Figure 7 were identified through an iterative process that originated from the outcomes specified in Welfare and Institutions Code section 5886(k). Community partners contributed to refining these initial outcomes, aiding the WestEd team in broadening our conceptualization of impact. This iterative process led WestEd to reimagine the ways in which outputs and outcomes relate to the broader model and are incorporated into the MHSSA Evaluation Framework.

Outputs are defined as changes resulting from MHSSA activities that are relevant to the achievement of outcomes. In other words, the implementation of an MHSSA-funded activity or service resulted in the outputs listed below. In the MHSSA Conceptual Model, these outputs are measured as part of the school-level mental health systems change construct.

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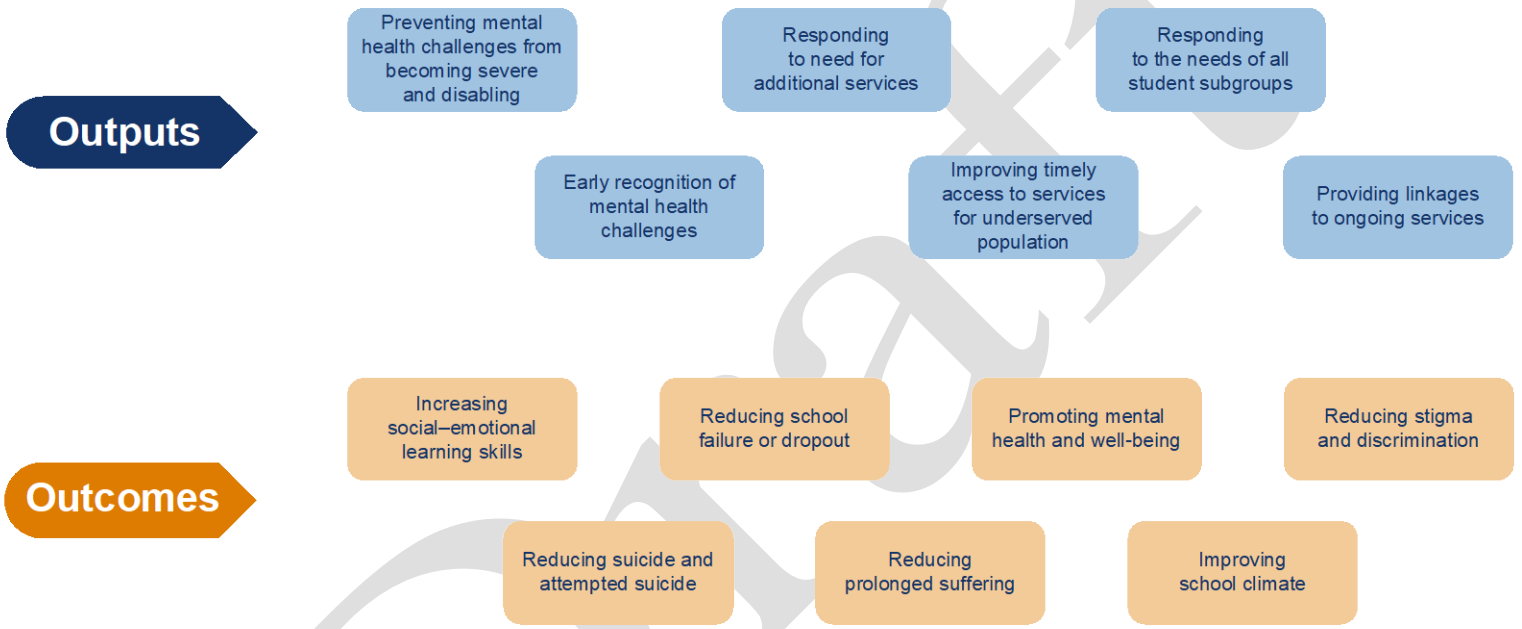
Figure 7. Measurement Model of the Meaningful and Equitable Outputs and Outcomes of the MHSSA



Meaningful and Equitable Outcomes Research Question

- How did improvements in the school-level mental health system support students' mental health needs and for whom?

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Community Factors

Community factors play an integral role in child and youth development, impacting achievement, health, and wellbeing (Bronfenbrenner, 1979; Center for Health and Health Care in Schools [CHHCS] et al., 2020). A common method of conceptualizing community factors is viewing them as social influencers. Social influencers of health and education refer to the characteristics of children's and youths' local environment that affect a broad range of health, wellbeing, and learning outcomes (Braveman & Gottlieb, 2014; CHHCS et al., 2020, 2021). This includes, for example, access to safe and stable housing, food security, neighborhood social connectedness, access to important resources, and language barriers. Each of the identified community factors can be a source of strength (e.g., strong public transportation options making access to services possible) or a barrier (e.g., lack of public transportation preventing access to services). As depicted in Figure 8, the MHSSA Evaluation will account for these important influencers, for which there is tremendous variability across the state.

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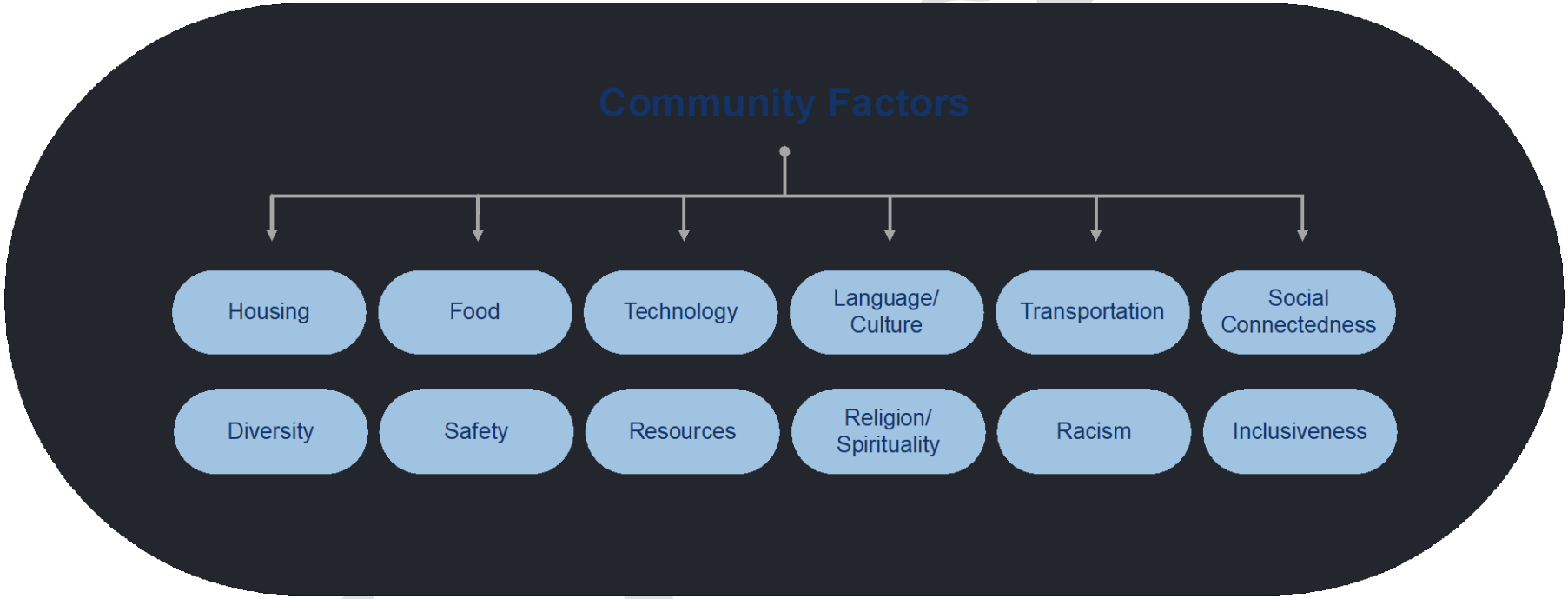
Figure 8. Measurement Model of Community Factors



Community Factors Research Questions

- What were the mental health strengths and needs of young people and their school communities?
- How did community factors serve as facilitators and/or barriers to school mental health systems change at each level (county, district, school)?

Other School Mental Health Initiatives

This evaluation examines the implementation and impact of the MHSSA within the broader school mental health landscape, particularly focusing on how counties and schools access/leverage funding streams to support school mental health systems change. Fiscal sustainability is an area of great interest among MHSSA partners. The evaluation will explore the ways in which county- and school-level decision-makers have utilized other school mental health funds to sustain the work of the MHSSA. It will also investigate the MHSSA's relationship with other program-funded services and activities, exploring their cumulative impact on school mental health systems at the county, district, and school levels.

Other School Mental Health Initiatives Research Question

- How did other school mental health initiatives serve as facilitators and/or barriers to the implementation of school mental health systems change at each level (county, district, school)?

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MHSSA Evaluation Plan

The purpose of an evaluation plan is to outline how data will be collected and analyzed to answer key evaluation questions (Brinkerhoff et al., 1983). It ensures that the evaluation is methodologically sound, allows for credible and reliable results, and enhances the transparency and accountability of the evaluation process.

Integrating Community Engagement Conducted During Evaluation Planning into the Evaluation Design

The MHSSA Evaluation design incorporates feedback from a diverse group of community partners and interest holders. WestEd identified key themes from all community engagement meetings during the planning phase and summarized the findings by each MHSSA Evaluation design component below.

Ongoing Community Engagement

WestEd has made significant investments in community engagement activities to foster trust, solicit feedback, collaborate, and codesign with partners. A principal insight from those activities is that partners value having a voice in the evaluation process and are committed to ongoing collaboration as the MHSSA Evaluation Plan is implemented. During listening sessions, partners conveyed the importance of being consulted and having opportunities to provide feedback to WestEd regarding questions or concerns related to the evaluation. They expressed appreciation when WestEd shared back a summary of their input, stating that this made them feel like the WestEd team cared about correctly interpreting the insights that were shared. Those partners with whom WestEd has engaged more deeply expressed an interest in regular and sustained collaboration centered on advising WestEd throughout the evaluation process.

Partners also expressed their interest in collaborating with WestEd to make sense of data throughout the evaluation. Partners emphasized that they bring unique insights, which are shaped by their communities and the school mental health systems in which they operate. For WestEd and its partners, collaborative sense making is key to ensuring that insights generated by the MHSSA Evaluation are valid, grounded in context, and reflect multiple perspectives, not just those of the WestEd team.

Partners also expressed an interest in reviewing MHSSA data to reflect on their school mental health systems change work and consider opportunities for continuous improvement.

To honor partners' interest in long-term collaboration, the MHSSA Evaluation will include engagement with partner groups that contributed to the development of the

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MHSSA Evaluation Plan, ensuring ongoing transparency and community collaboration. WestEd will engage with such groups in a variety of ways and throughout the evaluation, including regular listening sessions, a youth advisory group (YAG), and data sense making sessions. Responding to the expressed interests of different partner groups, engagement may take the form of information dissemination or deeper forms of engagement such as codesigning processes and protocols and collective sense making.

Contextual Descriptive Analyses

Partners agreed that in a California statewide evaluation, it is critical to understand and measure variation in school mental health across different regions and populations. They explained that because grantees were afforded flexibility in selecting and implementing school mental health activities and services, they tailored MHSSA-funded activities and services to meet the needs of their local communities. Partners emphasized that, in many cases, their ability to respond to the stated needs of schools and communities resulted in the innovation that was required during the COVID-19 pandemic.

In addition, while some school mental health data may be difficult to access, partners agreed that it was critical for the MHSSA Evaluation to leverage data that paints a picture of the diverse California school mental health landscape. There was an interest in better understanding outcome data related to school climate and student mental health and wellbeing.

In contrast, some partners cautioned against using quantitative data to measure the MHSSA's unique impact on student and school outcomes. Partners shared that the school mental health funding landscape was so complex that it would be difficult to disentangle the impact of MHSSA funds from the other funding sources that have been braided and blended to support the same set of outcomes.

In response to these insights and feedback, WestEd will conduct analyses using data on MHSSA outcomes to describe the school mental health landscape, measuring variation across geographic regions and school- and community-level characteristics. These analyses will not attempt to isolate the unique effects of the MHSSA on student- and school-level outcomes. Rather, they will highlight the diverse needs and experiences of communities throughout the state, providing a rich and nuanced context for the school mental health landscape in which the MHSSA was implemented. In addition, the quantitative descriptive analyses will be supplemented by qualitative case study data on outcomes, which is described below.

Process and Systems Change Evaluation

Partners shared that they would like to engage with meaningful and useful data through the MHSSA Evaluation. They wanted to use evaluation findings to share successes and

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challenges they have encountered around interagency collaboration, systems change, and the implementation of MHSSA-funded activities and services. Because there is significant variation in local context, school mental health systems, and the use of MHSSA funds, partners agreed that it would be beneficial to see not only statewide results but also results from schools and counties that are similar to their own.

Partners identified interagency partnerships as an area requiring additional data. Some partners wanted to see and use data to describe how MHSSA funds were used at the county-level, for which there is no consistent metric. They emphasized the importance of collecting data that would be used not only to satisfy reporting requirements but also to support continuous improvement efforts. At the same time, some partners were overwhelmed by the prospect of collecting and submitting large amounts of data for the MHSSA Evaluation. They were concerned that time-intensive data reporting would put additional strain on already overburdened teams.

To balance the interest in meaningful and useful data with concerns about the investment of time required to satisfy MHSSA Evaluation requirements, WestEd will collect targeted data that closely align to the MHSSA mechanisms of change. The MHSSA Evaluation will include a onetime online grantee survey that measures process and systems change data. WestEd will also facilitate sense making sessions with grantee teams to identify and share key insights, challenges, and actionable strategies for future school mental health systems change efforts.

Grantee Partnership Case Study

Grantees are proud of the work they do and want to demonstrate how LEAs and county behavioral health departments are “better together.” A recurring theme throughout the listening sessions was that the MHSSA is unique because it incentivizes interagency partnerships, which has been an important part of strengthening the county-level comprehensive school mental health system.

Partners and expressed a desire to learn from one another about how interagency collaboration is being used to create sustainable and cohesive school mental health systems that meet the diverse needs of school communities. Building on this topic, many partners expressed an interest in using evaluation findings to inform the ongoing improvement of both MHSSA-funded activities and services and of the broader school mental health system beyond the MHSSA grant period.

Responding to partners’ interest in learning from one another, the MHSSA Evaluation will use a case study method, with opportunities for case study grantees to participate in a data-driven grantee partner planning process for sustainability. This methodology will focus on the county context, exploring the relationship between partnerships and the county-level school mental health system and examining how changes at this level supports systems improvement at the district and school levels.

WestEd will consult with the MHSSA Technical Coaching Teams to determine how the

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MHSSA Evaluation can inform or be used to provide additional technical assistance and collaborative learning opportunities for grantees and other MHSSA partners. Case studies at both the county level and school level will use a systematic approach to select a diverse case study sample to measure the mechanisms of change outlined in the MHSSA conceptual model. Aligned with the antiracist participatory evaluation approach, WestEd will ensure that the evaluation is strength-based and does not inadvertently perpetuate disparities in implementation by focusing on a biased sample, while also providing opportunities for learning for counties and schools across a range of contexts, conditions, and MHSSA implementation stages.

Implementation and Impact School Case Study

Partners asserted that a meaningful and useful evaluation should include detailed information about the reasons why MHSSA-funded activities and services were selected, how they were designed to support local needs, what implementation facilitators and barriers were encountered, and what impact was achieved. As previously stated, each grant is tailored to the local context and is responsive to the dynamic needs of the local school mental and behavioral health system. Partners expressed an interest in understanding the school-level mental health system in which MHSSA-funded activities and services were implemented so that they could assess the extent to which different approaches may apply in their own school-level mental health systems.

Partners asserted that there are limitations to how counties with vastly different populations and communities can learn from one another. They shared that meaningful learning happens when they can see how implementation occurs in schools and communities that share characteristics with their own local context. Partners were interested in understanding contextual nuance and how insights gained from MHSSA implementation in similar settings can help them continue to strengthen their own school-level mental health systems.

Partners also recognized the value of thoroughly documenting the implementation process at the local level in addition to reporting statewide aggregate implementation data. They stated that much of the data that they collect and report does not speak to the nuanced impact of the MHSSA on students and schools. They suggested that collecting both detailed implementation data and statewide aggregate data would facilitate meaningful collective learning for a wide range of partners, particularly those implementing MHSSA-funded activities and services in schools. Partners emphasized the importance of incorporating qualitative data from a variety of sources within schools. They shared that, with a broader range of perspectives, the implementation story becomes more robust and comprehensive.

In response to partners' interest in better understanding the factors that improve school-level mental health systems, the MHSSA Evaluation will use a case study method that attends to the local context. This methodology is tailored to the specifics of the local

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school environment in order to investigate the facilitators and barriers related to the implementation of MHSSA-funded activities and services within the school-level system. This methodology will allow WestEd to tell a more comprehensive story of MHSSA implementation and impact. Furthermore, interviews and focus groups with school staff, mental/behavioral health professionals, school-level MHSSA coordinators, and families/caregivers will provide a nuanced description of implementation and impact. The case studies will also include in-depth engagement with students to understand how the MHSSA supported the mental health and wellbeing of young people in schools.

