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CENTER for HEALTH SERVICES and SOCIETY

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

Deliverable 10: Midpoint Progress Report on Formative/Process Evaluation

PREPARED FOR:
Mental Health Services Oversight and Accountability Commission (MHSOAC)

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Dedication

The UCLA Formative Evaluation Team dedicates this report to the memory of Richard Van Horn.

Richard Van Horn was an Episcopal priest who helped revolutionize the nation's and California's approach to mental health. He took leadership of recovery-focused programs, especially the Village Integrated Services Agency in Long Beach, working with Dr. David Pilon. Richard was a major leader in developing the California Mental Health Services Act, approved in 2004, working closely with state legislator Darrell Steinberg on this and other reform bills.

Rev. Canon Van Horn was born September 24, 1939 and died June 15, 2021. He attended Harvard University, spent a year teaching English prior to entering seminary, and was ordained in 1965. As a member of the Episcopal Bishop's staff, he volunteered for Mental Health America of Los Angeles, became a member of its board and then its chief executive. As a remarkable advocate, he had the ability to bring large groups to advocate for policy change. He helped pioneer the Village in Long Beach, Project Return, and other projects framed by a recovery model for mental health, influencing programs across the state and beyond. For the Mental Health Services Act Oversight and Accountability Commission (MHSOAC), he served as the Commission's Vice-Chair (2010-11), Chair (2013-14), and Evaluation Committee Chair (2015-16). Rev. Canon Van Horn was a member of the board of the Mental Health Association of California, California Institute for Mental Health (now California Institute for Behavioral Health), California Council of Community Behavioral Health Agencies, and National Council for Community Behavioral Health. Rev. Canon Van Horn was a member of the National Board of Directors of Mental Health America and testified to Congress on behalf of mental health consumers.

Richard Van Horn was also a long-time partner of the Center for Health Services and Society at UCLA. He participated in the MHSA-funded Center of Excellence (UCLA, UC Davis), including a project on emotional well-being with the US Surgeon General's Office (Feller et al., 2018), and was a stakeholder and policy advisor for the SB-82/833 evaluation. In this capacity, he worked closely with UCLA, UC Davis, and the MHSOAC, meeting with the participating county representatives to review options for meaningful stakeholder participation. He was an indefatigable advocate for meaningful stakeholder inclusion, and for achieving the goals for mental wellness and recovery under the MHSA through the vision and mission of the MHSOAC. As such, he was a key voice in the restructuring and expanding the stakeholder advisory board to include a breadth of stakeholders with both lived and professional experience, representing the vast landscape of the state. Our team remembers him for his willingness to lead, his insightful nature, and his lifelong dedication to the wellbeing of our larger community. Richard Van Horn was a generous, kind, and empathic person who, through his strong leadership and advocacy, brought forward a vision of togetherness in wellness and recovery. We are grateful for his vision, partnership, and leadership in our program evaluation of the SB-82/833-funded programs for children, adolescents, and their families. We dedicate this report in memory of the mental health reform he championed in our great state of California and continue to honor his legacy, carrying forth with us the vast depth of knowledge and appreciation for advocacy he imparted.

Acknowledgement

We gratefully acknowledge the contributions of the many stakeholders who have guided us during the development of the evaluation plan and who continue to shape our work through sharing their expertise and providing consultation. Our stakeholders have included, but are not limited to, our Stakeholder Advisory Board members, the Data Coordinator's Workgroup, the School-County Workgroup, the Child Workgroup, county agency leaders, program providers and peer supports, teachers, school-based counselors, child/parent advocates, and attendees at our public engagement activities.

We also acknowledge the work of our past collaborators, Drs. Jeanne Miranda, Sheryl Kataoka, Monique Gill, and Ms. Krystal Griffith, who contributed to previous deliverables.

We are also grateful to the Mental Health Services Oversight and Accountability Commission (MHSOAC) for their generous support, vision for a statewide evaluation to generate evidence, and commitment to a community-partnered approach throughout the project.

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Executive Summary

Overview

This report summarizes the first two years of a formative evaluation of ten Child/Youth and four School-County Collaborative Triage programs receiving Triage Grants under the California Investment in Mental Health Wellness Act of 2013 (SB-82/833). The purpose is to provide **an early understanding of the processes involved in implementing these programs over time**, from program start-up through mid-2021. Findings in this report are based on analyses of multiple rounds of interviews conducted with individuals involved in program implementation, supplemented by program survey data, and informed by a wide breadth of program and community partners.

Mental health triage programs are intended to expand crisis services in their communities by providing personnel to assess and meet the needs of individuals and families experiencing mental health crises in the least restrictive manner possible. Overarching goals for SB-82/833 Child/Youth Triage Grants include expanding crisis prevention and treatment services, increasing client wellness, decreasing unnecessary hospitalizations and associated costs, and reducing unnecessary law enforcement involvement and costs. For SB-82/833 School-County Collaborative Grants, goals include increasing access to a continuum of mental health services and supports through school-community partnerships, developing coordinated and effective crisis response systems on school campuses, engaging parents and caregivers in supporting their child's social-emotional development and building family resilience, and reducing the number of children placed in special education or removed from school and community due to their mental health needs.

The Child/Youth and School-County Collaborative programs discussed here began operating between October 2018 and November 2020. These programs vary in their characteristics because they are tailored to the existing service systems in their respective counties and the specific needs of their communities. Six programs are housed in schools or school wellness centers, four are located at a program or county mental health office, two are primarily mobile crisis teams in the field or community, one is housed in an emergency department, and one is housed in a police department. Within these settings, programs vary in their relationship to their existing service systems: seven programs constitute new units within their service system and seven programs augment (or expand) an existing unit within their service system. Consistent with their mandate to provide crisis triage, these programs also provide a wide array of mental health care processes including prevention, early intervention, acute crisis services, treatment, referral, care coordination, and community outreach. Acute crisis services, referrals, and care coordination are the three most common care processes, and each are targeted by the majority of programs. Six of fourteen programs also target prevention, early intervention, treatment, and/or community outreach. Most programs target at least three care processes, with programs based in schools especially engaged in integrating multiple types of care processes.

Over the last two years, SB-82/833 Child/Youth and School-County Collaborative programs continually adapted to the ever-changing needs of their communities as well as the unique challenges posed by the COVID-19 pandemic. Programs' ability to flex and develop innovative solutions to deliver crisis triage services that are tailored to their communities demonstrate how heterogeneity across programs can be necessary and advantageous.

Aims and Methods

The specific aims of this formative evaluation are:

1. To **describe and assess select program implementation activities, processes, and outcomes** over time while accounting for variation in programs as well as the impacts of the COVID-19 pandemic.

2. To **identify facilitators and barriers to program** implementation over time.

3. To **provide lessons learned and evidence-based recommendations** for future program implementation.

To accomplish these aims, we use a **mixed methods approach** which focuses on the analysis of qualitative data, with quantitative data used to enrich our qualitative findings. Our evaluation activities also follow a **community-partnered approach**, emphasizing engagement and collaboration with the individuals involved in program implementation as well as a breadth of community partners. Our framework for meeting these aims is also **informed by insights from implementation science**, especially the Consolidated Framework for Implementation Research (CFIR; Damschroder et al., 2009), which identifies five major domains that affect program implementation:

- **characteristics of the program**
- "**outer setting**" of external county and community context
- "**inner setting**" of the organization or agency that operates the program
- **characteristics of the individuals** involved in program implementation
- **processes** and strategies used to implement the programs

Building further from the insights of implementation science, we also address specific effects of these processes—known as implementation outcomes—such as the extent to which the programs are perceived as satisfactory or the extent to which programs can be executed successfully. Together, this approach leverages advances in implementation science and community-partnered research.

Data

Our primary data sources are qualitative interviews of program leads and their staff and surveys of program leads. Data and insights are also drawn from a variety of engagement activities following our community-partnered approach. Data collection for these data sources is explained in the following sections.

Interviews

Interviews with individuals involved in the implementation of each program were conducted every six months beginning in mid-2019. Interview guides for each round of interviews were developed to address specific factors from the Consolidated Framework for Implementation Research as well as evolving contexts such as the COVID-19 pandemic. This strategy of repeated interviews allows us to capture dynamic change over time, incorporate multiple individuals' perspectives on implementation, and address a variety of factors that affect program implementation. The table below summarizes the timing of and participants in the four rounds of interviews analyzed in this report. Each interview includes one or more individuals involved in implementing a given program and every program is

represented in each round of interviews. For two counties with both a Child/Youth and a School-County Collaborative Grant, a single baseline interview was conducted with leads for both programs.

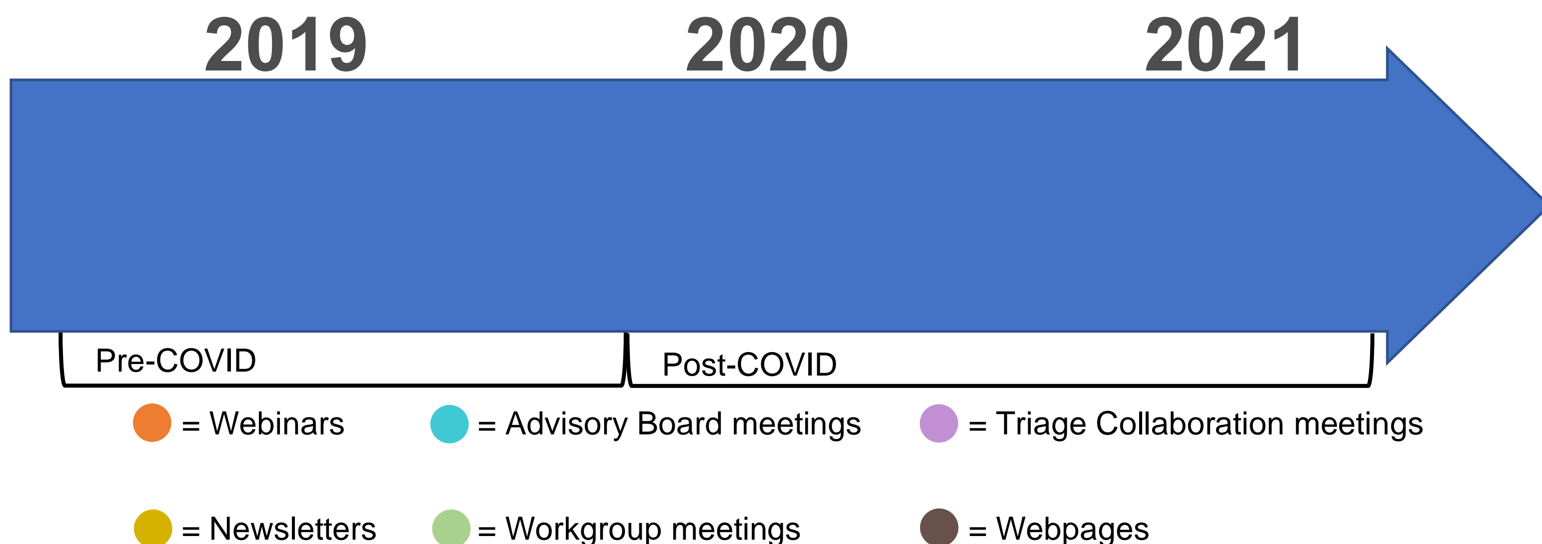
	Pre-COVID Closures		Post-COVID Closures	
	Baseline	**6-month**	**12-month**	**18-month**
Dates	June–Sept 2019	Jan–Feb 2020	June–Oct 2020	Feb–Apr 2021
Participants	Program Leads	Program Leads	Program Staff	Program Leads
# of Interviews	12	14	14	14

Program Surveys

To supplement qualitative interview data for the mid-point report, a program lead survey was conducted in mid-2021 to capture program leads' attitudes toward factors related to program implementation, the suitability and effectiveness of their programs for addressing Triage Program goals, and activities related to funding, revenue, and sustainability. A primary administrative lead from each of the fourteen programs completed this survey.

Engagement Activities

Collaboration with county and program partners and other engagement activities have continuously informed our progress in meeting the aims of the evaluation. The evaluation has benefitted from the contributions and input of approximately 175 collaborators, including individuals involved in program implementation, community partners, expert advisors, and members of the public. We engaged collaborators through webinars, newsletters, advisory board meetings, three regular workgroups, Triage Collaboration meetings, and the development of a webpage. The figure below visualizes the timing of these engagement activities between mid-2019 and the evaluation mid-point in 2021.



Analysis

Interview transcripts and notes from engagement activities were thematically analyzed by the evaluation team using mixed methods data analysis software. A codebook of important themes was developed using the evaluation framework, interview guide, SB-82/833 Triage Grant Program goals, and priority issues identified by our collaborators, with additional themes added to the codebook

during review of the data. Evaluation staff coded the qualitative data by applying thematic codes to appropriate excerpts and then examined the thematically coded excerpts to identify common barriers to and facilitators of implementation.

Data from the program lead survey were also cleaned, formatted, and analyzed to produce descriptive tables to supplement the thematic findings.

Preliminary Findings

Program Characteristics

Program characteristics are the features of a program that might influence how it is implemented. This includes descriptive characteristics of the programs and their components, such as the service settings in which they operate, the care processes and services they provide, program timing and maturation, and the level of grant funding they received. Other important characteristics directly relate to their suitability for implementation, such as how complex the program's structure is or how adaptable its components are.

SB-82/833 programs are very **heterogeneous** in their primary settings, care processes, timing and maturation, and amount of grant funding received. This heterogeneity is explained primarily by **tailoring of the programs** to the existing mental health and social service systems in their respective counties.

Funding cuts impacted early program implementation resulting in some **reductions** to the volume and type of services, number of sites, mix of staff roles, and number of geographic units that programs could serve. Funding cuts also increased the in-kind, often hidden, contributions implementing organizations made to ensure that their programs could be executed successfully.

Programs are **highly adaptable**, especially evident during the COVID-19 pandemic. The greatest barriers to adaptability relate to areas where programs **lack access to resources**, including funding, adequate organizational budgets, and community assets, or where barriers to implementation are **beyond the authority of the program** to address. For some programs, strong organizational partnerships mitigate these challenges.

Outer Setting

The **outer setting** of program implementation refers to the external contexts that might influence implementation, including the impact of global, national, or local conditions and events. This can include how programs respond to (and interact with) the conditions in their community and county—including available assets and needs of the community, and how the implementing organizations are connected with other organizations in the county. This can also include larger-scale social forces with an impact on program operations, such as the COVID-19 pandemic.

Programs are **tailored to the specific needs** of their communities, both in design and in the types of adaptations made over the course of implementation. Areas of particular concern and attention include the need for dedicated child mental health services as well as need for culturally appropriate care, especially for minoritized racial and ethnic communities, and need for care that is responsive to structural racism within communities and social service systems.

SB-82/833 programs partner and coordinate with a wide number of organizations and agencies in different sectors and at multiple levels, either due to their formal structure, by practical necessity, or as an intended outcome. A common intention is for partnerships to have a **long-term impact on linkages across sectors**, either by creating and sustaining durable formal partnerships, enabling practical cross-sector workflows, and/or creating better integrated social service systems.

SB-82/833 programs experience **barriers to implementation** when community assets for mental health, such as child psychiatric hospital beds, crisis stabilization units, crisis residential facilities, and even outpatient clinics and providers, are not available in-county or adequate to support effective crisis care.

The **COVID-19 pandemic** constituted a major context in which program implementation must be understood, leading to observed changes in community needs (such as greater and more severe mental health needs and an increase in basic needs) as well as changes in program demand and referral sources. Programs made **extensive adaptations and innovations**, including rapid uptake of telehealth, with mixed perspectives on its utilization and efficacy. Other innovations were also developed to address a variety of challenges including disruptions to program settings, referral sources, youth and family engagement, and in-person team coordination. Despite innovations, teams also experienced durable challenges including strain on their staff, lost time continually re-adjusting to an ever-changing landscape, new barriers to building and sustaining partnerships, increased uncertainty around future funding, and loss of access to critical resources.

Inner Setting

The **inner setting** of program implementation refers to features of the implementing organization that might influence implementation, including its organizational characteristics, culture and climate, and the extent of leadership engagement in the program. This involves how SB-82/833 programs operate within their organization(s), including how they coordinate, how the program fits with the goals and workflows of the organization, and how readily SB-82/833 services and staff are integrated into the organization and supported by leadership.

SB-82/833 programs are generally closely embedded in the organizations that implement or house them. **Programs coordinate closely with other units** in their organizations to deliver their services, fill gaps in their social service systems, share limited resources, and generally increase the capacity of their crisis care systems. A major challenge to this integration is **staff turnover and gaps**, which impacted many programs by changing the services they can provide, placing additional burden on remaining staff, and reducing programs' institutional knowledge and networks. Contributors to staff turnover include stresses related to the nature and structure of dedicated crisis roles, prevailing public sector mental health compensation, and work conditions. Some programs also experienced related **challenges in recruiting and hiring staff**, with additional challenges including hiring for short-term positions, provider shortages (both regional and linked to licensure requirements), and delays related to the COVID-19 pandemic. Smaller and more rural challenges experienced special challenges relating to both retaining and hiring staff.

Programs **generally fit well within their organizations' existing missions and workflows** and feel adequately prioritized by their organizational leadership. Programs that are housed in external organizations (e.g., schools, hospitals, police departments), however, have varying experiences ensuring that they are properly aligned with and prioritized within these settings. While many programs report successes, some describe extensive work to ensure that their programs are

successful within these settings. While such efforts are also a major contribution (indeed, goal) of programs, they take more time and resources to achieve depending on the particular site.

Programs report good support in terms of access to resources within their implementing organizations but note that such resources are heavily constrained in mental health systems. Organizations provide extensive support in the form of additional personnel for administration and data coordination, but programs report that the **resources needed often exceed the capacity of their organization** to supply. These challenges are especially **acute for smaller and more rural counties**.

Individual Characteristics

Individual characteristics are factors related to the particular individuals who are involved in implementation, most notably the leadership and staff of the programs. As such, we sought to explore characteristics of the individuals integral to implementing services, including their attitudes and level of engagement.

Although program staff work under challenging conditions due to their workloads and the nature of crisis work, they generally express **positive attitudes** toward program quality, as well as **passion and enthusiasm** for their work despite challenges. Program leads have positive impressions of their staff, emphasizing their **dedication and skills**.

Many staff go **above and beyond** to ensure the success of their programs. For some programs, this may also include heavy reliance on a **single champion** or extensive engagement from **staff not funded** by the SB-82/833 Triage Grant program.

Implementation Processes

Implementation processes are the processes and strategies that are carried out in program implementation, such as efforts to incorporate stakeholder input into planning, the extent to which staff “champion” the intervention, and the extent to which the intervention is carried out according to plan.

Most programs felt that **adaptations allowed them to generally execute the programs** they had intended. The biggest barriers to accomplishing this they identified were the **COVID-19 pandemic** and **limited resources**, with some programs also experiencing delays related to establishing critical partnerships.

For many programs, **data collection and reporting constitute a significant burden** that is linked to **access to resources** (especially staff capacity), differences in the quality of county and site data infrastructure, organizational and regulatory challenges, as well as complications from the pandemic.

Since grant support for programs varies, multiple programs describe efforts to **“patchwork” additional funding** or revenue to support their ongoing operations, including through Medi-Cal billing, other MHSA funds, county and community funds, and other grants. Across the 14 SB-82/833 programs, an **average of 2.3 funding sources were reported to supplement** Triage Grant funding. Programs also described efforts toward sustainability planning. Among the nine SB-82/833 programs with a sustainability plan in place, an **average of 3.2 funding sources were reported**. Both patchworking and sustainability planning required significant effort and confronted durable and systemic challenges related to the lack of options for adequate, predictable, and reliable support for mental health services.

SB-82/833 Triage Program Goals

SB-82/833 programs engage in a variety of activities that both address and fit with the goals of the Triage Grant Program. While Child/Youth programs and School-County Collaborative programs have some distinct Triage Grant goals, many Child/Youth programs show evidence of addressing School-County Collaborative grant goals and vice versa, attesting to the wide range of potential impacts of these programs on child mental health crisis systems.

Expand crisis prevention and treatment services:
Programs address expanding crisis prevention and treatment services by filling gaps in services systems and settings, identifying and responding to unmet community needs including those of underserved communities related to crisis services, and engaging in partnerships for improved linkage and utilization. Program leads in 13 programs agreed that their SB-82/833 activities and services are suitable for and effective at addressing needs that were not adequately met by other mental health programs in their county of community.

Increase client wellness:
Programs address increasing client wellness by providing crisis services that are targeted to the specific mental health needs of their communities. Program leads and staff work to ensure their operations are aimed at improving mental health outcomes and overall wellness. The majority of program leads in 13 programs agreed that the activities and services of their SB-82/833 program are both suitable for and effective at increasing client wellness.

Decrease unnecessary hospitalizations and associated costs:
Programs address decreasing unnecessary hospitalizations and associated costs by providing preventative care aimed at reducing the incidence of mental health crisis, providing early intervention services aimed at identifying needs or crises before the escalate to the point where hospitalization is considered, providing crisis services that improve the quality of crisis response to de-escalate, providing age-appropriate crisis services that improve the quality and depth of child crisis response to de-escalate crisis situations, and addressing unnecessary use of emergency departments for mental health crises.

Reduce unnecessary law enforcement involvement and costs:
Programs address reducing unnecessary law enforcement involvement and costs by providing parent trainings, preventive crisis services, social-emotional learning, and other supports to prevent the need for law enforcement involvement; providing a law enforcement alternative when mental health crises occur; improving law enforcement's understanding of mental health; and providing options for co-response with law enforcement to promote de-escalation.

Increase access to a continuum of mental health services and supports through school-community partnerships:
Programs address increasing access to a continuum of mental health services and supports through school-community partnerships by offering services that did not previously exist in schools, increasing the reach and intensity of existing services, and utilizing a partnered approach to offer greater depth of care. Among the four School-County Collaborative programs, all agreed that the activities and services of their SB-82/833 programs are suitable for and effective at both addressing this goal and developing new or strengthening existing school-community partnerships for mental health.

Develop a coordinated and effective crisis response systems on school campuses when mental health crises arise:
Programs address this goal by providing capacity and coordination for new referrals and tracking systems both prior to and during the COVID-19 pandemic, providing resources and support to ensure existing systems are used appropriately and effectively, and using referral systems to ensure major crises in schools are addressed timely and appropriately. Among the four School-County Collaborative programs, all agreed the activities and services provided by their SB-82/833 programs are suitable for and effective at addressing this goal.

Engage parents and caregivers in supporting their child's social-emotional development and building family resilience:
Programs address this goal by providing outreach, training, support, and resources to parents/caregivers beyond immediate interactions during discrete crises. Among the four School-County Collaborative programs, all agreed the activities and services provided by their SB-82/833 programs are suitable for and effective at addressing this goal.

Reduce the number of children placed in special education for emotional disturbance or removed from school and community due to their mental health needs:
Programs address this goal by tracking special education utilization and school discipline to understand how and when they may be disproportionately used for minoritized students or students with mental health needs, working with school staff in special education to improve knowledge and access to resources, and working with school staff to improve systems and cultures in school discipline before the COVID-19 pandemic. Among the four School-County Collaborative programs, two agreed the activities and services provided by their SB-82/833 programs are suitable for and effective at addressing this goal.

