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

May 2022

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EXECUTIVE SUMMARY

This report provides an update to the fiscal and policy committees of the Legislature on the implementation of the Mental Health Student Services Act (MHSSA), as required under the Welfare and Institutions Code (WIC), Section 5886.

Vision: Schools as Centers of Wellbeing

Prior to the COVID-19 pandemic, California's behavioral health system struggled to meet the needs of children, youth, and families. The pandemic has exacerbated the need for services, particularly in under-resourced and underserved communities. In October 2020, the Mental Health Services Oversight and Accountability Commission released a report calling for the establishment of schools as centers of wellbeing to address unmet needs and improve access to services by centering schools as a core component of the community behavioral health system.

The State has made a historic investment in school mental health through the MHSSA to realize this vision. The MHSSA provides funding to incentivize local partnerships between county behavioral health departments and local education agencies.

The Commission's Progress Implementing the Mental Health Student Services Act

The Commission has disbursed MHSSA funds to support school mental health partnerships in 54 of California's 58 counties. To support the successful implementation of MHSSA programs and continued learning, the Commission has established an MHSSA Learning Collaborative that meets quarterly to discuss barriers, challenges, and successes. The Commission also is collecting data from grantees on students served and is developing a strategic data reporting and monitoring plan.

We have learned from MHSSA grantees that although they have had success in building partnerships and delivering behavioral health services to students and families, they also have encountered struggles, particularly in hiring staff. Additionally, grantees have expressed concerns about their ability to sustain student behavioral health services and supports over time, particularly as student needs have increased with the pandemic.

The Commission has prioritized quickly distributing MHSSA grant funding to improve opportunities for local partners to support the mental health needs of students. The Commission also is working to build technical assistance and strategies to support grantee success. MHSSA awards are not intended to be supplemental funds; they are incentive funds designed to improve how local education agencies and county mental health departments invest in programs and services that support children, youth, and families. As local school mental health partners make progress in using their MHSSA funding, the Commission will

identify which programmatic approaches are most effective with the goal of documenting evidence-based practices that can be replicated over time and statewide.

Opportunities and Next Steps

The MHSSA is part of a broader investment in California's children and youth behavioral health system. The Commission also has made key investments in youth drop-in centers, early psychosis programs, and opportunities to elevate youth voice to shape the design and delivery of mental health services and supports. The Commission is working with the Department of Health Care Services, supporting the efforts of the Department of Health Care Access and Information, and participating in the Children and Youth Behavioral Health Initiative.

To ensure the MHSSA grants are effective, the Commission is pursuing the following strategy:

Data and Program Monitoring. The Commission is developing a data reporting and monitoring plan to establish performance metrics to track and report regularly on outcomes consistent with the requirements of WIC 5886(j) and WIC 5886(c)(3). This plan will require several steps, including:

- Engaging partners to inform the development of performance outcomes. A key goal of the MHSSA is to reach underserved and high-risk groups. Engagement with diverse partners will be critical to ensuring metrics are relevant to decision-making and supporting community understanding of the impact of the MHSSA.
- Conducting a landscape analysis to understand MHSSA in the broader context of school mental health and related community mental health needs. The MHSSA is one of several initiatives to bolster mental health services in schools. The Commission wants to understand how local partners are using MHSSA funds in the context of other school mental health initiatives.
- Gathering data and conducting analyses. The Commission's data analysis will focus on a combination of community-driven outcomes and understanding opportunities to leverage other resources, support fiscal sustainability, and ensure local school mental health partners have the information and guidance they need to best support mental health and educational outcomes.
- Address the needs of underserved communities. The MHSSA highlights the needs of underserved students and their families. The Commission's work – engagement, the landscape analysis, and data collection and reporting – will pay particular attention to meeting the needs of underserved communities.

INTRODUCTION AND BACKGROUND

Senate Bill 75, 2019, established the Mental Health Student Services Act (MHSSA), and provided $40 million in one-time and $10 million in ongoing funding to establish partnerships between county behavioral health departments and local education agencies focused on student mental health needs.

Schools represent an opportunity to reach students with mental health needs, strengthen awareness of mental health, address stigma, and support both mental health and education goals throughout the state.

Improved access to mental health services is foundational to supporting children and youth as they develop into healthy resilient adults. Comprehensive models and integrated services that are tailored to individual and family needs have the best chance of improving health and academic outcomes. The MHSSA is intended to foster stronger school–community mental health partnerships that can leverage resources to help students succeed by authorizing counties and local education agencies to enter into partnerships that provide prevention and intervention services for students with identified social-emotional, behavioral, and academic needs. School–community mental health partnerships offer an opportunity to reach children and youth in an environment where they are comfortable and that is accessible statewide.

Incentivizing Partnerships Across Systems

> *"The MHSSA grant was crucial to our county, providing needed support, aftercare, and further prevention planning in response to two students' deaths, which occurred just days apart. In both cases, having staff to collaborate with the school site during the immediate response, and having contracts with specialty agencies to employ professional development for the longer-term response and assistance have all been invaluable as resources to offer in these critical moments. Now, more than ever, having the increased capacity around mental health aid, in the form of the MHSSA grant, has proved to be timely on many levels."* Santa Cruz County Office of Education

The MHSSA incentivizes partnerships between county behavioral health departments and local education agencies for the purpose of increasing access to mental health services in locations that are easily accessible to students and their families. MHSSA funding has been released by the Mental Health Services Oversight and Accountability Commission in multiple rounds, based on funding availability. In the first round of funding, the Commission received 38 applications from local education and mental health partnerships. Available funding at that time – approximately $75 million – allowed the Commission to fund 18 programs. These funds were used to build the capacity of existing partnerships and support new and emerging partnerships as an increasing number of local education agencies and county behavioral

health departments recognized the opportunity to launch a collaboration or expand an existing partnership.