Youth Engagement

Partners emphasized the importance of centering the experiences of youth in the evaluation. For example, members of the YAGs shared many ways that young people can serve as evaluation partners, sharing power with adults and acting on the issues that most affect their lives. Partners also suggested that the evaluation include data collected directly from young people to learn about how youth perceive the impact of their school's mental health system on students, the MHSSA's intended beneficiaries.

Partners made recommendations on the most effective ways to gather data from youth. They emphasized the importance of establishing trust so that young people feel comfortable sharing about their experiences and perspectives. Conversations with partners provided insights into using nontraditional data collection methods to access student experiential data in more authentic ways.

Partners were interested in having young people provide recommendations for school mental health systems change. Youth also expressed their strong desire to communicate directly with leaders and collaborate with adults to improve mental health activities and services in their schools and communities.

Youth engagement and voice will be critical elements of the MHSSA Evaluation, which will offer an opportunity for youth to tell the story how school mental health affects their lives. The materials for the student focus groups and engagement opportunities are shaped by young people's feedback and will be further tailored with the input from students in participating case study schools. Responding to the call to elevate and center youth voice, the MHSSA Evaluation also includes a youth engagement component. It invites students from selected schools to participate in a series of conversations that culminate in a student panel. This panel will provide youth the opportunity to discuss school mental health with state and local leaders, allowing them to directly participate in the systems change process. Young people codesigned processes and protocols for youth engagement as part of the MHSSA Evaluation, and youth partners will collaborate with WestEd to cofacilitate youth engagement sessions.

Evaluation Design

The following section describes the methodological and analytic approach and

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dissemination strategy for the six MHSSA Statewide Evaluation activities listed below. Relevant instruments, protocols, and process documents are hyperlinked throughout the report.

1. Community Engagement
2. Contextual Descriptive Analyses
3. Process and Systems Change Evaluation
4. Grantee Partnership Case Study
5. Implementation and Impact School Case Study
6. Dissemination and Strategic Communication

Community Engagement

Brief Summary

WestEd will implement ongoing community engagement with a broad group of partners and interest holders throughout the MHSSA Evaluation. WestEd's engagement strategy will build upon previous community engagement efforts to include youth empowerment, youth-facilitated data collection, and ongoing partner collaboration and sense making.

Youth Advisory Group

A key component of the MHSSA Evaluation community engagement strategy will build on the YAG that participated in MHSSA Evaluation planning from February 2024 through October 2024. The YAG will be a key advisory body for the evaluation with the goal of empowering youth members to offer insights and feedback on evaluation activities and findings (Costa & Kallick, 1993). Additionally, as described below, four selected YAG members will be trained as youth data collectors and will facilitate youth engagement and codesigning of evaluation activities.

The YAG will consist of 10–15 diverse youth members, aged 14–20, who will participate in various activities to promote youth-centered and culturally responsive evaluation practices. The YAG may also support the development of outward-facing products that describe youth experience with the evaluation for dissemination to interest holders and the public. Two WestEd staff will plan and facilitate YAG sessions and meetings will be held quarterly on Zoom, each lasting 1.5 to 2 hours, with up to 1 hour of asynchronous work between sessions. Members will receive honorarium payments of $100 in the form of a gift card for completing prework and attending each meeting. YAG members may be invited to complete ad hoc tasks and be compensated further at a rate of $50 per 90 minutes.

Youth Data Collectors

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As part of the evaluation, WestEd will equip four youth to participate in data collection and codesign processes. Partnering with youth data collectors involves sharing power and enabling youth to make meaningful contributions to the MHSSA Evaluation.

Youth data collectors will be trained to cofacilitate virtual data collection activities. This will support their personal growth and professional development and improve their research and evaluation skills. Youth data collectors will convene up to eight times for training and debrief sessions. The youth data collector roles and responsibilities are described in the Impact and Implementation School Case Study plan.

Recruitment and Selection

Current YAG members will be invited to continue serving as members and WestEd will recruit new YAG members to ensure a diverse and engaged group across the evaluation period. To recruit additional members, WestEd will distribute a flyer that describes the role of the YAG to MHSSA partners. In outreach communications, WestEd will emphasize the importance of including diverse youth perspectives and outline YAG roles, responsibilities, and incentives. WestEd will also share the flyer with community-based organizations, such as local nonprofits and advocacy groups to reach underrepresented youth.

Interested candidates will be asked to complete an application form, which will be available through a link provided on the recruitment flyer. The application will collect demographic information, interest in mental health advocacy, and availability for scheduled meetings.

YAG applications will be reviewed by WestEd staff using a standardized process to ensure consistency and fairness. The WestEd evaluation team will collectively assess each application, taking into consideration factors such as the applicant's identity, interest in mental health advocacy, availability to attend meetings, past engagement in the YAG, and leadership potential. The final selection will ensure that the YAG comprises members with a wide range of perspectives and backgrounds.

WestEd will obtain parental consent for participants under 18 years old. Additionally, youth participants will be required to provide their own verbal assent when they agree to participate in the YAG.

Youth data collectors will be selected from a subgroup of the YAG. YAG members will learn about this opportunity and indicate through a survey whether they have interest in becoming a data collector. WestEd will select the data collectors based on interest, the groups' diversity, and availability for a minimum of 1 year. To onboard data collectors, WestEd will provide age-appropriate training on research methods, cofacilitation, data analysis, and presentation skills.

Engaging the Commission, Grantees, Other Vested Organizations, Evaluators, and State Agencies

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To ensure the evaluation of MHSSA is both comprehensive and responsive to community needs, WestEd will foster robust collaboration with a broad group of partners, including the Commission staff, grantees, and interest holders from vested organizations and, where appropriate, other state agencies. Community engagement focuses on two key areas: oversight and sense making.

Oversight

WestEd recognizes the unique and shifting contexts at the local and state levels in which the MHSSA Evaluation is being implemented. Consultation with community partners will support WestEd's ability to adapt evaluation approaches, when necessary, to ensure the evaluation remains comprehensive, relevant, and responsive to the needs of different communities (Sabet et al., 2024). Ensuring that evaluation processes are culturally responsive and aligned with community values not only improves transparency and fosters trust but also improves the validity and utility of the evaluation. Ultimately, this community oversight will contribute to more meaningful and actionable findings of the MHSSA Evaluation.

Sense Making

WestEd will conduct sense making sessions to inform the interpretation of data from each component of the MHSSA Evaluation. Sense making is a process where people collectively interpret information to develop a shared understanding, transforming raw data into meaningful insights and actionable knowledge (Intrac for Civil Society). These sessions will bring together partners to discuss emerging evaluation findings, deepen the collective understanding of the results, and refine WestEd's analytic approach and initial interpretation based on community perspectives and input. Each sense making protocol will be tailored to the needs of the evaluation and the specific partner involved.

Reporting

WestEd will summarize community engagement activities by generating brief summaries of each community engagement session. After each session, the summary will be shared back with participants for any additional feedback. Community engagement insights will be shared with the entire WestEd team to ensure that data collection, analysis, and the interpretation of findings integrate partners' perspectives and insights.

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Contextual Descriptive Analyses

Brief Summary

WestEd will use descriptive statistics and multilevel latent factor modeling to describe the current state of the mental health and wellbeing of students in California. Additionally, WestEd will explore school, district, and community characteristics that are related to students' mental health and wellbeing to better understand the differential experiences of students and schools by contextual factors at the county and school levels.

WestEd assessed secondary data sources to leverage in these analyses by determining item alignment with the MHSSA Evaluation Framework. As previously stated, while the MHSSA has been an important driver of school mental health systems change, it is one of many investments in school mental health systems within a larger state and federal funding landscape. Due to the complex nature of systems change within this braided funding scenario, this evaluation will not attempt to isolate the MHSSA's unique effect on the outputs and outcomes outlined in the MHSSA Evaluation Framework. Rather, WestEd will analyze secondary data aligned with these outputs and outcomes to offer context on the school mental health landscape statewide, within counties, and within schools.

Research Questions

The contextual descriptive analysis will address the research question listed in Table 6.

Table 6. MHSSA Research Questions Addressed by the Contextual Descriptive Analyses with Associated Data Sources

MHSSA Evaluation Framework Element	Research Question	Data Sources
Community Factors	11. What were the mental health strengths and needs of young people and their school communities?	California Healthy Kids Survey (CHKS), California Longitudinal Pupil Achievement Data System (CALPADS), Census, US Open Data Portal, Project Implicit

Sample

Descriptive analyses will leverage data from the 2023–24 school year. While a final list of MHSSA-funded schools has not been finalized, WestEd conducted a review of available California Healthy Kids Survey (CHKS) data for a preliminary list of 2,100 MHSSA-funded schools to assess the likely coverage in 2023–24 for the final sample of

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MHSSA-funded schools. This review showed that approximately 40 percent of elementary schools and 50 percent of secondary schools administered the student survey in 2023–24. Approximately 30 percent of MHSSA-funded schools completed the staff survey. This school sample will be used in the analyses described below.

One significant limitation of the contextual descriptive analysis is the available sample. While coverage of MHSSA-funded schools that completed the CHKS is limited, based on the sample outlined above, the schools that completed the survey are in 44 of the 57 funded counties for elementary (77%), 48 for secondary (84%), and 48 for schools completing the staff survey (84%) (see Figures 9–11). There is little to no CHKS usage in parts of the Inland Empire, Northern San Joaquin Valley, and Superior California (The California Complete Count, n.d.).

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Figure 9. Geographic Coverage of MHSSA-Funded Elementary Schools That Completed the CHKS (*n* = 452)

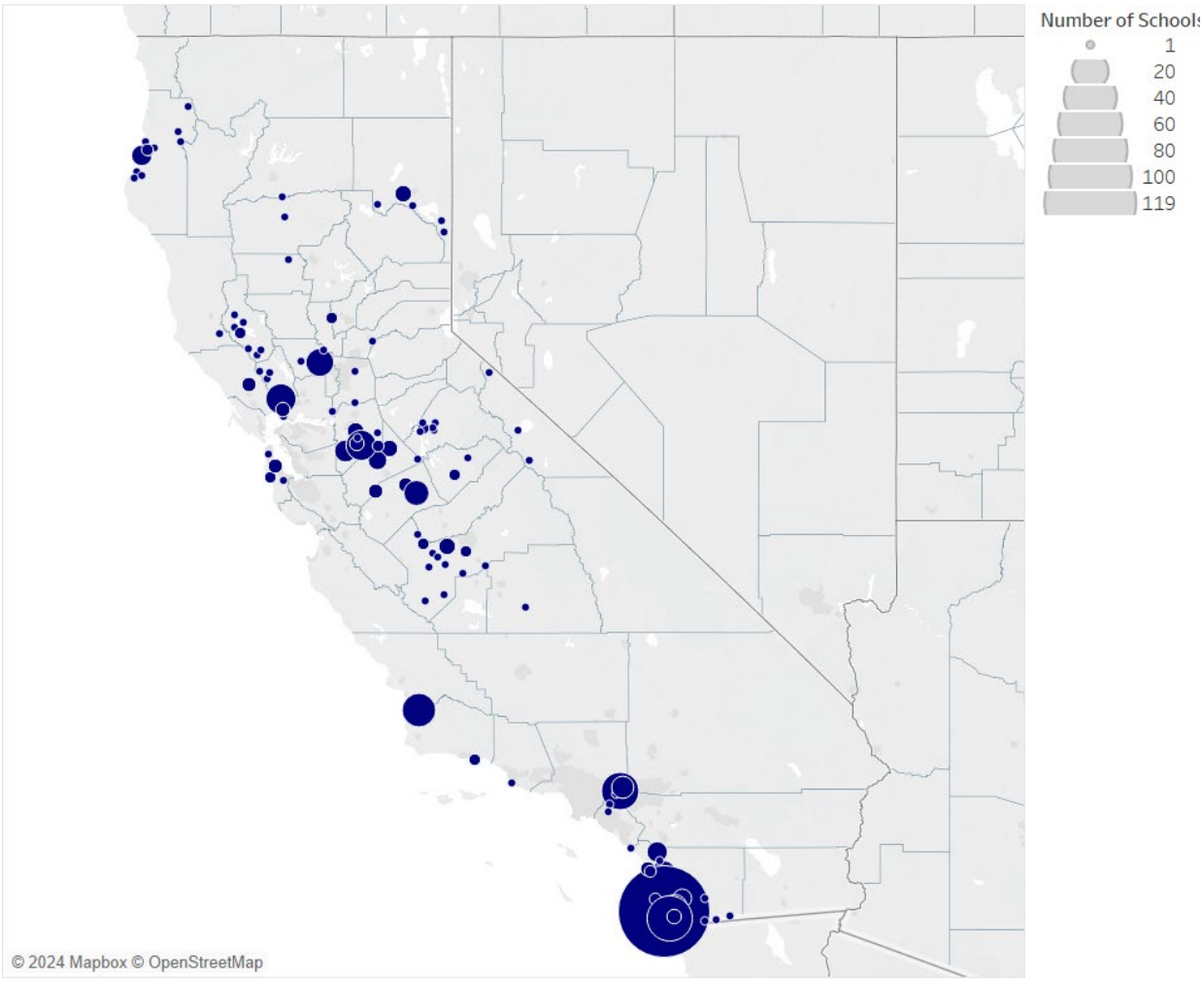


Figure 10. Geographic Coverage of MHSSA-Funded Secondary Schools That Completed the CHKS (*n* = 527)