Implementation Outcomes

Implementation outcomes are the impacts of implementation processes, and include program acceptability, appropriateness, feasibility, fidelity, penetration, and sustainability.

Program **acceptability**, the extent to which the service or program is perceived by leads and staff as satisfactory, is generally high with few major challenges to acceptability identified in the present findings. Challenges related to the limits of program adaptability and strain on program staff are presently among the most likely barriers to acceptability.

Program **appropriateness**, the relevance or fit of the service or program to a given context, is generally high, as programs are tailored to their settings and fit with their implementing organizations or work to overcome challenges in fit with partners in other sectors. A potential barrier to appropriateness concerns the extent to which sustainability planning may transition SB-82/833 programs to funding sources that reduce their ability to provide services that are well-tailored to their community needs and the gaps in their existing service systems, especially with respect to preventive care and universal interventions.

Programs are generally feasible in principle, but face some barriers to **feasibility** in their execution, especially for programs that are complex and highly networked. The biggest barriers to feasibility for SB-82/833 programs, therefore, concern the availability of necessary resources (including funding), access to critical community assets for mental health, and access to sufficient staff. Major factors that offset these challenges and thus made programs feasible—indeed possible—to deliver are the adaptability and high level of engagement of many program leads and staff.

Fidelity is the extent to which services and programs are executed successfully by the particular implementing organization or service setting. Most programs felt that adaptations made over the course of implementation allowed them to deliver their intended services and address their intended aims, even as the specifics of execution varied from what had been expected prior to the pandemic.

Programs vary in their **penetration**, that is, the level and type of integration with their organizations, especially for programs set in non-mental health settings. The biggest barriers to integration in these settings are the extent of external leadership buy-in and administrative capacity for partnerships, which were mitigated by SB-82/833 staff and leadership engagement.

Major facilitators of program **sustainability**, the extent to which the program is or can be maintained over time, include their **adaptability**, the extent to which they are **adequately prioritized** by their implementing organization(s) and **supported by leadership** in their organizations. The most impactful barriers to program sustainability, however, center on resources. Program **sustainability will be low to the extent that programs lack stable resources** necessary to sustain their operations on an ongoing basis or are unable to secure adequate, predictable, and reliable alternative sources of funding and revenue.

Early Lessons Learned

1. SB-82/833 programs make noteworthy contributions to mental health services in their counties and communities.
    - Programs are designed and implemented to **increase access** to mental health services for children and youth.
    - SB-82/833 programs are taking actions to **improve the quality** of mental health crisis services for children in their communities.
    - SB-82/833 programs **expand mental health and crisis services in schools**.

2. Some major advantages of SB-82/833 programs—including operation across multiple care processes on the crisis continuum, integration with teams both in and outside of their organizations, and partnerships across sectors—also make them more challenging to deliver. Programs would likely benefit from support directed toward these unique advantages and their corresponding challenges.
    - Given programs' level of specialization, complexity, involvement in partnerships, and tailoring to community needs, they may benefit from **more time to design, plan, and ramp up their programs prior to the start of service delivery** as well as support during this time to ensure that major barriers can be overcome.
    - **Additional administrative resources may be appropriate** to support extensive, ongoing coordination between organizations to promote success.
    - Given their heterogeneity and wide scope of activities, programs are likely to benefit from **flexibility in how their programs are designed and executed** to ease their efforts aligning contractual obligations with the needs of their communities, implementing organization, staff, and partnered organizations.
    - Programs would likely benefit from **additional support for developing effective partnerships in sectors relevant to their programs**. To the extent that specialized resources for support do not already exist, programs would likely benefit from access to venues to develop and share best practices for partnering with emergency departments/hospitals, police departments, schools.

- Formalized partnerships may be most appropriate when initiated organically and tailored to need rather than administratively/bureaucratically mandated.

3. SB-82/833 programs face **challenges in ensuring that they have access to adequate resources** to allow them to implement their programs and focus on program goals without straining their personnel.
    - Programs are likely to benefit from **increased clinical and other service staffing** to make workloads more manageable and reduce the likelihood of staff burnout.
    - SB-82/833 program implementation would likely benefit from **access to more robust community assets for child mental health in their counties**, such as youth psychiatric inpatient beds, crisis stabilization units, crisis residential programs, mental health urgent care clinics, and outpatient treatment resources.
    - Programs would likely benefit from more **stable, predictable, and long-term funding opportunities**.
    - Where programs would benefit from more resources than are immediately available, programs may need more **learning opportunities to increase their capacity to close resource gaps**.
    - To the extent that resources for child mental health services remain scarce relative to need, it may be advantageous to **ensure that grant-funded programs are appropriately scaled to the resources available**, especially if funding is reduced.

4. Especially given limited staffing and resources and the inherent challenges of crisis work, SB-82/833 program implementation would benefit from **support to develop strategies to reduce or mitigate staff turnover**.
    - Many programs would benefit from more **systematic efforts to assess staff workload, detect signs of burnout, and work with staff to address issues** before they progress. Many programs would also benefit from ensuring that remuneration for positions is competitive, which may involve action at the county level.
    - Since some amount of turnover in staff is inevitable (retirements, medical or family leave, etc.), programs would benefit from the **development of mechanisms to sustain resources, relationships, partnerships when staff turnover occurs**.

5. School-based programs, both Child/Youth and School-County Collaborative, have some special considerations that affect grant program design and program execution and should be addressed.
    - **School-based programs, in particular, may benefit from additional time between grant award and the expected start of services.** They may need to develop contracts and build relationships with school districts, hire staff in schools, establish a defined division of labor with existing school staff, or establish new workflows in schools. Programs would also likely benefit from time to plan their outreach efforts toward students and families.
    - **Alignment of grant funding with the school year** would ease implementation of school-based programs.
    - School-based programs may need additional **support developing strategies to navigate between the data and regulatory systems** that prevail in the mental health and educational sectors.

1. Introduction

This report summarizes the progress made in the statewide formative evaluation of SB-82/833 Child/Youth and School-County Collaborative Triage programs from the start of program implementation through mid-2021. The analysis and findings are preliminary and provide a provisional understanding of program implementation.

The formative evaluation uses mixed methods to provide a broad, statewide evaluation of SB-82/833 Triage program implementation and examine, in context, the implementation of the fifteen funded Child/Youth and School-County Collaborative Triage programs. The evaluation purposively balances the identification of commonly shared, broad features of the programs while allowing flexibility to accommodate specific differences in contextual factors, approach, target population, and intervention goals. Likewise, to address the heterogeneity of data sources and variations in data infrastructure and capacity across programs and counties, we have used a flexible approach to the identification, collection, and analysis of data in collaboration with program partners. This is achieved through the use of both qualitative and quantitative data, with quantitative data used primarily to enrich the qualitative findings.

The formative evaluation has also adopted a community partnered approach to the evaluation rooted in Community-partnered Participatory Research (CPPR; Jones & Wells, 2007), which aims to promote authentic partnership between academic researchers and community members. We have therefore sought to incorporate key CPPR principles, such as developing trust, earning respect, identifying mutually beneficial aims, and communicating regularly, into the entire evaluation process. Details on our partnership and stakeholder engagement activities are described in regular updates to the MHSOAC and detailed in section 2.2.

2. Formative Evaluation Aims and Logic Model

The SB-82/833 evaluation is a formative evaluation, defined as "a rigorous assessment process designed to identify potential and actual influences on the progress and effectiveness of implementation efforts" (Stetler et al., 2006). This entails data collection on implementation processes prior to and over the course of implementation to understand the initiative, what may be improved, and the potential for maintaining or sustaining interventions. While formative evaluations are often used to understand the implementation of a single given intervention, we use this approach to evaluate a broader set of interventions designed across counties/programs to achieve common goals. The formative evaluation has been conducted to achieve a discrete set of evaluation aims, with our partnership and engagement efforts, evaluation framework, and logic model providing the foundation on which our methodological and analytic strategies for meeting the evaluation aims are built.

2.1 SB-82/833 Child/Youth and School-County Collaborative Formative Evaluation Aims

The **formative evaluation aims** for Child/Youth and School-County Collaborative Triage programs are focused on describing the process of program implementation and adaptation across different phases, from proposal to initial implementation through transition to full implementation and maturity.

The specific aims are:

1. **To describe and assess selected program implementation activities, processes, and outcomes across the program phases.**
    - Subaim 1a. To examine variation in implementation by program type, region, new or augmenting, urban or rural, and relevant sociodemographics and contextual factors.
    - Subaim 1b. To understand the ongoing influence of the COVID-19 pandemic on implementation.

2. **To identify facilitators and barriers to program implementation across the program phases.**
    - Subaim 2a. To examine variation in facilitators and barriers to implementation by program type, region, new or augmenting, urban or rural, and relevant sociodemographics and contextual factors.
    - Subaim 2b. To understand the influence of the COVID-19 pandemic on existing facilitators and barriers to implementation.

3. **To provide lessons learned and evidence-based recommendations for future program implementation based on the analyses for Aims 1 and 2.**

2.2 Partnership and Stakeholder Engagement Activities

Collaboration with our county partners and other stakeholder engagement activities have continuously informed our progress in meeting the aims of the evaluation. We have implemented our community partnered approach through the following activities:

2.2.1 Stakeholder Advisory Board

Our Stakeholder Advisory Board met April 3, 2020, and July 17, 2020, including stakeholders such as Richard Van Horn, Karen Hart, Felica Jones, and other community partners. We expanded the board in 2021, soliciting nominations through program partners, our newsletter, and organizations focused on underserved mental health groups.

The expanded Stakeholder Advisory Board includes 10 stakeholders, including providers, peer partners, administrators, and community advocates. The Board represents a diverse geography, unique professional and lived experiences, and communities underserved by the mental health system. Our first meeting was held on April 27, 2021, where our Board stressed the importance of qualitative data, appropriate language, and unique barriers communities face. Following CPPR principles, the Board will meet again July 27, 2021, to explore nominating a leader and review our midpoint progress report. During the time of this writing, one of our stakeholders and lifelong leaders in mental health advocacy, Richard Van Horn, passed away.

2.2.2 Program Workgroups

As the evaluation has progressed, program staff requested the creation of new workgroups to share common challenges, solutions and lessons learned. The Data Coordinator's Workgroup began meeting in June 2019 and as new discussions emerged, the School-County Collaborative and school-based Child/Youth programs requested their own workgroup which began meeting in October 2019. In January 2021, the Child Workgroup also emerged as a space for Child/Youth programs to discuss relevant matters to their grant funded programs.

Staff from all programs (Adult/TAY, Child/Youth, School-County Collaborative) are invited to attend our quarterly Data Coordinator's Workgroup; previously, the workgroup was held on a monthly basis. Our Child and School-County Workgroups are held monthly for corresponding grantees. Staff attend the workgroups as feasible for their schedules and relevant program demands. We adjust workgroup meeting frequencies as requested by our partners. As programs have progressed, so have the formats of the workgroups; our meetings shifted from structured to semi-structured to allow programs greater room for cross-program collaboration. Recently, MHSOAC partners attended our School-County Workgroup held in May 2021 where program partners expressed great appreciation for their attendance. With such collaboration and relationship-building, programs report meeting independently of the workgroup to discuss relevant topics such as sustainability and have expressed their gratitude for the space to share narratives and support each other through program implementation.

2.2.3 Newsletter and Website

In collaboration with our UC Davis and MHSOAC evaluation partners, newsletters have been sent to program partners biannually, or as needed, since October 2019. Thus far, newsletters have been sent out in October 2019, March 2020, November 2020, and our latest newsletter in April 2021.

2.2.4 Webinar Series

We hosted two webinars: one focused on crisis literature reviews, held November 25, 2019, and another focused on the original evaluation plan, held May 21, 2020.

2.2.5 MHSOAC Sponsored Meetings

The MHSOAC has hosted a quarterly all-program meeting either in-person or virtually since May 2019. Members of the UC evaluation teams have attended all meetings, including the latest meeting on May 6, 2021, where our team presented preliminary findings. We look forward to the next all-program meeting held by the MHSOAC.

2.2.6 Qualitative Description of Stakeholder Input

As part of our community-partnered approach, the evaluation team has documented actionable input received from our stakeholders. A summary of stakeholder feedback and the responses of the evaluation team are provided in **Appendix A**.

2.3 Formative Evaluation Framework and Logic Model

Our conceptual and analytic framework and logic model provide the basic definitions, conceptual schemes, and processual models that structure the formative evaluation.

2.3.1 Conceptual and Analytic Framework

The conceptual and analytic framework is composed of nine domains that specify:

1. ***contexts and factors*** that influence implementation
2. ***key features and outputs*** of the SB-82/833 Triage Grant program
3. ***implementation outcomes*** that result from program execution

Each of the nine domains and their component concepts are described in this section and a table of the definitions for all domains and constructs reflected in the findings in this report can be found in **Appendix B**.

Contexts and Factors Influencing Implementation

To conceptualize the contexts and factors that influence implementation, we draw primarily on the Consolidated Framework for Implementation Research (CFIR; Damschroder et al., 2009), which synthesizes a broad literature in implementation science to specify constructs in five domains that organize the influences over and processes involved in implementation. Our adaptation of these five domains—***program characteristics, outer setting, inner setting, individual characteristics, and implementation processes***—constitute five of the nine domains in our framework and logic model.

Program Characteristics

Program characteristics are the features of a program that might influence implementation. This includes the ***descriptive characteristics*** of programs and their components, which are the basic features of the program and its interventions that provide context for, and may also impact, the course of implementation. Examples of descriptive characteristics include the specific settings, care processes, and timing of a program.

Other important program characteristics are the ***implementational characteristics*** of programs, which are those directly related to the suitability of a program for implementation. This includes factors like the ***complexity*** of a program and its components as well as its ***adaptability***, or the degree to which it can be tailored and refined to meet local needs and respond to changing conditions.

Outer Setting

The outer setting of implementation consists of the external contexts in which the program is carried out and includes both county/community contexts as well as larger-scale national/global dynamics with an impact on program operations, such as the COVID-19 pandemic. Important considerations related to the outer setting include the extent to which ***needs of patients and communities*** are known and prioritized by the program and the extent to which programs are connected to other organizations in their communities, which is known as ***cosmopolitanism***.

Inner Setting

The inner setting of implementation refers to features of the implementing organization that might influence implementation of the program, and includes:

1. ***structural characteristics*** of the implementing organization
2. ***networks and communication*** within the implementing organization
3. ***organizational culture and climate***
4. the organization's ***readiness for implementation***

Within each of these aspects of the inner setting are particular constructs of interest to understanding implementation:

Structural characteristics	- ***social architecture***, which concerns the functional division of labor within the organization and how the program is positioned within it - ***team stability*** within the program, that is, the extent to which staff remain in their roles for an adequate amount of time without excessive turnover
Networks and communication	- nature and quality of ***social networks*** within the organization - quality of formal and informal ***communication*** within the organization
Organizational culture and climate	- extent of ***compatibility*** or fit of the program with both the culture and climate of the organization as well as existing workflows and systems in the organization - perceptions of the ***relative priority*** of the program within the organization
Readiness for implementation	- extent of ***leadership engagement*** with the program, including organizational leadership's tangible commitment to and involvement in implementation - level and ***availability of resources*** dedicated to program implementation provided by the organization

Individual Characteristics

Individual characteristics are factors related to the particular individuals who are involved in implementation, most notably the leadership and staff of the programs. Important considerations related to the individual characteristics of the individuals involved in implementation include their:

1. ***knowledge and beliefs*** about the program, including their perceptions of and attitudes toward the program and its components
2. ***self-efficacy*** in their roles, including beliefs about their capabilities to deliver the program
3. their level of ***engagement****,* especially progress toward skilled and enthusiastic delivery of the program

Implementation Processes

Implementation processes are the processes and strategies involved in carrying out the program that might influence program outcomes. A major implementation process is the ***planning*** of the program, which can include efforts to consider stakeholder needs and perspectives in developing the program (***stakeholder consideration***), ***tailoring*** of the program to appropriate subgroups*,* and ***simplification*** of the program or its components to make execution easier.

In addition to consideration of the processes involved in the planning a program, ***executing*** the program refers to the extent to which a program or component is carried out according to plan. This can include whether or not the intended interventions are delivered, their quality, and their timing or intensity. It can also include the extent to which program goals and outcomes are addressed as intended.

A final two implementation outcomes of interest are ***progress tracking*** and ***reflection****.* Progress tracking refers to efforts to track progress toward goals and milestones, while reflection refers to opportunities for reflection and team debriefing on that progress as well as on experiences with program implementation.

Key Triage Program Features and Outputs

In addition to the CFIR domains and constructs, our conceptual and analytic framework also incorporates specific key features and outputs of the SB-82/833 Triage Grant program, including the overarching ***SB-82/833 triage program goals*** and a set of ***target program activities*** intended to meet those goals. ***Proximal program outcomes*** are the measurable outputs of these target program activities.

SB-82/833 Triage Grant Program Goals

An overarching goal for SB-82/833 Child/Youth and School-County Collaborative Triage Grants is ***increasing client wellness*** by expanding crisis prevention and treatment services.

Additional goals for Child/Youth grants include:
- ***decreasing unnecessary hospitalizations*** and associated costs
- ***reducing unnecessary law enforcement involvement*** and costs

For SB-82/833 School-County Collaborative Grants, goals include:

- ***increasing access*** to a continuum of mental health services and supports through school-community partnerships
- ***developing coordinated and effective crisis response systems*** on school campuses
- ***engaging parents and caregivers*** in supporting their child's social-emotional development and building family resilience
- ***reducing the number of children placed in special education or removed from school and community*** due to their mental health needs

Target Program Activities and Proximal Program Outcomes

The overarching SB-82/822 Triage Grant Program Goals are theorized as the basis for specific ***target program activities*** intended to align program goals and implementation, as well as discrete ***proximal program outcomes*** that constitute measurable outputs of those activities. **Table 1** lists the SB-82/833 Triage Grant program goals as addressed in this report, identifies and defines each target program activity, and specifies the corresponding proximal program outcome(s) proposed in the evaluation plan.

Cultivate partnerships	Building relationships for collaboration between program and other relevant community agencies	- Number and type of MOUs - Number of interdisciplinary team meetings
Integrate program teams	Expanding, adapting, shifting internal staff roles	- New communication channels - Changes in staff allocation and task shifting
Linkage of agency/school supports and referrals	Linking clients to appropriate supports and referrals	- Number and type of linkages and referrals
Deliver crisis prevention and intervention services to clients	Carrying out crisis prevention and intervention services	- Number and type of services and trainings delivered
Deliver mental health trainings and activities	Carrying out mental health trainings and activities	- Number and type of services and trainings delivered

Implementation Outcomes

The final element of our conceptual and analytic framework is ***implementation outcomes*** which, distinct from (and intermediate to) service or client outcomes, are "the effects of deliberate and purposive actions to implement new treatments, practices, and services" (Proctor et al., 2011). The evaluation considers seven implementation outcomes synthesized from the literature (Proctor et al., 2009; 2011) that are relevant to SB-82/833 programs: acceptability, appropriateness, cost, feasibility, fidelity, penetration, and sustainability. The evaluation to date has collected data relevant to the assessment of program implementation around six implementation outcomes:

1. ***Acceptability***: the extent to which stakeholders perceive the service or program to be satisfactory. For the evaluation of SB-82/833 programs this can include satisfaction with the relative ease, complexity, or delivery of program services, trainings, and other activities.
2. ***Appropriateness***: the relevance or "fit" of the service or program to a given context or problem. This would include how appropriate an SB-82/833 program is to meeting client and

community needs or filling county service gaps (outer setting) as well as how compatible it is with features of the implementing organization or service setting (inner setting).

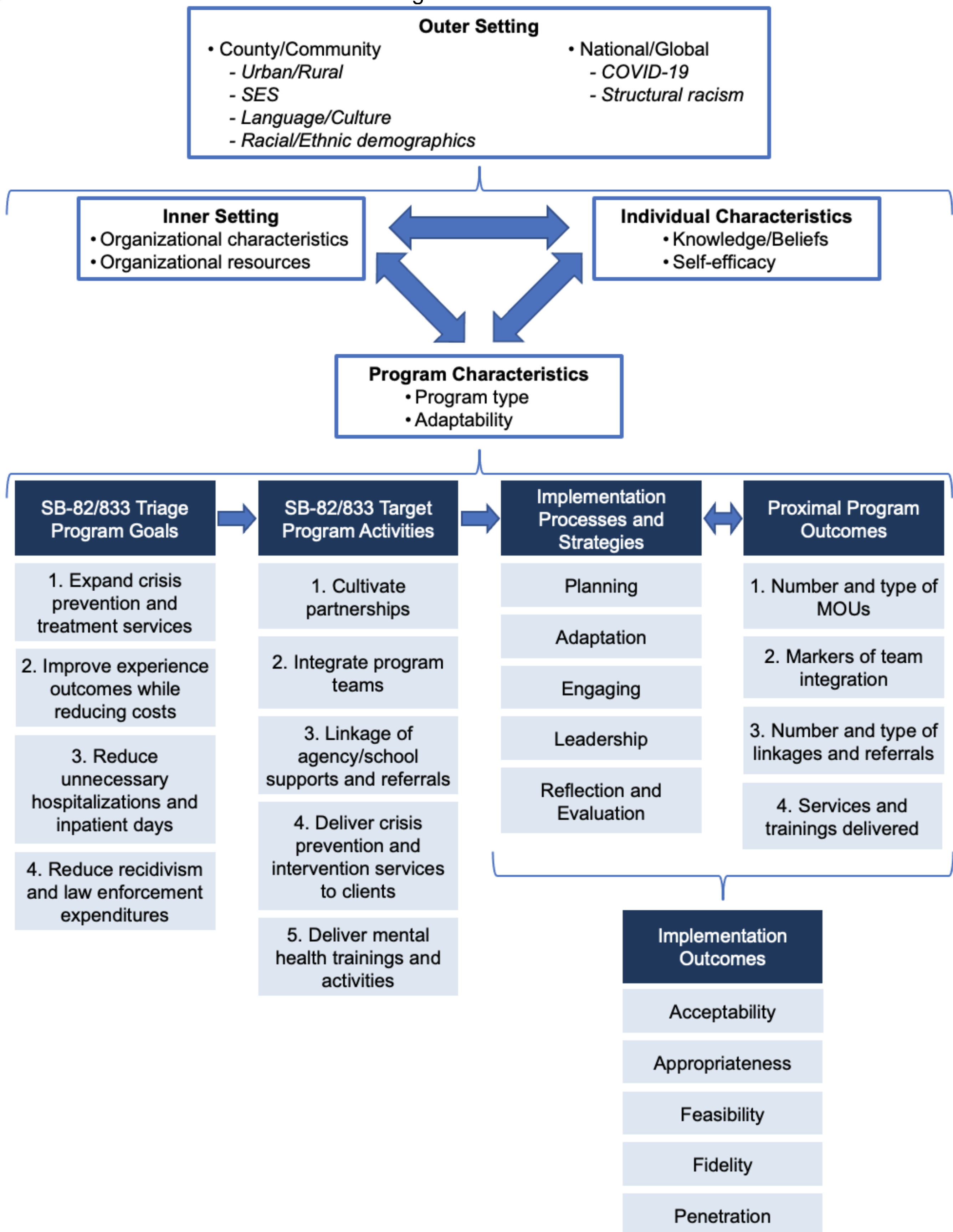
3. ***Feasibility***: the extent to which services and programs can be executed successfully by the particular implementing organization or within a given service setting. For SB-82/833 programs, this may include the extent to which a program is capable of carrying out its target activities and program goals, separate from whether or not those activities and goals are appropriate to the context or setting.
4. ***Fidelity***: the extent to which the program is implemented in accordance with plan or the intents of its designers. This could include how closely SB-82/833 program implementation matches the grant proposal, including in the types and frequency of services delivered, the quality of service delivery, or adherence to internal tracking and evaluation plans.
5. ***Penetration***: the degree to which the service or program has been integrated into its organizational context (inner setting). For SB-82/833 programs, this might include how well integrated program activities are into the regular operation of the agency or school or how extensively program services are used by clients, students, and teachers eligible for them.
6. ***Sustainability***: the extent to which the program is (or can be) maintained over time. We emphasize sustainability in terms of the ongoing and long-term viability of an SB-82/833 program, including its ability to secure the resources necessary to continue after the grant period ends.