In response to the high level of interest in the program, the 2021 budget provided an additional $95 million in state funds to provide grants to each of the unfunded 38 applicants, and $100 million in federal funding to expand the program to local partners that had not initially applied to participate. In early 2022, funding for the program was shifted from federal funds to state funds to streamline the administration of the program and related reporting requirements.

MHSSA funds support services that include, at a minimum, services provided on school campuses, suicide prevention services, drop-out prevention services, outreach to high-risk youth including foster youth, youth who identify as LGBTQ and youth who have been expelled or suspended from school, and placement assistance and service plans for students in need of ongoing support. Grants may be used to supplement, but not supplant, existing financial and other resource commitments.

Funding also may be used to hire qualified mental health personnel and professional development for school staff, and for other strategies that respond to the mental health needs of children and youth.

The Mental Health Student Services Act Fosters the Development of Schools as Centers of Wellbeing

> *"The Wellness Center has reached not only me but the entire community. Our goal is to spread awareness about mental health, helping students in and around our campus to be seen and encourage them to get help. We strive to create a safe space not only in the Wellness Center but in and around (our school). My goal as a Wellness Peer is to give struggling teens an outlet to remind them that they are not alone."* Wellness Peer

In 2020, the Commission released a report titled *Schools as Centers for Wellness and Healing* and recommended that the State make a significant multi-year investment to build and enhance partnerships between county behavioral health departments and local education agencies. The MHSSA realized this vision. The Commission recommended that the State invest in system-level capacities required to integrate resources, adapt evidence-based practices, and manage for continuous improvement. The capacity-building efforts include: (1) providing programmatic guidance; (2) addressing workforce needs; and (3) and designing a pathway to fiscal sustainability.

The goal of the MHSSA is to provide highly accessible, comprehensive, and effective services in schools where students spend a great deal of time. A key goal of comprehensive school-based mental health services is to reduce students' needs for more serious intervention. If

these services are well-designed and implemented, school mental health programs can reduce reliance on higher-level, more intensive services. School mental health initiatives include prevention and early intervention services, access and linkage strategies, stigma reduction and awareness programs, and support the state's overall strategies to meet the mental health needs of children, youth, and young adults.

Additionally, school mental health initiatives, in collaboration with initiatives focused on children from birth to age 5, represent cost-effective upstream prevention, education, awareness, and engagement strategies that target the whole family.

Despite the value of school mental health strategies, some students, particularly those in the upper grades, may not feel comfortable accessing services in school settings. Furthermore, school-based care may not offer the range of services necessary to meet the mental health needs of all youth. Paired with community-based services – such as youth drop-in centers, early psychosis intervention programs, and related strategies, school mental health services are a foundational investment in comprehensive care for children, youth, young adults, and their families.

Shared Learning Opportunities: Infrastructure to Support Program Success

California's MHSSA and the funding it provides are designed to incentivize and support local partnerships to meet the mental health needs of students. The MHSSA provides an opportunity for shared learning between local entities through a Statewide Learning Collaborative. Specifically, there are three overarching challenges that provide opportunities for shared learning and program improvement. These challenges include:

1. Programmatic guidance. MHSSA grant programs are diverse, as each local partnership is using MHSSA funding to meet needs that are tailored to their student population, the diverse members of their partnership, and community priorities. The Commission is working to identify the elements of each local MHSSA program and the characteristics of partnership and service-delivery models that foster optimal student outcomes, and to examine how programmatic best practices vary depending on the local context and resources. In other words, we are working to understand what works for whom and under what conditions to determine which evidence-based practices should be scaled across local programs and over time.
2. Workforce and staffing challenges. Mental health work force shortages are a persistent issue in California, particularly in rural communities. Workforce shortages limit the ability of MHSSA grantees to hire staff and successfully implement programs in a sustainable manner. Addressing California's mental health workforce needs will require ongoing collaboration between local partners and the state. The Commission

is working with the California Department of Health Care Access and Information and others in the Governor's administration to address challenges and strengthen workforce opportunities.

3. Fiscal sustainability. MHSSA grants are start-up funds, with the expectation that the county behavioral health and school collaboratives will be able to strategically pool resources and tap into diverse local funding sources to sustain the program over time. The Commission is working with the Department of Health Care Services and the Child and Youth Behavioral Health Initiative to expand access to Medi-Cal-funded programs, commercial insurance reimbursement where appropriate, MHSA dollars, and related educational funding to ensure that all children who need care can receive services and supports.

The Commission established quarterly MHSSA Learning Collaborative meetings to provide a forum for grantees to learn from each other and from statewide experts. These meetings are designed to facilitate connections and communication between grantees to share successes, improve strategies and practices, and help overcome barriers to program implementation. Commission staff also conduct monthly check-in meetings with local partners to identify and share information on barriers, successes, and best practices.