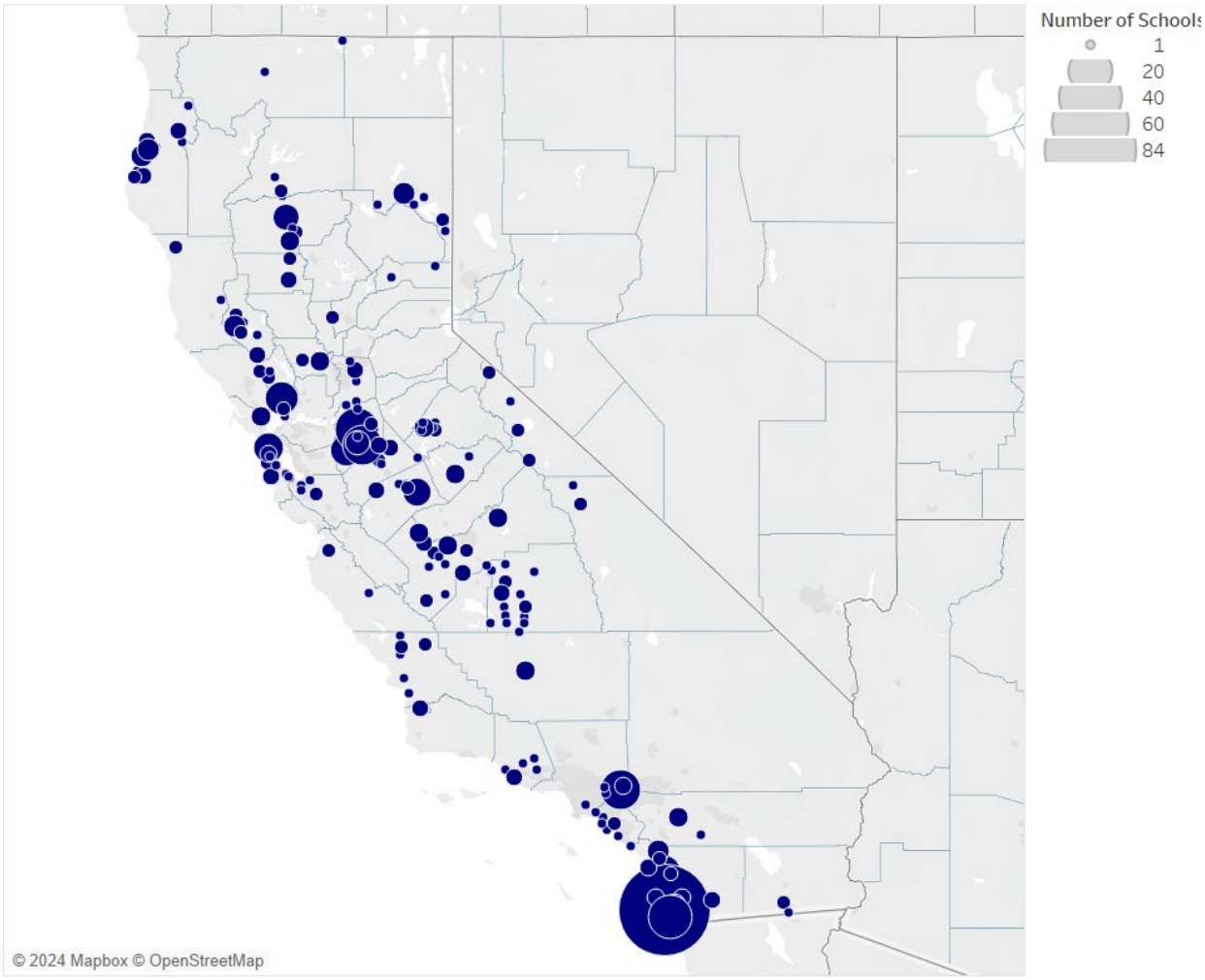
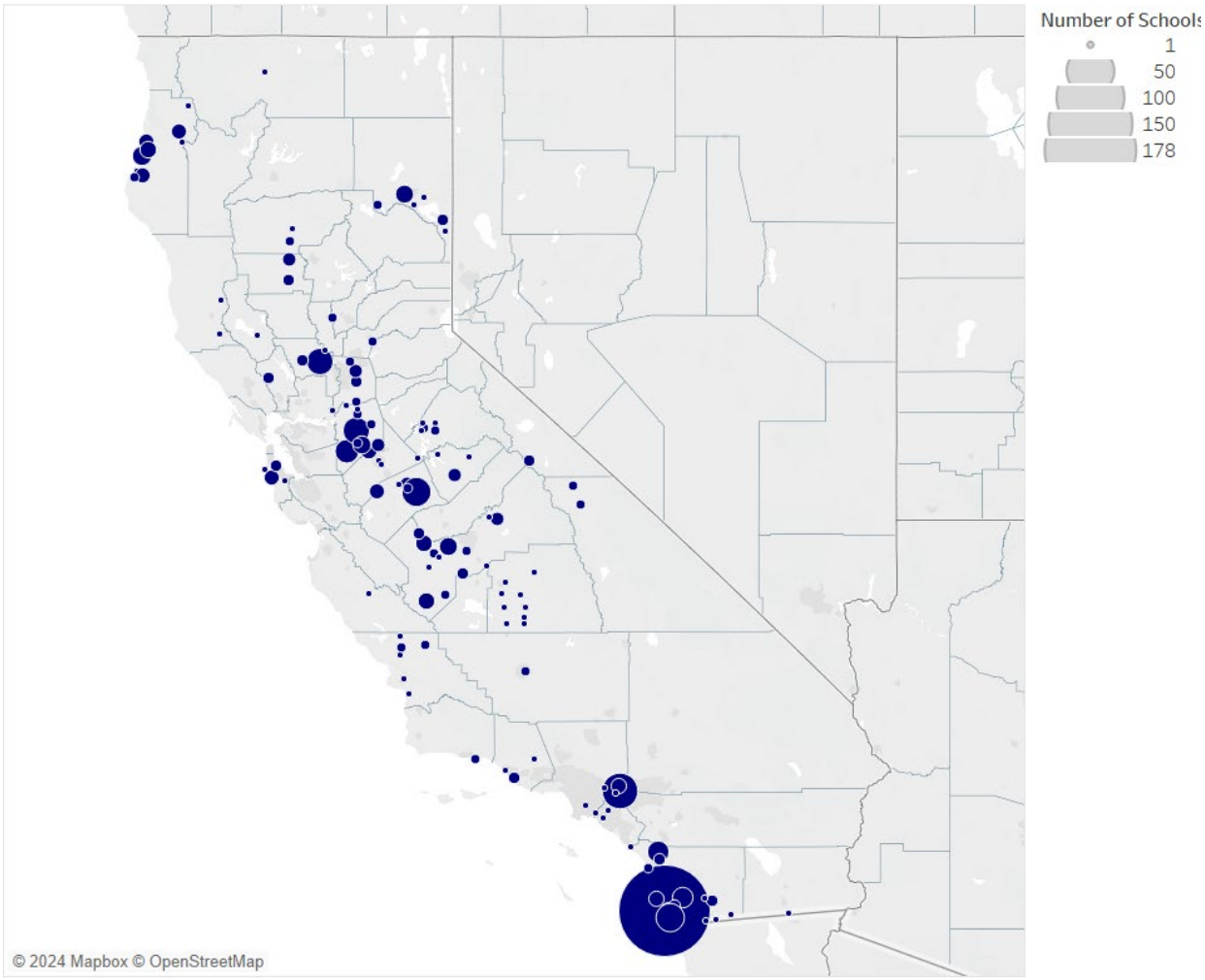


Figure 11. Geographic Coverage of MHSSA-Funded Schools That Completed the California Healthy Kids Staff Survey (*n* = 581)



There are some notable differences between MHSSA-funded elementary schools that completed the CHKS compared to those that did not. MHSSA-funded elementary schools that completed the CHKS were, on average, more urban/suburban (42%/31%) than noncompleters (34%/24%) and less rural (16%) than noncompleters (26%). MHSSA-funded elementary school completers and noncompleters looked very similar across all other school-level demographic characteristics included in this analysis (see Table 7).

A higher percentage MHSSA-funded secondary schools were regular schools (82%) compared to noncompleters (73%), and a lower percentage of secondary completers were alternative education schools (18%) compared to noncompleters (26%). MHSSA-funded secondary school completers were, on average, larger (819 students) than noncompleters (720 students). MHSSA-funded secondary school completers and noncompleters looked very similar across all other school-level demographic characteristics included in this analysis (see Table 8).

MHSSA-funded schools that did and did not take the staff survey looked very similar across all school-level demographic characteristics included in this analysis (see Table 9).

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Table 7. Demographic Characteristics of MHSSA-Funded Elementary Schools That Completed the California Healthy Kids Survey in 2023–24 Compared to MHSSA-Funded Noncompleters

Characteristic	Noncompleters (n = 6621)	Completers (n = 4641)
School type		
Regular school	647 (98%)	462 (100%)
Special education school	3 (0.5%)	0 (0%)
Alternative education school	12 (1.8%)	2 (0.4%)
Locale		
Urban	227 (34%)	196 (42%)
Suburban	161 (24%)	146 (31%)
Town	101 (15%)	50 (11%)
Rural	173 (26%)	72 (16%)
Total students	439.35	461.44
% Female	48.41	48.64
% Male	52.01	51.33
% Nonbinary	0.25	0.24
% American Indian or Alaska Native	2.37	2.11
% Asian	4.80	2.90
% Black or African American	2.60	2.50
% Filipino	1.00	1.30
% Hispanic or Latino	53.04	54.69
% Native Hawaiian or Pacific Islander	0.80	0.68
% Two or more races	5.26	6.30
% White	27.68	25.78
% English learners	23.19	25.98
% Foster youths	1.01	0.73
% Homeless	4.41	5.74
% Migrant	3.06	3.66
% Socioeconomically disadvantaged	67.41	63.22
% Students with disabilities	13.37	14.26

Table 8. Demographic Characteristics of MHSSA-Funded Secondary Schools That Completed the California Healthy Kids Survey in 2023–24 Compared to MHSSA-Funded Noncompleters

Characteristic	Noncompleters (n = 376)	Completers (n = 387)
School type		
Regular school	275 (73%)	317 (82%)
Special education school	4 (1.1%)	0 (0%)
Alternative education school	97 (26%)	70 (18%)
Locale		
Urban	127 (34%)	135 (35%)
Suburban	86 (23%)	99 (26%)
Town	91 (24%)	88 (23%)
Rural	72 (19%)	65 (17%)
Total students	720.19	819.22
% Female	46.03	46.86
% Male	54.64	52.97
% Nonbinary	0.52	0.40
% American Indian or Alaska Native	2.50	2.62
% Asian	3.85	2.60
% Black or African American	2.70	2.00
% Filipino	0.80	1.30
% Hispanic or Latino	56.51	54.21
% Native Hawaiian or Pacific Islander	0.70	0.77
% Two or more races	4.50	5.19
% White	26.65	26.69
% English learners	18.12	17.20
% Foster youths	1.81	0.99
% Homeless	4.53	5.44
% Migrant	3.41	3.05
% Socioeconomically disadvantaged	70.87	64.88
% Students with disabilities	2	0

Table 9. Demographic Characteristics of MHSSA-Funded Schools That Completed the California Healthy Kids Staff Survey in 2023–24 Compared to MHSSA-Funded Noncompleters

Characteristic	Noncompleters (n = 1,5251	Completers (n = 6391)
School type		
Regular school	1,158 (86%)	563 (91%)
Special education school	14 (1.0%)	3 (0.5%)
Alternative education school	174 (13%)	53 (8.6%)
School Level		
Elementary	775 (58%)	351 (57%)
High	308 (23%)	148 (24%)
Middle	200 (15%)	105 (17%)
Not reported	1 (<0.1%)	0 (0%)
Other	60 (4.5%)	15 (2.4%)
Secondary	2 (0.1%)	0 (0%)
Locale		
Urban	467 (35%)	241 (39%)
Suburban	360 (27%)	147 (24%)
Town	241 (18%)	112 (18%)
Rural	278 (21%)	119 (19%)
Total students	564.43	569.41
% Female	47.57	47.92
% Male	52.77	51.99
% Nonbinary	0.47	0.38
% American Indian or Alaska Native	2.10	3.09
% Asian	3.80	2.50
% Black or African American	2.60	2.60
% Filipino	1.10	1.20
% Hispanic or Latino	53.98	54.50
% Native Hawaiian or Pacific Islander	0.78	0.72
% Two or more races	5.21	5.93
% White	27.67	25.80
% English learners	20.63	22.08
% Foster youths	1.27	0.98

% Homeless	4.53	6.00
% Migrant	3.26	3.03
% Socioeconomically disadvantaged	66.23	66.24
% Students with disabilities	14.93	14.62

Measures

Student Mental Health and Wellbeing

WestEd will use mental health and wellbeing subscale scores from the CHKS and student attendance and disciplinary exclusion data, such as suspensions and expulsions, from the CALPADS. The analysis will be conducted at the school level for several reasons: (a) all school-level data are publicly available, (b) the large sample of schools using the CHKS provides ample statistical power, and (c) student-level data is not required to describe state- and community-level mental health status and moderators of that status.

The CHKS is a validated annual, state-subsidized assessment for students aged 10 (i.e., 5th grade) and older facilitated by the California Department of Education (CDE). The Core module includes questions on school climate, social–emotional and physical health, behavioral health and substance use, and other risk behaviors, with versions tailored to students in elementary, middle, and high school, along with a staff survey.

The majority of item responses for the elementary survey used a 4-point scale (i.e., *no, never*; *yes, some of the time*; yes, most of the time; *yes, all of the time*). The middle school, high school, and staff surveys used a variety of response scales, including estimated frequencies (e.g., zero times up to four or more times) and agreement (e.g., *strongly disagree* through *strongly agree*, *not at all true* through *very much true*). Due to the variation across surveys, data from each survey will not be aggregated, and results will be presented by survey.

The following CHKS domains will be included in this analysis. See the Contextual Descriptive Analysis Metrics document for all CHKS domains, example items, and their associated MHSSA Evaluation outputs and outcomes.

California Healthy Kids Elementary and Secondary Core Survey Domains

- Academic Motivation
- Antibullying Climate
- Emotion Regulation
- Fairness
- Life Satisfaction
- Loneliness
- Optimism

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- Positive Behavior
- Promotion of Parental Involvement
- Responses to Trauma
- School Coregulation Supports
- School Connectedness
- School Violence Perpetration
- Social and Emotional Learning Supports
- Social–Emotional Distress
- Stress-Associated Health Symptoms
- Suicidal Ideation Indicator
- Total School Environment
- Violence Victimization

California Healthy Kids Staff Core Survey Domains

- Antibullying Climate Scale
- Caring Relationships Scale
- Emotional Safety at School Scale
- Fairness and Rule Clarity Scale
- High Expectations Scale
- Instructional Equity Scale
- Promotion of Parental Involvement Scale
- Respect for Diversity Scale
- Staff Collegiality Scale
- Staff Efficacy for Promoting Student Wellbeing Scale
- Staff Working Environment Scale
- Student Learning Environment Scale
- Student Meaningful Participation Scale
- Student Readiness to Learn Scale
- Support for Social Emotional Learning Scale

The CALPADS is a longitudinal data system used in California to maintain individual-level data, including student demographics, course data, discipline, assessments, staff assignments, and other data for state and federal reporting. In order to comply with federal law as delineated in the Every Student Succeeds Act (ESSA) of 2001 (20 U.S.C. Sec. 6301 et seq.), California Education Code Section 60900 requires LEAs to use

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unique pupil identification numbers (Statewide Student Identifiers, or SSIDs) for students enrolled in California public K–12 LEAs and to retain all data required by ESSA, including, but not limited to, data required to calculate enrollment and dropout and graduation rates.

The following CALPADS student outcome data will be included in this analysis. See the Contextual Descriptive Analysis Metrics document for a list of all CALPADS student outcome data and their associated MHSSA Evaluation outputs and outcomes.

CALPADS Disciplinary Data

- Disciplinary incident
- Action taken for disciplinary incident

School, District, and Community Characteristics

The following CALPADS school-level data will be included in this analysis. See the Contextual Descriptive Analysis Metrics document for a list of all CALPADS school-level items.

CALPADS School-Level Demographic Data

- Grade level
- Gender
- Race/ethnicity indicators, as federally required
- SEO (socioeconomic disadvantage status)
- Homeless status
- Migrant status
- Special education status
- Foster youth status
- Primary language
- The recommended composite measure of high school student success
- Number of days students attended regular school (for all students enrolled under the county-district-school [CDS] code listed)

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CALPADS School-Level English Learner and Academic Data

- English language acquisition status code
- English language acquisition status start date
- English Language Proficiency Assessment for California (ELPAC) scores
- California Assessment for Student Performance and Progress (CAASPP) English Language Arts
- CAASPP Math

Additional data measuring school, district, and community characteristics that are related to students' mental health and wellbeing will come from the U.S. Census, the California Open Data Portal, Project Implicit, and the CHKS. Several surveys are used to gather data for the U.S. Census. The Decennial Census is a survey sent to all U.S. addresses every 10 years to provide an official count of population demographics. The American Community Survey is an annual survey distributed to a sample of U.S. addresses, focusing on specific topics such as jobs, education, internet access, and transportation. The California Open Data Portal is a housing-related website, sponsored by the Government Operations Agency, which offers downloadable state-collected data sets from a wide range of agencies. This project will incorporate county- or community-level data on food accessibility (e.g., affordability, SNAP, WIC), income inequality, and violent crime.

Racism is an important community factor in the MHSSA Evaluation Framework and will be measured by a proxy indicator from Project Implicit. Project Implicit is a multi-university research collaboration founded in 1998, focused on fostering dissemination and application of implicit social cognition using the Implicit Association Test, which is completed through an online portal and open to both the public and research participants. This project will utilize county-level data from the Race Implicit Association Test, in which participants are instructed to quickly categorize faces of varying races and/or positive and negative attributes as a measure of their individual implicit bias.

The following school, district, and community data related to students' mental health and wellbeing will be included in this analysis. See the Contextual Descriptive Analysis Metrics document, which lists all data outlined below and their associated MHSSA Evaluation Framework element.

School, District, and Community Data

- Race
- Ethnicity
- Disability rate and types
- Class of worker
    - Employment rate
    - Industry

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    - Occupation
    - Mean weekly hours worked
- Food affordability
    - SNAP participation
    - WIC redemptions
    - Modified retail food environment index
- Income inequality
- Income/earnings
- Poverty
- Children in house under/over 18
    - Family size
    - Household types (e.g., married, single)
    - Residential mobility
    - Rent
    - Homeownership rate
    - Housing value
- Language spoken at home
    - U.S. and not U.S. born
- Poverty
    - Residential segregation
- Race Implicit Association Test
- Health care coverage
    - Educational attainment
- Violent crime rate
- Violence Victimization Scale
- Antibullying Climate Scale
- School Connectedness Scale
- Caring Relationships Scale
- Computer and internet use
- Means of transportation to work

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Method/Process

WestEd will complete a data sharing application for the California School Climate and Health Learning Survey (CalSCHLS) system project at WestEd, delineating the following details:

- start and end data of the analysis
- purpose of the study
- plan for dissemination
- surveys, administration years, districts, and schools needed
- file type needed
- requested data delivery date

Once approved, the data transfer will occur.

Analytic Plan

To conduct the contextual descriptive analyses, WestEd will first pull and merge all publicly available data for use in this analysis.

WestEd will conduct a data quality analysis to inform the analytic approach aimed at evaluating student health and wellbeing. This analysis will examine the quantitative data across all data sets mentioned in the preceding measures section. The data will be reviewed for quality and completeness to identify any issues that may impact the analyses.

Descriptive Statistical Analysis

Descriptive statistics will provide the foundation for understanding the basic trends and patterns in the data. This will include means, medians, standard deviations, frequencies and percentages for variables measuring student health and wellbeing, along with school, district, and community characteristics.

Multilevel Modeling Analysis

Multilevel modeling will be used to describe the current state of student mental health and wellbeing in California. This analysis will estimate covariate-adjusted community average mental health and wellbeing subscores, as well as attendance and disciplinary exclusions. WestEd's models will include three levels: (a) school, (b) district, and (c) county. Thus, the data are nested, meaning that schools are not independent of their districts or counties, which WestEd's statistical model will account for using multilevel modeling.

Multilevel models, also known as hierarchical linear models (Raudenbush & Bryk, 2002) or mixed-effects models, are regression models that statistically account for data nesting and ensure that the standard errors are correctly estimated. WestEd will conduct all multilevel modeling in R using the *lme4* package (Bates et al., 2015) and estimate covariate adjusted averages for all dependent variables. These values will

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provide a robust estimate of California students' overall mental health and wellbeing.