2.3.2 Logic Model

The analytic framework for addressing the aims of the formative evaluation is summarized in the Logic Model in **Figure 1**. We use this model to organize and illustrate the analytic relationships between the nine domains of our framework. Figure 1 is intended as a visualization of the relationships between the domains and constructs, not as an exhaustive accounting of the contents of each domain. The ***outer setting*** is the broadest context in which program implementation takes place, with the ***inner setting***, ***individual characteristics***, and ***program characteristics*** mutually interacting within that community context. Those interactions then generate the path of implementation, whereby the overarching ***SB-82/833 Triage Program goals*** are translated by SB-82/833 programs into ***target program activities*** intended to meet those goals. These target activities are carried out through ***implementation processes*** and result in particular program outputs that can be understood as ***proximal program outcomes,*** and ultimately coalesce into the ***implementation outcomes***. This framework emphasizes implementation as an interactive process featuring continual adaptations to dynamic contexts (Chambers et al., 2013; Chambers & Norton, 2016).

The framework and logic model provide a basic structure which guide our data collection and analysis while retaining a high degree flexibility. Its components constitute the starting point from which we identify, within and across program contexts, relevant elements of SB-82/833 program implementation that may constitute barriers or facilitators to implementation. The flexibility of the model allows us to discover relevant elements and position them in the existing model as needed or adjust our areas of focus based on our ongoing analyses.

Figure 1. SB-82/833 formative evaluation logic model



3. Methods

3.1 Mixed Methods Approach

Integrating the goals of the initiative, scientific literature, and stakeholder input, we use a mixed methods approach to the formative evaluation which focuses on the analysis of qualitative data, with quantitative data used to enrich our qualitative findings (Bayliss et al., 2014; Creamer, 2018; Klassen et al., 2012; Tomoaia-Cotisel et al., 2013). Drawing primarily on qualitative data allows us to create a statewide story of SB-82/833 programs which identifies commonalities in programs' efforts toward implementation while ensuring programs are understood in their distinctive local contexts. This approach balances shared goals and county/program characteristics, with flexibility to allow for the description of the unique strengths and challenges that stimulated innovation. As a mid-point, we describe quantitative and qualitative methods, with corresponding preliminary findings in section 4. Further findings from program surveys to enrich the final qualitative analyses will be reported in the final report.

3.2 Study Design

We adopt a repeated cross-sectional observational study design to guide our data collection and analysis. This design, summarized in **Figure 2**, accommodates variation in program start time, follows the full course of program maturation, and captures program responsiveness and innovation in care delivery following the onset of the COVID-19 pandemic.

Figure 2. Study design

2018	2019	2020	2021	2022	2023
O N D	J F M A M J J A S O N D	J F M A M J J A S O N D	J F M A M J J A S O N D	J F M A M J J A S O N D	J F M A M J J A S O N D

Qualitative (Phase 1) Child/Youth: *Berkeley City, Calaveras, Humboldt, Placer, Riverside, Sacramento San Luis Obispo, Santa Barbara, Stanislaus, Yolo* School-County: *CAHELP, Humboldt, Placer, Tulare*	**Baseline**	**6-month**	**12-month**	**18-month**	**24-month**	**Final** [1]	**30-month**[2]	**Final**[2]
	Program Leads	*Program Leads*	*Site/ Agency Staff*	*Program Leads*	*Clinical Super-visors*		*Program Leads*	*Peer/ Parent Partners*

Qualitative (Phase 2) Los Angeles County: Antelope Valley, East, Metro, San Fernando, San Gabriel, South, South Bay/Harbor, West	**Planning**	**Planning**	**Baseline**	**6-month**	**12-month**	**18-month**	**24-month**	**Final**
	Program Leads	*Program Leads*	*Program Leads*	*Site/ Agency Staff*	*Program Leads*	*Clinical Super-visors*	*Program Leads*	*Peer/ Parent Partners*

Quantitative (Phase 1) Child/Youth: *Berkeley City, Calaveras, Humboldt, Placer, Riverside, Sacramento San Luis Obispo, Santa Barbara, Stanislaus, Yolo* School-County: *CAHELP, Humboldt, Placer, Tulare*	**Start Q4**	**Y1Q1**	**Y1Q2**	**Y1Q3**	**Y1Q4**	**Y2Q1**	**Y2Q2**	**Y2Q3**	**Y2Q4**	**Y3Q1**	**Y3Q2**	**Y3Q3**	**Y3Q4**	**Y4Q1**[2]	**Y4Q2**[2]	**Y4Q3**[2]	**Y4Q4**[2]
	Pre-COVID-19						Early COVID-19		Mid-COVID-19		COVID-19 Transition		COVID-19 TBD				

Quantitative (Phase 2) Los Angeles County: Antelope Valley, East, Metro, San Fernando, San Gabriel, South, South Bay/Harbor, West	**Start Q4**	**Y1Q1**	**Y1Q2**	**Y1Q3**	**Y1Q4**	**Y2Q1**	**Y2Q2**	**Y2Q3**	**Y2Q4**	**Y3Q1**

Case Studies School-County: *CAHELP, Humboldt, Placer, Tulare*	**Projected Additional Data Collection**

3.2.1 Study Phases

Child/Youth and School-County Collaborative programs are separated into two phases, Phase 1 and Phase 2, based on program start date. Phase 1 programs include all Child/Youth and School-County Collaborative programs that started delivering services before the end of 2019. Phase 2 programs include all SB-82/833 programs that had delays due to development of contracts with community-based mental health programs resulting in a program start date after 2019. Phase 1 Child/Youth programs include Berkeley City, Calaveras, Humboldt (Child/Youth), Placer (Child/Youth), Riverside, Sacramento, San Luis Obispo, Santa Barbara, Stanislaus, and Yolo. Phase 1 School-County Collaborative programs are CAHELP, Humboldt (School-County), Placer (School-County), and Tulare. Phase 2 programs include the 8 sites in Los Angeles County. Each Service Planning Area (SPA) in Los Angeles County is conceptualized as a "county" given the variation in implementing agencies and the sociodemographic characteristics of each area. This approach has been used successfully in a prior statewide evaluation of quality of care for children receiving publicly funded outpatient mental health services (Zima et al., 2005).

3.2.2 Study Time Intervals

The study time intervals for Phase 1 and 2 programs are conceptualized in 6-month/biannual time periods for our main qualitative data collection (interviews) and in 3-month/calendar quarterly time periods for our main quantitative data collection (program survey). Using calendar quarters for quantitative data collection is an update to the evaluation plan from the study time intervals proposed in Deliverable 4a to better accommodate the reporting periods of SB-82/833 programs. Figure 2 reflects these adjusted reporting periods as well as corresponding updates to our proposed COVID periods. Supplemental data collection also occurs across the entire study period as needed given the variation in start dates of implementation and start dates for tracking clients served.

3.2.3 Comparison Groups

In addition to the time intervals related to program phase and COVID-19 context described above, our study design also incorporates substantive comparison groups for programs based on our aims, which include understanding variation in implementation and facilitators and barriers to implementation across program characteristics and contexts. The main comparison groups are SB-82/833 ***grant type*** (Child/Youth or School-County Collaborative), whether the program is ***school-based or non-school-based*** (provides most services in a school setting or a non-school setting), whether the program is ***new or augmenting*** existing crisis services, whether the program is ***directly operated or contracted***, what ***region*** in the state of California the program serves, and whether the program serves a primarily ***urban or rural*** county. By comparing programs within and between these groups we can better understand implementation in terms of three of our logic model domains: program characteristics (grant type, school or non-school), inner setting (new or augmenting, direct or contracted), and outer setting (region, urban or rural). These comparison groups can be used to structure comparative analyses using both qualitative and quantitative data.

Per the flexibility built into our evaluation plan in Deliverable 4a, some changes have been made to our study comparison groups with impacts on how some programs are categorized. Based on feedback from programs, we have revisited the new and augmenting categories to ensure that they more accurately represent the extent to which programs are either expanding/extending an existing service or constitute a new service within their implementing organization. To be clear, all programs are contributing something new to their service systems and all programs, at least broadly, augment

social services that already exist; this distinction thus captures organizational/structural newness rather than whether or not programs provide a wholly unique function. The distinction between direct and contracted programs has also been revised to reflect programs that are *directly operated* ("Direct"), programs that are (at least partially) contracted to other *public agencies* ("Public"), and programs that are (at least partially) contracted to a *private mental/behavioral health organization* ("Private"). **Table 2** presents the revised comparison group classifications used for findings in this report. These categories, and the classifications made using them, will continue to be refined over the course of the evaluation.

Table 2. Study comparison groups

Program	**Program Characteristics**		**Inner Setting**		**Outer Setting**	
	Grant Type	**School/ Non-School**	**New/ Augmenting**	**Direct/ Contracted**	**Region**	**Urban/ Rural**
Berkeley City	Child	School	Augmenting	Direct	Bay Area	Urban
CAHELP	School	School	Augmenting	Direct	Southern	Urban
Calaveras	Child	Non-School	New	Direct	Central	Rural
Humboldt (Child)	Child	Non-School	Augmenting	Direct	Superior	Rural
Humboldt (School)	School	School	New	Public	Superior	Rural
Los Angeles – Antelope Valley	Child	Non-School	New	Private	Los Angeles	Urban
Los Angeles – San Fernando Valley	Child	Non-School	New	Private	Los Angeles	Urban
Los Angeles – San Gabriel Valley	Child	Non-School	New	Private	Los Angeles	Urban
Los Angeles – Metro	Child	Non-School	New	Private	Los Angeles	Urban
Los Angeles – West	Child	Non-School	New	Private	Los Angeles	Urban
Los Angeles – South	Child	Non-School	New	Private	Los Angeles	Urban
Los Angeles – East	Child	Non-School	New	Private	Los Angeles	Urban
Los Angeles – South Bay/Harbor	Child	Non-School	New	Private	Los Angeles	Urban
Placer (Child)	Child	Non-School	New	Direct	Central	Urban
Placer (School)	School	School	New	Direct	Central	Urban
Riverside	Child	Non-School	Augmenting	Direct	Southern	Urban
Sacramento	Child	School	New	Public	Central	Urban
San Luis Obispo	Child	Non-School	Augmenting	Private	Southern	Urban
Santa Barbara	Child	Non-School	New	Direct	Southern	Urban
Stanislaus	Child	Non-School	Augmenting	Private	Central	Urban
Tulare	School	School	New	Direct	Central	Urban
Yolo	Child	Non-School	Augmenting	Direct	Central	Urban

3.3 Data

Following our mixed methods approach, the data sources include both quantitative and qualitative data. Our main source of quantitative data for the findings in this report is a two-part program survey (Data Coordinator Survey and Program Lead Survey), which provides additional details on program operations and the perspectives of individuals involved in implementation. Our main source of qualitative data for the findings in this report is semi-structured interviews to capture the perspectives of the individuals involved with program implementation, which are supplemented by notes on other meetings and other supplementary data provided by programs. **Table 3** summarizes major data

elements and sources used for the analysis and findings in this report, organized by logic model domain. Some listed data elements rely on data collection that is in progress and will be assessed when possible.

Table 3. Data summary by logic model domain

Data Element	Data Source(s)
Program Characteristics	
Program settings - Base setting - Service setting(s)	Interviews, Data Coordinator Survey
Program services - Target care processes	Interviews, Data Coordinator Survey
Program start date	Interviews
Grant funding amount	MHSOAC records
Program complexity	Interviews
Program adaptability	Interviews
Outer Setting	
Communities served - ZIP code	Data Coordinator Survey
Community characteristics and dynamics: - Geographic characteristics - Population size - Urban/rural - Socioeconomic status and poverty - Language - Cultural demographics - Racial/ethnic demographics and dynamics	Interviews
Needs of patients and communities - Clinical severity - Program demand	Interviews
Cosmopolitanism (external partnerships)	Interviews
Community resources and assets	Interviews
Local/national/global affairs - COVID-19 - Structural racism and social/racial justice uprisings	Interviews
Government policies	Interviews
Inner Setting	
Social architecture	Interviews
Team stability	Interviews, Program Lead Survey
Networks and communication	Interviews, Program Lead Survey
Compatibility	Interviews, Program Lead Survey
Relative priority	Interviews, Program Lead Survey
Leadership engagement	Interviews, Program Lead Survey
Available resources	Interviews, Program Lead Survey
Individual Characteristics	
Knowledge and beliefs	Interviews
Self-efficacy	Interviews
Staff engagement	Interviews

Implementation Processes	
Stakeholder consideration	Interviews
Tailoring	Interviews
Simplification	Interviews, Program Lead Survey
Executing	Interviews, Program Lead Survey
Funding and sustainability planning	Interviews, Program Lead Survey
Progress tracking	Interviews, Program Lead Survey
Reflecting	Interviews, Program Lead Survey
SB-82/833 Triage Grant Program Goals	
Increase client/student wellness	Interviews, Program Lead Survey
Decrease unnecessary hospitalization	Interviews, Program Lead Survey
Reduce unnecessary law enforcement involvement	Interviews, Program Lead Survey
Increase access to mental health services and supports through school-community partnerships	Interviews, Program Lead Survey
Develop crisis response systems on school campuses	Interviews, Program Lead Survey
Engage parents and caregivers	Interviews, Program Lead Survey
Reduce special education placement and school/community removal	Interviews, Program Lead Survey
Target Program Activities and Proximal Program Outcomes	
Cultivate partnerships: - Number of MOUs - Type of MOUs	Interviews, Program Lead Survey
Integrate program teams: - Task shifting - Interdisciplinary team meetings	Interviews, Program Lead Survey
Linkage of supports and referrals: - Mental health referrals made (#) - Non-mental health referrals made (#) - Successful linkages (#)	Interviews, Data Coordinator Survey
Deliver crisis services to clients: - Services delivered (#) - Services delivered (type) - Clients served (#) - Client demographics	Interviews, Data Coordinator Survey
Deliver mental health trainings and activities: - Program activities delivered (#) - Program activities (type)	Interviews, Program Lead Survey

3.3.1 Program Survey

We use a program survey as our primary quantitative data source to collect aggregate data on selected program target activities and proximal program outcomes as well as to supplement qualitative data as specified in Table 3. We worked closely with our program partners to develop an approach to survey data collection that reduces burden. The survey instrument itself is divided into two components—a Data Coordinator Survey and a Program Lead Survey—to ensure that data elements are obtained from appropriate parties within programs and to reduce the total burden on any one individual in a given program.

The Data Coordinator Survey for Phase 1 programs collects aggregated data on program services, clients, and activities by calendar quarter. It was developed with extensive input from program leads and data coordinators to maximize alignment with data elements collected by programs as well as to allow customization of the survey itself to the characteristics of each program.

The Program Lead Survey for Phase 1 programs is focused on administrative program leads' attitudes toward implementation and activities related to funding, revenue, and sustainability and will be administered twice, once in mid-2021 and again at the end of the grant period to identify any changes in attitudes as well as developments in sustainability planning. A shorter form of the Program Lead Survey, without elements on team stability and funding/sustainability planning, is also offered to day-to-day program leads with direct knowledge of program operations.

Both surveys were deployed on the Qualtrics platform with extensive use of branching and other logic features to only display questions that were pre-determined to be applicable and feasible for each SB-82/833 program. The surveys were provided in Deliverable 7/8c.

Progress in Program Survey Data Collection

Data collection with the Data Coordinator Survey is ongoing. Tentative target dates for receiving data by calendar quarter through the Data Coordinator Survey can be found in **Table 4**. Target dates are simply dates for county partners to aim for when aggregating and submitting each calendar quarter of data. We will continue to be in contact with each program to adjust as needed and minimize burden. As of July 15, 2021, we have collected 78 quarters of data across the 14 Phase 1 programs through the Data Coordinator Survey. Our first round of data collection using the Program Lead Survey was completed in early June 2021; all 14 Phase 1 administrative leads completed the survey, and another 20 responses were received from day-to-day leads across all Phase 1 programs.

Table 4. Phase 1 data coordinator survey timeline

Calendar Quarter	Target Date	Calendar Quarter	Target Date
Grant Year Q4	5/31/2021	Y3Q1	7/15/2021
Y1Q1	5/31/2021	Y3Q2	7/15/2021
Y1Q2	5/31/2021	Y3Q3	10/15/2021
Y1Q3	5/31/2021	Y3Q4	1/15/2022
Y1Q4	5/31/2021	[1]Y4Q1	4/15/2022
Y2Q1	6/30/2021	[1]Y4Q2	7/15/2022
Y2Q2	6/30/2021	[1]Y4Q3	10/15/2022
Y2Q3	6/30/2021	[1]Y4Q4	1/15/2023
Y2Q4	6/30/2021	--	--

[1]School-County Collaborative programs only

Data collection for Phase 2 programs is in a preliminary phase. The evaluation team is meeting regularly with leads at the Los Angeles County Department of Mental Health to ensure that the survey instrument is properly tailored to the Phase 2 programs.

3.3.2 Interviews

Our primary source of qualitative data is twice-yearly semi-structured interviews with program staff. These interviews provide rich data on staff perspectives on implementation settings, activities, processes, and proximal outcomes that can be used to identify barriers to and facilitators of

implementation. Interviews are rotated between four main stakeholder groups: 1) Program Leads, 2) Site or Agency Staff, 3) SB-82/833 Clinical Supervisors, and 4) Parent or Peer Partners working with the SB-82/833 program.

Sampling Strategy

Consistent with our aims, we use a two-stage purposeful sampling strategy to generate detailed information efficiently with minimal burden to informants (Landsverk et al., 2012). We purposefully identify and enroll individuals that are especially knowledgeable about program implementation and sample from the four sampling groups to capture multiple perspectives that offer a range of views and assessments of implementation. These strategies will offer a depth of understanding within and across all intervention sites while capturing data systematically to allow for comparison.

We first use a Criterion-i sampling strategy to select program lead stakeholders from each Child/Youth and School-County Collaborative Program (Marshall, Rapp, Becker, & Bond, 2008; Palinkas et al., 2015). The selection criteria for the recruitment of program lead participants are: 1) serving in a leadership role, or their designee, for the SB-82/833 grant-funded program; and 2) knowledge about program implementation. Each program is invited to participate in the interview via email and asked to identify appropriate personnel meeting these selection criteria.

Next, we use a snowball sampling strategy to identify and interview stakeholders representing the other three main stakeholder groups:

- Site or Agency Staff (such as staff/administrators at implementing organizations, school staff, emergency department staff, sheriff's department staff)
- Clinical Supervisors (clinicians who are part of the SB-82/833 implementing staff)
- Peer or Parent Partners (who are part of the SB-82/833 implementing staff, not consumers of services)

Program leads are asked to provide contact details for 1–3 stakeholders from each group, using the selection criteria described above. Especially in smaller programs, a single staff member may meet the criteria for more than one stakeholder group. Stakeholders are contacted via email or phone and provided information on the interview format and areas of interest. Those who express willingness to participate are scheduled for an interview within the windows shown in **Figure 3**. Following the 12-month round of interviews we received feedback from interview participants that it would be helpful for them to review the interview guides prior to our scheduled interview. In response to this, we now send each participant the interview guide at least a few days before the scheduled interview for their review.

Interview Procedure

Interviews are ongoing and take place every six months following the sampling group schedule in Figure 3 and **Table 5**. Leads from each program are interviewed at least once per year, and one representative per program from each of the other stakeholder groups is interviewed at least once within the length of the grant cycle (approximately 24 months). Interviews may include one or more participants from a given program and last approximately one hour. Due to delays in Phase 2 programs, the interview schedule for these programs is slightly modified: two pre-baseline planning interviews were conducted with county-level leads to align with the baseline and 6-month interviews for the Phase 1 programs and Phase 2 baseline interviews with program leads were aligned with the 18-month interviews for Phase 1 programs. The Phase 2 programs will not have second round of

interviews with the program leads for the 6-month interviews, but rather skip to the sequence of interviews described in Table 5 for the 12-month interviews and then continue in that order until their final round of interviews in mid-2023.

Interviews take place over the phone or using a video conferencing platform and are audio-recorded with the verbal consent of the participant(s). Participants have the option to stop recording at any time or request that statements be considered “off the record.” Following the interview, the recording is transcribed by evaluation staff, and all individual identifiers are removed from the transcript. If consent for recording was not obtained (or later retracted), the evaluation staff present for the interview compare and combine their notes to be used as data. Starting with the Phase 1 18-month and Phase 2 baseline interviews, we used a demographic survey sent after the interview to collect data on the gender, race, and ethnicity of participants.

Figure 3. Interview timeline by program and sampling group

Phase 1 Child Crisis Intervention Programs

= Program Leads

= Site or Agency Staff

= Clinical Supervisors

= Peer or Parent Partners

School-County Collaborative Programs

= Program Leads

= Site or Agency Staff

= Clinical Supervisors

= Peer or Parent Partners

Phase 2 Child Crisis Intervention Programs

= Program Leads

= Site or Agency Staff

= Clinical Supervisors

= Peer or Parent Partners

Table 5. Interview domain focuses by interview phase and sampling group

Interview Phase[1]	Sampling Group	Domain Focus
Baseline	**Program Leads**	General program information and documenting funding changes
6-month	**Program Leads**	Program Characteristics Implementation Processes
12-month	**Site or Agency Staff**	Inner Setting Implementation Processes
18-month	**Program Leads**	Inner Setting Individual Characteristics
24-month	**Clinical Supervisors**	Program Characteristics
30-month[2]	**Program Leads**	Outer Setting Implementation Processes
Final	**Peer or Parent Partners**	Outer Setting

[1]Phase 2 programs follow a modified schedule
[2]School-County Collaborative programs only

Interview Guide and Data Elements

Our interview protocol addresses the first five domains of our logic model: program characteristics, outer setting, inner setting, individual characteristics, and implementation processes. Each semi-structured interview protocol includes questions related to particular domain(s) and their component constructs, eliciting diverse stakeholder perspectives in order to track the full course of program implementation over time and across stages of program development, implementation, and sustainment. Each round of interviews focuses on 1–2 logic model domains (as shown in Table 5) and each interview builds on the previous one, following up on key constructs that relate to implementation, whether in common across all grantees or site-specific. The semi-structured nature of the interviews allows for exploration of important themes while also allowing the interviewee to guide the discussion (Seidman, 2013). Interview guides used for the Phase 1 baseline, 6-month, 12-month, and 18-month interviews and Phase 2 pre-baseline and baseline interviews were provided in Deliverables 7/8a–c.