Four MHSSA Learning Collaborative meetings were held in 2021 and have addressed the following topics:

1. Program implementation. Discussions focused on shared understanding of how local partners are using MHSSA funding, the challenges they face, and the opportunities they see.
2. Preparing for students to return to in-person learning. Many local education agencies faced uncertainties as they prepared for in-person learning following the relaxation of COVID-related isolation requirements. MHSSA grantees shared information on how they prepared for the return to school and the systems and strategies they put in place to support students who presented with unmet mental health needs.
3. Establishing Wellness Centers on school campuses. A common strategy across MHSSA grantees has been the establishment of Wellness Centers, which allow students to step out of the stresses of a school day, seek mental health support and information, and to connect with others. The Commission facilitated student-led discussions on preferred strategies to meet student mental health needs and Wellness Centers represented the most student-friendly proposal under discussion. The Commission has supported cross-partnership collaboration on how to best design and implement student Wellness Centers to meet student mental health needs.

4. Addressing workforce and hiring issues. As mentioned above, staffing challenges continue to frustrate local efforts to respond to the mental health needs of students. Local MHSSA partnerships are sharing strategies for recruitment, hiring, training, and related approaches to meeting their workforce needs.
5. Supporting program sustainability. School and county partners are increasingly concerned that they will not be able to sustain their local school mental health partnerships. Learning Collaborative discussions include how different partnerships are approaching this challenge.

Since establishing the MHSSA Learning Collaborative and providing a contact list of grantees, the Commission has observed that grantees communicate with each other, seek out advice, and provide informal technical assistance between meetings.

As more grants have been awarded, the MHSSA Learning Collaborative meetings have grown. The Commission is exploring with grantees how best to establish multiple learning cohorts based on county population, region, services provided, and method of service delivery (e.g., Wellness Centers, Mobile Treatment Units, on-campus counseling).

The goal of this strategy is to provide relevant information that aligns with the needs of each grantee while leveraging the capacity and expertise of all grantees to support their collective impact and progress.

MHSSA GRANT AWARDS AND PROGRAM IMPLEMENTATION

MHSSA grant awards have been awarded in three phases as funding has been made available to expand the program. See Appendix A for more information.

Phase 1 grants were awarded to 18 out of 38 applicants in 2020.

- Phase 1 grants were awarded in two categories:

  (1) An existing history of partnership between county and local education agencies (*n* = 10); and

  (2) New and/or emerging partnerships between county and local education agencies (*n* = 8).

  A total of $75 million was issued for the four-year MHSSA grants, with awards determined by county size (small, medium, and large). Phase 1 grantees were slated to begin their programs in Fall 2020 but many experienced significant delays in hiring staff and implementing their programs due to the COVID-19 pandemic. As a result, the four-year grants were amended to allow for a fifth year.

Currently, Phase 1 grantees have implemented their MHSSA programs and have been in operation for a year and a half or less.

Phase 2 grants were awarded to 19 applicants in 2021.

- The Budget Act of 2021 provided an additional $95 million to fund applicants who applied to the first round of MHSSA funding (Phase 1) but did not receive a grant. These applicants were approached by the Commission to see if they were still interested in the MHSSA grants and whether their proposal was still applicable. One original applicant chose to not participate. Phase 2 grant contracts were issued between August 2021 and March 2022. In addition, grantees were given additional time to make changes to their original proposal and submit a modified budget within 90 days after the contract was executed.

  Phase 2 grantees are in the early phase of program implementation.

Phase 3 grants were awarded to 17 applicants in February 2022.

- The Federal American Rescue Plan (ARPA) provided up to $100 million through the State Fiscal Recovery Fund (SFRF) to support the remaining 20 California counties in establishing an MHSSA program. The Commission surveyed the 20 eligible counties to understand why they did not apply for a Phase 1 grant and asked what their main barriers would be for submitting a proposal. Counties reported a lack of resources and staff to develop a plan and submit a proposal as the primary barrier to participating in the MHSSA program. It should be noted that most of these counties are small, rural counties, many of which had been significantly affected by natural disasters such as wildfires as well as the pandemic. The Commission offered one-on-one sessions, confidential guidance on plan development, and a four-month planning phase to overcome barriers. Phase 3 grant contracts were executed on March 1, 2022.

  Phase 3 grantees have not begun implementing their programs.

Grantees Face Barriers and Challenges Due to the Pandemic

The COVID-19 pandemic has been the primary barrier to program implementation. Grantees reported that the pandemic made it more difficult to build or strengthen relationships among partners, and when needed, establish memorandums of understanding across county behavioral health programs, local education agencies, county offices of education, and charter schools. These initial challenges led to delays in hiring staff and providing services and supports to students and families.

The following provides a brief summary of the challenges and barriers to program implementation due to the pandemic that grantees reported to the Commission:

- The main priority for counties and local schools was to respond and adjust to the pandemic and school closures. Thus, implementing MHSSA programs became a lesser priority, particularly as a result of being "stretched thin" with fewer staff available due to hiring freezes and quarantines.
- The unpredictability of school closures and the shift between in-person and virtual instruction made it more difficult to schedule meetings between partners, particularly in rural, remote areas with limited access to the internet. For grantees with new and emerging partnerships, virtual meetings made it more difficult to build strong, working relationships across partners and sectors.