School and Community Characteristics Analysis

Inclusion of school and community characteristics allow WestEd to explore school, district, and community characteristics that are related to students' mental health and wellbeing to better understand the differential experiences of students and schools by contextual factors at the county and school levels. Each multilevel model will include school- and county-level moderators, with coefficients coded to allow for covariate-adjusted estimates by moderator. These models will provide insights into key differences in student and school outcomes by a range of contextual factors.

Reporting and Dissemination

Findings from the contextual descriptive analysis, which aims to identify patterns in student wellbeing and achievement, will be detailed in the final technical report and final community-facing report, as outlined in the Dissemination and Strategic Communication Section.

The contextual descriptive analysis is scheduled to occur at the beginning of the evaluation to allow for these data to be incorporated into sense making sessions throughout the evaluation. Within these sense making sessions, data from the contextual descriptive analyses will be presented using multiple modalities, including bar chart dashboards disaggregated by subgroup, dashboards illustrating trends over time, and maps utilizing graduated color symbology, as well as a variety of other data visualization strategies. Sense making sessions described here and throughout the MHSSA Evaluation Plan will build the capacity of MHSSA grantees to use data-driven approaches for continuous improvement (WestEd-MHSOAC, 2023).

While all efforts will be made to present findings in accessible ways, WestEd recognizes that, often, quantitative data can be difficult to understand. Without adequate context or clear communication, quantitative data can inadvertently reinforce a deficit narrative about the "achievement gap" experienced by historically marginalized students (Safir & Dugan, 2021). Therefore, WestEd will use data from the contextual descriptive analysis to tell an important but incomplete story of equity across the state, county, and school levels. These data illuminate patterns of inequity in student wellbeing and achievement, ideally pointing participants in a general direction for further investigation.

Recognizing the limitations of findings from the contextual descriptive analysis, WestEd's goal will be to present these quantitative data as one of many sources to inform statewide school mental health systems change efforts.

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Process and Systems Change Evaluation

Brief Summary

WestEd will closely collaborate with the Commission to incorporate MHSSA grant monitoring data into the Process and Systems Change Evaluation. MHSSA grant monitoring data will be collected and analyzed by Commission staff. Key findings from these analyses, possibly including fiscal reporting and MHSSA implementation data, will be included.

In addition, WestEd will collect survey data from grantee leads and teams that provide information about

- grantee partnerships,
- county- and school-level mental health systems change,
- the implementation of MHSSA-funded activities and services,
- community strengths and needs,
- the relationship between the MHSSA and other school mental health initiatives, and
- school mental health outcomes.

Building on the contextual descriptive analyses, grant monitoring data, and grantee survey data, WestEd will facilitate sense making sessions with grantee teams. These sessions aim to identify key insights, challenges, and actionable strategies for advancing future school mental health systems change efforts. The sense making sessions will inform the evaluation and simultaneously provide an opportunity for grantees to engage with their MHSSA Evaluation data.

Research Questions

The Process and Systems Change Evaluation component will address the research questions listed in Table 10.

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Table 10. MHSSA Research Questions Addressed by the Process and Systems Change Evaluation with Associated Data Sources

MHSSA Evaluation Framework Element	Research Question	Data Sources
Grantee Partnership	**1.** Who was involved in the MHSSA-funded partnerships?	Grantee Survey
County- and School-Level Mental Health System	**4.** What was the relationship between MHSSA grantee partnerships and the county-level school mental health system?	Grantee Survey, Grantee Sensemaking Sessions
	6. What was the relationship between the county-level and the school-level mental health system?	Grantee Survey, Grantee Sensemaking Sessions
MHSSA-Funded Activities and Services	**8.** What activities and services were implemented using MHSSA funding?	Grantee Survey, Grant Monitoring Data
Community Factors	11. What were the mental health strengths and needs of young people and their school communities?	Grantee Survey, Grantee Sensemaking Sessions
Other School Mental Health Initiatives	13. How did other school mental health initiatives serve as facilitators and/or barriers to the implementation of school mental health systems change at each level (county, district, school)?	Grantee Survey, Grantee Sensemaking Sessions

Sample

WestEd will invite all grantee partnership teams to complete the grantee survey that will provide statewide process and systems change data for the MHSSA Evaluation. The survey will be limited to grantee partnership leadership, teams, and key staff.

The number of partnership entities (e.g., county behavioral health departments, COEs, County Superintendent of Schools, districts, schools, charter schools) vary considerably from grantee to grantee. Thus, WestEd will request that each grantee partnership have 5–10 key staff at the county level (Behavioral Health and Education) and 3–5 key staff from each district partnership entity complete the survey. Grantees that have focused their efforts at a select number of schools (e.g., implementing wellness centers) may also ask school-level staff to complete the survey.

WestEd anticipates that approximately 1,900 respondents will complete the survey based on the 661 county- and district-level partnership entities listed in the MHSSA Grant Summaries from May 2023. This includes 57 county behavioral health departments, 51 COEs, 13 other county-level offices, and 540 districts contributing a minimum of five surveys completed by each of the 56 counties (*n* = 280) and three surveys by each of the 540 districts (*n* = 1,620).

In addition to MHSSA directors, managers, and coordinators, WestEd will invite other key staff involved in leading and facilitating the implementation of MHSSA activities and school mental health systems change at each entity to complete the survey. Other key staff may include those with knowledge and expertise related to school mental health systems change, the MHSSA partnership and/or other school mental health initiatives, and the implementation of MHSSA activities and services within and across the county, district, and school mental health system. These may include administrators, mental/behavioral health and health staff, educators, parent and youth leaders, and key partners from other partnering agencies (e.g., Child Welfare, Juvenile Justice).

Survey completion will require knowledge of the MHSSA-funded activities and services as well as the broader school mental health system. It is unlikely that any single individual will have the breadth of knowledge required to answer every question within the survey. Thus, it is important to ensure representation from all key partnership entities and to draw from a range of roles and expertise—such as mental/behavioral health, education, equity, family youth engagement, evaluation, information technology, fiscal, legal, youth, and family decision-making authority—needed to lead their school mental health systems change to deliver timely, equitable, and high-quality mental health services within school communities.

Measures

Grant Monitoring Data

The Process and Systems Change Evaluation component of the evaluation will include grant monitoring data that has been collected and analyzed by the Commission. Grant monitoring data, as determined by the Commission, may include data from annual fiscal reports, quarterly hiring reports, and/or the MHSSA data reporting tool.

Grantee Survey

WestEd is developing the grantee survey to align with the MHSSA conceptual model. The survey will focus on the following measurement models: grantee partnerships, school mental health systems, MHSSA-funded activities and services, and student mental health outcomes. It will also gather information about the factors influencing MHSSA implementation and impact, including community factors/social influencers and other school mental health initiatives. The focus of the survey will be on school mental health systems, including partnerships and collaboration at all levels of California's school mental health service delivery system (county, district, school). Following

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completion, the survey will be submitted to the Commission by December 15.

WestEd is developing the grantee survey using a validation process consistent with DeVellis and Thorpe's (2021) instrument development standards. The initial step involves a thorough review of the related literature on school mental health and systems change to identify the critical components of implementation across the various levels of the service delivery system. WestEd has inventoried and reviewed over 30 validated school mental health and partnership (i.e., collaboration and teaming) measures, instruments, and tools—which were summarized in a School Mental Health metrics report submitted to the Commission by WestEd on July 17, 2024. This review not only informed the elements of the measurement models within the conceptual framework but will also guide their refinement throughout the survey development process into clearly defined domains (i.e., constructs).

To generate the initial item pool for the survey, a team of senior researchers with expertise in school mental health is reviewing, coding, and sorting the existing measures to ensure alignment with the conceptual model's elements. This initial pool of items will be based on this review of existing instruments, research literature, and relevant contextual factors identified through community engagement.

The preliminary draft of the survey will be reviewed by two to three senior WestEd researchers. The survey will be further refined based on their feedback. Then, a panel of additional nationally recognized content experts, the Commission, and grantees will review the survey. Using a 4-point scale, each panelist will review the survey and provide feedback on the relevance and clarity of each item, providing suggestions on how to improve low-scoring ones. The panel will review the survey in its entirety regarding its feasibility, utility, and extent to which equity and culturally sustainable practices are infused into the items.

The WestEd team will use a structured process to analyze the feedback provided by panel members and revise to improve the survey as needed. WestEd will consider 80 percent or higher agreement among panel members as the criterion for determining that an item was relevant, and those that meet this criterion will be retained in their current form.

Finally, WestEd will conduct cognitive interviews with two to three grantees leading implementation of the MHSSA and school mental health systems change. The cognitive interviews will be conducted to solicit feedback on the clarity of the survey items and to ensure that partners are interpreting the survey items correctly. Interviewers will follow a structured protocol in which interviewees verbalize their interpretation of each item, their thought process while rating each item, and any questions they may have (Beatty & Willis, 2007; Drennan, 2003; Schecter et al., 1996; Willis, 1999). Participants will also provide feedback on any terms or phrases that were confusing or included jargon. WestEd will revise any items identified as problematic during this process.

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Data Collection

WestEd will collaborate with grantees to recruit participants in the first few months of the evaluation. The survey will be administered in winter 2025. During this data collection window, SurveyMonkey will be used to collect the grantee survey, allowing WestEd to track completion efficiently. Participants will have 2 months to complete and submit the survey. WestEd will be available and in communication with grantee leads and teams throughout the process, providing reminders, support, and answers to any questions or concerns grantee teams may have.

Analytic Plan

The grantee survey will be analyzed for two purposes: first, as part of the purpose of the sense making process described below, and second, for final reporting.

Analysis for Sense Making

Data cleaning and analysis will occur in winter 2025. Following a thorough data cleaning process within the SurveyMonkey platform, which will support the development of data dashboards (described below), the quantitative data will be reviewed for quality and completeness. This analysis aims to identify any potential data issues that may impact subsequent analyses.

Qualitative data (e.g., open-response items) will be analyzed using thematic analysis conducted in a coding software (Dedoose). Thematic analysis involves a six-step process: *familiarizing* by reading and reviewing the text (often multiple times); *coding* the data based on recurring or prominent points; *creating* themes based on the codes; *reviewing* the themes; *defining and labeling* the themes; and finally, *writing* the findings (Caulfield, 2023; Naeem et al., 2023).

Analysis for Final Report

WestEd will analyze grantee survey data using descriptive statistics, multilevel modeling, and confirmatory factor analysis.

Descriptive Statistics

Means, medians, and standard deviations will be used to describe variables that measure partnership and collaboration across the different levels of California's school mental health service delivery system. Frequencies and percentages for categorical variables will also be reported. Furthermore, WestEd will explore patterns across domains aligned with the MHSSA conceptual model and descriptively analyze data at the county, district, and school levels.

Confirmatory Factor Analyses

WestEd will conduct a confirmatory factor analysis (e.g., Brown, 2015) on the grantee survey data to increase the credibility of this measure and demonstrate its usability for future research and evaluations. Confirmatory factor analysis provides evidence for the constructs measured by a tool while also estimating the tool's reliability within a given

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sample. WestEd will use the domains related to the MHSSA conceptual model to inform the structure to be tested using the confirmatory factor analysis. The confirmatory factor analysis will result in both an estimate of the internal consistency reliability of the tool and domain-based subscales, as well as confirmation of which items best align with their respective subscales.

With the proposed sample, WestEd anticipates there will be a large number of survey responses to make a confirmatory factor analysis possible. However, if the number of respondents is much lower than anticipated, WestEd will assess the viability of the confirmatory factor analysis and report, at minimum, internal consistency estimates from the obtained sample.

Multilevel Modeling

Multilevel modeling will be used to explore covariate-adjusted relations between grantee-level predictors and grantee survey outcomes across aspects of school mental health systems. WestEd's models will include two levels: (a) respondent and (b) grantee. Thus, the data are nested, meaning that respondents are not independent of their grantees, which will be accounted for using multilevel modeling.

Multilevel models, also known as hierarchical linear models (Raudenbush & Bryk, 2002) or mixed-effects models, are regression models that statistically account for data nesting and ensure that the standard errors are correctly estimated. WestEd will conduct all multilevel modeling in R using the *lme4* package (Bates et al., 2015) and estimate covariate adjusted averages for all dependent variables. These values will provide a robust estimate of MHSSA grantees' overall school mental health systems.

Respondent and Grantee Characteristics Analysis

Inclusion of respondent and grantee characteristics will allow WestEd to explore respondent and grantee characteristics that are related to reported school mental health systems characteristics and understand the differential experiences by contextual factors at the respondent and grantee level. Each multilevel model will include respondent- and grantee-level moderators, with coefficients coded to allow for covariate-adjusted estimates by moderator. These models will provide insights into key differences in reports of school mental health systems by a range of contextual factors.

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Reporting and Dissemination

Summary of Results for Sense Making

WestEd will customize a SurveyMonkey data dashboard for each grantee, highlighting key findings from all grantee team respondents. The SurveyMonkey data dashboard data and data presentation will be customized to best support grantee learning. Each grantee will receive a separate qualitative data summary report that succinctly presents key insights from open-response items.

Summary of Results for the Final MHSSA Evaluation Report

Refer to the Final Report description under the Strategic Communication and Dissemination section below.

Sense Making Process

The WestEd team will facilitate sense making sessions with grantees to help the WestEd and grantee teams understand and contextualize the grant monitoring and survey data results. This process will support grantee in using MHSSA Evaluation data, as well as ensuring that the grantee teams validate the final presentation of findings.

Grantee data sense making sessions will occur in spring 2025. WestEd will facilitate these optional sessions, which will include a reflective discussion amongst grantees based on the survey results related to MHSSA district/county partnerships and school-level mental health systems change, grant monitoring data, and CalSCHLS and CALPADS data. Grantees will identify key insights and initial ideas for using applicable data with guidance and support from WestEd staff. For details on these sessions, please see the Grantee Data Sense Making Session Protocol.

Grantee Partnership Case Study

Brief Summary

WestEd will conduct case studies with 10 grantees to contextualize how school communities across the state are reimagining school mental health systems change. The partnership case study will inform the evaluation while also providing a technical assistance opportunity for grantees to engage in the Grantee Partnership Planning Process (G3P). The G3P will involve WestEd supporting grantee partners in gathering, reviewing, analyzing, and action planning for sustainability. Data will include grantee-specific survey data, quantitative (descriptive) data collected by WestEd and the grantee, and qualitative data that will be gathered throughout the G3P. The sessions with the grantee leadership team will explore

- grantee partnerships,
- county- and school-level mental health systems change,
- the implementation of MHSSA-funded activities and services,

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- community strengths and needs,
- the relationship between the MHSSA and other school mental health initiatives, and
- school mental health outcomes.

The G3P will involve grantee partners participating in a sequence of meetings that follow a data-driven cycle of inquiry and sense making with the support of WestEd facilitators (Butler et al., 2015; Pedaste et al., 2015). The G3P will align with best practices in leveraging systems tools, measures, and data to support leadership teams facilitating school mental health systems change (Hoover et al., 2019; Kincaid & Romer, 2021; Splett et al., 2017). The G3P will

- focus on grantee-specific MHSSA and school mental health priorities;
- provide multiple qualitative and quantitative data sources to better understand the partnership, school mental health system, implementation, and contextual factors;
- support grantee partners in data analysis and sense making; and
- result in an initial set of action items toward an effective and sustainable school mental health system.

The G3P is currently in development, and the final version and all supporting documentation will be submitted to the Commission on December 15, 2024. A team of senior WestEd staff is leading the development of the survey and the corresponding G3P that will guide the partnership case study.

Research Questions

The grantee partnership case study will address the research questions listed in Table 11.

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Table 11. MHSSA Research Questions Addressed by the Grantee Partnership Case Study with Associated Data Sources

MHSSA Evaluation Framework	Research Question	Data Sources
Grantee Partnership	2. What were the facilitators and/or barriers related to leadership teaming and collaboration?	G3P
County- and School-Level Mental Health System	3. What were the facilitators and/or barriers related to the implementation of school mental health systems change at each level (county, district, school)?	G3P
	4. What was the relationship between MHSSA grantee partnerships and the county-level school mental health system?	G3P
	6. What was the relationship between the county-level and the school-level mental health system?	G3P
MHSSA-Funded Activities and Services	7. How did the MHSSA grantee partnerships support the implementation of MHSSA-funded activities and services?	G3P
	9. How were MHSSA-funded activities and services selected, designed, and implemented to close the equity gap?	G3P
Community Factors	11. What were the mental health strengths and needs of young people and their school communities?	G3P
	12. How did community factors serve as facilitators and/or barriers to school mental health systems change at each level (county, district, school)?	G3P
Other School Mental Health Initiatives	13. How did other school mental health initiatives serve as facilitators and/or barriers to the implementation of school mental health systems change at each level (county, district, school)?	G3P
Meaningful and Equitable Outcomes	14. How did improvements in the school-level mental health system support students' mental health needs and for whom?	G3P

Sample and Recruitment

WestEd will conduct a systematic sampling of 10 grantee partnership teams, ensuring diversity based on a set of several county-level characteristics.[4] First, the sampling process will begin with the separation of partnerships by cohort. WestEd will aim to recruit teams from three to four counties per cohort. Within Cohorts 1 and 2, partnership type will then be prioritized, aiming for two existing and one new partnership within Cohort 1, as well as one existing and two new partnerships within Cohort 2. Partnership type does not exist for Cohort 3 and will therefore not be prioritized for this cohort.