Progress in Interview Data Collection

To date, the evaluation team has completed baseline, 6-month, 12-month, and 18-month interviews with Phase 1 program stakeholders according to schedule. The pre-baseline round of interviews was conducted with county-level leads planning implementation of the Phase 2 programs in Los Angeles County and, once those programs were in operation, baseline interviews were conducted with program leads for those sites in March of 2021. **Table 6** provides the dates of all interviews conducted through mid-2021.

Table 6. Interviews conducted to date, by phase

Program	Baseline	6-month	12-month	18-month
Phase 1				
Berkeley City	8/7/19	2/13/20	7/7/20	3/22/21
CAHELP	6/7/19	1/29/20	7/20/20	3/3/21
Calaveras	6/6/19	2/28/20	7/21/20	3/11/21
Humboldt (Child)	5/28/19[1]	1/16/20	6/17/20	3/9/21
Humboldt (School)	5/28/19[1]	1/22/20	6/25/20	4/13/21
Placer (Child)	7/19/19[1]	2/27/20	7/14/20	2/22/21
Placer (School)	7/19/19[1]	2/14/20	8/14/20	2/24/21
Riverside	7/17/19	2/27/20	8/25/20	2/17/21
Sacramento	7/1/20[2]	1/14/20	6/23/20	2/16/21
San Luis Obispo	9/24/19	2/27/20	7/28/20	3/1/21
Santa Barbara	7/10/19	2/14/20	8/4/20	3/2/21
Stanislaus	6/5/19[2]	1/15/20	10/20/20	2/1/21
Tulare	6/7/19	2/11/20	9/25/20	2/11/21
Yolo	6/13/19	1/17/20	8/18/20	2/1/21
	Pre-Baseline		**--**	**Baseline**
Phase 2				
Los Angeles 1	8/8/19[3]	2/13/20[3]	--	3/29/21
Los Angeles 2	8/8/19[3]	2/13/20[3]	--	3/21/21
Los Angeles 3	8/8/19[3]	2/13/20[3]	--	3/19/21
Los Angeles 4	8/8/19[3]	2/13/20[3]	--	3/8/21
Los Angeles 5	8/8/19[3]	2/13/20[3]	--	3/22/21
Los Angeles 6	8/8/19[3]	2/13/20[3]	--	3/22/21
Los Angeles 7	8/8/19[3]	2/13/20[3]	--	3/12/21
Los Angeles 8	8/8/19[3]	2/13/20[3]	--	3/11/21

[1]Interview covered Child, School-County, and Adult/TAY programs
[2]Interview covered Child and Adult/TAY programs
[3]Interview covered multiple sites

3.3.3 Other Data Sources

Where available and feasible, we also use additional data sources to supplement the data from the program survey and interviews, including notes from our stakeholder workgroups, program records, and publicly available datasets. These data sources are primarily used to complement and triangulate with data in the interviews and program surveys.

Workgroup Notes

Keeping in line with the CPPR approach, as described in our Framework for Engagement in section 2.2, we are facilitating and engaged in multiple groups comprised of key stakeholders: a Stakeholder Advisory Board, Data Coordinator's Workgroup, School-County Workgroup, and Child Workgroup.

The primary function of the Advisory Board and workgroups is stakeholder engagement: they are oriented towards and structured around building relationships and partnerships, both among the programs themselves and between programs and the evaluation team. Nevertheless, where information is shared that will enhance the evaluation, the research team uses this information as data. Although data collection strategies and input are often a topic of discussion, the agendas for these meetings are not designed to solicit of data from the workgroup itself. That is, the workgroup meetings are a source of data only incidentally, not by design. For this reason, the workgroups are not identified as intended data source options for any particular data element types in Table 3. Moreover, to encourage candid participation and genuine collaboration, the meetings are never recorded. Rather, evaluation staff take notes on the meetings which can later be used to inform the evaluation or be incorporated into the qualitative thematic analysis as a supplement to our interviews.

Progress in Workgroup Notes Data Collection

Our data collection process is ongoing for our Data Coordinator's, School-County, and Child Workgroups. A list of completed and pending workgroup meetings to date can be found in **Table 7**. Multiple evaluation staff members take notes during each of our workgroups, producing more than one set of notes. We then compile the notes into one complete set by consensus to ensure consistency and accuracy.

Table 7. Workgroup meeting dates

Data Coordinator's				School-County				Child
2019	**2020**	**2021**	**2022**	**2019**	**2020**	**2021**	**2022**	**2021**
6/13/19	1/9/20	1/14/21	1/13/22	10/3/19	3/12/20	1/21/21	1/6/22	1/22/21
7/11/19	4/9/20	4/8/21	4/14/22	12/5/19	4/2/20	2/4/21	2/3/22	2/26/21
8/8/19	7/9/20	7/8/21	7/14/22		5/7/20	3/4/21	3/3/22	3/26/21
9/13/19	11/12/20	10/14/21	10/13/22		6/4/20	4/1/21	4/7/22	4/23/21
10/10/19					7/16/20	5/6/21	5/5/22	5/28/21
11/14/19					8/13/20	6/17/21	6/2/22	6/25/21
12/12/19					9/3/20	7/1/21	7/7/22	7/23/21
					10/1/20	8/5/21	8/4/22	8/27/21
					12/10/20	9/2/21	9/1/22	9/24/21
						10/7/21	10/6/22	10/22/21
						11/4/21	11/3/22	11/26/21
						12/2/21	12/1/22	

= Completed

= Pending Completion

Program Records

Supplemental sources of quantitative and qualitative data for the formative evaluation are obtained from records kept by the intervention programs. Program records may consist of MOUs, hiring reports, grant proposals, summaries of changes, check-in reports, or any other internal records provided by the program or county. This list is neither exhaustive nor applicable to every program, as records vary by county and be tailored to the type of activities being delivered in each Child/Youth or School-County Collaborative program. Many program records, such as MOUs and internal records,

are provided to the evaluation team at program initiative and discretion. **Table 8** is a complete list of the program records received and the current quantities for each.

Table 8. Program records received

Program Record Type	# of Programs	# Total	Programs
Grant proposals	15	15	Berkeley City, CAHELP, Calaveras, Humboldt (Child), Humboldt (School), Los Angeles, Placer (Child), Placer (School), Riverside, Sacramento, San Luis Obispo, Santa Barbara, Stanislaus, Tulare, Yolo
MOUs	1	1	Calaveras
Summary of changes	14	14	CAHELP, Calaveras, Humboldt (Child), Humboldt (School), Los Angeles, Placer (Child), Placer (School), Riverside, Sacramento, San Luis Obispo, Santa Barbara, Stanislaus, Tulare, Yolo
Check-in reports	14	56	Berkeley City, CAHELP, Calaveras, Humboldt (Child), Humboldt (School), Placer (Child), Placer (School), Riverside, Sacramento, San Luis Obispo, Santa Barbara, Stanislaus, Tulare, Yolo
Roadmap reports	4	8	CAHELP, Humboldt (School), Placer (School), Tulare
Satisfaction surveys	3	5	Placer (Child) Santa Barbara, Tulare
Tracking logs/tools	5	7	CAHELP, Humboldt (Child), Humboldt (School), Los Angeles (SPAs 1–8), Santa Barbara, Tulare
Other	7	18	Berkeley City, CAHELP, Calaveras, Humboldt (Child), Humboldt (School), Riverside, Tulare

Publicly Available Datasets

As accessible and feasible, data on features of the outer setting will be abstracted from publicly available datasets, such as the U.S. Census Bureau's Decennial Census, American Community Survey (ACS; U.S. Census Bureau, n.d.), and Household Pulse Survey (HPS; Fields et al., forthcoming); the California Department of Education's California Healthy Kids Survey (CHKS; California Department of Education, 2020a) and DataQuest system (California Department of Education, 2020b); the Child Opportunity Index (COI; Noelke et al., 2020); and the California Health Interview Survey (CHIS; UCLA Center for Health Policy Research, n.d.). Data on the COVID-19 pandemic context and effects on communities can also be obtained from sources such as the State of California's COVID-19 data dashboards and databases (State of California, 2021), and the websites of county departments of public health. We are in the process of onboarding staff to begin data abstraction from these sources.

Miscellaneous

Data sources that do not fall into the above categories, such as COVID-19-pandemic-related data, are also incorporated into our evaluation plan as necessary and feasible. Throughout the evaluation, we have been monitoring potential threats to external validity. In doing so, we are sourcing data on COVID-19 pandemic indicators, wildfires, and other external factors that may influence program implementation. Data on COVID-19 include records of mandated statewide orders, school district statuses, quantity of new cases per month by county, and, more recently, quantity of vaccinations

administered by county. Data is sourced from reputable websites, such as California Department of Public Health (https://www.cdph.ca.gov). Abstraction has been largely successful and feasible to maintain.

3.4 Mixed Methods Thematic Analysis

As qualitative interviews constitute the core source of data for this evaluation, a thematic analysis of interview transcripts is the central method for addressing our evaluation aims. The thematic analysis is used to address data every domain in our logic model, providing particular insight on stakeholders' perspectives on implementation contexts, activities, processes, and outcomes, as well as to generate "stories" of program impacts from the perspective of different stakeholders (Bromley et al., 2018).

Interview transcripts and workgroup notes for Phase 1 programs were thematically coded by the evaluation team using Dedoose (2018), a mixed methods data analysis software platform. Thematic analyses of semi-structured interviews from program leads, agency staff, clinical supervisors, and peer or parent partners allow us to generate rich descriptions of program implementation (Ryan & Bernard, 2003). An initial codebook was developed based on the evaluation framework and logic model, semi-structured interview guide, SB-82/833 Triage Grant Program goals, and priority issues identified by stakeholder advisors (Maxwell, 2005). All data elements in Table 3 were included in the initial codebook. In addition to codes developed deductively, codes are also generated inductively during early rounds of coding, with such codes added to the codebook through coder consensus. Various coding methods may be used in code and theme development, including axial, descriptive, in vivo, process, and values coding (Miles, Huberman, & Saldaña, 2014). For Phase 2 programs, evaluation staff are in the preliminary phases of codebook development and analysis for the pre-baseline and baseline interview transcripts. Findings in this report therefore address early implementation in Phase 1 programs only.

Test coding for Phase 1 programs was completed by evaluation staff in accordance with our research plan. Evaluation staff met to review and discuss the codebook to ensure clarity and consistency in the thematic codes and practice identifying themes in the transcripts. Three evaluation staff were assigned transcripts across multiple programs and interview phases to test-code, with the results discussed as a group to reach consensus on any discrepancies and further refine the codebook. To conduct the thematic analysis, evaluation staff reviewed all 59 extant Phase 1 transcripts and 25 sets of workgroup notes and coded them by applying thematic codes to appropriate excerpts. Evaluation staff overlapped on 20% of the transcripts to ensure consistency and met regularly during the coding process to resolve discrepancies, refine the codebook, and share observations and reflections on the data. Evaluation staff examined the thematically coded excerpts to identify common barriers to and facilitators of implementation within each domain of our logic model, using features of the analysis software to help identify and draw out trends across comparison groups and between themes.

Data from the first quarter of data from the Data Coordinator Survey as well as the administrator version of the first round of our Program Lead Survey were cleaned, formatted, and analyzed to produce descriptive tables to expand on and support the themes identified in the qualitative analysis. A detailed supplemental analysis of the results of the first round of the Program Lead Survey is also provided in **Appendix C**.

4. Findings

The findings in this report draw primarily on the thematic analysis of interview data, supplemented by relevant data elements from the Data Coordinator Survey and Program Lead Survey, to provide an understanding of the major themes underlying program implementation and point to corresponding barriers to and facilitators of that implementation. Supporting quotes from individuals involved in program implementation are labeled with the individual's role, a program identifier (prefixed with "P"), and an individual identifier (prefixed with "I"). Where individuals have more than one role in a given program or are involved in the implementation of multiple programs, the role that is most relevant to their statement is provided.

4.1 Program Characteristics

We provide two sets of findings about SB-82/833 program characteristics:

1. findings on the ***descriptive characteristics of programs***, including the ***service settings*** they operate in, ***care processes and services*** they provide, level of ***maturation*** and timing of program start, and level of ***triage grant funding*** support; and
2. findings on the ***implementational characteristics of programs***, specifically the ***complexity*** and ***adaptability*** of SB-82/833 programs.

4.1.1 Descriptive Characteristics of Programs

Our analysis to date has revealed a ***high degree of heterogeneity among programs*** in terms of their primary program settings, care processes, program maturation, and amount of SB-82/833 Triage Grant program funding. **Table 9** summarizes the number and proportion of programs fitting each descriptive characteristic of programs: ***program setting*** (including where the program is predominantly based and where programs predominantly provide services), main ***care process target areas***, ***grant funding*** amount, ***program maturation***. The number and percentage of programs in each category are presented by grant type and school-based mental health service status.

While sharing many of the same goals and target outcomes, a key finding to explain this heterogeneity is that both Child/Youth and School-County Collaborative Triage programs propose and carry out interventions that are ***highly tailored to the existing mental health and other social service systems in their respective counties***.

Table 9. Phase 1 program characteristics by grant type and school-based status

	N(%)	Grant Type N(%)		School-based/Non-School-based N(%)	
	Overall N=14	**Child** N=10	**School** N=4	**School** N=6	**Non-School** N=8
Setting program is predominantly based in:					
In the field or community	2(14)	2(20)	0(0)	0(0)	2(25)
Emergency department	1(7)	1(10)	0(0)	0(0)	1(13)
School-based services	4(29)	2(20)	2(50)	3(50)	1(13)
School-based wellness center	2(14)	1(10)	1(25)	2(33)	0(0)
Program or county mental health office	4(29)	4(40)	0(0)	0(0)	4(50)
Police department	1(7)	1(10)	0(0)	0(0)	1(13)
Setting program predominantly provides services in:[2]					
In the field or community	5(36)	5(50)	0(0)	0(0)	5(63)
Emergency department	2(14)	2(20)	0(0)	0(0)	2(25)
School-based services	6(43)	2(20)	4(100)	5(83)	1(13)
School-based wellness center	1(7)	1(10)	0(0)	1(17)	0(0)
Program or county mental health office	1(7)	1(10)	0(0)	0(0)	1(13)
Care process target areas:					
Health prevention	6(43)	2(20)	4(100)	5(83)	1(13)
Early intervention	6(43)	2(20)	4(100)	5(83)	1(13)
Crisis services	14(100)	10(100)	4(100)	6(100)	8(100)
Treatment	6(50)	3(30)	3(75)	4(67)	2(25)
Referral	11(86)	7(70)	4(100)	6(100)	5(63)
Care coordination	9(71)	7(70)	2(50)	4(67)	5(63)
Community outreach	6(50)	3(30)	3(75)	5(83)	1(13)
Funding:					
<250,000	2(14)	2(20)	0(0)	1(17)	1(13)
250,001-500,000	3(21)	3(30)	0(0)	0(0)	3(37)
500,001-750,000	1(7)	1(10)	0(0)	0(0)	1(13)
750,001-1,000,000	1(7)	1(10)	0(0)	0(0)	1(13)
1,000,001-1,500,000	2(14)	2(2)	0(0)	0(0)	2(25)
1,500,001-2,000,000	1(7)	1(10)	0(0)	1(17)	0(0)
2,000,001-5,000,000	0	0(0)	0(0)	0(0)	0(0)
5,000,001-10,000,000	4(29)	0(0)	4(100)	4(67)	0(0)
>10,000,001	0	0(0)	0(0)	0(0)	0(0)
Program maturation:					
New	7(50)	4(40)	3(75)	4(67)	3(37)
Augmenting	7(50)	6(60)	1(25)	2(33)	5(63)

Program Settings

SB-82/833 programs are variously based and deliver services in several different settings—school and other educational settings, mental or behavioral health offices, the field, emergency departments, and a police department (see Table 9). Five programs identified the field or community as the primary service setting for their program and more than half of both Child and School-County Collaborative

programs reported providing some services in the field or community during their first quarter of operation.

Schools and educational agencies are an especially notable setting for SB-82/833 programs, both for programs that received a Child/Youth grant and for several programs that received a School-County Collaborative grant. Eight Phase 1 SB-82/833 programs are based in and/or focused on school or educational settings, but their role in and relationships to those educational settings vary. Of the four School-County Collaborative programs, all entail, by design, some formal partnership with local education agencies, such as county offices of education, SELPAs, and school districts, with each structuring these partnerships differently. One School-County program is administered by the county children's mental health agency and staffed by both the county and individual school districts, one is run by a consortium of local education agencies that provides support and services to their members, one is administered by the county office of education and has partnerships with school districts, and one is co-administered by the county children's system of care and the county office of education and has partnerships with school districts.

Among the Phase 1 Child/Youth programs, four are either school-based or school-focused. School-based Child/Youth programs are housed in educational settings and involve similar types of partnerships as those of School-County Collaborative programs: one is administered by the county children's mental health agency and contracted to the county office of education, which provides services in partnered school districts who also employ the program staff. The other school-based Child/Youth program is administered and run by a municipal children's mental health agency in a partnership with one school in which they provide services. Additionally, two more Child/Youth programs are school-focused but not school-based, in that they but do not primarily operate out of school sites but were designed to address either a lack of school-based crisis services or lack of capacity in existing school-based crisis services. While they develop relationships with the schools to enhance their service delivery, these programs do not require formal partnerships with local education agencies or schools to be able to carry out their regular operations and therefore relationships with educational agencies do not impact program implementation in the same ways that programs that are housed in, require formal partnerships with, and/or provide services directly to schools experience. To the extent that there are commonalities in the barriers and facilitators of implementation of school-based and school-focused programs, these considerations will be raised throughout the findings in this report.

Care Processes and Services

SB-82/833 programs provide a wide array of mental health care processes and services, consistent with their mandate to provide crisis triage. Since crisis services are for utilization by "anyone, anywhere and anytime" (Substance Abuse and Mental Health Services Administration [SAMHSA], 2020, p. 8) and properly entail a variety of care processes across the full continuum from prevention to long-term care, programs designed for crisis triage can be expected to deliver a range of services with varying areas of emphasis depending on program design and community need. Given this inherent diversity in crisis care, ***SB-82/833 programs are both heterogeneous in the care processes and services they target and many target multiple care processes and services in their programs***.

While every SB-82/833 operates within the crisis care continuum, programs vary in the care processes they target and services they deliver. The evaluation identified seven main care processes targeted by SB-82/833 programs: prevention, early intervention, acute crisis services, treatment, referral, care coordination, and community outreach. Table 9 presents the percentage of programs

that that reported targeting each care process in the Data Coordinator Survey. Acute crisis services, referrals, and care coordination are the three most common care processes, with each targeted by a majority of Phase 1 programs. Almost half of Phase 1 programs also target prevention, early intervention, treatment, and/or community outreach. While similar proportions of school-based and non-school based programs target acute crisis, care coordination, and referral care processes, among programs targeting crisis prevention, early intervention, and community outreach, the majority are school-based. Programs also vary in whether their focus is on providing individualized, clinical mental health crisis services to children and families or providing crisis programming in the form of activities and trainings directed at school staff and teachers, parents and caregivers, children and families, or the community at large. School-based programs, in particular, describe extensive efforts to provide crisis-oriented activities aimed at training school staff and teachers and directly engaging parents and families.

Most Phase 1 programs also target multiple care processes and services. While two programs are exclusively aimed at acute crisis response, the majority of programs target at least three care processes with their services. ***School-based programs, in both their operations and understanding of crisis services, are especially engaged in integrating multiple types of care processes into crisis service systems***. Of the seven Phase 1 SB-82/833 programs that target five or more care processes, all but one are school-based.

Program Maturation and Start Date

There are two aspects of program maturation that are of particular relevance to SB-82/833 program implementation: 1) whether the program itself is ***new or augments an existing program/service*** and 2) ***when the program started operating*** during the triage grant period.

Of all fifteen SB-82/833 programs, seven augment crisis services that were already in operation prior to the grant period and eight provide crisis services that broadly augment the mental health service system but did not directly build from or expand a specific existing service program (see Table 9). At one end of the spectrum, some augmenting programs entered the grant period with workflows that could be readily adapted to a new unit, a setting with which they were already familiar, staff able to help acclimate new hires, and/or already well-established relationships with critical partners. Some new programs, on the other hand, required extensive planning to navigate relevant settings, hire and onboard staff, develop workflows, and gain buy-in from critical partners.

The other major difference in programs with respect to maturation is the start date of programs during the grant period. Phase 1 program start dates, defined as the date that the program reported first service delivery, range from the first month of the grant period, October 2018, to August 2019, with only half of programs reporting a start date within the first six months of the grant period. Phase 2 programs began service delivery in late 2020 and early 2021.

New and augmenting programs may have different types of experiences implementing their programs, but these differences are not sufficient to explain differences in program start date. The major explanations for variation in start date include 1) the extent to which programs required significant alterations following triage grant funding cuts and subsequent contract amendments (both with their partnering organizations and with the MHSOAC), 2) differences in the timelines for implementation proposed by each program, and 3) variable delays related to developing partnerships, executing contracts, securing program sites, and hiring qualified staff. The distinction between new and augmenting programs is important for contextualizing some differences in how programs were

implemented, including what barriers and facilitators they experienced, while differences in program start date are important for contextualizing and interpreting data on program services and activities.

Grant Funding

SB-82/833 Child/Youth and School-County Collaborative Triage programs were awarded a wide range of funding for personnel, from support for less than one full-time staff position to entire teams (see Table 9). Phase 1 Child/Youth programs were funded for between $207,921.35 and $1,684,568.99. Each School-County Collaborative Program was funded for $5,293,367.35. This variation is both important for contextualizing and interpreting data on program services and activities as well as for considering the barriers to and facilitators of program implementation.

All programs experienced reductions to their grant funding after their initial awards were announced and, in some cases, after the programs had started early implementation processes. The impacts of these budget cuts were summarized in statements of changes prepared by the SB-82/833 programs and described in interviews with program leads. In addition to delaying the start of implementation for some programs, some school-based programs noted that delays impacted their ability to align their program with the school year. More broadly, ***SB-82/833 programs variously reported that these cuts resulted in 1) reductions in the volume and types (e.g., clinical, prevention, outreach) of care processes that could be provided for youth and families, 2) reductions in the number of sites (e.g., schools, hospitals) that program teams could serve, 3) changes to the composition of staff roles on program teams (e.g., less peer and parent partner supports), and/or 4) expansion of the geographic areas that each regional team would serve***. Program leads described the cuts as "painful" and impactful on their capacity with respect to initial program outcomes, describing that they "had to get very creative" to reduce their staff and services but still "do all the things that we said we would do in the grant."