Most grantees experienced delays in implementing their MHSSA program. In addition, the original design of MHSSA programs were developed based on local priorities before the pandemic. These priorities changed due to the pandemic and grantees had to adapt their planning and programming.

Many grantees reported challenges associated with pivoting to provide instruction and mental health support through online, virtual strategies. This shift was particularly difficult for rural counties since many students did not have internet access and had to rely on spotty cell phone services. Grantees noted that they had to put extra effort into building rapport and trust with students and their families when there was not a pre-existing relationship that could be built upon with virtual interactions. Grantees also had to find creative ways to increase their visibility and engagement with students and families.

Student risk and needs intensified during the 2021–2022 academic school year. Grantees have reported increases in at-risk behavior and in students seeking mental health and related services. They report these increases are occurring at a time when school districts are already "overwhelmed." Students and staff are absent from school due to COVID-19 exposure and infection, and school districts are struggling to maintain their staffing capacity due to teacher turnover, shortages of substitute teachers, and staff burnout. For some grantees, the winter holidays intensified students' struggles with grief and sadness and resulted in an increase in crisis incidents.

COVID-19 continued to have an impact on workforce capacity with cases rising and teachers and staff testing positive and entering quarantine. Schools, in some cases, struggled to find substitutes when staff were ill. Unpredictable and unexpected absences interfered with program operations and service delivery, prompting one county to consider hiring part-time workers as substitutes.

Some grantees expressed concerns about not having enough staff to respond to escalating student needs. In one county, the volume of mental health crises was higher than expected,

creating capacity challenges that shifted attention away from preventive screening and assessments. Another county reported that referrals had significantly increased, resulting in staff feeling "overwhelmed by it and the amount of paperwork," which then slowed down the referral process.

Although more than half of grant programs were fully staffed and operational, there were several who were struggling to find qualified candidates for MHSSA positions. Small counties had the most trouble with hiring and retaining staff. As a result, MHSSA staff were sometimes "stretched thin" due to absences, medical leaves, workforce shortages, and staff turnover. Also, in some cases, district leaders and staff were overseeing the COVID response, limiting their time to prioritize MHSSA partnership communication and coordination of services.

During this time, grantees managed to continue to strengthen partnerships and coordinate the referral process. Several grantees mentioned receiving few if any referrals from particular schools after having met with school teams. These grantees held additional discussions to reintroduce the referral process to schools, and distributed flyers to staff that listed available services and whom to contact.

Grantees experienced different coordination challenges between partners depending on the local context. These include aligning MHSSA programs with preexisting services on school campuses, creating consent and confidentiality paperwork that met both county and district requirements, and settling disagreements when clinical perceptions and standards of practice came into conflict. These challenges reflect the need to highlight and replicate strategies used by school mental health partnerships that have successfully addressed these challenges.

Grantees Report Successes Despite the Pandemic

> *"One of our students is making significant progress after working with our staff. This student was initially referred because a family member had died, and they were experiencing grief and using drugs as a coping mechanism. The student lost focus on schoolwork and their grades began to drop. MHSSA staff were able to support the student in multiple areas including helping them connect with mental health resources, teaching alternative coping skills, providing support with academics, and supporting them in college research. This student is now doing better in school and is receiving mental health services."* Kern County Monthly Report

Currently, 37 MHSSA grantees and their partners are implementing programs in 465 school districts and 27 charter schools. Developing a partnership involves assembling a multi-disciplinary staff that includes family advocates and peer mentors/partners. Although specific information (e.g., number of trainings, outreach events, or student served) are pending

reporting from grantees, monthly status reports provided by grantees to the Commission indicate that MHSSA programs across the state are successfully establishing a continuum of services and support in schools.

The following section provides local examples of strategies and successes from the MHSSA program. For detailed descriptions of select programs, see Appendix B.

1. Providing training to teachers, staff, and parents on mental health literacy and related topics to increase awareness and access to services. Tulare County reported holding several training sessions in November 2022 for educators and parents on suicide prevention and intervention, supporting a child's mental health needs, and self-care for helpers, with a total of 141 participants attending these trainings.
2. Implementing schoolwide prevention curriculum to support student wellness. At the start of the 2021–2022 school year, Placer County reported that transitional kindergarten and kindergarten students were having a hard time transitioning to school due to the pandemic. They provided prevention support and classroom lessons to help teachers increase student skills and family awareness of the MHSSA program.
3. Conducting outreach to support the health and wellbeing of students and families. In San Luis Obispo, Family Advocates, in partnership with Student Assistance Program counselors, conducted a two-day clothing and school supply giveaway in their North County school districts. Students received new or slightly used clothing, gift cards for local stores, backpacks, and school supplies.
4. Implementing universal and targeted screening for students for early detection and intervention. Kern County screens foster and unhoused students for adverse childhood experiences and reported receiving over 50 referrals to the MHSSA program. Referred students receive mentoring services, therapy, and referrals for other services.
5. Establishing Wellness Centers on school campuses. Grantees such as Calaveras, Fresno, Placer, Santa Clara, and Ventura counties are building and/or creating Wellness Centers in schools in socioeconomically disadvantaged areas with high needs. Youth are participating in the design and delivery of services through peer mentoring. These centers provide an array of services including outreach to families. One county reported that a parent contacted staff to say "Thank you so much for getting my family hooked up with the Wellness Center. Everything is going so well for [student] and I couldn't do it without you."
6. Providing students with mental health services and supports on school campuses. Trinity-Modoc reported a trend toward reduced mental health referrals to the

community due to the presence of Wellness Center Liaisons at school sites. The Liaisons are trusted in the school communities because they have provided support and resources to students and families affected by wildfires.