Next, the regional distribution of counties will be considered, with a goal of including one county from each designated region (i.e., Northern, Central, and Southern) within each cohort. Finally, the county's locale will be considered based on the California State Association of Counties caucus designations, with a recruitment goal of at least one urban, one suburban, and one rural county within each cohort.

Partnership teams will be composed of 5–10 members. As the survey and inventory are developed, guidance on the composition and structure of the partnership team will be finalized. To recruit the sample of grantee team members from partnership entities leading the implementation of MHSSA activities and services and school mental health systems change, WestEd will collaborate with behavioral health agency and education county and district grantee leads.

Method/Process

School Mental Health System Inventory

The G3P is currently being developed to use a school mental health systems change planning process that aligns with the grantee survey, which will assess the MHSSA conceptual model elements of this case study (see p. X). The G3P will be informed by the cycle of inquiry and collaborative inquiry research (Butler et al., 2015; Pedaste et al., 2015) and will consist of a four to five session sequence of 1.5- to 2-hour Zoom meetings. WestEd will work closely with grantee leads to schedule sessions (e.g., a partnership team may prefer more frequent, shorter meetings).

An example session sequence follows:

Session 1: Overview of G3P (2 hours)

- Provide overview of the G3P process.
- Identify partnership team goals and priorities.
- Present summaries of the grantee survey and other data gathered by WestEd.

[4] Timing of the Grantee Partnership Case Study is critical to ensure the inclusion of all grantees across Phases 1–3 in the sampling frame. The following counties have contracts that end in summer or fall 2025: San Mateo, Orange, San Luis Obispo, Santa Clara, Solano, Trinity-Modoc, Tulare, Lake, Marin, Monterey, Nevada, Sacramento, Santa Cruz, Sonoma, and Tuolumne.

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- Identify additional data that partnership teams may provide related to the unique focus of their MHSSA activities and services and/or school mental health systems change.
- Assesses overall readiness to engage in the G3P.
- Assign next steps (e.g., review of data prior to next meeting).

Session 2: Team Calibration (1.5 hours)

- Review questions, observations, and concerns related to specific domains of the survey and other data sources.

Session 3: Analysis of Data (2 hours)

- Facilitate data analysis using a sequence of data visuals and guiding questions.

Session 4: Action Planning (1.5 hours)

- Use action planning to move from data to practice by focusing on equitable implementation outcomes, improvement plans, and aspects of sustainability.

As previously noted, WestEd is developing the G3P alongside the grantee survey. The G3P will be reviewed by three to four internal and external subject matter experts, as well as by the Commission and grantees.

Data Collection

G3P

The G3P will be completed by five grantee partnership teams in the spring of 2025, followed by another five teams in the fall. Grantee partnership teams whose contracts end in summer 2025 will participate in the spring 2025.

Secondary Data

WestEd will collect relevant documents at the county and district levels from each county's school mental health system to contextualize each case study. Documents and aggregated data at the school, district, or county levels will be used in the secondary data analysis. WestEd will not request any individual-level student data.

Analytic Plan

Data from Grantee Partnership Case Study will be analyzed at each stage of the G3P. The following provides a high-level overview of the planned analyses within each phase. Throughout the sessions, partnership teams will review data, complete G3P activities that will serve as process artifacts, and respond to guiding questions within this process. Sessions will be recorded for the WestEd team to review for clarification as necessary.

Prework

Prior to the first Grantee Partnership Case Study session, WestEd will create a summary of each grantee's survey data, as well as data from the Contextual Descriptive

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Analyses. Means, medians, and standard deviations will be used as descriptive statistics. Frequencies and percentages of categorical variables will also be reported. Data visualizations (e.g., line graphs and scatter plots) will be created as appropriate.

Postsession Analyses

Each Grantee Partnership Case Study session will be guided by a set of questions. Following each session, responses to these questions will be summarized to identify key areas of strength and need, as well as additional information to hypothesize root causes. Data will be synthesized across the participating 10 grantee teams to identify cross-case themes that will inform collective learning from the MHSSA Evaluation.

Reporting and Dissemination

Partnership case study findings will be included in the ongoing strategic communications and final report described at the end of this report. WestEd will collaborate closely with grantees to gather input and feedback on how the findings from G3P are summarized and presented in the final evaluation and other communications.

Case Study Reports

WestEd will create a brief case study report about each school that participated in the Implementation and Impact School Case Study.

Summary of Results for the Final MHSSA Evaluation Report

The results of the cross-case thematic analysis will be reported in the final evaluation report. The summary of results will include the themes identified through the analysis, as well as a summary of insights gained through sense making.

Implementation and Impact School Case Study

Brief Summary

WestEd will conduct a multimethod case study of 12 MHSSA-funded schools. Case-centered research design is a strategy in which researchers conduct an in-depth study of one or more cases. The cases are time and activity bound, and researchers collect detailed information over an established period using a variety of data collection procedures (Creswell, 2009).

WestEd will collect qualitative data for the Implementation and Impact School Case study through interviews, focus groups, and document reviews (Denzin & Lincoln, 2011; Patton, 2002). WestEd will collect existing MHSSA-related documents at the school and district levels, as well as data on mental health and wellbeing activities and services at each school, to contextualize each case study. Primary data collection will include interviews and focus groups with school staff, mental/behavioral health professionals, students, and families/caregivers. As part of a Youth Engagement Supplement (YES), WestEd will partner with students from four schools to co-interpret data and support

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young people in making recommendations for school mental health systems change to state and local school mental health system leaders.

The Implementation and Impact School Case study will help to explain the impact of MHSSA-funded activities and services and school mental health system changes on school and student outcomes. It will also explore intervention conditions and describe MHSSA implementation in the context of each participating school.

Research Questions

The Implementation and Impact School Case Study will address the research questions listed in Table 12.

Table 12. MHSSA Research Questions Addressed by the Implementation and Impact School Case Study with Associated Data Sources

MHSSA Evaluation Framework	Research Question	Data Source
County- and School-Level Mental Health System	3. What were the facilitators and/or barriers related to the implementation of school mental health systems change at each level (county, district, school)?	MHSSA Implementation Liaison
	4. What was the relationship between MHSSA grantee partnerships and the county-level school mental health system?	MHSSA Implementation Liaison
	5. What was the relationship between MHSSA-funded activities and services and the school-level mental health system?	MHSSA Implementation Liaison School Staff School Mental and Behavioral Health Professionals
	6. What was the relationship between the county-level and the school-level mental health system?	MHSSA Implementation Liaison
MHSSA-Funded Activities and Services	7. How did the MHSSA grantee partnerships support the implementation of MHSSA-funded activities and services?	MHSSA Implementation Liaison
	8. What activities and services were implemented using MHSSA funding?	Document Review MHSSA Implementation Liaison

	9. How were MHSSA-funded activities and services selected, designed, and implemented to close the equity gap?	Document Review MHSSA Implementation Liaison School Staff School Mental and Behavioral Health Professionals
	10. What were the facilitators and/or barriers to implementing MHSSA-funded activities and services?	MHSSA Implementation Liaison School Staff School Mental and Behavioral Health Professionals
Community Factors	11. What were the mental health strengths and needs of young people and their school communities?	Document Review School Staff School Mental and Behavioral Health Professionals Students Families/Caregivers
	12. How did community factors serve as facilitators and/or barriers to school mental health systems change at each level (county, district, school)?	Document Review School Staff School Mental and Behavioral Health Professionals Students Families/Caregivers
Other School Mental Health Initiatives	13. How did other school mental health initiatives serve as facilitators and/or barriers to the implementation of school mental health systems change at each level (county, district, school)?	MHSSA Implementation Liaison School Staff School Mental and Behavioral Health Professionals
Meaningful and Equitable Outcomes	14. How did improvements in the school-level mental health system support students' mental health needs and for whom?	School Mental and Behavioral Health Professionals Students Parents

Sample and Recruitment

WestEd will systematically sample a diverse group of 12 MHSSA-funded schools to participate in the case study based on several school-level characteristics. While data will be collected in two to three waves, school sampling will occur prior to the first wave of data collection. Recruitment will take place prior to each wave of data collection and sample selection adjusted accordingly.

Inclusion and Exclusion Criteria

Based on an initial list of MHSSA-funded schools, there are 842 elementary schools, 304 middle schools, 425 high schools, and 564 combined schools that have received funding through the MHSSA. WestEd will consult with the Commission and grantees to update the list of MHSSA-funded schools that will be used as the sampling pool.

Schools will be eligible for inclusion in the Implementation and Impact School Case Study if

- the school used funding from MHSSA to directly fund staff;
- the school received an adequate amount of funding to allow for sufficient school-level dosage of MHSSA-funded activities and services;[5]
- The school recently completed a schoolwide student survey and can provide WestEd with aggregate school-level data that is aligned with the MHSSA Evaluation Framework (CHKS or similarly aligned survey).

Selection

Sampling will follow the Grantee Partnership Case Study methodology described above. WestEd will sample a group of 12 MHSSA-funded schools based on the funding phase and several school-level characteristics listed in Table 13 below. WestEd will select schools for participation using stratified random sampling (Kalton, 2002). Strata will be defined by school-level variables using a cluster analysis, a methodology for identifying similar patterns across observations and creating classifications (Tipton, 2013).

The final school case study sample will be selected to reflect the variety of MHSSA-funded activities and services. This approach ensures that the narratives generated from the Implementation and Impact School Case Study reflect the diversity of MHSSA-funded activities and services implemented statewide. WestEd will validate the selection of schools with grantees to ensure their readiness and fit.

Table 13. School Case Study Sampling Frame Data Sources

Relevant variables	Secondary data source
• **Elementary, middle or high school** • **% White, non-Hispanic** • **Average daily attendance** • **% Socioeconomically disadvantaged**	CALPADS school-level data
• **Urban/rural/suburban designation**	CA State Association of Counties

[5] Dosage criteria will be determined in collaboration with partners before the school sampling is conducted

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Site Recruitment

WestEd will recruit four schools from each funding phase that include at least one elementary school, one middle school, and one high school. The first wave of recruitment will prioritize Phase 1 schools within MHSSA grantee counties whose grant awards expire in 2025 (*n* = 4). The next wave(s) of data collection will include Phases 2 and 3 schools in MHSSA grantee counties with later grant end dates (*n* = 8).

To support initial outreach, WestEd will partner with grantees from the sample school's county to connect WestEd to an MHSSA Implementation Liaison (see Table 14 below for roles and responsibilities of each school case study partner and participant) to ensure that the data collection plan and timeline is appropriate for the school. WestEd will share recruitment materials that outline the purpose and the goals of the MHSSA Evaluation, participation requirements, a data collection timeline, and potential risks and benefits to participating in the case study with prospectives sites. As an incentive for schools to participate in the case study, WestEd will provide a $1,000 gift card for the purpose of purchasing school supplies.

Method/Process

Data Sharing Agreements

WestEd will establish a data sharing agreement with each school that will include

- start and end data of the case study,
- purpose of the study,
- requested information,
- data type,
- requested data delivery/collection date, and
- plan for dissemination.

Secondary Data Collection

WestEd will collect related school- and district-level related documents about each selected site's school mental health system for the purpose of contextualizing each case study. Data may include documents as well as aggregated data at the school- or district-level. WestEd will not request any individual-level student data.

Primary Data Collection Planning and Coordination

Protections to Ensure the Health and Wellbeing of Evaluation Participants

Several safeguards are in place to protect the health and wellbeing of evaluation participants. Before data collection begins, WestEd will get Institutional Research Board (IRB) approval the from the California Committee for the Protection of Human Subjects and from WestEd's Office of Research Integrity. All WestEd research staff will be trained on guidelines to protect participant confidentiality and securely handle data (see the Data Security Plan document). At the start of each focus group, behavioral

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guidelines will be discussed, including agreements to keep the information shared during the focus group confidential and to limit the use of names of individuals not in the focus group.

Due to the sensitive topics covered in qualitative interviews and focus groups, adults and students may feel embarrassed or experience strong emotions during conversations with WestEd researchers. To proactively support students, a trusted adult from the school community will be present during all student data collection activities.

WestEd will follow research guidelines outlined in the Adapted Trauma-Informed Social Research Guide. All data collection protocols have been developed using a trauma-informed lens (Alessi & Kahn, 2023; Dowding, 2021) and will be reviewed by three to five mental health professionals before data collection begins. Contacts at school sites will also have the opportunity to review protocols before they are implemented. Consent and assent will be revisited throughout the data collection process. Senior WestEd staff will debrief with all data collectors following each round of interviews and focus groups, which will help uncover any new risks or potential issues.

To protect participant anonymity within their school, interview and focus group notes and transcripts will be de-identified from the start. The data manager will maintain a list of participants and assign them a unique project ID number. Interviewers will use this ID number on the hard copy focus group protocol, notes, and recordings/transcripts. The use of names will be avoided as much as possible during the notetaking process.

For in-person and virtual interviews and focus groups, notes will be taken on encrypted WestEd laptops and the notetaker will upload their notes and recordings to a designated project box folder. Once the data manager confirms that data has been properly synced and is complete, the manager will notify the interview notetaker, who will then delete the data from their recording devices and laptops.

Aside from uploading data privileges for the interview/focus group notetakers, only the project directors and the Implementation and Impact School Case Study lead will have full access to this special project Box folder. Information will be stored in such a way that no unauthorized persons (including unauthorized WestEd staff) can retrieve or alter it using a computer, remote terminal, or any other means. The notes and transcripts will be reviewed by the focus group manager to ensure that names or other identifiers are deleted. Once cleaned, de-identified focus group notes will be transferred to a project analysis folder.

De-identified focus group data will be analyzed using qualitative data analysis software, and the analysts will use copies of these de-identified data to categorize and code the data. Selected summaries of these analyses or copies of selected de-identified interview/focus group notes may be shared with the larger WestEd research team for analysis.

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Site-Specific Process Planning

The Impact and Implementation School Case Study will include virtual and on-site data collection. WestEd will conduct a 2-day site visit to each school with two or three WestEd facilitators who bring expertise in participatory qualitative research, are trained in trauma-informed data collection methods, and have experience collecting data in school settings.

WestEd will conduct interviews and focus groups with school staff, mental/behavioral health providers, students, and families/caregivers. These discussions (see Table 14 for more information about each group) will focus on the coordination and implementation of MHSSA-funded activities and services. Additionally, they will address the impact of MHSSA-funded activities and services on the broader school mental health system and the impact of school mental health systems change on school and student outcomes.

For documentation purposes, all interviews and focus groups will be audio recorded. WestEd will partner with each site to establish the appropriate processes and procedures for on-site data collection activities, ensuring protocols accommodate participant schedules. This includes the option to use Zoom for data collection when on-site methods are not feasible for select evaluation participants. WestEd will collaborate with the MHSSA Implementation Liaison, the Site Coordinator, and the Student Liaison to facilitate data collection planning and preparation (see Table 14 for roles and responsibilities).

Table 14. Implementation and Impact School Case Study Role Information

Role/Title	Description/Role	Compensation[6]
MHSSA Grantee Contact	The point of contact from the grantee partnership who works directly with someone at the school to coordinate implementation of MHSSA-funded activities and services	N/A
MHSSA Implementation Liaison	An individual funded by MHSSA at the school who is responsible for communicating or coordinating with the MHSSA grantee partnership team. The MHSSA implementation liaison will provide a referral for the site coordinator and a student liaison and participate in an interview.	School incentive $1,000
Trusted Adult	A school staff member, possibly school counselor or other mental health professional, who attends youth focus groups and youth engagement sessions, both on-site and virtual. The trusted adult should have appropriate training to provide support to students if their participation in an evaluation activity causes distress.	$200 digital gift card

[6] In cases where local policies do not allow monetary compensation, WestEd will collaborate with the school to identify alternative compensation of the same amount.

Student Liaison[7]	A student leader identified in partnership with the MHSSA Implementation Liaison to inform the student focus group recruitment strategy	$25 digital gift card
State and Local School Mental Health System Leaders	Adults with leadership roles in the school mental health system. Leaders will be invited to participate in sessions 4 and 5 of the YES.	N/A
Site Coordinator	A site staff member identified by the MHSSA Implementation Liaison who will facilitate scheduling onsite sessions and focus group recruitment.	$200 digital gift card
School Site Staff	School-based staff who interact with students on a regular basis as teachers, coaches, administrators, or other role (e.g. bus driver). They will participate in the school case study as focus group participants.	$50 digital gift card
Mental and Behavioral Health Professionals	Community-based providers, school counselors, social workers, school psychologists, wellness center directors, etc. They will participate in the school case study as focus group participants.	$50 digital gift card
Students	Young people who attend the school selected for the case study. They will participate in the school case study as focus group participants.	Pizza party $50/session for students participating in the YES
Youth Data Collectors	Young people who are a part of the MHSSA YAG and are trained to cofacilitate youth engagement sessions.	$50 per hour
Family/Caregiver	Family or caregiver of a student who attends the school. They will participate in the school case study as focus group participants.	$50 digital gift card Light refreshments at focus groups

MHSSA Implementation Liaison

WestEd will virtually meet with the MHSSA Implementation Liaison as part of the outreach process described above to establish a relationship and begin planning for data collection. WestEd will ask the MHSSA Implementation Liaison to select an appropriate individual to act as the site coordinator.