In responses to the Program Lead Survey, most Phase 1 administrative leads agreed in some capacity with the statement "This SB-82/833 program is possible to implement with the funding provided by the SB-82/833 grant," with three leads disagreeing and one that neither agreed nor disagreed. Interviews and open-ended responses provide details on the aspects of program implementation for which funding was more or less satisfactory. While programs were grateful for the grant funding and the work that it enabled for their counties and communities, they also noted challenges relating to the structure of the grant funding. A major concern was the extent to which program implementation depended on "significant contributions (in-kind)" from both implementing agencies and organizations and their partners. A particular concern was the lack of funding available to support non-direct service staff including supervisors (clinical and administrative), contract monitors, and analysts. As one county analyst who is not funded by the grant explained:

> *the way that the grants are structured, there's not a lot of room for funding positions like mine that provides support to the program. A lot of it is tied to folks that provide direct services… there's a lot of hidden work involved with… these grants, that on the surface you don't even know really honestly exists. And it starts becoming evident how much support these programs need and so, I think for a county to be truly successful, they need to be able to have labor that will support these programs.* [County Staff: P11 I030]

A lead from another program also noted how this affected partnered programs, including School-County Collaboratives, since their success (and sustainability) depended on additional support from *their partners:*

> *one of the things that's really difficult to comprehend is how much this grant is depending upon the sort of well wishes of the other partners, right. I mean the number*

> *of folks who are putting work into the grant that are doing this in essence pro bono if you will, right, because we want it to succeed.* [School-County Collaborative Program Lead: P10 I088]

A final example of contributions required to implement programs concerns the allocation of funding for less than one full-time position. While programs appreciated access to funding of any amount to increase their service capacity, one program lead in a rural county noted that a certain baseline in funding was nevertheless required to be able to achieve even the minimum of program capacity (e.g., in staffing and infrastructure), regardless of their population size.

4.1.2 Complexity

Program complexity refers to the overall intricacy of a program, including its components, structure, and organization, as a way of capturing the relative ease with which it can be executed and used. For programs with a wide scope of services composed of multiple interventions, such as in crisis services, some degree of complexity is to be expected and even necessary for meeting program goals. Indeed, SB-82/833 crisis programs, even those targeting a modest number of care processes, all evince some degree of complexity in the duration of their interventions, the scope and depth of care they aim to provide children and families, and the intricacy of the service systems they navigate to provide individualized care. Interviews with program leadership and staff routinely reflected their understanding of the inherent difficulty of both structuring and delivering crisis services.

SB-82/833 programs do, however, vary in three particular types of complexity with impacts on overall program implementation:

1. ***Organizational complexity*** occurs in programs that rely on organizational partnerships with multiple departments or agencies, especially where these partners are spread across different sectors (e.g., education, hospitals, law enforcement) and entail multiple bureaucracies programs must navigate. More organizationally complex programs may experience greater challenges in proportion to their number of partners/relationships, however, organizationally complex programs with a relatively small number of partners also experience distinct challenges since each partnership is more critical to and impactful on the success of the program.
2. ***Structural complexity*** occurs in programs whose operations are structured into many units, such as programs that operate at multiple sites or regions and/or where staff are organized into multiple specialized teams (e.g., by age/grade, type of service/target area). Such programs may also be organizationally complex to the extent that their multiple sites or teams are housed in different organizational settings, such as multiple local schools, or hospitals
3. ***Regulatory complexity*** may be a function of organizational and structural complexity and occurs when programs must interface with multiple regulatory systems to carry out their services and activities. The extent of regulatory complexity, however, does not depend entirely on the number of organizations or structural units involved in implementation, but rather depends a lot on what *types* of partners the program has and how different their regulatory environments are from that of the implementing organization.

Challenges Related to Complexity

These three forms of complexity are each linked to distinct challenges for implementation frequently faced by programs and expressed by program leadership and staff in interviews. However, due both to the nature of crisis triage and the specific aims of many programs to build and strengthen relationships to deliver mental health services across sectors, such complexity is perhaps impossible

to fully avoid. Successful implementation of such programs therefore requires efforts to mitigate their challenges as well as account for their impact when evaluating programs' progress towards meeting SB-82/833 Triage Program goals and summative outcomes. This is especially important for the new (as opposed to augmenting) SB-82/833 programs, both because all but one of the programs categorized as new entailed complexity of all three types and also because new programs have less pre-existing experience and support to navigate this complexity. The analysis indicates some particular needs of programs by the type of complexity they entail; providing support for programs to meet these needs could therefore improve implementation by reducing complexity-related challenges.

Programs with a greater degree of ***organizational complexity***, for example programs that operate in or depend on non-mental health primary service setting(s) such as schools, hospitals, or law enforcement, often need substantial dedicated resources (especially time) to maintain those organizational relationships as well as to navigate the organizational systems and bureaucracies of those partners. A substantial degree of buy-in from the leaderships in those organizations is likely necessary to meet both of these needs. Programs with a greater degree of ***structural complexity*** may, independent of their organizational complexity, need special strategies for ensuring that staff turnover in their sites and/or teams does not disproportionately impact their programs, as such programs may be less flexible in staffing and unable to rapidly reallocate staff who are regionally dispersed. These programs may also need a higher level of administrative and supervisory resources to maintain overall program integration across their teams or regions. Programs with a greater degree of ***regulatory complexity*** often need significant time and resources to identify the regulatory systems that are relevant to and may impact implementation (such as in hiring, service coordination and delivery, data collection and maintenance) as well as to develop procedures for navigating these systems. For minimal disruption to services and activities, this is best achieved in advance of the start of service operations. Since programs partnered with law enforcement and schools experienced the greatest impacts of regulatory complexity on implementation, it is also important to consider the special needs involved in delivering crisis services in these sectors and settings.

Across all SB-82/833 programs, school-based programs seem to have the greatest challenges related to complexity since many have to deal with all three types: they operate at multiple sites run by different organizations, each with distinct sectoral and local regulations. These challenges were described from the start of the grant period, with school-based program leadership and staff noting both the overall differences in institutional "culture" and "language" between the educational and behavioral health sectors and the wide variation in culture, climate, and structure between and within the school districts and schools. As one program lead described:

> *You don't just walk on to a campus, so there's kind of this belief, oh you could just do a mental health program with mental health people in a school site. It's not as easy as it sounds and it's definitely not as easy as we wrote in the [grant] application.* [School-County Collaborative Program Lead: P18 I032]

This variation, including in the leadership at multiple levels (school/district/county office of education) and in the size and type of school or district, often required that many aspects of program implementation be worked out site by site. Navigating multiple organizations and their regulations also manifested in multiple programs requiring extensive and very lengthy work, for up to a year in one program, to resolve difficulties developing policies and workflows to ensure simultaneous compliance with HIPAA and FERPA as well as the use of multiple data systems that cannot interface (which sometimes involved laborious double documentation of services and activities to accommodate these systems). One program lead even expressed some appreciation for the delays resulting from the SB-82/833 Triage Grant program budget amendments, as it gave staff more time to work through these issues before the start of program operations. These challenges became even

more acute during the COVID-19 pandemic, when the already complex policies and relationships with schools were compounded by variation in school status (open/hybrid/remote) and school/district policies that impacted program operations (especially access to school sites), both of which changed frequently in some communities during the pandemic.

4.1.3 Adaptability

The adaptability of a program refers to the extent to which it can be tailored or refined to meet local needs or adjusted in response to changing conditions. ***On the whole, SB-82/833 programs are highly adaptable: focused on meeting bigger picture goals*** (increasing access, meeting community and patient needs) ***rather than narrowly focused on arbitrary targets***. Indeed, this adaptability was an important feature of many programs, especially new programs, as one School-County Collaborative program lead explained:

> *Having started the school program from the ground up… with that, comes a lot of learning and challenges and we realized what we envisioned was in the grant application wasn't exactly maybe the best way to roll things out. And so, having some flexibility and changing the program as we learn more has been important.* [P22 I069]

Adaptability was evident in programs' efforts to adapt to cuts in their grant funding as well as continuous adjustments to customize their supports to the needs of their sites and communities. This adaptability was most evident, and critical, however, during the COVID-19 pandemic, as almost every program required some substantial adaptation to continue operating.

Barriers to Adaptability

For SB-82/833 programs, the most evident barriers to adaptability do not directly involve the design or structure of the programs themselves but rather their relationship to factors that are exogenous to and, at least partially, out of their direct control such as access to resources and ability to exercise authority over the conditions of their operations. Such factors do not always inhibit program implementation, but where they 1) cannot be overcome as a result of program actions (regardless of how flexible or innovative those actions are) and 2) impact the core components of a program, such factors can drastically impact a program's operations and service delivery. That is, the biggest limit to adaptability, particularly during the COVID-19 pandemic, is essentially the limit of a program's ability to change the institutions and conditions exogenous to it. Where the adaptations that would be required to overcome a barrier exceed the resources or authority of a program, the limit of the program's adaptability is reached.

Two major examples are the limits to programs' ability to adapt to changing community needs and changes in program demand during the pandemic. Even when programs made extensive adaptations to their programs to address increases in the acuity of patient needs, they were not necessarily sufficient where community assets for mental health (e.g., child inpatient psychiatric beds, crisis stabilization units, available clinicians to which they can refer clients/families) were inadequate or absent. This is also the case for programs with limited access to resources (or referrals to resources) to help support under-resourced communities and families (e.g., high speed internet access or devices, transportation costs). Similar limits to adaptability exist for programs addressing changes in the demand for their program's services during the pandemic. Where, as a result of policies over which they did not have authority, programs were no longer able to 1) regularly contact (or use) their usual referral base or 2) access information about community needs, it was difficult if not impossible to overcome changes in demand by adapting the program itself.

A final potential barrier to adaptability concerns the extent to which grant terms provide enough flexibility to permit the sorts of adaptations that programs felt were necessary to carry out their intended programs most effectively. Some programs leads and staff described some tension between their desires to ensure that their programs were responsive to lessons learned on the ground as well as compliant with contractual obligations. Especially as programs dealt with practical challenges described in this report (including with staff stability, changing community needs, limited resources and community assets, and strain on staff), program leads expressed the desire for grant terms to better facilitate the types of adaptations that they needed to effectively implement their programs.

…it seems like if grants allow for a little bit of flexibility that to shift focus or shift some things and that's, that's helpful. I think we tried to write the grants to have some flexibility and so, we have been able to shift things around some. So, definitely a lot of learning has gone on over the last few years. [Child/Youth Program Lead: P11 I069]
We certainly don't want to be on bad terms with a big funder… but at same time, we also want to be proactive and saying this is kind of where we're at and if you're not able to give us some flexibility with how to spend the grant funds, then maybe we want to let you know ahead of time, so that you can re-allocate the funding somewhere else or whatever. So, it is a small piece, but it's still important and I think that the concept of the SB-82 grant is something we want to develop… whether we have the grant funding or not. [Child/Youth Program Lead: P20 I034]

Some areas where program leads or staff expressed a desire for flexibility included how SB-82/833 funding can be allocated or blended, how staff roles are allocated and defined, and what activities or services are considered "crisis services" (which was a special concern for school-based programs that emphasize target crisis prevention and universal supports).

Facilitators of Adaptability

These limits and barriers to adaptability are, in some cases, mitigated by relationships: that is, programs with stronger pre-existing networks and relationships often evince greater adaptability and able to navigate these challenges. However, especially during the COVID-19 pandemic, even programs that expressed confidence in their leadership engagement and partnerships encountered barriers that were either beyond their agency's control or beyond the ability of their partnerships to solve such as systemic deficiencies in resources and asset or government policies and bureaucratic regulations that could not be modified. Moreover, these limits aren't completely reducible to the pandemic as a novel and fundamentally destabilizing external force; indeed, challenges to adapting to community needs in the absence of critical resources and assets were evident in programs prior to the pandemic.

4.2 Outer Setting

Outer setting findings are focused on how programs respond to and interact with their external settings, including both local and broader community contexts. These are organized into:

1. findings on how programs understand and prioritize the ***needs of their patients and communities/counties***
2. findings on programs' ***connections to other organizations and assets in their communities/county*** (known as "cosmopolitanism")
3. findings on the impacts, adaptations, and innovations related to the ongoing ***COVID-19 pandemic***

Detailed analyses and data tables on program lead survey items on programs' responses to ***needs of patients of communities*** and ***cosmopolitanism*** by program maturation, school-based status, and urban/rural county can be found in Appendix C [sections C.1.1 and C.1.2, tables 26–29].

4.2.1 Needs of Patients and Communities

The needs of patients and communities are incorporated into 1) the ***design and development process*** of SB-82/833 programs as well as 2) the ***ongoing course of their implementation***, that is, by tailoring program implementation to those needs.

Needs of Patients and Communities in Program Design

While programs conducted needs assessments as a component of their SB-82/822 Triage Grant program applications, data from interviews provide additional detail on which needs program leads consider to be of particular relevance, both based on the input they received from stakeholders as well as their practical experience in children's mental and behavioral health. Since programs were tailored to communities with different social characteristics and different configurations of existing mental and behavioral health services, they therefore sought to respond to a diverse set of needs in their program design, including those of children, caregivers and families, schools, and localities. **Table 10** summarizes the types of community needs mentioned in interviews with program leads.

Table 10. Community needs addressed in SB-82/833 program design

Children/youth	- increase in child crisis - more robust options for individualized crisis services
Caregivers and families	- caregiver engagement - options for individualized crisis services - caregiver desire to limit/reduce use of psychiatric hospitalization - caregiver desire to limit/reduce law enforcement involvement
Schools	- unmet student need for mental health - mental health services for schools with underserved populations - assistance in service delivery for schools with special organizational needs
Localities	- services for regions with greatest mental health needs - customized mental health services by region

Needs of Patients and Communities in Program Implementation

Implementation of SB-82/833 programs is also tailored to the specific needs of patients and families in the communities in which the programs operate. While interviews to do not provide a complete or exhaustive accounting of programs' efforts to understand and respond to community needs, they point to needs to which SB-82/833 programs are particularly responsive and prioritize. ***Two areas of overall concern on the part of SB-82/822 program staff are need for culturally appropriate care, especially for minoritized racial and ethnic communities, and need for care that is responsive to structural racism within communities and their social service systems***. Eight programs discussed the importance of providing more culturally appropriate care, including through more culturally appropriate service delivery, more culturally appropriate and inclusive program settings, and staff that represent the cultural diversity of their communities. Examples of their efforts to tailor their programs to meet these needs include redesigning program components and settings to promote inclusion and reduce stigma, building connections with community and faith-based organizations, and

providing cultural responsiveness trainings to their own program staff as well as to staff in other agencies. Responsiveness to structural racism was also mentioned by six programs in interviews and addressed in workgroups as a major area of interest to program leadership. Concerns related to structural racism included the extent to which minoritized racial and ethnic groups are systematically underserved in health systems; disproportionality in school discipline and law enforcement involvement (especially for Black youth); the impacts, both mental health and otherwise, of racism and racial trauma on youth; the need for more racially diverse program staff to break down barriers to mental health usage for minoritized students; and demand for staff trainings related to racial and historical trauma.

Programs also identified needs specific to particular populations and communities in their counties: **Table 11** summarizes these population-specific needs and provides examples of the ways that their programs are tailored to address them. Each of the populations and needs summarized in Table 11—needs of children and families experiencing homelessness, needs of communities and families in rural areas, needs of Native American and other Indigenous communities and families, needs of immigrant communities and families, and needs of Spanish-speaking communities and families—were mentioned in interviews with at least five programs.

Table 11. Examples of SB-82/833 tailoring to community needs

	Needs	**Examples of Tailoring**
Children and Families Experiencing Homelessness	- Linkage to resources	- Directly linking families to existing resources - Coordination with outreach teams - Coordination with school liaisons for unhoused students
Communities and Families in Rural Areas	- More services - Outreach and access - Timely service response	- Engaging in dedicated outreach to isolated regions - Modification of procedures to accommodate remote areas - Locating program services in areas with limited existing services - Providing mobile response to isolated regions
Native American and other Indigenous Communities and Families	- Culturally appropriate engagement and care	- Partnering with local tribes and Indigenous organizations - Hiring Indigenous program staff - Engaging in dedicated community outreach - Providing cultural trainings to program staff
Immigrant Communities and Families	- Outreach and access - Culturally appropriate engagement and care	- Increasing targeted preventive and early intervention services - Tailoring outreach for families concerned with legal status
Spanish-speaking Communities and Families	- Access to Spanish language care and resources	- Hiring bilingual staff - Offering Spanish language activities and trainings - Offering informational resources in Spanish

Challenges Related to Meeting the Needs of Patients and Communities

Program staff also offered some perspectives on significant challenges related to meeting these types of community needs. For needs of communities and families in rural areas, these challenges included a lack of resources for mental health and difficulties recruiting and retaining clinicians in rural and

more isolated regions. Challenges related to meeting the needs of Native American and other Indigenous communities included substantial language barriers with monolingual Indigenous groups and difficulties recruiting and retaining clinicians. For meeting the needs of immigrant communities and families, a major challenge regards the legal precariousness of undocumented children and families and fear in these communities of legal repercussions from contact with providers or use of mental health services. Tailored outreach for communities with significant numbers of undocumented children and families, including migrant farmworkers, were therefore aimed at mitigating these concerns. An ongoing challenge for meeting the needs of Spanish-speaking communities and families is the need for more bilingual staff, which is particularly challenging for programs with a small number of program staff.

4.2.2 Cosmopolitanism

Cosmopolitanism refers to the extent to which programs are connected, both formally and informally, with other organizations and community assets. ***SB-82/833 programs are connected or partnered with a wide number of organizations and agencies in different sectors and at multiple levels*** (national/state, county, community/local), including:

- Mental and behavioral health agencies
- Mental health providers, facilities, and clinics
- Multidisciplinary care teams
- Public health agencies
- Health and human services agencies
- Hospitals and emergency departments
- Medical transportation
- Community Emergency Response Teams
- Alcohol and drug boards
- Offices of education and superintendencies
- School districts/local education agencies
- SELPAs
- Schools
- Head Start programs
- First 5 commissions
- Juvenile justice and probation departments
- District Attorney's offices
- School Attendance and Review Boards
- Law enforcement agencies
- Child Protective Services
- Child welfare agencies
- Child abuse prevention councils
- Child and family services agencies
- Family resource centers
- Crisis centers
- Domestic violence shelters
- Employment assistance centers
- Food banks
- Cultural service organizations
- Native American tribal nations
- Faith-based organizations
- Mental health advocacy organizations
- Institutions of higher education
- Other community non-profits

As one School-County Collaborative program staff member explained:

> *I think it's just we collaborate with a lot of different agencies… any agency that is there to assist our students and families, we want to know about it. We want to connect them.* [P01 I062]

Types of Cosmopolitanism

A key finding about these partnerships is that SB-82/833 programs are generally ***not merely highly connected but necessarily (and often inherently) so, in that their operation is critically dependent on partnerships with other organizations and agencies in their counties and communities***. An important corollary to the organizational complexity described in section 4.1.2 is that SB-82/833 programs are not just complex in their connections within the implementing

organization, but their ***critical organizational partnerships often span sectors*** for one (or more) of three reasons:

1. the formal ***structure*** of programs, especially for the School-County Collaborative and other school-based programs that are partnered with or housed in schools, as well as the four Phase 1 programs that involve contracted services,
2. by ***practical necessity*** both since crisis triage by definition occurs at the intersection of many care processes and because crisis itself is socially complex, with precipitating factors, response, and ongoing management linked to a variety of social service sectors, and
3. as an identified ***goal or program feature***, that is, where an integral part of the intended contribution of the program is to bridge sectors, organizations, and resources.

Common intentions for all three of these forms of cosmopolitanism are for the partnerships to have a ***long-term impact on linkages across sectors, either by creating and sustaining durable formal partnerships, enabling practical cross-sector workflows, and/or creating better integrated social service systems***.

Structural cosmopolitanism is most common for programs that are physically housed in or provide services directly in a cross-sector organization, which requires a greater degree of coordination and direct collaboration across the relevant sectors. For programs that are cosmopolitan by ***practical necessity***, formal partnerships are more likely to be negotiated as needed or, in some cases, as mandated by actors external to the programs. Programs with an ***identified goal*** of bridging sectors and resources vary in the formality of their partnerships depending on the types of services they provide; that is, they are not more likely to be structurally cosmopolitan merely because they aim to bridge sectors but rather because a formal partnership directly facilitates services that are housed or delivered in that other sector. These programs are often in counties with significant existing community assets for mental health but insufficient links between them or counties with limited resources that need to make the most of what they have.

The specific cross-sector partnerships programs engage in vary: as with the program characteristics, particular relationships are often tailored to needs and gaps in the existing local social service system as well as program needs based on their main care processes and services. Some programs enhance existing relationships, and some create partnerships that did not already exist. Collaboration across sectors also varies in intensity and duration: while programs that are cosmopolitan by design or as a goal tend to have a higher number of durable, longer-term partnerships, programs that are cosmopolitan only by practical necessity tend to have more ad hoc, as-needed partnerships. Even the latter, however, require time and resources to sustain since staff consider them crucial either for ensuring smooth day-day workflows or managing critical incidents when they arise.

Advantages of Partnerships

All SB-82/833 programs use partnerships to address critical target areas and execute their target activities. Beyond the program itself, however, ***some of these partnerships also promote inter-agency and sector task reorganization and shifting***, providing experienced and dedicated mental health staff that reduce the burden for mental health response and services on non-mental health agencies and staff such as law enforcement, school counselors, and hospitals:

> *…now instead of a Sheriff's deputy being the first response to a kid in crisis on the campus, they can call [program staff]… I think [program staff] has probably taken some pressure off the school resource officers as well*. [Child/Youth Program Lead: P19 I091]

…law enforcement asked for us to help them to intervene, so they didn't have to place people on 5150s and spend a lot of time with consumers on the street and families. They wanted us to come take it over, so, we've been able to do that. [Child/Youth Program Lead: P12 I060]
I think for me, also, it's assisting the school counselors being able to get back to that academic counselor rather than having to be a crisis counselor, a therapist. [Child/Youth Program Clinician: P19 I021]

Alongside relieving the burden of mental health services on non-mental health agencies, some programs also describe providing opportunities for increased training and knowledge about mental health for staff in these sectors:

I would say at both schools, their school counselors are very hesitant to provide any kind of mental health service. …they are there to provide more of an academic guidance, but they are also capable and able to provide some safety assessments. So that because as we shared the number of students at each school, that's a lot for just one clinician. So, they've provided some leadership and support to helping those school counselors be able to also conduct safety assessments. [Child/Youth Program Lead: P05 I056]
One of the things in collaboration with the special ed department: they really weren't well versed in… the mental health world and which services were available and how do you make referrals. … So, we've been sort of answering questions, sort of helping them better understand what makes community mental health different from someone with private insurance, and begin to see how we can identify kids earlier in the pipeline that might benefit from mental health services; that's one. [Child/Youth Program Lead: P16 I079]

Some advantages of partnerships about which program leads and staff express the most enthusiasm, however, are using new partnerships to center mental health in conventionally non-mental health settings, making existing relationships between agencies and sectors more "solid", using partnerships to fill and bridge gaps in existing resources. These align with federal and state priorities concerning the importance of developing more comprehensive and integrated mental and behavioral health systems (e.g., SAMHSA, 2020).