7. Providing referrals to community agencies and assisting students and families with accessing those services. Humboldt County reported success using Navigators to help students and their families in remote areas of the county access and stay connected to mental health services, as well as coach teachers on how to manage challenging student behaviors in the classroom.
8. Responding swiftly and appropriately to student crises. Solano County reported that 85 percent of students served via mobile crisis services were de-escalated and stabilized, and thus diverted from emergency rooms and inpatient hospitalization. These students received brief follow-up case management and were linked to MH services.
9. Responding to community safety issues. Tuolumne had a recent issue with students being taken of advantage of by local adults online, and quickly responded to identify and address the mental health consequences of these incidents and provide support to victims.
10. Striving to build the infrastructure and workforce capacity for sustainability. Orange County is building sustainable mental health service capacity within school districts using a Trainer of Trainers (ToT) model. In the Fall of 2021, Regional Mental Health Providers (RMHCs) facilitated a 10-session group counseling at six different school sites. These sessions are part of the RMHCs' training towards becoming certified trainers in evidence-based modalities such as Cognitive Behavioral Intervention for Trauma in Schools (CBITS). After certification, RMHCs will be able to train school-based mental health staff to conduct these group counseling sessions at their school sites.

EARLY LESSONS LEARNED DURING PROGRAM IMPLEMENTATION

This section provides key lessons learned about MHSSA programs and their implementation. This information was primarily derived from MHSSA Collaboration meetings, listening sessions, and monthly reports from grantees.

1. Grant partners need ample time to work together to hire staff and launch their programs. Depending on local resources and capacity, it may take three months to one year after contract execution for programs to be operational and able to provide services to students, families, teachers, and staff.

2. Grant programs are heterogenous. MHSSA legislation allowed for flexibility in grant programs as long as they were designed to meet MHSSA goals. Thus, each county has a different approach because they tailored their program to respond to students' needs and meet gaps in service delivery. Programs provide a continuum of services and support with some focused primarily on a specific tier or type of service such as prevention and early intervention, crisis services, or referral and linkage. The heterogeneity of programs poses challenges to evaluating outcomes and developing model partnership programs that can be brought to scale, since essentially there are 54 unique partnership programs. It should be noted that MHSSA staff and services are embedded in broader initiatives and programs and are not independent.

3. Hiring and retaining staff has been a challenge, especially in rural counties with mental health professional shortages. Hiring staff for MHSSA programs can require several steps, including establishing multiple Memoranda of Understanding between county behavioral health departments and school districts, and getting the appropriate approvals for the positions (e.g., Board of Supervisors, Human Resource Departments). The requirement of holding a Pupil Personnel Services (PPS) Credential to work in schools has also been a roadblock to hiring mental health clinicians. Grantees have suggested the State should find solutions to this challenge and fast-track individuals who are already in the process of earning their PPS credential. These issues are compounded for small, rural communities that already have mental health professional shortages. For these counties, recruiting qualified staff has been very difficult, and some have had to reconsider their staffing model as a result.

   Grantees need ongoing State-supported technical assistance to build their local workforce and recruit and retain qualified staff.

4. Program sustainability is an ongoing concern among grantees. Counties have different approaches to financing their partnership programs, leveraging different sources of funding (e.g., Medi-Cal, private insurance, MHSA, LCFF/LCAP and other local, state, and federal funding). Grantees have reported an increased need for student and family mental health services but have struggled to identify and secure other sources of funding to support additional staffing and services.

   Grantees need ongoing State-supported technical assistance to make their partnership programs sustainable in the long term and not dependent exclusively on grant funding. To address this challenge, the Commission's Children's Committee will take up the issue of MHSSA program sustainability as a primary focus.

5. Perceived HIPAA and FERPA requirements present a challenge for data sharing and collection. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Family Educational Rights and Privacy Act (FERPA) are federal rules designed to protect patient and student privacy. Both rules permit the sharing of data to state entities for audit/monitoring or research purposes when there are assurances that personally identifiable information (PII) is safeguarded and protected. MHSSA contracts require grantees to share PII on students served. However, grantees have shared concerns about their ability to obtain PII data from their school partners, and/or have concerns or confusion about rules and liability under HIPAA and FERPA regarding sharing those data with the state.
6. Small rural counties lack capacity to respond to lengthy applications. The planning for MHSSA Phase 3 procurement revealed that rural applicants did not have the internal resources or staff capacity to complete grant or program applications. This challenge was mitigated by offering one-on-one sessions, confidential guidance on plan development, and a four-month planning phase.

DEVELOPING A STRATEGY FOR MEASURING OUTCOMES

The MHSSA provides an opportunity for the Commission to develop a strategic data reporting and monitoring plan which would allow the Commission to: (1) gather data and provide data summaries on students served, including demographics; (2) allow the Commission to identify successful strategies, needs for services, and lessons learned; (3) investigate the benefits of the MHSSA for students and the community; (4) assess and report on outcomes of students that directly or indirectly benefit from MHSSA services; and (5) provide feedback to grantees in the form of technical assistance.