Site Coordinator

WestEd will meet virtually with the Site Coordinator to better understand the school context and tailor recruitment materials and data collection protocols for each site's specific needs. In addition, WestEd will ask the Site Coordinator to identify an

[7] Implementation and Impact School Case Study methods will be adapted in elementary school settings. All coordination activities will take place with the support of adults only.

appropriate student to serve as the student liaison and recruit for and schedule on-site data collection to account for school and community events, professional development or early-release days, and other site-specific opportunities or constraints.

One month before data collection begins, WestEd will ask the Site Coordinator to distribute data collection information flyers to the school community. Interested individuals will be asked to complete a brief interest survey that includes contact and demographic information, as well as group-specific questions to determine their fit for the MHSSA Evaluation data collection activity. WestEd will select individuals to participate in data collection activities based on their answers to the brief survey. The Site Coordinator will also be asked to communicate directly with students and their families/caregivers to obtain consent.

Student Liaison

WestEd will meet virtually with the Student Liaison to gather input on how to best adapt recruitment materials and/or data collection protocols and processes to be culturally responsive. WestEd will work with the Student Liaison to identify a trusted adult within the school to attend student focus groups and engagement sessions.

Primary Data Collection

WestEd will conduct interviews and focus groups with school staff, mental/behavioral health professionals, students, and families/caregivers using a trauma-informed and culturally responsive approach. Table 15 provides detailed information about each data collection activity.

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Table 15. Interview and Focus Group by Implementation and Impact School Case Study Participant

Participant	Interview/Focus group	Number of participants per session	Protocols
MHSSA Implementation Liaison[8]	One 60-minute interview	1–4	MHSSA Implementation Liaison Interview Questions
School Staff	Up to two 60-minute focus groups	6–10	School Staff Focus Group Questions
School Mental and Behavioral Health Professionals	Up to two 60-minute focus groups	6–10	School Mental and Behavioral Health Professionals Focus Group Questions
Students from Grades 5–12	One 90-minute focus group	10–15	Student Focus Group Questions
Family/Caregiver	Up to two 60-minute focus groups	6–10	Family/ Caregiver Focus Group Questions

Youth Engagement Supplement (YES)

The YES is a five-session protocol designed to deeply engage young people in the MHSSA Implementation and Impact School Case Study. WestEd will cofacilitate engagement activities across four schools selected from the sample of Implementation and Impact School Case Study sample. This supplement aims to gather deeper student insights and perspectives on school mental health services and foster student engagement state and local school mental health systems change initiatives.

The YES sample will be limited to late middle and high school students who are at a critical developmental stage where they can fully participate in all MHSSA Evaluation engagement activities.

Each of the four participating schools will follow a cohort model, in which the same group of students from each school will be invited to participate in all five sessions.

[8] If the MHSSA Implementation Liaison works closely with additional staff at the school for MHSSA implementation, the protocol will be adapted for a focus group.

School Selection and Onboarding

Four schools will be selected from an initial pool of 12 case study schools, representing diverse local contexts and MHSSA-funded activities and services. To qualify, schools must be a middle or high school, and the site coordinator must have the capacity to support session coordination. If more than one school meets the inclusion criteria, WestEd will randomly select a participating school.

Youth Recruitment

In partnership with the Site Coordinator and Student Liaison, WestEd will recruit up to 15 middle and high school students (ages 13–19) utilizing flyers and a social media campaign. WestEd will collect an online application form and selected students will be contacted with information about the sessions to set appropriate expectations. WestEd will ask interested students to attend all sessions to foster trust and cohesion among the student cohort.

Session Protocols

WestEd will partner with each school to adapt the YES implementation plan to meet the needs of each student community. Planning will involve initial meetings with each school's site coordinator to finalize session dates and ensure there is an appropriate space for each session.

A subgroup of the MHSSA Evaluation YAG consisting of high school and early college-aged students from across California will be trained to serve as youth data collectors for the YES. These youth data collectors will play an active role in facilitating the YES sessions. They will contribute by creating introductory content, facilitating virtual discussions, and taking notes during key activities. The sections that follow provide an overview of the goals and activities of each of the five sessions.

Session 1: In the first session, WestEd facilitators will assist students in becoming familiar with and interpreting data sources relevant to their school's case study, such as CHKS data and school focus group data. While on-site in a designated classroom, WestEd facilitators will lead relationship-building activities, orient students to data sources, and engage in small and full group discussion making meaning of the data (EdTrust, 2024). While not directly participating in the session, youth data collectors will create an introductory video about themselves and the MHSSA to establish a youth-centered atmosphere. Across all five sessions, the same trusted and appropriately trained school staff member will be present and will be invited to cofacilitate sections of each session to support trust-building and ensure ethical protections of youth during and after the sessions.

Session 2: During the second session, WestEd will gather youth perspectives about school and community mental health strengths and needs (Burns et al., 2012). Using a protocol adapted from the Advancement Project, WestEd facilitators will incorporate student insights into a product (map or list) that will be shared with state and local school mental health system leaders during Session 4.

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Session 3: In the third session, WestEd facilitators will help students prepare to share their perspectives about school mental health with state and local school mental health system leaders. Held virtually, this session will continue to emphasize trust building, while also including a presentation skills workshop and practice session to prepare for the student panel.

Session 4: In the fourth session, WestEd will facilitate a virtual student panel with state and local school mental health system leaders. Students will present their insights and asset map in a structured panel format.

Session 5: In the final session, WestEd will facilitate a reflective discussion about student experiences participating in the five-session series. The meeting will close with an opportunity for students to consider opportunities for ongoing engagement with student mental health systems change.

Analytic Plan

WestEd researchers will meet weekly during the Implementation and Impact School Case Study data collection, analysis, and reporting periods to engage for reflective discussions and peer debriefing to ensure that any biases or assumptions have minimal impact on data collection and analysis (Roller & Lavrakas, 2015).

Following transcription, WestEd will conduct a summative thematic analysis of the transcripts using the process described in the Grantee Partnership Case Study section above. The goal of the thematic analysis will be to identify trends within and across schools to gain insight on the associated research questions. Following an initial analysis, WestEd will engage in sense making with youth data collectors and other partners and findings will be refined, revised, and disseminated.

Reporting and Dissemination

WestEd will disseminate case study findings to each participating case study school, as well as with broader MHSSA partners, using the strategic communications and final report described in the following section.

Case Study Reports

WestEd will prepare a brief case study report for each school that participated in the Implementation and Impact School Case Study with key findings.

Summary of Results for the Final MHSSA Evaluation Report

WestEd will report the findings from the cross-case thematic analysis in the final evaluation report. For more information, please refer to the Final Report description under the Strategic Communication and Dissemination section below.

Dissemination and Strategic Communication

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Brief Summary

WestEd will produce content for quarterly products for key audiences to ensure transparency, solicit input, and increase the visibility of the MHSSA Evaluation. WestEd will also produce two final MHSSA Evaluation reports, one community facing and one technical, as well as a final presentation of evaluation findings to present to Commission staff at the end of the evaluation.

Method/Process

Quarterly Communication Products

WestEd will develop content for quarterly products for key audiences. These products will include disseminating evaluation findings and highlighting evaluation products generated during the evaluation. Examples include a newsletter containing preliminary evaluation findings; a county, school or participant impact story; or a presentation from a YES cohort.

Final Reporting

WestEd will develop a technical summative evaluation report that includes an executive summary, introduction, evaluation questions, research design, results, and discussion. Data from all evaluation components will be used to generate the results.

WestEd will also create a community-facing summative evaluation report that will provide information necessary for a general audience to understand the MHSSA Evaluation's purpose, approach, and outcomes. WestEd will follow several recognized methods for effectively communicating evaluation findings to nontechnical audiences to ensure the report is accessible to policymakers and practitioners. WestEd will integrate data visualizations into the body of the report in accordance with Evergreen's (2017) design principles.

WestEd is skilled at visually representing data using current techniques and trends, allowing readers to better understand study results and will ensure that the visualized insights are understandable and compelling for the intended audiences. Within the community-facing report, WestEd will avoiding jargon and highly technical terms to describe evaluation findings (Torres et al., 2005).

WestEd research staff will work with the WestEd Communications Department, which includes professional editors and designers, to create final reports. WestEd's Communications Department has an efficient quality assurance review process for all reports and ensures that high-visibility reports are thoroughly reviewed and made accessible to all audiences.

The MHSSA Evaluation will leave behind data infrastructure and evaluation technical assistance resources that the Commission, grantees, and participating school sites can continue to use after the evaluation period.

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Lastly, WestEd staff will prepare an in-person presentation of the key evaluation findings to share with Commission staff. The presentation will be tailored to the needs of the Commission staff, with the goal of summarizing the study's findings and generating ideas and discussion.

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Appendix A. Associated Document List

Appendices B-P contain the following documents:[9]

- Appendix B. Grantee Table
- Appendix C. Contextual Descriptive Analysis Metrics
- Appendix D. Grantee Data Sense Making Session Protocol
- Appendix E. Data Security Plan
- Appendix F. Adapted Trauma-Informed Social Research Guide
- Appendix G. MHSSA Implementation Liaison Interview Questions
- Appendix H. School Staff Focus Group Questions
- Appendix I. School Mental and Behavioral Health Professionals Focus Group Questions
- Appendix J. Student Focus Group Questions
- Appendix K. Family/Caregiver Focus Group Questions
- Appendix L. Youth Engagement Supplement (YES) Session 1 Agenda
- Appendix M. Youth Engagement Supplement (YES) Session 2 Agenda
- Appendix N. Youth Engagement Supplement (YES) Session 3 Agenda
- Appendix O. Youth Engagement Supplement (YES) Session 4 Agenda
- Appendix P. Youth Engagement Supplement (YES) Session 5 Agenda

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[9] WestEd communications department, community partners, and content experts will complete their review of documents included in Appendices B-P by December 15th.

Appendix B. Grantee Table

Grantee Table

Grantee	Phase	Size	Total funding	Contract end date	MHSSA-Funded Elementary schools	MHSSA-Funded Middle schools	MHSSA-Funded High schools	MHSSA-Funded Combined schools
Calaveras	1	Small	$3,174,751	12/31/26	7	0	0	3
Fresno	1	Large	$7,619,403	8/31/26	171	38	57	78
Humboldt	1	Small	$3,174,751	12/31/26	18	8	15	25
Kern	1	Large	$7,619,403	8/31/26	0	6	2	0
Madera	1	Small	$3,174,150	9/30/26	0	1	1	4
Mendocino	1	Small	$3,174,751	12/31/26	7	3	6	7
Orange	1	Large	$7,619,403	8/31/25	7	5	5	1
Placer	1	Medium	$5,079,602	12/31/26	4	0	0	0
San Luis Obispo	1	Medium	$3,856,907	8/31/25	1	5	1	2

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Grantee	Phase	Size	Total funding	Contract end date	MHSSA-Funded Elementary schools	MHSSA-Funded Middle schools	MHSSA-Funded High schools	MHSSA-Funded Combined schools
San Mateo	1	Large	$5,999,999	9/30/24	13	6	10	3
Santa Barbara	1	Medium	$5,022,151	9/30/26	22	6	11	7
Santa Clara	1	Large	$7,619,403	10/31/25	0	3	3	0
Solano	1	Medium	$5,079,602	8/31/25	0	0	0	4
Tehama	1	Small	$3,174,751	9/30/26	10	6	4	11
Trinity-Modoc	1	Small	$2,945,830	9/30/25	3	1	10	14
Tulare	1	Medium	$5,079,602	8/31/25	0	5	6	17
Ventura	1	Large	$7,619,314	12/31/26	1	0	7	0
Yolo	1	Medium	$5,079,602	12/31/26	24	7	12	10
Amador	2	Small	$2,487,384	8/31/26	6	2	3	0
Contra Costa	2	Large	$7,613,588	12/31/26	0	2	0	0
Glenn	2	Small	$2,500,000	7/31/25	3	2	4	0
Imperial	2	Small	$3,174,751	7/31/26	0	0	10	2
Lake	2	Small	$2,499,450	9/30/25	7	3	11	16
Los Angeles	2	Large	$7,619,403	12/31/26	0	0	7	0

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Grantee	Phase	Size	Total funding	Contract end date	MHSSA-Funded Elementary schools	MHSSA-Funded Middle schools	MHSSA-Funded High schools	MHSSA-Funded Combined schools
Marin	2	Medium	$5,079,602	7/31/25	0	3	4	0
Monterey	2	Medium	$3,999,979	8/31/25	14	3	5	1
Nevada	2	Small	$3,174,050	8/31/25	3	0	0	0
Riverside	2	Large	$7,272,483	8/31/26	0	0	5	1
Sacramento	2	Large	$7,619,403	8/31/25	12	5	9	4
San Bernardino	2	Large	$5,998,000	1/31/26	19	5	7	4
San Diego	2	Large	$7,111,133	6/30/26	263	70	67	99
San Francisco	2	Large	$6,000,000	9/30/26	0	13	3	0
Santa Cruz	2	Medium	$5,079,602	8/31/25	3	4	6	0
Shasta	2	Small	$2,965,755	12/31/26	0	0	4	6
Sonoma	2	Medium	$5,079,602	7/31/25	7	7	11	3
Sutter-Yuba	2	Small	$2,618,184	1/31/26	1	1	3	17
Tuolumne	2	Small	$2,494,962	10/31/25	0	0	2	8
Alameda	3	Large	$7,619,403	12/31/26	3	12	5	3
Berkeley City	3	Small	$2,500,000	6/30/26	11	3	2	0

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Grantee	Phase	Size	Total funding	Contract end date	MHSSA-Funded Elementary schools	MHSSA-Funded Middle schools	MHSSA-Funded High schools	MHSSA-Funded Combined schools
Butte	3	Medium	$5,079,602	9/30/26	12	7	5	9
Colusa	3	Small	$2,500,000	12/31/26	5	2	4	4
Del Norte	3	Small	$2,500,000	12/31/26	5	1	2	7
El Dorado	3	Small	$5,044,665	12/31/26	23	8	10	11
Inyo	3	Small	$2,499,444	6/30/26	4	1	2	2
Kings	3	Small	$3,174,751	12/31/26	3	2	1	1
Lassen	3	Small	$2,274,040	6/30/26	3	2	5	12
Mariposa	3	Small	$2,500,000	12/31/26	0	0	3	7
Merced	3	Medium	$4,810,949	12/31/26	13	4	9	4
Mono	3	Small	$2,500,000	6/30/26	2	1	3	3
Napa	3	Small	$2,954,476	12/31/26	17	6	7	7
Plumas	3	Small	$1,749,800	6/30/26	3	0	3	5
San Benito	3	Small	$2,500,000	12/31/26	1	4	2	15
San Joaquin	3	Large	$7,619,403	12/31/26	40	12	31	93
Sierra	3	Small	$1,566,204	6/30/26	2	0	1	2

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Grantee	Phase	Size	Total funding	Contract end date	MHSSA-Funded Elementary schools	MHSSA-Funded Middle schools	MHSSA-Funded High schools	MHSSA-Funded Combined schools
Siskiyou	3	Small	$3,174,751	12/31/26	0	0	0	1
Stanislaus	3	Medium	$5,079,602	12/31/26	40	14	10	21
Tri-City	3	Medium	$4,852,204	12/31/26	29	5	9	10

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Appendix C. Contextual Descriptive Analysis Metrics

Contextual Descriptive Analysis Metrics

This document provides a series of tables that show the MHSSA Evaluation metrics and their associated data sources. The document covers all secondary data sources that will be used in the contextual descriptive analysis, including the California Healthy Kids Survey (CHKS), the California Longitudinal Pupil Achievement Data System (CALPADS), the California Open Data Portal, Project Implicit, and the U.S. Census. It also lists the CALPADS school-level demographic data that will be used in the Contextual Descriptive Analysis.