…to me it feels like we have some really robust, solid programs that are unintentionally siloed just by the nature of having too much work for each of those programs. And this grant, has really brought in resources to try to function as a conduit or interface between those programs." [School-County Collaborative Lead: P10 I088]
…working in conjunction with other community partners where we are able to bridge gaps between County Systems, which has already happened many times, and our family resource centers and other places where folks could be accessing services, but they just don't have the wherewithal or they don't you know, even know it exists. And so we are able to really bridge those gaps. [School-County Collaborative Lead: P18 I073]
…why coordination is such a big piece—because there are youth involved in the individual systems and, due to the release of information and HIPAA, [they] don't talk to each other. So, at the county, being able to see these youth involved in different systems get the appropriate authorization from them to interact and sit down together and coordinate care, to reduce the systematic barriers and also reduce crisis. That has been a big part of my role." [Child/Youth Program Staff: P20 I070]

> *I feel, you know, this program has intervened not only in the public, but also within partnering relationships to help their loads and to provide services that are needed. There are missing pieces sometimes and I think some of the pieces are being filled with this program.* [Child/Youth Program Lead: P19 I021]

Challenges Related to Partnerships

Program leads and staff described particular challenges related to building and sustaining partnerships, similar to (and often extensions of) those related to program complexity. As a program lead of a School-County Collaborative program explained:

> *…integrated collaborations are hard, and anyone who says they're not is lying to you.* [P18 I032]

Several programs expressed needing to address some form of role ambiguity with their partners, wherein both the role of the program and its staff required clarification so that partners did not attempt to co-opt or reallocate staff for their own purposes or misinterpret the primary goal of the SB-82/833 Triage program:

> *So, we have clarified roles with them, because they saw [program staff]… almost like a social worker for them. So, we had to be real clear that that wasn't her job, but… she will partner with them.* [Child/Youth Program Lead: P19 I012]

> *… [we] had a couple of sites where some of the things they expected folks to do during COVID, like they wanted our staff to be the ones who sat in the room where kids came in if they had a fever and had to go home, they wanted them to be the ones waiting with them until the parent came. And it was like, well, it doesn't… seem like a good use of these wonderful grant dollars that we have. So, you know, we've had to work through some of those pieces.* [School-County Collaborative Program Lead: P18 I016]

> *…if the state wants to continue projects like this I think there has to be a lot more work done on how do you show [what] an integrated team is, how do we get really clear on what a school counselor does versus what a mental health specialist does versus what a liaison does. That's been a lot of the work we've done is like sitting in those uncomfortable conversations and really carving out roles and making sure that folks feel like they're not obsolete because of this program.* [School-County Collaborative Program Lead: P18 I016]

> *…we are pretty protective that our staff are [on site] to do these triage services. So… when… the two coordinators were at each site, I mean, their first month was really building relationships with staff but also informing them of their roles and creating a system. A referral system, so they weren't going to be kind of… used as other duties as assigned.* [Child/Youth Program Lead: P05 I056]

A clinician in one School-County Collaborative program also described early role definition as one major facilitator of program implementation:

> *…having just the integration… with [school counselor] right from the beginning… it was really easy for us to sit down and go. "Okay here's my role; here's your role. How are they going to overlap? What are we going to do different? How are we going to differentiate?" I think really taking the time to really be intentional … it allowed us to be more successful … and if those weren't there it would have been more of a challenge.* [School-County Collaborative Program Lead: P18 I078]

A second challenge concerns the necessity of regular communication and coordination to sustain those partnerships, including effort to align goals and priorities and secure engagement from leadership across sectors. Partnership and coordination across bureaucracies requires significant time and resources under any circumstances, but this is especially apparent for programs with *multiple* partners in another sector, such as programs that do not represent a single connection between schools and the county, but *many* connections between cross-sector partners (schools, local education agencies, county offices of education; multiple hospitals; etc.). The additional regulatory and organizational complexity of such programs on top of the ongoing effort needed to sustain those crucial relationships once established requires a significant investment of time and resources for many programs. Several programs described challenges with these more complex cross-sector partnerships:

…let's say there's ten different school districts. They might have ten different ways that they're doing their risk assessment for suicidality. And then, for us to come in and say never mind what you guys decided, we're going to do it this way. So, that's one of the barriers that I recognize… how to make something that's going to be meaningful and have buy in and doesn't necessarily have to be universal across the board for each district, just something that makes it to where we know we are all using the speaking the same language regardless of which system they're using. [Child/Youth Program Clinician: P14 I097]
at least for my personal experience, [a challenge] is not knowing the infrastructure and the bureaucracy that we would run into in different organizations. So, we know that County has their own sort of chain of command that you would run a contract through execution. It's very different from [county office of education]'s end and there's additional steps that are there that [other agency] doesn't have. In addition to that, we also have the districts involved as well, so even just putting out a job description means you need to get board approval first… [Child/Youth Program Lead: P05 I089]

For new programs, building new long-term relationships also involved distinct challenges, which one program lead described as "building the plane as we're flying it." Because partnerships require coordination across bureaucracies and regulatory systems, navigating these issues while trying to roll out new services created delays and challenges for several programs. These were compounded by the short-term nature of the grants, which meant that program staff were trying to build these critical relationships without being able to assure their partners that the programs would exist long-term. This was further compounded for some school-based programs by the lack of alignment between the start of the grant and the school year. As one School-County Collaborative Program lead explained:

… it's even created some challenges for us initially when we were building relationships and getting schools on board with this project because they've become a little unsure and fearful about what happened when this leave midyear. They really want to invest in a project that they know is going to be there for their students, so having to try to figure that out with them and be confident that we can figure something out, so that we can really get this project going, you know that that's taken a little while to do that. [P18 I016]

Facilitators of Partnerships

Several programs also described the ***advantages of either leveraging pre-existing relationships or putting time into building relationships prior to the start of their programs***. In some cases, personnel with experience in multiple sectors were also able to provide a starting point for building

critical relationships with partners. Asked what had made program implementation easier, one School-County Collaborative program lead explained:

…it sounds a little corny, I think the fact that we had really spent time prior to this program even dreamed up, developing the relationships between County Mental Health and our school system. Um, those relationships were really solid, um, you know we've met regularly, we know each other's systems and so, that's really, I think enabled us to move pretty quickly when we got the funding to um, really going from the idea into actual seeing kids and providing services. [P22 I069]

Some programs in smaller counties or with highly integrated systems of care also specifically noted the advantages of their social service systems for implementation as they are already highly networked and coordinated.

There's some tremendous strengths and weaknesses that you'll see with rural versus urban. One great thing is that we, we have a much easier time collaborating across all departments because it's so small and, and so, that's an advantage to moving forward and getting MOUs and just creating partnerships in the community; so that's a strength. [Child/Youth Program Lead: P19 I012]
I think that I have like a ton of advantages like I think that there is like especially with services for children, especially, there is this real move in California, this continuum of care reform to really integrate all the services. So, you need child welfare, probation, mental health, the education system, you need them all working together and in our, in our branch it's like you could put them together and start working collaboratively on some different things. [Child/Youth Program Lead: P20 I034]
… our collaboration… it is deep, it is strong, that makes this all easier. I just want to cheerlead that for a minute and I am not the biggest or loudest cheerleader around here, but, that is one of the things that makes everything easier. If we have any sort of discussion, it's just we get together and we talk about it or we go across the parking lot or across the wall, anyway, that makes things so much easier because we know that we have good strong trust in our partners. [School-County Collaborative Program Lead: P18 I054]

Connections to Community Assets for Mental Health

While SB-82/833 programs both benefitted from and worked to enhance partnerships, a critical element of external network partnerships for program implementation is the ***ability to connect with and access community assets and resources providing mental health services***. Because these programs tend to be mutually dependent on external agencies with varying access to resources and because they operate across the full range of the mental health care continuum, there are many points at which community resources and assets can either facilitate or constitute barriers to implementation, with certain target outcomes for programs likely to be linked to these resources/assets. Community assets on which programs depended vary, but center on a core set of mental health treatment facilities and community mental health services, including psychiatric hospitals, psychiatric health facilities, crisis stabilization units, crisis residential treatment programs, psychiatric emergency facilities, mental health urgent cares, crisis resolution centers, short-term residential therapeutic programs, substance abuse treatment centers, and outpatient clinics and providers.

While triage programs are designed to provide alternatives to, and diversion from, many forms of intensive psychiatric care (including inpatient hospitalization), the nature of crisis care necessarily puts them in contact with some youth and families for whom such options are indicated or even

legally mandated. For ***many SB-82/833 programs, especially those that are focused on crisis response care processes and those in smaller and more rural counties, deficiencies in community assets for mental health services are therefore a significant barrier to program implementation***, resulting in both burden on youth and families and ongoing, time-intensive challenges for program staff. In many counties, youth and families must either travel out of county for appropriate care or wind up in inappropriate placements, such as emergency departments:

…we have a lot of gaps in the county and so, if [agency] doesn't have a place for the kid to go and the kids not getting hospitalized and the parents aren't able to take them for whatever reason, whatever the barriers are, they literally have nowhere to go. Like in other counties, there might be residential in the county or there might be these other options, but we might not have these other options. So, we have some bigger gaps, I think than other counties in general. [Child/Youth Program Clinician: P11 I092]
I think it would be really helpful to have a youth CSU, but I know it's a lot of money and it's really expensive. But… having a youth crisis stabilization unit eventually would really be helpful, I think. The problem with youth is they all go out of county 'cause we don't have a bed, so that's scary for the parents, that's scary for the kid. [Child/Youth Program Clinician: P14 I013]
Honestly, the only thing I can think of right now is the resources. We need more psychiatric hospitals to take people to get help, so they're not stuck in emergency rooms. I think that would help the burden. I mean we help, but if there's nowhere for us to take people, we're kinda stuck. People are still going to be stuck in emergency rooms and that's going to be, that's just going to add to their stress. [Child/Youth Program Clinician: P12 I076]

These differences in community resources, especially for smaller counties, were also reported for other services including youth mental health urgent care, outpatient clinics, and long-term outpatient providers.

…we have, I think countywide, a limited number of mental health providers and spaces to actually send youth and families and so, just getting them in for long-term services can sometimes be a challenge. [School-County Collaborative Program Lead: P22 I069]

The contrast in community assets across counties with SB-82/833 programs is important to note since ***counties with a greater variety and depth of existing mental health related assets may appear more successful at certain program outcomes*** in part because they are better resourced to provide youth and families with care appropriate to their needs. In contrast, programs with more limited community assets, especially in rural areas, may appear less able to accomplish certain concrete program targets such as linking to services. However, ***that same lack of resources may also allow programs in less-resourced counties produce a bigger relative impact on mental health services in their communities*** since they are potentially filling bigger gaps and addressing bigger deficiencies in access. That is, in absolute terms their impact on targeted outcome metrics may be less than what is possible in a larger, more robustly equipped county, but may add more value to their respective county's mental health system than a new program in a large metropolitan county with a stronger mental health service infrastructure.

4.2.3 COVID-19 Pandemic

The COVID-19 pandemic constitutes an additional outer setting context that affected program responses to community needs and partnerships, but also profoundly impacted many other aspects of program implementation. SB-82/833 program staff described significant and ongoing changes to their communities' needs, including mental health and basic needs, and described extensive and

innovative adaptations made both to meet those needs and to continue service delivery during an unprecedented global crisis.

Changes in Community Needs

Over the course of the pandemic, program staff reported changes in both the mental health needs and basic needs of their communities. These impressions reflect staff experiences with the pandemic and help explain how these perceptions impacted program implementation.

With little exception, staff expressed that the pandemic had resulted in an overall ***increase in mental health needs for children and families***. In the earlier period of the pandemic, program staff described active concerns about new and changing needs related to factors such as social isolation, disruption of routines, anxiety around the pandemic, strain on families during stay-at-home orders, and grief due to personal and social losses. As the pandemic progressed into fall of 2020, renewed concerns emerged, especially among school-based program leads and staff, that needs would increase and change again as schools reopen and children and families readjust to life in person. These concerns, often based on clinical observations and interactions with staff at schools, included concerns over anxiety about reestablishing in-person contact, needs to rebuild social and coping skills, another disruption to routines, and needs that weren't addressed earlier and potentially built up. ***For several school-based programs, these increased mental health needs motivated an increased emphasis on preventive and universal supports for mental health***, including renewed emphases on social emotional learning and strategies for self-care. One program also noted that the increase in mental health needs for all students had prompted a re-framing of universal supports such that a higher, more targeted level of mental health supports should be made available to all students.

Especially in interviews through mid-2020, program leads and staff also observed and/or expressed concerns over ***increases in the clinical severity or acuity of patients***. Staff in ten of fourteen Phase 1 programs mentioned an increase in clinical severity (of the programs that did not, one does not provide direct clinical services and one was not in operation for most of the pandemic). Staff in five programs specifically mentioned an increase in suicidality. Explanations provided by staff for this increase in severity and suicidality included new family stressors, "isolation malaise" due to school closures and stay-at-home orders, and worsening of existing symptoms due to loss of existing routines and replacement of in-person care with telehealth. Staff in five programs also expressed concerns that they were seeing patients in a later stage of crisis than they would ordinarily, with two programs expressing specific concerns that families were delaying seeking treatment until a child was in severe crisis due to concerns due to COVID-19 risks and regulations. Other explanations for changes in clinical severity during the pandemic included lack of access to preventive and early intervention services in schools, lack of earlier detection of crisis at schools, families and caregivers unable to identify early warning signs of crisis. Program staff also identified other changes in the clinical presentation of clients during the pandemic, including reductions in behavioral and family conflicts relative to acute crises, increases in substance use, and an increase in younger onset mental health needs. Some school-based programs also observed a change in which students had greater mental health need, noting that students who were well-adjusted prior to the pandemic were experiencing an increase in their mental health needs while, in some cases, students who had previously struggled with or been isolated in the school environment experienced improvement in their mental health needs.

A general trend across programs during the COVID-19 pandemic was a ***shift towards increased support for basic needs*** in addition to mental health needs. Staff in more than half of the SB-82/833 programs specifically raised the issue of increases in basic needs and described their efforts to adapt

their programs to help clients and families in key areas, including supports for accessing resources related to food, housing, public benefits, and access to connective technology (e.g., internet access, internet-ready devices).

Impact of the Pandemic on Program Demand

While most programs observed increases in mental health needs during the COVID-19 pandemic, most also observed substantial decreases in program demand and utilization during the same periods. Staff in many programs expressed concerns about the extent of unmet need and made significant adaptations to their programs to attempt to better meet need. As one program lead noted, they had to “throw out whatever rulebook they were playing from” to meet increasing needs in spite of changes to their program settings and operations as a result of the pandemic.

Many programs reported ***significant drops in demand for and utilization of services in spring 2020*** (some as much as 75–80%, according to the estimates of program staff), frequently timed and attributed to school closures. By the summer of 2020, referrals for school-based programs were still reported to be lower than usual, with some non-school based programs describing fewer referrals from schools and some reporting increases in program utilization relative to the first months of the pandemic. One non-school-based program suggested that their relative increase in crisis referrals may be due to schools remaining closed; that is, that they were receiving clients that otherwise would have been addressed within (and by) schools. Another suggested that a major shift in the times they received referrals (an estimated decrease of as much as 75% in referrals during the SB-82/833 program hours, with many calls afterhours) may also be linked to school closures.

In the fall of 2020, most programs reported relative increases in demand and referrals, especially for programs in areas where some school districts were returning to in-person instruction. Ongoing barriers to demand for some school-based programs persisted, especially for programs with limited or no mechanism for in-person contact (and particularly for programs that usually receive clients via drop-in service). School-based programs described challenges with limited follow-up and adherence by youth via remote services, noting that it is very hard to get students to engage in “another virtual thing” and that “Zoom fatigue is real.” Additionally, some school-based programs described new challenges related to parental engagement and consent, especially for programs that previously met need for drop-in services using minor consent. By the fall and winter of 2020, several school-based programs noted new and increased demand for support, trainings, and programming for teachers and school staff.

By the first quarter of 2021, while some programs were still reporting lower than average referrals—especially where schools remained in distance learning—other programs report that their demand is back to “normal,” “busy,” or that they are handing “tremendous” volume of referrals, typically connecting it to the return of students to schools. For programs in areas still awaiting school reopenings in early 2021, a common concern is that “when schools go back, we will be very, very busy from all the pent-up lack of mental health services that happened during this COVID stay-at-home.”

Adaptation during the COVID-19 Pandemic

SB-82/833 programs made significant, and often innovative, changes to their program operations, service delivery, and activities as a result of the COVID-19 pandemic. Some of these changes were responses to policy changes (e.g., social distancing requirements, school closures, and stay-at-home orders) and some were voluntarily taken on by program staff in response

to changes in need and demand described above. All programs shifted at least some of their program operations and activities to remote platforms during the pandemic, coordinating with their team and partners via remote platforms, providing some services by telehealth, and conducting outreach activities remotely. There is high variability in the extent to which program operations shifted to remote formats, as some programs continued (and even prioritized) in-person services throughout the pandemic. However, many programs—especially those housed in or providing services at external organizations such as schools, police departments, and hospitals—had little input on whether or not their program could coordinate or deliver services in person. Even programs whose ability to provide services in person or in their normal service setting was not directly impacted experienced challenges related to the pandemic to which they had to adapt, including social distancing protocols, changes in their referral bases, and increases in the needs of patients and communities. Across all programs, the pandemic was (and continues to be) a continual exercise in "trying to ride and tame the elephant."

Telehealth

One of the most significant adaptations made by programs was uptake of telehealth for a significant portion of program services and activities. Telehealth comprises various methods of remote service delivery, such as phone, video chat platforms, email, and secure web-based messaging. While all programs shifted some component to a remote platform, many programs, particularly mobile and field-based programs providing services at the time of a crisis, maintained in-person service delivery when possible. Many programs, especially school-based, found that telehealth services were better suited to care processes such as outreach activities, prevention trainings, and follow-up. When using telehealth, the choice of platform was often selected based on type of service provided as well as client preference. For example, many programs found video chat platforms helpful for prevention-focused and outreach services, such as mindfulness trainings, whereas phone calls were often preferred to connect with parents of youth clients for follow-ups and case management.

Uptake of Telehealth

Uptake of telehealth was generally rapid for programs that used it, though some programs reported a "learning curve" with the adjustment. Challenges with this rapid shift included ensuring that its deployment was compliant with relevant privacy and consent regulations and equipping staff with the appropriate technologies. Some programs found it necessary to revise existing procedures, including those related to consent and risk assessment, to better fit remote service delivery. During the shift to telehealth services, some clinicians found themselves working to build new relationships and rapport with new clients and parents/caregivers remotely. While, for the most part, programs adapted quickly and developed a flow for relationship-building with clients and parents/caregivers, it was not without challenges:

…And it's like how do you get all that stuff, right? So, just trying to get everybody technically, technologically situated to do remote working in telehealth stuff has been very difficult. [Child/Youth Program Lead: P20 I034]
I mean the biggest barrier is that we've never done [virtual services] before. So, we didn't know how to. There's a huge learning curve for everyone when it comes to that. [School-County Collaborative Clinician: P10 I061]
Oh, at first… it was a really big transition period. I think it was a little difficult because it was figuring out how to build rapport with parents over the phone versus face to face in person at the hospital. …And then, slowly you get into that phase where you kind of have a better way of going about it, introducing yourself, explaining who you are and what your part is in all of this, and why you're contacting them. And so, I think initially…,

especially for me, it was really, kind of a little shaky there at first, but now it's kind of second nature, part of the program now and it's just the way that we respond to clients. [Child/Youth Clinician: P09 I103]

Even after protocols had been established, clinicians found that they needed to be ***flexible with the platforms they used to deliver services based on the client or need***. While some school-based programs primarily used videoconferencing platforms, programs providing more acute crisis interventions and services tended to be more mixed in the telehealth modalities they used. When delivering services remotely, such programs often utilized both telephone and teleconferencing platforms, often depending on the reason for connecting or preference of client. Services related to an acute crisis event—but not a crisis event itself—such as consults, follow-ups, and parent/caregiver outreach were often handled more through telephone than services directly provided during a time of crisis. Regardless of program type, however, programs generally attempted to meet youth and families according to their specific circumstances:

Honestly, a lot of the times, the parents really don't have access, they're tired, they really often are just exhausted from the process. You know, they're in that drain off sort of period often because they've gotten out of the hospital and when I've mentioned telehealth or we talked about it, often they're just really like, "no, can we just you talk, if possible." And it's just one more thing that they have to do per se. [Child/Youth Staff: P09 I183]
…we mostly do everything over the phone however, if we do have a client that gets discharged…they would have to come across the street to our office, so we would provide…services that way. [Child/Youth Clinician: P09 I103]
Um, because usually it is in the moment of crisis and so, we are not setting up the meeting and everything. And so we are using phone contact and then will, for follow-ups, we'll assess the need of the family, whether they do Zoom or what's easiest for them. And honestly, because of it being crisis, usually it's in the moment. So, phone. [Child/Youth Program Lead: P19 I021]

Telehealth also had mixed implications for program reach; in some cases, reliance on telehealth resulted in new barriers to accessibility but for some programs it also allowed programs to expand their reach. ***Barriers to the accessibility of telehealth were reported where access to internet or technology is limited, particularly in rural or low-income areas***. This constituted a significant obstacle to both program service delivery and the particular youth and families affected, especially to the extent that programs could not mitigate them:

And then, access, we have so many rural communities. We are a rural community so– I mean, Internet access is not the greatest. It is very hard connecting with these students especially if they don't have cell phones, sometimes their parents are working, and we are not able to connect with them certain hours of the day. And if they don't have good internet connection, that's a barrier. [School-County Collaborative Clinician: P01 I020]
Yeah. And we don't have… any like loner tablets or, you know, like anything that we can provide for them and we don't have access to providing free Internet for families or anything like that. They don't have Internet, they're kind of disconnected. [School-County Collaborative Staff: P10 I098]

While such barriers limited the accessibility of some programs, some programs also reported that certain program activities aimed at increasing reach were, at least in some respects, well-suited to telehealth and remote communication methods. For technologically equipped youth and families,

virtual programming lowered some barriers to entry for certain types of activities and facilitated outreach for program activities such as parent trainings and support.