This process of developing a strategic data reporting and monitoring plan is timely considering the State's recent investments in children and youth mental health, including with the Children and Youth Behavioral Health Initiative. The Commission has addressed the need for the development or identification of comprehensive and universal metrics related to child and youth behavioral health. The development of a strategic data reporting plan for the MHSSA provides an opportunity to support child and youth mental health initiatives on a broad scale.

Because the primary focus of the Commission's work regarding the MHSSA has been to ensure the successful distribution of funds to counties, the process for developing a strategic data monitoring and monitoring plan, while important, was secondary to the awarding of

funds and implementation of services. The Commission is in the early stages of developing a plan for monitoring and reporting on student outcomes as described in this section.

Progress in Measuring Outcomes

What We Know About Student Outcomes. MHSSA grant programs are still in the start-up and early implementation phases of their partnerships and projects. While data on student outcomes associated with the MHSSA are not yet available, the Commission is in the process of: (1) collecting data on students; (2) developing a strategic data reporting and monitoring process on student outcomes; and (3) designing a reporting and data visualization strategy to convey outcome and related information to MHSSA partners, policymakers, and the public.

What We Know About Grantee Implementation Outcomes. As described earlier in this report, county behavioral health departments were successfully awarded MHSSA grants, and services have begun to be implemented. Grantees are demonstrating early successes with implementing a continuum of mental health services and/or expanding the school based mental health infrastructure including hiring staff and providing training, implementing prevention curricula including suicide prevention, conducting outreach, implementing universal and targeted screening, establishing wellness centers, providing students with onsite mental health services and supports ranging from group counseling to crisis services, engaging in family advocacy, and providing referrals to community agencies. MHSSA Request for Funding Applications (RFAs) required grantees to address in their applications how they would meet statutory requirements.

The Commission is Currently Collecting Data from MHSSA Grantees

The Commission formed an MHSSA Data Workgroup from among the initial county grantees to provide guidance on the type of data that grantees could reasonably collect about students who participate in and benefit from services. That workgroup will be expanded as new partnerships are launched.

The initial MHSSA Data Workgroup included participants from five counties, representing small, medium, and large, rural and urban, and new and established partnerships. The Workgroup developed a draft data tool to outline the aggregate demographic data that the Commission would ask grantees to collect. Commission staff worked with members of the Data Workgroup to develop a survey to determine potential barriers to the Commission's proposed data collection strategy which was then distributed to all 18 Phase I grantees. Based on the information from that survey, the Commission established a set of data definitions and reporting requirements and outlined them in an MHSSA Data Dictionary.

Initially, the Commission worked to set up the MHSSA data reporting and monitoring guide based on the initial grantees' input and to also reflect the need to collect individual-level data

in accordance with requirements outlined in the initial MHSSA RFA. As participation in the MHSSA has expanded statewide, the Commission is working to modify its early data reporting and monitoring plans to align with the needs of a larger and more diverse group of school mental health partners and program designs.

Commission staff engaged in a series of discussions with county grantees to address questions related to data submission. The goals of these data meetings were to: (1) build rapport with county grantee team members responsible for collecting and sending data to the Commission; and (2) provide insight and clarification about the MHSSA data collection strategy, including minimally sufficient information needed from grantees, data collection deadlines, and the processes for uploading data to a secure data transmission network. In these meetings, Commission staff worked to address concerns from grantees regarding collecting, submitting, and reporting person-level data.

As a result of lessons learned from these early data engagement and exploration sessions with county grantees, the Commission decided it was important to more intentionally and strategically develop the MHSSA data reporting and monitoring process. In addition, Commission staff recognized that identification of MHSSA program types or clusters could serve as learning clusters and be useful for targeted technical assistance and community engagement around data collection. Counties are currently in the process of submitting data to the Commission.

Developing a Strategic Monitoring and Reporting Plan

The Commission's strategic monitoring and reporting plan for the MHSSA will incorporate a theory of change or logic model, with clear and concise goals and objectives for data collection, monitoring, and reporting. It will incorporate a plan and process for community engagement and outline a process for data reporting, program improvement, and community feedback.

The plan also will reflect principles of diversity, equity, and inclusion, as included in the Commission's forthcoming Racial Equity Action Plan, to ensure that effort is aligned with the goals of the MHSSA to address disparities and the school mental health needs of underserved and high-risk youth.

As mentioned above, the process for developing a strategic data monitoring and reporting plan will incorporate but not be limited to the following:

1. Engaging partners to inform the development of performance outcomes.
   Performance outcome measures should be designed to reflect the extent to which programs respond to the needs of people served, as well as to the needs of policy and program decision makers, and the general public. To ensure performance measures

are aligned with the goals of the MHSSA program, the Commission will engage MHSSA grant partners, students, families, state and local agencies, and community partners to understand their needs and how performance measures can support those needs. A key goal of MHSSA is to reach underserved and high-risk groups. Engagement with these groups will be critical to developing relevant and appropriate metrics.