Table 1. MHSSA Evaluation Metric and Associated CHKS Data

MHSSA Evaluation Outputs and Outcomes	CHKS Domain/Scale
Promoting mental health and wellbeing	**Student Surveys** • School Co-Regulation Supports Scale • Responses to Trauma Scale • Stress Associated Health Symptoms Scale • Loneliness Scale • Optimism Scale • Life Satisfaction Scale
	Staff Survey • Caring Relationships Scale • High Expectations Scale • Student Readiness to Learn Scale
Providing linkages to ongoing services	**Student Surveys** • School Co-Regulation Supports Scale
	Staff Survey • Staff Efficacy for Promoting Student Well-Being Scale
Improving timely access to services for underserved populations	**Student Surveys** • School Co-Regulation Supports Scale

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Improving school climate	**Student Surveys** • Total School Environment Domain and Subdomains • School Connectedness Scale • Academic Motivation • Social and Emotional Learning Supports Scale • Fairness Scale • Positive Behavior Scale • Violence Victimization Scale • Antibullying Climate Scale • Promotion of Parental Involvement Scale • School Violence Perpetration Scale
	Staff Survey • Student Learning Environment Scale • Staff Working Environment Scale • Staff Collegiality Scale • Caring Relationships Scale • High Expectations Scale • Student Meaningful Participation Scale • Promotion of Parental Involvement Scale • Support for Social and Emotional Learning Scale • Fairness and Rule Clarity Scale • Respect for Diversity Scale • Instructional Equity Scale • Antibullying Climate Scale
Reducing prolonged suffering	**Student Surveys** • Social Emotional Distress Scale • Optimism Scale • Life Satisfaction Scale
	Staff Survey • Staff Efficacy for Promoting Student Well-Being Scale
Increasing SEL skills	**Student Surveys** • Emotion Regulation Scale • Social and Emotional Learning Supports Scale • Positive Behavior Scale **Staff Survey** • Support for Social and Emotional Learning Scale • Student Readiness to Learn Scale
Reducing suicide/attempted suicide	**Student Surveys** • Suicidal Ideation Indicator
Reducing school failure/dropout	**Student Surveys** • Academic Motivation Scale
Reducing stigma/discrimination	**Student Surveys** • Emotional Safety at School Scale

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Table 2. MHSSA Evaluation Metric and Associated CALPADS Data on Student Outcomes

MHSSA Evaluation Outcome	Aligned CALPADS Domain
Reducing school failure/dropout	**Disciplinary Outcome** • Disciplinary incident • Action taken for disciplinary incident

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Table 3. CALPADS School-Level Demographic Data Used in the Contextual Descriptive Analysis

Data Type	Data Items
Demographics	• Grade level • Gender • Race/ethnicity indicators as federally required • SEO (socio-economic disadvantage status) • Homeless status • Migrant status • Special education status • Foster youth status • Primary language • The recommended composite measure of high school student success (that would replace A-G courses completed) • Number of days students attended regular school (for all students enrolled under the CDS code listed)
English Learner Outcomes	• English language acquisition status code • English language acquisition status start date • ELPAC scores
Academic Outcomes	• CAASPP ELA • CAASPP Math

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Table 4. MHSSA Evaluation Metric and Associated Secondary Data Source

MHSSA Evaluation Community Factors	Relevant Items from Existing Tool
Diversity	**Census** • Race • Ethnicity • Disability rate and types
Employment	**Census** • Class of worker • Employment rate • Industry • Occupation • Mean weekly hours worked
Food	**CA Open Data Portal** • Food affordability • SNAP participation • WIC redemptions • Modified retail food environment index
Household Income	**CA Open Data Portal** • Income inequality
	Census • Income/earnings • Poverty
Housing	**Census** • Children in house under/over 18 • Family size • Household types (e.g., married, single) • Residential mobility • Rent • Homeownership rate • Housing value
Language/Culture	**Census** • Language spoken at home • U.S. and not U.S. born
Racism	**Census** • Poverty • Residential segregation
	Project Implicit • Race Implicit Association Test (IAT)

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Resources	**Census** • Health care coverage • Educational attainment
Safety	**CA Open Data Portal** • Violent crime rate
	CHKS • Violence Victimization Scale • Antibullying Climate Scale
Social Connectedness	**CHKS** • School Connectedness Scale • Caring Relationships Scale
Technology	**Census** • Computer and internet use
Transportation	**Census** • Means of transportation to work

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Appendix D. Grantee Data Sense Making Session Protocol

Grantee Data Sense Making Session Protocol

The WestEd team will facilitate sense making sessions with grantees to develop understanding and contextualize the grant monitoring and survey data results. This protocol provides an overview of what will occur during these sessions.

Objectives:

- WestEd will facilitate a data-based reflective discussion.
- Grantees will identify key insights to support the next steps of MHSSA implementation or the implementation of related school mental health initiatives.

Participants:

- 10 grantee sites per session
    - Representation includes leads and teams and at least one representative each from the county behavioral health department and county department of education.
- 10 WestEd facilitators

Duration:

- 2 hours

Materials Needed:

- Data summaries and visualizations for each grantee generated from the following sources:
    - Grantee Survey
    - CHKS Data (if available)
    - CALPADS
    - US Open Data Portal
    - Census
- PowerPoint

Community Agreements:

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- Keep an open mind while challenging ourselves and one another.
- Communicate directly, openly, and clearly.
- Support yourself. Be respectful and patient with one another.
- Be present in the work and when engaging with each other.
- Center youth and community.

Agenda:

1. Welcome and Introduction (10 minutes)
    - Facilitator welcomes participants and introduce the session's objectives.
    - Facilitator briefly reviews the agenda and community agreements for the session.
2. Data Overview (10 minutes)
    - Facilitator presents data structure and content to grantees.
    - Facilitator explains the Group Reflection Protocol.
3. Grantee Group Reflection Protocol (60 minutes)
    - Facilitator asks grantees to
        - review the data with their teams and describe what they see without judgment or interpretation. (15 mins)
        - interpret the data, answering the question: "What does the data suggest?" (15 mins)
        - discuss the implications of the data by answering the question: "What does this mean for our county/district/school?" (30 mins)
4. Break (10 mins)
5. Group Presentations (25 minutes)
    - Each group presents their key learnings to the larger group.
    - WestEd allows time for questions and clarification after each presentation.
6. Closing and Next Steps (5 minutes)
    - WestEd thanks participants for their contributions and participation.

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Appendix E. Data Security Plan

Data Security Plan

This document provides an overview of WestEd's data security approach, infrastructure, and resources.

WestEd maintains a secure computing infrastructure, employing the latest hardware and software technology on a robust network to deliver information and technology services to staff and projects. WestEd operates industry-standard network devices for communications, file sharing, email, database applications, and videoconferencing.

WestEd promotes and enables the protective measures necessary to secure all data. WestEd's data security system has been developed in accordance with the ISO 27001 standard for information security management, as well as with the Federal NIST800-53 standard for security and privacy controls. In addition, WestEd implements a range of security procedures to maintain network and data security. Using tools such as virtual private networks, network firewalls, centralized secure servers, antivirus applications, deniable file systems, and multifactor authentication, WestEd uses the same care with coordinating the collection, management, and analysis of all data.

In consultation with their Institutional Review Board and Data Security teams, WestEd will develop an internal data security plan to detail steps for the storage, transfer, and access of sensitive data (including personally identifiable information [PII]). All data files containing PII data will be encrypted using currently approved National Institute of Science and Technology (NIST) algorithms when being electronically transferred across an internal network. If appropriate, WestEd's Secure Computing Environment (SCE) will also be used to handle highly sensitive data. The SCE is a highly secure online cloud-based storage and processing environment for highly sensitive data. WestEd's SCE is engineered to provide a workspace for client data to be analyzed and assessed, minimizing risk of integrity, compromise, and loss. Using Microsoft's Azure services, WestEd provides a platform backed by industry-leading security standards. The Data Protection Office at WestEd, in collaboration with WestEd's Information Services, controls the policy and deployment of the architecture to ensure that compliance is met.

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In addition, to preserve anonymity and confidentiality, randomly generated numbers (pseudocodes) will be assigned to each individual participant, district, and school, and all data files will be deleted once the project is complete.

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Appendix F. Adapted Trauma-Informed Social Research Guide

Adapted Trauma-Informed Social Research Guide

This guide is adapted from Dowding's Trauma-Informed Social Research guide. It provides practical advice on applying the principles of trauma-informed practice to research activities. For WestEd's purposes, this guidance will specifically inform the planning, execution, and follow-up to focus groups and one-on-one interviews. The tips are organized by before, during, and after the focus group or interviews take place.

Research Checklist: Before

- Participant preferences have been considered when choosing the physical or online venue
- Any accessibility needs are known and have been met collaboratively
- If you will be discussing sensitive topics, participants have had an opportunity to see the questions in advance
- Participants have received accessible information about facilitator(s), the purpose and what to expect, where and when the session will be happening, and if there are refreshments
- Participants have been offered the chance to meet with the facilitator(s) ahead of the session if subject matter is potentially activating
- Whether the session will be recorded is decided, alongside how you will ask for consent to record
- Questions are checked to ensure each question helps you meet a specific aim (i.e., that you are not asking people to share any sensitive information unnecessarily)
- Plans are in place if anyone becomes distressed in the session and needs to take a break
- *Focus groups only:* Potential power dynamics between participants (like line managers and employees, workers and clients) have been considered and there are plans to keep people feeling safe to share their views
- *Focus groups only:* Each topic has enough time allocated, so that everyone can be heard and can explore their views in detail

Research Checklist: During

- Introductions, the purpose, and confidentiality are explored with opportunities to ask questions

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- Participants will be asked whether they are comfortable with being recorded, and will be made aware that they can retract anything they share later on
- Participants will be told about their options if they feel overwhelmed and they would like a break
- Participants are told where recording devices are and when they are turned on and off
- The facilitator(s) planned to meet participants' basic needs throughout, including toilet breaks and water
- Participants will be asked to speak generally rather than ask specific people to feedback (as this could feel pressuring)
- The facilitator(s) plan to pay attention to non-verbal cues or discomfort and address them appropriately
- *Focus groups only:* A group agreement will be made about how everyone is expected to act in the space to keep it feeling respectful and safe
- *Focus groups only:* Participants will be told how all others in the space handle any information that is shared
- *Focus groups only:* Facilitator(s) are aware of their role to facilitate the group discussion, not to present
- *Focus groups only:* Participants will be reminded to be respectful to all people and views, and plans are in place for if this does not occur
- *Focus groups only:* Every participant will be supported to speak and reflect equally

Research Checklist: After

- Participants are told about opportunities to add anything they feel is important before the session closes, and notified if they can continue to contribute after the session
- Facilitator(s) have summarized key points and reassured participants that the information was heard and valued and anyone who became distressed in the session is individually checked in with
- Participants have been thanked for their time and energy
- Signposting materials and debriefing options have been shared for anyone who may be impacted by the contents of the session
- Participants have been given an opportunity to comment on any draft reports, or to be informed when a final report is made available
- Participants have been given the opportunity to feedback on the process in person or via email, during or after the session
- The facilitator(s) have created a dedicated space to reflect on the session and to continuously develop trauma-informed practices

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Appendix G. MHSSA Implementation Liaison Interview Questions

MHSSA Implementation Liaison Interview Questions

Introduction Questions

1. To start, can you tell us your title, role, and how long you have been in this role?

County- and School-Level Mental Health Systems

First, we want to talk about county/school collaboration related to the MHSSA and school mental health more broadly. We will use the term "school mental health system," and when we do, we are referring to the full array of supports and services that promote positive school climate, social and emotional learning, and mental health and well-being, while reducing the prevalence and severity of mental illness. School mental health systems also include the strategic collaboration between school staff, mental and behavioral health professionals, students, families, and community health and mental health partners. These systems also assess and address the social, political and environ-mental structures, like public policies and social norms, that influence student mental health outcomes. Do you have questions about this definition?

2. How have you been involved in MHSSA-funded work at the county- and school-level?
3. What does collaboration between the county and school look like related to school mental health?
4. To what extent has collaboration between the county and school changed since MHSSA funding became available? What has that looked like?
5. How does school mental health systems work within [name of county] affect school mental health systems work at [name of school]?
6. Conversely, how does school mental health systems work at [name of school] affect school mental health systems work within [name of county]?

Implementation

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7. Please describe the activities and services funded by the MHSSA at [name of school].
8. How did local needs within [name of school] or [name of city or town] influence the [MHSSA-funded activities and services] that is/are being implemented at [name of school]?
9. How have [MHSSA-funded activities and services] been implemented over time.
    a. Please describe any challenges in the implementation process.
    b. Please describe how [MHSSA-funded activities and services] connect to broader school mental health efforts at [name of school].
10. In what ways has collaboration between [name of school] and [name of county] supported the implementation of [MHSSA-funded activities and services]?

Outputs and Outcomes

11. What equity gaps, if any, have you seen [MHSSA-funded activities and services] address?
12. How has the implementation of [MHSSA-funded activities and services] impacted the school-level mental health system?
    a. Preventing mental health challenges from becoming severe and disabling ***(output)***
    b. Early recognition of mental health challenges ***(output)***
    c. Responding to need for additional services ***(output)***
    d. Improving
        i. timeline access to services for underserved populations ***(output)***
    e. Responding to the needs of all student subgroups ***(output)***
    f. Providing linkages to ongoing services ***(output)***
    g. Increasing social-emotional learning skills ***(outcome)***
    h. Reducing ***(outcome)***
        i. suicide and attempted suicide
        ii. school failure or dropout
        iii. prolonged suffering
        iv. stigma and discrimination
    i. Promoting ***(outcome)***
        i. Mental health and wellbeing
        ii. Positive school climate

Closing

Before we end, we want to give you the opportunity to share anything else that we haven't asked about.

13. Is there anything else you would like to share related to how the MHSSA has affected the school's capacity and connections for school mental health?

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Appendix H. School Staff Focus Group Questions

School Staff Focus Group Questions

Introduction Questions

1. To get started, please share your name and role, and one way in which you have seen students benefit from the mental and behavioral supports at your school.

School Mental Health System

We want to hear a bit about your perceptions of [name of school]'s school mental health system. By school mental health system, we are referring to the full array of supports and services at [name of school] that promote positive school climate, social and emotional learning, and mental health and well-being, while reducing the prevalence and severity of mental illness.

2. How well equipped do you feel to support student wellbeing and how has your school helped build your capacity to do so?
3. How are teachers and other school staff equipped to support student wellbeing?
4. What are some of the most significant student mental and behavioral health needs at [name of school]?
    a. Are there certain groups of students (e.g., racial/ethnic groups, low-income students, homeless youth, etc.) whose needs are not being met?
    b. What resources are needed to serve the needs of all students in this school?
5. How well is the school mental health system at [name of school] addressing these needs?
    a. How does the school mental health system promote mental health and wellbeing?
    b. How does the school mental health system prevent mental health challenges from becoming severe and disabling?
    c. How does the school mental health system enable the early recognition of mental health challenges?
    d. How does the school mental health system ensure timely access to services for underserved population?
    e. How does the school mental health system respond to the need for additional services?
6. What are the barriers at [name of school] or in the broader community that make it difficult to meet students' mental health needs?
7. In the time you have been in this role, have you seen changes, either positive or negative, to the way [name of school] has supported student mental health?
    a. This could include changes in promoting positive student outcomes or reducing the prevalence and severity of mental illness.

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8. If you have seen changes occur, what are some of the things that were driving that change?
9. What are some of the structural things that still need to occur at [name of school] to adequately support the mental health needs of all students?

MHSSA within the Broader School Mental Health System

We want to hear a bit more about how MHSSA-funded activities and services fit within the broader continuum of care at your school.

10. For those of you who are involved in or aware of the activities and services at [name of school] that are funded by the MHSSA, please describe:
    a. How these new activities and services may have contributed to positive systemic change in the way [name of school] supports student mental health.

The Relationship between County- and School-Level School Mental Health Systems

11. To what extent are you aware of and/or involved in county-level work to strengthen school mental health systems county-wide? If you are aware of and/or involved in county-level school mental health systems work, please describe the ways in which you and/or your colleagues at [name of school] collaborate/communicate with the county towards a shared goal of promoting schools as centers of wellbeing.

Closing

Before we end, we want to give you the opportunity to share anything else that we haven't asked about.

12. Is there anything else you would like to share related to school mental health systems and systems change?

Draft

Appendix I. Mental and Behavioral Health Professionals Focus Group Questions

School Mental and Behavioral Health Professional Focus Group Questions

Introduction

1. To get started, please share your name, your role, and a sentence or two about the school mental health programs or supports you provide at [name of school]

Student Needs and the School Mental Health System

Our first series of questions focus on the needs of students and how they can be supported by [name of school's] school mental health system. By school mental health system, we are referring to the full array of supports and services that promote positive school climate, social and emotional learning, and mental health and well-being, while reducing the prevalence and severity of mental illness. School mental health systems also include the strategic collaboration between school staff, mental and behavioral health professionals, students, families, and community health and mental health partners. Finally, these systems also assess and address the social, political and environmental structures like public policies and social norms that influence student mental health outcomes. Do folks have questions about this definition?

2. What are some of the most significant student mental and behavioral health needs at [name of school]?
    a. Are there certain groups of students (e.g., racial/ethnic groups, low-income students, homeless youth, etc.) whose needs are not being met? If so, please describe.
    b. What resources are needed to serve the needs of all students in this school?
3. How well is the school mental health system at [name of school] addressing these needs?
    a. How does the school mental health system promote mental health and wellbeing?