> *So, I will say, during COVID, we were able to push a lot for social media and I think that's necessary anyways, especially our audience is families and parents use social media to stay connected. And so, we've been able to really, really use social media, not only to promote our upcoming trainings, but to connect with people. So, little family tips, little fun things to say, "hey, you're doing a great job, we're here for you." That's been our huge thing.* [School-County Collaborative Staff: P10 I024]

Attitudes toward Telehealth

Perspectives of program staff on the appropriateness and efficacy of telehealth were somewhat mixed, but generally higher earlier in the pandemic. Some clinicians felt surprised with the relatively high level of connection possible with clients via telehealth:

> *I wanted to be in the room. And I think there's something very palatable that happens in the room with the person. But I have been surprised at how effective and efficient Telehealth has been. So, I mean it's kind of been one of those odd surprises for me.* [Child/Youth Clinician: P11 I092]

> *So, I don't know if it's you know, with the technology piece of it that somehow, they may feel more comfortable or maybe I feel a little more comfortable but having that has helped move forward with okay what is the next step now, what kind of services are going to be the best for you. But um that connection piece has been, pretty successful so far.* [Child/Youth Peer Partner: P02 I028]

Other clinicians, however, expressed concern for its effectiveness, with one clinician particularly concerned that it was linked to patient decompensation:

> *…I haven't heard anything positive. I think initially people thought it was, it was good because they were getting, they were seeing people more often 'cause it was easier to, they don't have to drive themselves to the clinic, they have to take a bus, they don't have to make arrangements with their insurance and go to their, therapies. They can just pick up the phone or their tablet. But they really want, they weren't being uh, it wasn't effective for them.* [Child/Youth Clinician: P12 I076]

Regardless of personal perspective on telehealth, most programs mentioned the need to continue some level of in-person interaction with clients, even many programs that had been successful with telehealth. While telehealth offered a way to safely provide numerous services during the pandemic, many programs noted that ***client engagement through telehealth became a barrier over time***, particularly after a few months of attending school through video teleconferencing. "Zoom fatigue" was a regular point of discussion among the school-based programs conveyed through our School-County Workgroup meetings.

Related, clinicians frequently felt ***interpersonal connection being lost on a virtual platform***. Across Child Crisis Intervention and School-County Collaborative programs, one of the most prevalent observations was the expression of desire for face-to-face contact when providing services to clients. During the 12-month interviews with clinicians and staff in the summer of 2020, telehealth was the primary mechanism for service delivery for most programs. At this time, clinicians and staff clearly voiced the need for in-person service delivery, mainly because body language nuances and other critical elements of interpersonal care were hampered through remote platforms. This challenge prompted the programs to develop compensatory innovations, some of which are described in the following section.

That's the feeling and the feedback that I get from a majority of the kids is that if they don't like it… it feels more impersonal to them and that they would prefer to meet face to face, which is surprising. You know seeing as how you would think that would be the medium that most of them are using is and how they're chatting with their friends and such. But I think that the ones that are interested in making some changes, I think—I think that they're missing just that connection when they're able to sit down and talk with somebody versus it just being over a screen. [Child/Youth Program Lead: P14 I097]
The kids needed that physical, that one-on-one connection so we can both build rapport and so that to me has been extremely difficult virtually. And my little ones virtually— you can only imagine—their attention span physically is less than 20 minutes. And so, virtually, it is a lot less than that. [School-County Collaborative Clinician: P01 I062]

Challenge, Innovation, and Opportunity during the Pandemic

Adaptation to the COVID-19 pandemic entailed, for all programs, navigation of a wide range of changes with varying impacts on their programs. While, in its totality, the pandemic constituted a major challenge that adaptations were aimed at overcoming, ***its particular impacts were often complex: variously constituting durable challenges, stimulating innovations, and even creating new opportunities***. Programs showed significant resilience, even optimism, throughout the pandemic. As one School-County Collaborative program lead reflected [paraphrased from notes]:

This COVID period is a reminder that even though we [as mental health service providers] are told that there are things we can't do, that this is showing well what is possible when we are really stepping up. The situation has allowed [the SB-82/833 team] to really show what they are capable of. [P10 I042]

Where challenges proved more durable and even innovations could merely mitigate it was most often because the conditions leading to the challenge exceeded the capacity of program resources or authority to overcome (see section 4.1.3). In many cases these challenges were also cascading, meaning that challenges within the organizational purview and capacity of a program to adapt often remained durable to the extent that they were linked to upstream challenges outside of the implementing organization's scope of influence. However, aspects of the pandemic that were durable challenges to some programs were sometimes either manageable or even unexpected opportunities to others, shedding light on what dynamics mediated the effects of the pandemic on program implementation.

Challenge and Innovation

The set of ***pandemic impacts that stimulated the most innovations*** included changes in patient and community needs, reductions in schools' prevention and early intervention capacity, challenges with detecting need remotely, disruptions to referral source(s) and channels used before the pandemic, barriers to (or loss of) in-person service delivery, youth engagement with and adherence with telehealth, parent/caregiver engagement and consent, disruptions to (or loss of) in-person team coordination, and increases in strain on program staff. **Table 12** provides a list of examples of the innovative solutions described by program leads and staff in response to these challenges.

Table 12. Major COVID-19 challenges and innovations

Challenge	Innovations
Changes in Patient and Community Needs	- new outreach initiatives (in-person, email, websites, social media) - new community needs assessments - compiling new resources for youth and families (especially basic needs) - new trainings to external organizations on mental health needs during COVID - expansion of program reach to additional schools/sites - increased focus on universal supports and self-care
Reduction in School Prevention and Early Intervention	- new remote universal supports, SEL, and mindfulness programming - new remote wellness centers and offices - remote classroom observation and breakout rooms - support to schools in restoring these supports
Remote Need Detection	- revisions to crisis protocols for remote contact - new trainings to staff and schools on detecting signs of need remotely - school-issued device monitoring - remote truancy monitoring - additional outreach to youth/students with known needs - new surveys and referral forms to detect needs - remote classroom observation - new routine screeners for remote appointments
Disruptions to Referral Source(s)	- email blasts to advertise services to new potential referees - increased staff time for coordination with referral sources - increased coordination with school counselors - creative/remote monitoring of existing referral lines - new referral platforms (e.g., surveys, online forms, warmlines) - direct advertising (e.g., social media, newsletters, email blast)
Barriers to/Loss of In-person Service Delivery	- use of telehealth and other remote contact - development of new remote consent procedures - new online drop-in groups - securing spaces for socially-distanced indoor contact - use of socially-distanced outdoor contact - increasing home visits - development of new practices for digital warm handoff - increased remote contact and follow-up with clients and families
Youth Engagement and Adherence with Telehealth	- development of incentives for telehealth adherence - new social and recreational programming for youth
Parent/Caregiver Engagement and Consent	- new remote engagement programming (e.g., social media, support groups) - flexibility and customization of mode communication (e.g., Zoom, text messaging, email, phone, surveys) - socially distanced in-person family outreach where permitted - new parent trainings on need and early warnings - new brochures and handouts for distribution in community

Loss of In-person Team Coordination	- creative use of remote work platforms - increased frequency of communication and meetings - social check-ins to mitigate for loss of informal in-person interaction
Staff Strain	- new mindfulness and self-care programming for staff - motivational email blasts

Even for the challenges that stimulated the greatest innovations, there were still durable challenges as well as unexpected opportunities. Programs could effectively adapt to ***changes in patient and community needs*** only to the extent that their internal resources—particularly staff time—would allow and to the extent that community resources (for both mental health and basic needs) were available to which programs could refer youth and families. Ability to adapt to ***reductions in schools' prevention and early intervention capacity***, much of which was disrupted during the transition to remote schooling, depended largely on a program's proximity to and involvement in schools. School-based programs had a greater capacity to provide additional support and encouragement to schools to either restart such programming via innovative means or reprioritize the services provided by their programs. However, developing new means of detecting youth and family needs was a particular challenge for school-based programs, which often depend on direct in-person observation by teachers, counselors, and program staff to identify student needs and could only partially replace these efforts through remote detection strategies.

We kind of had a captive audience in terms of reducing barriers to mental health services… it was easy to just provide services because students are having strong feelings in the moment, they want to talk to somebody, and we're right there. Whereas now, we did a survey at the end of the school year, we found out that a lot of our students were reporting really high levels of stress, since going on distance learning they were really feeling the impacts of it, but a lot of them weren't necessarily reaching out for help. And so that's kind of concerning I think… I hope that they're getting that help at home… I hope that they're able to rely on the people around them, but we don't necessarily know because we don't have that direct contact with them. [School-County Collaborative Program Clinician P18 I078]
And what we've heard from the beginning is that the lack of really being able… to see what's going on, read a student's body language, and those kinds of things that you get in person, it's really tough to do on a Zoom meeting. …I think our schools feel like they don't have as good of a sense of how a student is doing and so, they don't know if someone is struggling, if someone is hanging in there okay, and so I think that they just feel like they don't have as quite a good of a handle on how students and families are doing to know when they need support or when they might need a referral. And so, unless something really pops up that's really obvious, so I think that's been harder on the school staff and just knowing how to check in with students, how to check in with families, how to stay upright of how they're doing and monitoring that—it's been more challenging. [School-County Collaborative Program Lead: P22 I069]

While some school districts initiated, and involved SB-82/833 programs in, extensive efforts to evaluate student need, staff in one program specifically described the challenge of knowing that youth were struggling but not being able to get the school district to coordinate with them on processes for identifying student needs.

As the pandemic unfolded, these increases in needs and (at least temporarily) reduced school capacity for prevention and early intervention were also linked to challenges related to the ***disruption of pre-pandemic referral sources***, which significantly impacted most programs. Since schools are often a major source of referrals for youth mental health crisis programs, regardless of whether they

are school-based and school-focused, the challenges identifying student needs within schools also had a broader impact on the programs to which such needs would ordinarily be referred, including mobile crisis programs that continued to operate in the field. These programs often had other referral bases they could still use, but some were concerned that they were receiving referrals for cases further along in the progression of a crisis due to reduced detection and interventions from schools. Loss of school-based referrals may also account for some portion of the drops in program demand early in the pandemic for both school-based and non-school-based programs, but may have had greater impacts on school-based programs in schools or districts that did not initiate large-scale outreach to their student bodies or who did not directly involve the SB-82/833 programs in those efforts to translate them into actionable referrals.

Whether or not programs were able to identify needs and access referrals by normal means, many experienced ***barriers to service delivery*** as a result of either shifts to remote platforms or loss of access to their pre-pandemic sites for in-person service, both of which were often the result of administrative decisions far above the level of the programs themselves. While programs who were required to shift to telehealth did so very rapidly and with limited to no interruptions in their ability to provide services, perspectives on the use of telehealth varied widely, as described in the previous section. Some durable challenges related to remote service delivery, however, were those related to ***youth engagement and adherence with telehealth*** as well as ***willingness of parents to engage with or provide consent for telehealth services***. While programs attempted to incentivize telehealth usage, "Zoom fatigue" was an increasingly persistent barrier to both youth and family engagement as the pandemic wore on. This was a two-fold challenge for school-based programs that had previously depended on student self-referrals and drop-ins: students were already exhausted from remote schooling and, even where students were interested in services, parent engagement was now also necessary in interactions that would previously have occurred under minor consent. As one school social worker described:

> *We have to go through the parents and the parents are like, "can you stop calling me, why do you keep calling me, what do you want?" …parents are not quite as used to talking to us regularly and probably feel like we are harassing them a little bit and check in on the kids. And we're like well, your kid loves talking to me every week, maybe you don't, but your child does.* [School-County Collaborative Program Staff: P01 I037]

While engagement via telehealth was a durable challenge for some programs, others reported that the pandemic also created opportunities for better engagement with some individual youth and families, even as it required significant flexibility in determining the appropriate mode and frequency of contact. While some families, especially those facing challenges in basic needs, may have been harder to engage, programs also noted that some parents were more engaged on issues of mental health that were brought to light during (and by) the pandemic:

> *…navigators are spending a bit more time just offering psychoeducation and connecting with parents. But they did express, they feel like parents they seek the knowledge now, they want to know, they have questions, that in a way that they weren't seeing previously. They weren't seeing that level of parental or caretaker engagement prior to the pandemic.* [Child/Youth Program Lead: P09 I156]

And while "Zoom fatigue" affected telehealth utilization for many programs, some program staff also noted that the rise of telehealth was sometimes more conducive to engagement with youth who were already accustomed to, and may prefer, remote platforms:

> *…in some ways I see some youth who wouldn't have engaged as much. … Like some of the young youth. I can think of a couple boys who are super into FaceTime and may not be super engaged in a meeting. And so that has been refreshing.* [Child/Youth Program Staff: P11 I040]

A final opportunity for increased engagement via telehealth was that several programs, mostly school-based, noted that the increased use of virtual platforms for services, trainings, and outreach programming had allowed them to increase the geographic or site reach of their programs without placing an additional burden on their staff.

In addition to service delivery, challenges and opportunities related to remote communication also impacted ongoing ***program operations and team coordination***. Programs were generally nimble in transitioning to remote work platforms as needed but, paralleling some concerns with the use of telehealth for service delivery, noted that it was not always conducive to sustaining team relationships and cohesion. For programs that were accustomed to in-person coordination, it represented a barrier to interpersonal connections that was difficult to overcome. Many program leads and staff attested to this challenge and attempts to mitigate it:

I mean it's really changed my relationship with my staff, whereas, you know I would be there, we would have face to face, you know you have that time for chit chat. And so, what I've implemented for myself is every week I call them in just chat, just to see how are you doing, and not talk about work. You know just tell me how you're doing, how was your weekend you know just stuff like that. Just say, you know, I just wanted to see how things are going and leave it at that. But it's not as effective as that daily one on one, getting to be with each other. [Child/Youth Program Lead: P02 I001]
…it's so much nicer, there's so much more communication that goes on when you're in person. So, you know we've been doing, doing the best job we possibly can and while being safe and following COVID protocols and everything, but it's put a damper on everything. There's a lot of isolation and you can see that in some of our referrals around isolation, anxiety and all that stuff. I think it's a… parallel process that we've been going through too for all of us. [School-County Collaborative Program Lead: P22 I039]
…there are times during COVID, when there are days when it feels very transactional. I think that's been one of the hardest things about COVID is just, you don't have that in person connection. I think you know for us therapists and as team members, it does really make a difference. So, just really trying to build in that structure of checking in multiple times per week, I think that has that has helped to keep the communication and relationships as strong as they can be. [Child/Youth Program Lead: P16 I084]
The being able to you know have a hug and get together, and share some food, and have all those sorts of things, that's what people are missing very much. And so, Zoom fatigue is just a piece of it, it's really the actual face to face interaction of being able to share and tell stories in a couple minutes offline, to be able to you know. It definitely changed things and I expect some of these changes will be there in the future. [Child/Youth Program Lead: P02 I054]
…I mean I think our supervisors do a good job of making themselves available, but I think it's accurate to say just the day-to-day kind of camaraderie that you have is that's been, there's some of that that's been lost obviously. We try to plan social distanced things and include each other in group texts just to kind of keep each other in the loop of what's going on with stuff. [Child/Youth Program Clinician: P14 I097]

Programs that were usually remote or in-person but geographically dispersed, on the other hand, reported a different variety of experiences with remote work during the pandemic. For some such programs, the broader normative shift to new platforms for remote work created an unexpected opportunity to improve their existing communicative flows: reducing the impact of long commutes, scheduling conflicts, and other challenges coordinating and meeting with their teams. Some programs were also able to expand the range of trainings and support provided

to their teams by leveraging the increased number of remote resources that were either known or made available by counties during the pandemic.

Whether programs were generally satisfied or dissatisfied with remote work, most acknowledged that the pandemic had contributed to increased strain related to their work, whether due to increases in their workloads, new challenges with work/life/family balances (especially for staff working at home with children), rapidly changing conditions requiring continually adaptation, or anxiety connected to COVID-19 risk in the course of their work. Even advantages of remote work platforms in facilitating contact between teams created new challenges as many program leads and staff reported that they were overburdened with meetings, often scheduled back-to-back without breaks. To the extent that increased burdens on staff related to their work conditions were tied to factors well outside the control of an individual organization, these challenges could only be partially mitigated. Even program leads who were acutely aware of the importance of staff self-care and burnout avoidance struggled to balance this in light of the concrete pressures placed on their programs by the pandemic.

Durable Challenges

In addition to challenges that stimulated innovation, programs also experienced ***durable challenges related to the pandemic that were not necessarily amenable to innovation***, including time spent on COVID-19 adaptations, building and sustaining programs and relationships, pandemic-related administrative decisions that affected their program operations, revenue and sustainability planning, loss of critical resources, and the creation of new equity issues. For some programs, these were challenges to which they had to adapt but could not innovate their way out of: more durable to the extent that they were inherent to the situation, closely linked to decisions outside of the authority of the program or its leadership, or closely linked to resources that are outside of the control of the program team or implementing organization(s). Due to differences in programs characteristics and circumstances, however, what were durable challenges to some programs were, in some cases, sources of opportunity or growth for other programs.

At the broadest level, perhaps the least controllable impact of the COVID-19 pandemic for all programs concerns the ***time spent continually adapting to it***. For some programs, this was a durable challenge with little upside:

> *…just sort of responding to this, this COVID pandemic it… eats up a lot of time, right. And so, time that we would normally be spending on other things, is getting spent on… all of the different things that have come along with COVID.* [Child/Youth Program Lead: P20 I034]

Every adaptation made by programs, however innovative, took time to develop and implement that was not factored into program design and planning. While some, if not many, of those adaptations enhanced the intended goals and aims of the programs—that is, added value to the program in unanticipated ways—time spent directly managing closures and re-openings (both school and office) undoubtedly impacted the time available for staff to address the core components of their programs. The “huge learning curve” for the transition to remote work and telehealth and the rapid transition that many programs achieved came at the cost of significant time and effort. For school-based programs in particular, the rapid and frequent changes in the format of schooling in some areas required extensive time to manage: staff often needed to prepare for and rapidly shift between in-person, remote, or hybrid formats (or multiple at once) as well as a “ton of work” supporting schools in their transitions. “Schools are scrambling,” one program lead noted, so “it feels like a scramble” for the program staff as well. Even office re-openings created new time intensive demands as program leads worked out the logistics of socially distanced work on site. The time intensity of adapting to the

pandemic forced many programs, even those whose settings and service delivery was minimally disrupted, to reassess their priorities and make necessary adjustments to the format and intensity of services they offered.

One of the aspects of implementation that was most difficult for some programs to sustain during the pandemic was unfortunately also one that they regarded as critical: building and sustaining relationships. Especially for new programs who were working to initiate essential partnerships, the pandemic constituted an additional challenge to relationship-building:

it was just a rough start just all around for everybody; admin trying to figure out what they were doing just for their school site in general, plus having this new program on site, and our staff trying to get in there without being too pushy and trying not to add another stressor to the admins to-do list, but still trying to, you know, make those connections, and asking to join staff meetings to introduce themselves to staff, and trying to, you know, in a virtual world trying to make connections and build relationships which can be challenging. [School-County Collaborative Program Lead: P01 I019]
…just getting our two systems together and with COVID and everything, it's just all into the lower priority. It's not that we haven't attempted it or tried it, it's just been prioritization and capacity. [Child/Youth Program Lead: P05 I065]
But that relationship, the building relationships, building the trust, knowing each other, being able to talk about calls we've been out on, and educating, educating them and them educating us, that's been lost for a while. And frankly, I feel some grief over the past year. [Child/Youth Program Lead: P02 I001]

In contrast, some programs—especially augmenting—noted that the ***sudden rise in community needs created an unexpected new spotlight on mental health and wellness in their communities, schools, and social service system*** that they could leverage to strengthen and create new partnerships. Several programs described renewed appreciation from partners for the services they were providing, greater trust in and reliance on their services within non-mental health settings, and opportunities to extend their reach through new partnerships:

I think now that the resources that the mental health team are providing to the community are kind of at the forefront and I think COVID has amplified that, it's providing a tremendous opportunity for us to collaborate with [school], in particular around asset mapping. [Child/Youth Program Lead: P16 I079]
I think at the district level, they've evolved to see this as a priority for wellness and COVID probably contributed some to that. [School-County Collaborative Program Lead: P18 I032]

Other ***durable challenges for programs were also linked to administrative or leadership decisions beyond the scope of authority of the program leadership or staff***. Many programs experienced persistent challenges related to loss of access to their normal program sites, including schools, hospitals, and police stations. Several programs were also impacted by hiring freezes and restrictions that were initiated at the start of the pandemic and affected their ability to fill existing vacancies in their programs or adapt to staff turnover during the pandemic, resulting in one SB-82/833 program being essentially suspended as a result of decisions at the county level not to hire a new clinician for the program. Another program did not begin until the end of 2020 due to a pandemic-attributed delay in review by the county's board of supervisors.

Efforts around ***revenue generation and sustainability planning were also affected by the pandemic***, not least by reducing the amount of time available to program leads to consider their options.

…I think we've just all been in this parallel process with COVID of survival mode, trying to just get on to the next thing, making sure that all the students are sort of getting their basic needs met, making sure this program can stay afloat, all the current information… it's a changing process everyone just sort of knows. So, we've all kind of been keeping our heads above water, but not really being able to get out of the water and say, ok, what are we looking at now. [Child/Youth Program Lead: P05 I089]
Now, it doesn't mean that we can't engage [in] the conversations, find the right people, make sure that they're getting into the room together, you know those sorts of things because we do and will. But COVID did set us back hugely. [School-County Collaborative Program Lead: P18 I054]

To the extent that programs were able to step back and have conversations around revenue and sustainability in funding, however, they were also affected by conditions created by the pandemic. Efforts to estimate potential revenue generation through Medi-Cal billing, for example, were affected by pandemic related shifts in program demand, utilization, and even changes in the conditions of service delivery (such as telehealth). One program lead noted that without the COVID-19 pandemic:

…you probably would have a better baseline as to how we can sustain the program and how many units can be potentially Medi-Cal reimbursable services and how many are not. [Child/Youth Program Lead: P05 I089]

At a broader level, the pandemic also created greater uncertainty on what types of short and long-term funding options would be available as both counties and school systems grappled with anticipated but uncertain impacts on their revenues and budgets. Even one of the programs with the most robust pre-developed sustainability plans explained:

…that's where COVID has kind of wreaked a bit of havoc is… the unpredictability of the [funding] landscape. [School-County Collaborative Program Lead: P01 I010]

A common refrain among program leads was that, with regards to the pandemic, "no one knows" what the future will bring.