2. Document and analyze MHSSA projects. Following release of all available funds, the Commission will engage local partners to document how funds are being used, the range of services that are offered, and lessons learned by local partners on the impact of the MHSSA programs. Reviews will assess whether grantees are engaging in activities consistent with their grant funding and document the varying strategies local agencies have deployed to meet school mental health needs. Preliminary analysis will identify patterns in program design with attention to how local partners have prioritized uses of MHSSA funding and the basis for those decisions.
3. Conduct landscape analysis to understand MHSSA in context. The MHSSA reflects just one of several state-based funding streams or initiatives to bolster mental health services in schools. The Commission's analysis will explore how local partners have worked to access MHSSA and other funding to address school mental health goals. This analysis will improve understanding of opportunities to sustainably fund school mental health strategies.
4. Identify performance metrics and report on outcomes. The MHSSA directed the Commission to develop and assess metrics for a range of outcomes, with recognition that not all metrics will be relevant to the student population served. Based on community-defined priorities, the Commission will identify relevant outcomes that align with the MHSSA and can be monitored with available data from grantee reporting and/or existing data systems that the Commission can access. The Commission is exploring opportunities to link program-level data with other state-based data sets to better understand student-specific and population-level outcomes associated with services offered through the MHSSA. Included in that analysis, to the extent feasible, will be an analysis of the demographic characteristics of students served and associated outcomes.
5. Provide recommendations for best practices. In response to the information obtained from performance metrics, ongoing engagement with local partners, learning collaboratives, and related community engagement activities, the Commission will identify best practices and recommendations to fortify statewide efforts to meet the mental health needs of children, youth, and young adults through school-based and related mental health strategies.

CONCLUSION AND SUMMARY

In 2019, SB 75 established the MHSSA to incentivize school mental health partnerships among county behavioral health departments and local education agencies. The MHSSA provided $40 million in one-time and $10 million ongoing funding to support existing mental health partnerships between county behavioral health departments and local education agencies and to incentive new partnerships.

The Commission initially awarded grant funds to selected counties in 2020 and expanded grant funding to additional counties in 2021 and 2022. Despite challenges, grantees have made great strides in establishing schools as centers of emotional and behavioral wellness. The onset of the COVID-19 pandemic presented a challenge and an opportunity for programs as they began to implement services in 2020. In addition, the limited mental health workforce proved to be a persistent challenge to increasing access to school-based mental health services. However, MHSSA services are being rolled out and partnerships and linkages have been established or enhanced through the availability of MHSSA funds, and a continuum of school-based mental health services have been created or expanded.

Ensuring MHSSA programs are fiscally sustainable will be critical to the success of the MHSSA investment. In the MHSSA proposals, grantees were asked to explain their partnership's ability to sustain services and activities after the grant ends. Specifically, their ability to collect information on health insurance carriers for students, seek reimbursement for mental health services through Medi-Cal and private insurance companies, and leverage other funding sources will be part of that sustainability strategy. The Commission is devoting future MHSSA Learning Collaboration meetings to addressing opportunities to sustain these investments over time. The Commission will continue to monitor local partnership efforts and document how grantees are leveraging funding towards sustainability.

Mental Health Services Oversight & Accountability Commission

APPENDIX A: MHSSA FUNDING TABLE AS OF MARCH 2022

County	Size	Phase 1: Budget Act of 2019	Phase 2: Budget Act of 2021	Phase 3: Budget Act of 2021
Alameda	Large			$ 6,000,000
Alpine	Small			
Amador	Small		$ 2,487,384	
Berkeley City	Small			$ 2,500,000
Butte	Medium			$ 4,000,000
Calaveras	Small	$ 2,500,000		
Colusa	Small			$ 2,500,000
Contra Costa	Large		$ 5,995,421	
Del Norte	Small			
El Dorado	Small			$ 4,000,000
Fresno	Large	$ 6,000,000		
Glenn	Small		$ 2,500,000	
Humboldt	Small	$ 2,500,000		
Imperial	Small		$ 2,500,000	
Inyo	Small			$ 2,499,444
Kern	Large	$ 6,000,000		
Kings	Small			$ 2,500,000
Lake	Small		$ 2,499,450	
Lassen	Small			$ 2,274,040
Los Angeles	Large		$ 6,000,000	
Madera	Small	$ 2,499,527		
Marin	Medium		$ 4,000,000	
Mariposa	Small			
Mendocino	Small	$ 2,500,000		
Merced	Medium			$ 4,000,000
Mono	Small			$ 2,500,000
Monterey	Medium		$ 3,999,979	
Napa	Small			$ 2,500,000
Nevada	Small		$ 2,499,448	
Orange	Large	$ 6,000,000		
Placer	Medium	$ 4,000,000		
Plumas	Small			$ 1,749,800
Riverside	Large		$ 5,862,996	
Sacramento	Large		$ 6,000,000	
San Benito	Small			
San Bernardino	Large		$ 5,998,000	
San Diego	Large		$ 6,000,000	
San Francisco	Large		$ 6,000,000	
San Joaquin	Large			$ 6,000,000
San Luis Obispo	Medium	$ 3,856,907		
San Mateo	Large	$ 5,999,999		
Santa Barbara	Medium	$ 4,000,000		
Santa Clara	Large	$ 6,000,000		
Santa Cruz	Medium		$ 4,000,000	

County	Size	Phase 1: Budget Act of 2019	Phase 2: Budget Act of 2021	Phase 3: Budget Act of 2021
Shasta	Small		$ 2,500,000	
Sierra	Small			$ 1,566,204
Siskiyou	Small			$ 2,500,000
Solano	Medium	$ 4,000,000		
Sonoma	Medium		$ 4,000,000	
Stanislaus	Medium			$ 4,000,000
Sutter-Yuba	Small		$ 2,215,438	
Tehama	Small	$ 2,500,000		
Tri-City	Medium			$ 3,820,932
Trinity-Modoc	Small	$ 2,492,684		
Tulare	Medium	$ 4,000,000		
Tuolumne	Small		$ 2,494,962	
Ventura	Large	$ 5,999,930		
Yolo	Medium	$ 4,000,000		
TOTALS	-	**$ 74,849,047**	**$ 77,553,078**	**$ 54,910,420**