Draft

    b. How does the school mental health system prevent mental health challenges from becoming severe and disabling?
    c. How does the school mental health system enable the early recognition of mental health challenges?
    d. How does the school mental health system ensure timely access to services for underserved populations?
    e. How does the school mental health system respond to the need for additional services?
4. What are the barriers at [name of school] or in the broader community that make it difficult to meet students' mental health needs?
5. What are the things within [name of school] that help make it easier to provide student mental health services?
6. In the time you have been in this role, have you seen changes, either positive or negative, to the way [name of school] has supported student mental health?
    a. This could include changes in promoting positive student outcomes or reducing the prevalence and severity of mental illness.
    b. If you have seen changes occur, what are some of the things that were driving that change?
7. What are some of the structural things that still need to occur at [name of school] to adequately support the mental health needs of all students?

MHSSA within the Broader School Mental Health System

We want to hear a bit more about how MHSSA-funded activities and services fit within the broader continuum of care at your school.

8. For those of you who are involved in or aware of the activities and services at [name of school] that are funded by the MHSSA, please describe:
    a. How these activities and services have been implemented over time.
    b. Any challenges in the implementation process.
    c. How these new activities and services connect to broader school mental health efforts at [name of school].
    d. How these new activities and services may have contributed to positive systemic change in the way [name of school] supports student mental health.

The Relationship between County- and School-Level School Mental Health Systems

9. To what extent are you aware of and/or involved in county-level work to strengthen school mental health systems county-wide?
    a. If you are aware of and/or involved in county-level school mental health systems work, please describe the ways in which you and/or your colleagues at [name of school] collaborate/communicate with the county towards a shared goal of promoting schools as centers of wellbeing.

Community Needs and Strengths

10. Lastly, we are interested in learning about the needs and strengths of the [name of city/town] community and how they inform the student mental health supports provided at [name of school].

Draft

Closing

Before we end, we want to give you the opportunity to share anything else that we haven't asked about.

11. Is there anything else you would like to share related to school mental health systems and systems change?

Draft

Appendix J. Student Focus Group Questions

Student Focus Group Questions

Introduction[10]

1. Let's start with introductions. Please share your first name and one thing at school that makes you feel encouraged, comfortable, or happy.

Student Needs

2. What does student wellbeing mean to you?
3. What kind of mental health supports and services do students at your school need?

School Mental Health Supports and Services

4. What do you think schools should do to support students' mental health and wellbeing?
5. Please describe the mental health supports and services at your school.
    a. Where do students at your school go when they need mental health support?
6. What is your school doing especially well to support student mental health?
7. How could your school improve the way it supports student mental health?
8. Your school offers [describe MHSSA-funded activity and service]. Have you ever had the opportunity to use the service?
    a. If yes, how was it? What went well and what could be better?
    b. If not, why not?

Contextual Factors

9. What are the mental health and wellness supports and services outside of school that young people in your community access?
10. What are things other than school that impact students' mental health and wellbeing?
    a. What about what's happening in your neighborhood?
    b. What about what's happening on social media?
    c. What about what's happening in your home life?

[10] Language used with younger aged students will be appropriately leveled.

Draft

Closing

Before we end, we want to give you the opportunity to share anything else that we haven't asked about that you think is important to share.

11. Is there anything else you would like to share related to student mental health and wellbeing at [your school]?

Draft

Appendix K. Family/Caregiver Focus Group Questions

Family/Caregiver Focus Group Questions

Introduction
Let's start with introductions.

1. Please share your first name and your child's grade at [name of school].

How Schools Support Student Mental Health and Wellbeing
We'd like to learn more about how your school supports student mental health and wellbeing.

2. What does student wellbeing look like for your child?
3. What is the school's role in supporting student mental health and wellbeing?
4. How likely are you to turn to [name of school] for mental health support and services for your child? Why or why not?
5. What do you think [name of school] is doing well to support student wellbeing?
6. What do you think [name of school] could improve to support student wellbeing?
7. What kinds of activities or services support students' mental health and wellbeing at [name of school]?
8. What kinds of activities or services at [name of school] help families and caregivers support their child's mental health and wellbeing?

Closing
Before we end, we want to give you the opportunity to share anything else that we haven't asked about that you think is important to share.

9. Is there anything else you would like to share related to students' mental health and wellbeing at [name of school]?

Draft

Appendix L. Youth Engagement Supplement (YES) Session 1 Agenda

Youth Engagement Supplement (YES) Session 1 Agenda

Session Objectives

- Provide an overview of the goals and purpose of the YES
- Familiarize youth with basic principles of data interpretation
- Explore available and relevant school case study data and engage in shared sense-making through a data equity walk

Time

- 110 minutes

Location and Set-up

- Onsite in a designated classroom with WestEd facilitators and a trusted adult from the school

List of Materials

- Post-it notes, poster paper, printouts of case study data

TIME	ACTIVITY
10 minutes	**Welcome, Introductions, Icebreaker & Community Agreements**
10 minutes	**Overview of Youth Engagement Supplement** ▪ About the school case study ▪ Goals and objectives of the YES ▪ Q&A ▪ Review agenda
15 minutes	**Framing and Key Concepts** ▪ Group discussion: What do we already know about this topic? How do your peers understand this topic? ▪ What is the role of schools for supporting students' mental health? ▪ The 'why' of school mental health systems
10 minutes	**Introduction to School Case Study Mental Health Data**
5 minutes	**BREAK**

Draft

45 minutes	**Data Equity Walk** (*adapted from EdTrust West's Data Equity Walk protocol*) ▪ Overview of data equity walk group agreements ▪ Orientation to available data (CHKS data, county-level mental health data, etc.) ▪ Round 1 data equity walk – youth add post-it notes to data on posters around the room in response to *guiding questions (see below)* ▪ Think-pair-share – discuss *guiding questions* ▪ Whole-group discussion of *guiding questions* **Guiding Questions**[11] 1. What are your general reactions to the data? What questions do these data raise for you? 2. What's the story behind the data? How does this connect to your personal experience? 3. What further information would be helpful? 4. What solutions can you think of to address the issues raised by these data?
15 minutes	**Closing** ▪ Recap of Session 1 and preview Session 2 ▪ Feedback survey

[11] A trauma informed script will be used that sets norms for how individuals might share in a way that feels safe.

Draft

Appendix M. Youth Engagement Supplement (YES) Session 2 Agenda

Youth Engagement Supplement Session 2 Agenda

Session Objectives

- Gather students' perceptions about school mental health services and supports
- Engage in a facilitated discussion about available mental health resources and needs in the school community
- Collaboratively develop a student mental health and wellbeing assets map using a Participatory Asset Mapping protocol

Time

- 120 minutes

Location and Set-up

- Onsite in a designated classroom with WestEd facilitators and a trusted adult from the school

List of Materials

- Post-it notes, poster paper, markers

TIME	ACTIVITY
10 minutes	**Welcome and Icebreaker**
10 minutes	**Stage Setting** ▪ Recap of Session 1 ▪ Session 2 agenda
10 minutes	**Introduction to Participatory Asset Mapping** (*adapted from the Advancement Project*)

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75 minutes	**Participatory Asset Mapping** ▪ Conversation norm setting ▪ Individual reflection (*sample questions below*) ▪ Think-pair-share ▪ Whole-group discussion ▪ Collaborative mapping
15 minutes	**Closing** ▪ Recap of Session 2 and preview of Session 3 ▪ Feedback survey

Sample Questions[12]

5. What do you know about the available mental health resources at school (in-person and/or virtual)?
6. What other mental health resources are there in the community?
7. Where do students get information about how to access mental health resources? What supports have you heard of that work well for students?
8. What kinds of supports do you think students could use more of?
9. Based on your experience, are there students who have an easier or harder time accessing mental health services at your school?

Draft

[12] A trauma informed script will be used that sets norms for how individuals might share in a way that feels safe.

Appendix N. Youth Engagement Supplement (YES) Session 3 Agenda

Youth Engagement Supplement Session 3 Agenda

Session Objectives

- Prepare students for communicating their Participatory Asset Map and panel questions with state and local education school mental health system leaders

Time

- 65 minutes

Location and Set-up

- Virtual via Zoom with WestEd facilitators, MHSSA Youth Data Collectors[13], and a trusted adult from the school

List of Materials

- Laptop and reliable internet connection

TIME	ACTIVITY
10 minutes	**Welcome** • Introduce MHSSA Youth Data Collectors • Icebreaker • Temperature Check
5 minutes	**Stage Setting** ▪ Recap of Session 1 and Session 2 ▪ Session 3 agenda

[13] Roles and responsibilities of the MHSSA Youth Data Collectors will be determined during the Youth Data Collector training.

Draft

45 minutes	**Preparation for Student Panel** (*sample questions below*) ▪ Share participant protections within this context ▪ Individual reflection ▪ Group discussion ▪ Rehearsal
5 minutes	**Closing** ▪ Recap of Session 3 and preview of Session 4 ▪ Feedback survey

Sample Student Panel Questions[14]

10. What kind of school mental and behavioral supports positively impact the wellbeing students?
11. What makes it easy to access these mental and behavioral supports at school?
12. What makes it more difficult to access these mental and behavioral supports at school?
13. What additional school mental and behavioral supports are needed?
14. What is one hope you have related to student mental health and wellbeing at your school?

Draft

[14] A trauma informed script will be used that sets norms for how individuals might share in a way that feels safe.

Appendix O. Youth Engagement Supplement (YES) Session 4 Agenda

Youth Engagement Supplement Session 4 Agenda

Session Objectives

- State and local school mental health system leaders listen to youth share their insights about school mental health
- Students share Participatory Asset Map and responses to panel questions with state and local school mental health system leaders

Time

- 85 minutes

Location and Set-up

- Virtual via Zoom with WestEd facilitators, MHSSA Youth Data Collectors[15], a trusted adult from the school, and state and local school mental health system leaders

List of Materials

- Laptop and reliable internet connection

TIME	ACTIVITY
10 minutes	**Welcome and Icebreaker**
10 minutes	**Session Overview** ▪ Goals and objectives of the Student Panel ▪ Conversation norm setting ▪ Review agenda ▪ Introduce Student Panel presenters

[15] Roles and responsibilities of the MHSSA Youth Data Collectors will be determined during the Youth Data Collector training.

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60 minutes	**Student Panel** ▪ Students respond to panel questions (*sample questions below*) ▪ Students present Asset Map ▪ State and local school mental health system leaders ask questions that were shared with students prior to the session for a structured Q&A
5 minutes	**Closing** ▪ WestEd facilitators close meeting ▪ Feedback survey

Sample Student Panel Questions

15. What kind of school mental and behavioral supports positively impact the wellbeing students?
16. What makes it easy to access these mental and behavioral supports at school?
17. What makes it more difficult to access these mental and behavioral supports at school?
18. What additional school mental and behavioral supports are needed?
19. What is one hope you have related to student mental health and wellbeing at your school?

Draft

Appendix P. Youth Engagement Supplement (YES) Session 5 Agenda

Youth Engagement Supplement Session 5 Agenda

Session Objectives

- Reflect on experience participating in the 5-session series
- Discuss opportunities for continued youth engagement in school mental health systems change

Time

- 50 minutes

Location and Set-up

- Virtual via Zoom with WestEd facilitators, MHSSA Youth Data Collectors[16], and a trusted adult from the school

List of Materials

- Laptop and reliable internet connection

TIME	ACTIVITY
5 minutes	**Welcome** • Icebreaker • Temperature check
5 minutes	**Overview of Session**

[16] Roles and responsibilities of the MHSSA Youth Data Collectors will be determined during the Youth Data Collector training.

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25 minutes	**Group Reflection and Discussion**
	▪ Individual reflection
	  ○ What surprised you about this experience?
	  ○ What was challenging about this experience?
	  ○ What did you enjoy about this experience?
	▪ Group discussion

10 minutes	**Thinking Forward** • Consider opportunities for continued engagement in state and/or local school mental health systems change
5 minutes	**Closing and Gratitude**

Draft

Mental Health Services
Oversight & Accountability Commission

EVALUATION OF THE MENTAL HEALTH STUDENT SERVICES ACT (MHSSA)

This document provides an overview of the evaluation of the MHSSA. In June 2023, the Commission partnered with WestEd to plan and conduct the evaluation, which is being completed in two phases:

Phase 1: Evaluation Planning. The Commission and its evaluation partner WestEd collaborated on a robust evaluation planning process, grounded in community engagement, that resulted in a feasible and meaningful plan to evaluate the MHSSA (presented below).

Phase 2: Evaluation Plan Implementation and Dissemination. The Commission and WestEd will implement the plan to evaluate the MHSSA and disseminate findings and lessons learned on a regular basis as they become available.

PHASE 1: EVALUATION PLANNING

The MHSSA Evaluation planning process took place between June 2023 and October 2024. During this time, the Commission and WestEd have made significant investments in community engagement activities to foster trust, solicit feedback, collaborate, and codesign the evaluation with partners. Activities were designed to solicit feedback on deliverables including a community engagement plan, theory of change and logic model, evaluation questions and metrics, and a draft evaluation plan.

The following briefly summarizes the activities and events that occurred during the evaluation planning process. The Commission and WestEd:

- Held six MHSSA Evaluation Workgroup meetings to engage subject matter experts and the public.
- Held over 30 Listening Sessions with diverse community partners including students, parents, educators, mental health providers, and others.
- Established a Youth Advisory Group comprised of 16 youth from diverse backgrounds to guide evaluation planning.
- Presented at MHSSA Collaboration meetings.

A principal insight from those activities is that partners value having a voice in the evaluation process and are committed to ongoing collaboration.

In addition, several methodological constraints and priorities emerged from community engagement with partners during the MHSSA Evaluation planning phase. Each MHSSA grantee has taken a unique approach to funding services and supports that address student mental health needs and improve student wellbeing. This is because the MHSSA provides critically important flexibility for grantee partners to innovate. However, this flexibility

introduces methodological challenges in evaluating the statewide implementation of a heterogeneous set of MHSSA-funded activities and services.

An additional challenge for this evaluation's design relates to the timeline of MHSSA implementation versus that of the evaluation. The MHSSA Evaluation planning process began after grants were awarded. MHSSA local implementation has been underway since the first phase of funding in 2020. This timeline presents constraints on the methods that can be used, particularly quantitative research methods that require a baseline comparison.

PHASE 2: EVALUATION PLAN IMPLEMENTATION AND DISSEMINATION

The MHSSA Evaluation Plan has been designed to measure how this early and substantial statewide investment has impacted interagency collaboration and transformational systems change to ultimately support schools in becoming centers of wellbeing and healing. The Evaluation has been codesigned by WestEd, the Mental Health Services Oversight & Accountability Commission (the Commission) and a broad group of community partners to ensure that the Evaluation reflects diverse community perspectives.

Community engagement activities will be embedded throughout implementation of the evaluation. WestEd's engagement strategy will build upon previous community engagement efforts in Phase 1 to include youth empowerment, youth-facilitated data collection, and ongoing partner collaboration.

The evaluation will be implemented between November 2024 and June 2027, and the scope of work includes four key evaluation components.

1. Contextual Descriptive Analyses
2. Process and Systems Change Evaluation
3. Grantee Partnership Case Studies
4. Implementation and Impact School Case Studies

The following table provides a brief description of the four proposed methods for evaluating the MHSSA. The table also includes community engagement feedback from the planning phase (Phase 1) that informed each component of the evaluation.

Evaluation Components	**Community Engagement Feedback**
<u>1. Contextual Descriptive Analyses</u> The current state of the mental health and wellbeing of students in California will be described by county and include exploration of school, district, and community characteristics that are related to students' mental health and wellbeing.	Grant and community partners stated that it was critical to understand and measure variation in student mental health across different regions and populations.

2. Process and Systems Change Evaluation The evaluator will conduct a statewide evaluation to understand implementation of MHSSA and how it has brought about systems change. The evaluation includes collecting survey data from all grantees on their partnerships, implementation of MHSSA-funded activities and services, community strengths/needs, other school mental health initiatives, and outcomes. The evaluation will be designed to provide grantees with useful feedback that can support their local planning and programming efforts.	Grant and community partners shared that they would like to engage with meaningful and useful data through the MHSSA Evaluation. They wanted to use evaluation findings to share successes and challenges they have encountered. They emphasized the importance of collecting data that would be used not only to satisfy reporting requirements but also to support continuous improvement.
3. Grantee Partnership Case Studies The evaluator will conduct case studies with 10 county behavioral health and education grant partners to contextualize and describe how school communities across the state are reimagining systems change through local incentivized partnerships to build comprehensive and effective school mental health systems.	Grant and community partners emphasized that MHSSA is unique because it incentivizes interagency partnerships. They are proud of the work they do and want to demonstrate how LEAs and county behavioral health departments are "better together."
4. Implementation and Impact School Case Studies The evaluator will conduct case studies of 12 MHSSA-funded schools that will explain the impact of MHSSA-funded activities and services, and school mental health system changes on school and student outcomes. It will also explore intervention conditions and describe MHSSA implementation in the context of each participating school.	Grant and community partners expressed an interest in understanding the school-level mental health system in which MHSSA-funded activities and services were implemented so that they could assess the extent to which different approaches may apply in their own school-level mental health systems.

Next Steps

If approved by the Commission, the MHSSA Evaluation will be implemented beginning in November 2024. As the evaluation unfolds, the Commission and WestEd will publicly disseminate findings as they emerge. It is our goal to keep community partners informed and produce findings and lessons learned on a regular basis that can be incorporated into school mental health planning and practice.