APPENDIX B: CASE STUDIES OF SELECT PARTNERSHIPS

Appendix B highlights four counties and their early successes implementing MHSSA programs and services. The following counties were chosen to represent different sizes (large, medium, and small), geographic regions, and grant categories (established or new/emerging partnerships). It should be noted that all grantees are increasing their staff capacity through hiring to provide a broader continuum of services and supports.

1. San Mateo County is building a strong prevention and early intervention system and striving to reduce equity gaps. Formed in early 2020, San Mateo County's SYSTEM (Success for Youth and Schools through Trauma-Informed & Equitable Modules) Support is a new partnership between San Mateo County Health, Behavioral Health and Recovery Services (BHRS), and the San Mateo County Office of Education (SMCOE). Through this partnership, a strong Tier 1 prevention and early intervention system is being implemented in schools in 12 districts. Teachers and staff have received training, coaching, and support to provide a universal social and emotional learning (SEL) curriculum in 12 school districts. In addition, over 1,000 teacher and staff have been trained in the Community Resiliency Model, which educates individuals about their nervous system and teaches easy-to-learn wellness skills to be used for self-care as well as for caring for others.

An early success in implementing the SEL curriculum is that the school districts are intentionally including student voice in the development of SEL lessons. A documentary film is also being developed with students that tells their stories about mental health and wellbeing.

To address equity gaps, the partnership has hired wellness counselors to support three districts and an isolated continuation high school. A universal screening tool is being used to identify students who have a high risk of behavioral health challenges, including trauma. Upon early identification, students are referred to wellness counselors for intervention. Students and families whose needs cannot be met at the school site are guided to CareSolace, an online mental health care matching resource, which provides tailored assistance in locating follow-up care and treatment for more complex needs from a provider in the community.

2. Tehama County has developed a strategic plan for schoolwide prevention that includes universal screening, promoting social and emotional skills, and teacher/staff professional development. The Tehama County Student Services Collaborative (TCSSC) is a new partnership including the Tehama County Department of Education, Tehama County Health Services Agency, and multiple schools within Tehama County. The partnership is implementing a Strategic Prevention Process that includes universal screening, assessment, implementation of social-emotional wellness and self-regulatory skills, and professional development. Schools participating in the collaborative are establishing or updating their

facilities to develop Wellness Centers on campus and are providing on-campus individual and group counseling services.

TCSSC has also partnered with First 5 Tehama to ensure that all children have received a developmental screening prior to attending kindergarten, and transition meetings are held with families and school officials to review results and develop an intervention plan if needed.

In Fall of 2022, professional development at one elementary school grew was prompted by staff feedback to their administration that they wanted more training and content exposure to Trauma Engaged Practices. The TCSSC has shared this training model with the other districts and have identified three additional sites for a similar training series beginning in 2023.

3. Tulare County is leveraging its partnerships and MHSSA dollars to expand its existing School–County Collaboration program. The Tulare County Mental Health and Tulare County Office of Education partnership is in the third year of implementing its School–County Collaboration Triage Grant. The grant supports several components, including the placement of triage social workers in 48 schools across the county, providing mindfulness training to students, and providing numerous trainings related to supporting youth mental wellness and suicide prevention to schools, families, community members, and mental health professionals. MHSSA funds are being used be used to expand the current program to serve additional schools. MHSSA program components include:

- Developing a collaborative system to provide training, support, and assistance to local pediatrician's offices to screen children for adverse childhood experiences.
- Forming a new partnership with Tulare County Probation to provide social work services to youth who are currently incarcerated or recently released.
- Expanding peer support specialists.

The partnership reported a recent effort to mitigate the stress of the holidays and the winter break. MHSSA staff created winter activity coping kits for students at high risk who would benefit from additional resources. Kits included mindfulness and stress reduction tools, activities to cope with stress, and craft supplies. Staff reported that students were very excited and grateful to receive these kits and found them useful.

4. Ventura County establishes Wellness Centers in local high schools that have the greatest need for student services. The Ventura County Mental Health Services in Schools Partnership was established in 2012 between the Ventura County Behavioral Health Department and the Ventura County Office of Education. The partnership provides mental health and support services for Ventura County's students with special education needs, as well as for additional populations of youth at highest risk of mental health needs in 15 of the county's 20 school

districts. Using MHSSA funds, the Ventura County Wellness Center Program is being established to augment the partnership's mission in eight high schools across five school districts which have the greatest need for services and have available space to dedicate to the program.

Services provided through Wellness Centers include suicide prevention, drop-out prevention, placement assistance and service planning for students in need of ongoing services, and outreach to high-risk youth.

The Wellness Centers held grand openings for the 2021-22 academic school year in all locations except one and are providing in-person services. The Wellness Centers hold monthly mental health awareness campaigns to promote events, services, and resources. Students are at the center of these efforts, as the Center Coordinators have trained peers to staff the Center, and regularly seek input from students.