In ongoing program implementation, though, programs also faced challenges to the extent that ***community and county resources on which they depended were no longer available or severely impacted by the pandemic***, including psychiatric hospitals and other crisis care facilities, emergency rooms, medical transportation, outpatient services, and juvenile probation. Given the extent to which programs are linked with such resources both to deliver their services and refer youth and families, such indirect losses were challenging for programs:

…a lot of the community providers are still not doing in-person… services those that are, are really impacted. So, I think that's probably one of the barriers, at this point we don't have any [barriers to delivering crisis response], but that it's the community services that we try to link families to that [are] impacted, that is impacting their ability to get services. [Child/Youth Program Lead: P02 I096]
it's totally affected those relationships because you know we have a hospital, you know, inpatient psychiatric unit for adults, but they only take people who are COVID negative and that affected our, our crisis stabilization unit, also it takes only people that are

> *COVID negative. They are in the same building as the inpatient and so… things are sort of moving down in that situation.* [Child/Youth Program Lead: P11 I063]

Restrictions on COVID-19-positive patients in psychiatric care facilities combined with capacity problems at hospital emergency departments created an especially significant challenge for some programs, who described both tension with emergency departments and few alternative options for acute psychiatric crises:

> *It got worse just because of the pandemic and the emergency departments getting filled with COVID, and you know the hospitals kind of reaching capacity, and them not wanting any mental health folks in the emergency department at all. So, we really had to scramble to kind of, you know, try to get more creative about placing kids.* [Child/Youth Program Lead: P21 I059]

> *…people are stuck in an emergency room waiting for their COVID test to be accepted [at a psychiatric facility]. So they end up being stuck sometimes for the entirety of their 5150: they're not really getting treatment then. So, they're calling us to evaluate them and see if we can interrupt and provide some additional support. Sometimes we can, a lot of times we can't. It's just a matter of, there's… nowhere to take them. They're not accepting them.* [Child/Youth Program Clinician: P12 I076]

> *I think that one, one of the relationships that especially since the COVID, has… taken some extra massaging and working with is with the folks in the emergency rooms. Just because that is where we're bringing all of our holds and the police are bringing all of their holds. And so, like I was saying earlier, there will be sometimes seven or eight people in beds waiting for placement at a hospital and four of them have COVID. And nobody is going anywhere anytime soon. … And I think that… they understand… that's the only place that we can take him. But when we're coming in with our fifth hold… We kind of get… the sighs and… I know they understand but it really does—it's kind of creating these de-facto inpatient units in emergency rooms and they're not necessarily equipped to deal with it.* [Child/Youth Program Clinician: P14 I097]

These challenges compounded existing deficiencies in dedicated community and county resources for child and youth mental health crisis.

Finally, ***the pandemic also exacerbated other existing equity and access problems in meeting the mental health needs of children and families***. Program staff described concerns that the increases in basic needs they observed represented an expansion and deepening of existing social inequalities. Moreover, staff observed that the shift to remote and hybrid schooling and increased utilization of telehealth created new opportunities for inequity in access to mental health crisis services. These concerns were often expressed by program leads and staff in counties with more rural regions, which lack the robust high-speed internet infrastructure of large urban centers, and programs servicing regions where a significant percentage of households experience poverty:

> *…we're experiencing a bunch of different kinds of challenges that we never expected to experience, so, you have connectivity issues… like do our clients have the kind of technology that they need, do they have telecommuting equipment, do they have phones, do they have internet service?* [Child/Youth Program Lead: P20 I034]

> *A lot of parents don't have computers, they're using their phones. So, that's another barrier for us, just because maybe they don't have enough memory to download Zoom or whatever it is. And you know, before, in-person, we would be able to teach them how*

> *to download the app or whatever we were using…* [School-County Collaborative Program Lead: P10 I098]

While telehealth makes possible new opportunities to overcome geographic distance in access to mental health, these opportunities can't be fully realized if inequalities in access to technology exist. While programs were often actively involved in linking clients to resources and breaking down these barriers where possible, when programs did not have access to the resources needed to mitigate or eliminate them, they remained durable challenges to program implementation

4.3 Inner Setting

While the inner setting of implementation specifically concerns the features of the implementing organization, this structure is hard to clearly demarcate for SB-82/833 programs in general, as well as many individual programs, due both to the complexity and inherent cosmopolitanism of most programs. Many organizations or agencies that would be considered the outer (or, external community) setting for one program are directly administering or housing program operations for another, especially for school-based programs and programs that contract some (or all) of their services to an external agency or organization. Even within individual programs, structural complexity may result in different program components having different relationships to a single organization, such that the organization comprises the inner setting of one component and the outer setting of another. The organizational complexity of programs also complicates the distinction between inner and outer setting, as some programs are negotiating multiple inner settings (including organizations that are contracted to provide services) or are housed in organizations that don't have direct authority over implementation but control resource and access to information that constitute the inner setting. Therefore, as a corollary to previous findings on the complexity and inherent cosmopolitanism of programs, ***triage crisis programs are sufficiently complex and networked that, on a practical level, they break down distinctions between which organizations are best understood as implementing organization(s) versus partnered organizations***.

While continuing to adopt the *conceptual* distinction between these two contexts, the features of these programs mean that it is not always practical or even helpful to fully disentangle which organizations are which. This section therefore addresses findings related to the aspects of implementation that are most immediately proximate to the delivery of program activities and services on an ongoing/day-to-day level (including but not limited to the SB-82/833 program teams themselves). These are organized into:

1. findings on the ***structural characteristics*** of implementing organizations, including the ***social architecture*** of their internal units and the ***stability of their staff***
2. findings on the ***networks and communication*** within the implementing organizations
3. findings on ***organizational climate and culture***, including programs' ***compatibility*** and ***relative priority*** within those organizations
4. findings on the ***readiness for implementation*** of organizations, including the ***extent of leadership engagement*** in implementation and the ***availability of organizational resources*** for implementation

Detailed analyses and data tables on program lead survey items on programs' ***team stability***, ***compatibility***, ***relative priority***, ***leadership engagement***, and ***availability of organizational resources*** by program maturation, school-based status, and urban/rural county can be found in Appendix C [sections C.1.3–6, tables 26–29, 30–37].

4.3.1 Structural Characteristics

Findings on the structural characteristics of implementing organizations involve the relationship of SB-82/833 programs to other organizationally proximate service teams and the relative stability (or turnover) of staff that impact program operations.

Social Architecture

Paralleling their relationships with multiple organizations***, SB-82/833 programs are frequently closely integrated with or embedded in organizationally proximate service teams***. While some programs operate relatively autonomously within their implementing organization, many work hand-in-hand with existing team(s), especially (but not limited to) the programs defined as augmenting. Some programs perform functions that require direct coordination with another localized team (e.g., to receive referrals, engage in care coordination, or conduct handoffs) such that their day-to-day workflows are intertwined with those teams. Some SB-82/833 staff are not part of a wholly separate program, but rather perform a dedicated triage role in a larger team that receives funding from multiple sources (such as county/municipal funds, other grants). Some programs are at least partially integrated with other teams because their funding does not support enough staff hours to meet demand, relying on support from another team to stopgap during the hours or days when their program is not operating (including in some cases, other county SB-82/833 triage programs). Similar to the relationships programs have with larger organizations, these relationships with other teams often significantly enhance program implementation but also create the possibility of role ambiguity, especially for smaller programs and those in smaller and more rural counties with less resources for mental health services.

Team Stability

Almost all SB-82/833 programs report experiencing some combination of staff turnover and lengthy gaps in staff coverage due to leaves, with some reporting delays to and impacts on their programs as a consequence. Although staff turnover is to be expected in any organization and some is unavoidable (e.g., retirement, medical and family leaves), the relative size of the SB-82/833 programs and their complex interdependencies with both their implementing and housing organization(s) and external organization(s) results in related barriers to implementation in many programs. Our findings address the consequences of and reasons for turnover and gaps in program staffing described by program leads and staff as well as challenges related to hiring and staff reallocation in SB-82/833 programs. While such issues were not uncommon for all types of programs (school-based and non-school based, new and augmenting, rural and urban), ***programs with less staff and those in smaller or more rural (and geographically dispersed) counties may have experienced disproportionate impacts***.

Extent and Impacts of Staff Turnover, Gaps, and Leaves

At least thirteen of the fourteen Phase 1 programs experienced some turnover, gaps, or hiring delays related to their internal program staff. For some programs, this was a regular issue within their agencies and a routine occurrence for their programs:

> *we go through these bursts where three or four or five staff will leave at one time, and then we build back up. And then we have to go through periods of time where… we're well staffed, we keep the same staff for a long period of time, and all of a sudden, they go off in chunks.* [Child/Youth Program Lead: P12 I060]

> *…that's an ongoing concern for our agency, for all of our programs and it's not been any different for this program. Like I said, in this year we have not had a period of time where we've had all… clinician positions filled.* [School-County Collaborative Program Lead: P22 I069]

In survey responses to the statement "Implementation of this program has been significantly impacted by staff turnover, gaps, and leaves," program leads from seven of the fourteen Phase 1 programs responded affirmatively (somewhat agree, agree, or strongly agree). **Table 13** summarizes the responses that leads from these seven programs provided when instructed to select which impacts occurred as a result of turnover, gaps, and leaves (two response options provided, "Hire temporary worker(s)" and "Substitution of permanent staff with volunteers, students, trainees, or interns," were not selected by any program leads).

Table 13. Specific impacts for programs reporting significant impact of staff turnover, gaps, or leaves (N=7).

Impact	Count (%)
Cessation/elimination of services	2 (14.3)
Change in the range or quality of services	6 (42.9)
Outsource services to another unit or community partner	2 (14.3)
Increase in staff work hours	2 (14.3)
Increase in staff case load	4 (28.6)
Reduction in staff productivity	2 (14.3)
Reduction in staff morale	4 (28.6)
Loss of professional expertise	4 (28.6)
Loss of clinical expertise	4 (28.6)
Loss of institutional knowledge	4 (28.6)
Reduction in community access to MH services	3 (21.4)
Reduction in community access to non-crisis-related services	3 (21.4)
Don't know	1 (7.1)

Interviews with program leads and staff also provided insight on the impacts of staff turnover and gaps on their programs, including ***impacts on staff work hours and caseloads***. Program staff describe taking on additional work to fill gaps or even being assigned additional responsibilities outside of their normal job responsibilities. For smaller programs, which have fewer staff to share the additional workload, this can result in a single individual taking on double the responsibilities:

> *we do have a clinician on our team who has actually been out on leave for 7 months. It's really impacted us like [program clinician] doesn't have her clinical peer who would carry half of the workload. That person is unfortunately out right around the time that [program clinician] came in. So, [program clinician] has had to have that responsibility as a new person but also singularly…* [Child/Youth Program Lead: P11 I040]

These interviews also highlight lead and staff perspectives on the ***consequences of turnover and gaps on programs' institutional knowledge and ability to maintain critical relationships and partnerships***. Since organizationally complex and cosmopolitan SB-82/833 programs often depend on the maintenance of complex, long-term relationships between multiple agencies, the loss of the institutional knowledge and social capital of a single individual can constitute a significant challenge to program implementation.

> *…we don't have a replacement identified for [program lead] yet and there's nobody with his depth of experience. …whoever comes into the position is going to, probably have a pretty big learning curve and training.* [Child/Youth Program Lead: P02 I096]

> *there's been a little bit of… just like institutional changes where [program clinician] had established herself. So, she had come in and established herself and you know, as it takes time for, to kind of buildup that relationship in the agency where people are aware that it's a service that's available and then that went away, and everybody is like well that's gone.* [Child/Youth Program Lead: P20 I034]

> *…on a regular day when we're fully staffed I would have, I think it's about seven districts under me, where I would be able to communicate a little bit better with them because you build that relationship with them a little closer.* [School-County Collaborative Program Lead: P10 I098]

A lead for a program with relatively stable staffing (one clinician took a temporary leave, no turnover) explicitly credited that stability as one factor in their progress in improving relationships with their critical partner organizations:

> *…when you have consistent staff, then they can build those relationships and maintain them. If your staff are constantly changing, you know, it's really hard to build those relationships.* [Child/Youth Program Lead: P21 I059]

Another aspect of staff stability related to building and sustaining partnerships concerns turnover at the partner organizations. Nearly half of SB-82/833 programs mentioned challenges related to staff turnover at their housing organizations or in their program settings, including leadership and other key partners. Given the high degree of integration and mutual dependencies with other teams/agencies in many organizationally complex and/or cosmopolitan programs this sometimes posed a barrier to both service coordination as well as sustaining relationships in both the program's inner and outer settings:

> *…one other challenge is… there is a lot of turnover in administrators and staff in some of the schools, so you are constantly developing new relationships. …turnover makes knowledge transfer challenging.* [Child/Youth Program Staff: P19 I091]

In a point of contrast, though, one program noted an unintended advantage to staff gaps in the school housing their program, as it created a new opportunity for them to integrate themselves in the setting:

> *…when we talked about vacancies, I think it actually worked a little bit to our advantage, because on one level with the vacancies it… forced some of the school staff to be a little bit more integrated with the wellness center right away when we were at one of the campuses. The school counselor for the campus was actually in there because we didn't have anyone else right at the moment and was clearly taking some ownership over that which we really liked to see.* [School-County Collaborative Program Lead: P18 I054]

Reasons for Staff Turnover

Program leads and staff described a variety of possible explanations for the turnover in program staff. Although some gaps and leaves are the result of personal circumstances (e.g., retirement, medical and family leaves), staff turnover was often attributed by leads and staffs to factors related to roles, programs, agencies, sectors, and even geographic regions. While it was not, in most cases, possible to identify the precise reasons that individual program staff left their respective SB-82/833 programs, staff insights pointed to major push and pull factors relevant to their programs.

A first explanation concerns ***the nature of crisis triage work***. As one mobile crisis clinician explained, “any program like this, there’s always changes” because of the intensity, especially for new clinicians:

> *I think the nature of the work, crisis work is pretty stressful. A lot of the clinicians that are hired are you know, associates, so maybe it’s kind of hard to come in and do this as your first job or internship or something like that. It’s pretty—it’s not easy. So, a lot of people… it’s just not a good fit for them and then go on to do something a little different.* [Child/Youth Program Staff: P12 I076]

A lead in another program, however, suggested that crisis work is also a difficult fit and possibly unsustainable even for “very skilled” and experienced clinicians since it involves a great deal of “vicarious trauma” and potentially “compassion fatigue.” Staff also acknowledged that the demanding workload of many crisis triage roles may push some staff to find other jobs:

> *one of the things that… that was a big, huge indicator for me was that amount of the sites that we had, and the limited time with everything else. So that was something that—and I know that I can’t speak for all of the staff that had the left—but in conversations that I’ve had with them is that they have mentioned that that was the biggest indicator.* [School-County Collaborative Program Staff: P01 I051]

Program leads and staff also noted that these challenges may be compounded by the ***rate of compensation in public sector mental health services***, which is sometimes lower than the private sector or, for a given county, lower than the public sector pay scales in neighboring counties. This was described as a particular problem for program staff earlier in their careers or in rural areas, who may be taking roles in county behavioral health agencies to gain experience before leaving for the private sector.

> *We don’t really pay enough to attract licensed staff that have experience. We can sometimes get newly licensed staff, but then they get discouraged in a couple of years when they see their classmates going to [large private non-profit health system] or going to [neighboring] county and making ten, fifteen dollars an hour more.* [Child/Youth Program Lead: P12 I060]

> *…experience in the county is incredibly valuable and is a great ticket to getting hired in another position because you’ve dealt with a diversity of mental health issues and presumably, a lot of the times, you get exposed to dealing with acute mental health crises. They get a lot—it’s a great place to get experience, but it’s not necessarily the place people want to stay.* [Child/Youth Program Lead: P19 I091]

> *What we see a lot as far as staffing patterns is we will get students that graduate from [local public university] who are, you know, fresh out of school, very little experience, they hire on with the county. They get a little bit of experience and then they tend to apply for jobs back in either their home where they came from or other larger cities that have a higher pay scale.* [School-County Collaborative Program Lead: P22 I069]

Program leads in another county noted a disparity in both rates of pay and work conditions between the county behavioral health agency and school districts, the latter of which experience lower staff turnover and to which county behavioral health clinicians who leave their positions frequently move. Another program lead even noted an unintended consequence of their own success in building relationships, as several clinicians had left the county to work at partnered agencies. While these are certainly particular challenges for smaller counties with more limited resources, at least one program described challenges retaining county employees who were leaving for a neighboring county with very comparable overall county resources but significant differences in their standard pay scales for mental health providers.

A problem that is likely to be unique to smaller and more rural counties, however, concerns the ***difficulty of retaining staff in particularly remote areas***, especially for structurally complex programs in which program staff are stationed in different regions.

> *I think one of the things that that has maybe also been challenging for those clinicians is that as they are stationed out in the different regions of the county… they're not quite as connected to our main clinic here with other clinicians that are working in other programs. … So, if someone's not really solid and feeling comfortable in the work that they're doing, that could be a pretty challenging position… especially, for a new a newer clinician who may not be licensed and feel like they're out there on their own a little bit. So, I worry that that might contribute to some of our turnover.* [School-County Collaborative Program Lead: P22 I069]

> *I think… actually the biggest problem for us is… if we get applicants from out of county who don't move into the county, eventually they get tired of the commute.* [Child/Youth Program Lead: P19 I091]

In addition to describing possible reasons for turnover, some program leads and staff also described factors that they believe might reduce turnover. One lead in a program that experienced no turnover in the first two years of implementation emphasized the importance of "finding someone who's passionate about crisis work and enjoys it." He also emphasized the critical importance of providing support to staff in retaining them:

> *…it's… really providing a lot of support to staff. Being available for staff, I think all of our supervisors and myself and then, our manager, we carry our phones seven days a week, you know sometimes 24/7. So, if a staff gets in a bind at you know 10:00 o'clock at night, they know they can pick up the phone and call and one of us will pick up.* [Child/Youth Program Lead: P21 I059]

The lead for another Child/Youth program suggested that the inherent challenges of crisis triage work necessitate mitigating its impacts by rotating responsibilities between staff, thereby keeping such roles time-limited. While these observations may help identify some important (or even necessary) conditions for staff retention, however, it is likely that they are not *sufficient.* Indeed, for each of these three recommendations, there are SB-82/833 programs that serve as negative cases in that they experienced challenges with turnover despite having passionate program staff, providing ample support to those staff, and attempts to restructure roles to reduce long-term exposure to crisis on individual staff.

Challenges with Hiring and Reallocation of Staff

Some challenges with staff retention are also relevant to challenges in hiring staff for SB-82/833 programs, for example in challenges related to pay and working conditions in public sector mental health services. Program leads described challenges recruiting sufficiently experienced (and properly licensed) program staff with "wages that are competitive," suggested that some qualified candidates don't want to work for counties because they involved a "burdensome" amount of paperwork or are too "grind" and compliance-oriented, or noted that the hiring processes alone are very slow for government jobs. As with retention, some programs also described the difficulty of hiring staff for isolated areas, both due to the relatively fewer qualified local candidates available and because "not everybody wants to go all the way out there." This may have an outsized impact on programs that serve already underserved communities including rural communities, migrant and farmworker communities, and Native American and other Indigenous communities.

Program leads also described additional factors that they perceived as barriers to hiring, including those related to the structure of the SB-82/833 Triage Grant program. Since grant funding is short-term it can be difficult for programs and agencies to recruit qualified candidates to whom they cannot promise long-term employment or to justify hiring replacement staff to county leadership when a role is vacated for any reason. Some school-based programs also noted that the grant start and end dates created challenges in hiring (and potentially retention) to the extent that they were not aligned with the school year. For programs that began (and therefore also expected to end) during a school year, they expect both a smaller pool of candidates as well as challenges recruiting for positions that are not guaranteed to span a full school year (as the staff will also be disadvantaged looking for a new position mid-year).

Even without such limitations, several program leads described provider shortages and barriers to recruitment related to the specialization and licensure requirements for many program roles. Several programs described receiving either zero applicants or no qualified applicants for a posted position. Credentialing requirements in school systems was mentioned as a barrier to programs that are set in schools. While some rural programs also described particular challenges finding qualified clinicians, this barrier was not wholly unique to them. And at least one program had extensive delays in hiring due to restrictions at the organization housing their program, which required extensive background checks. For some job candidates with lived experience this did not merely delay, but inhibit, program hires.

A final set of factors that program leads identified as barriers to hiring relates to the COVID-19 pandemic. One program noted increased challenges hiring staff to work in field-based roles during the pandemic and another stated that they were delaying hiring for certain field-based roles until pandemic related risk lowered. Several other programs also described pandemic-related administrative decisions beyond their program's authority that delayed or inhibited hiring, including hiring freezes and delays in approving positions. Some program leads also suggested that the pandemic had created a new competitive disadvantage in hiring for their programs as mass shifts to telehealth have led to a rise in private teletherapy:

> *I think it's due to the pandemic. I think it's become too darn easy to be a therapist on Zoom. And there's like companies that are recruiting people and… they will get all your clients for you and all you have to do is sit in an office at home and do therapy. You don't have to deal with billing, you make 100 bucks an hour. It's hard to compete with really and that's happening here and it's happening in other places too.* [Child/Youth Program Lead: P11 I063]

While programs may have limited control over many aspects of recruitment and hiring, some have shown resilience by modifying how existing staff are allocated. However, the same degree of flexibility is not possible in all programs: programs that are structurally complex, especially those with multiple regional teams or teams with staff who have different specializations and credentials, may be less able to reallocate staff. Organizationally complex teams in which all staff are not employed by the same organization have similar challenges in flexibly reallocating staff to fill gaps.

4.3.2 Networks and Communication

Per the social architecture finding (and analogous to their partnerships with external organizations), ***SB-82/833 programs are highly networked programs within their implementing organization(s) and immediately proximate partners***: they both benefit from and enhance other departments and service teams in their organization(s) through ongoing relationships entailing extensive

communication and coordination. They actively collaborate with a variety of internal units in their implementing organization(s) and immediately proximate partners, including:

- crisis intervention and response teams
- emergency dispatch and response teams
- crisis stabilization teams
- agency or organizational administration
- agency or organizational clinical and non-clinical service providers
- full-service partnership teams
- wraparound service teams
- child welfare agency staff
- outpatient clinics and providers
- school wellness centers
- school counseling staff
- other SB-82/833 Crisis Triage programs

Some of these entities are also listed as outer setting partners in the findings on cosmopolitanism (section 4.2.2) because some teams that are external to one program are internal to another or because the distinction is unclear or complex for some programs. Findings in this section, however, are focused on the direct, immediate connections and communications between units needed to deliver core program services and activities rather than the broader dynamics of partnerships between organizations. These direct, immediate networks constitute the primary contexts in which program implementation takes place.

Programs generally report satisfaction with the quality of their inner setting networks, the relationships they have with other units, and the channels of communication within their immediate organization. SB-82/833 program leads and staff report that their teams communicate frequently, both with relevant units and internally using a variety of modes of contact, both in-person and remote, including by phone, text messaging, email, workplace communication platforms (e.g., Slack, Teams), and video platforms (e.g., Zoom, Webex, Teams). Programs report regular use of informal, unscheduled communication as well as routine meetings, both internal and interdepartmental/interdisciplinary.

Much of the communication that takes place within programs involves routinized workflows for service coordination which, due to the nature of crisis triage, often involves handoffs between multiple staff on both SB-82/833 funded teams and non-SB-83/833 funded teams. Especially once programs adapted to budget cuts, ***many programs required active collaboration with teams that are not grant funded in order to carry out the core components of their programs***. For some programs, this is because they depend on another unit to handle crisis calls or referrals to their program, at which point the SB-82/833 program responds. In other cases, SB-82/833 programs work directly with other programs to co-respond, entailing a complex division of labor to carve out roles. As one Child/Youth Crisis program lead explained:

> *…they worked really closely with our crisis intervention program… because we are open and we will accept them if they want to come in and get connected with services, you know, sooner than later. So, they coordinate with one another pretty consistently. It's almost… tough to even separate them, you know, to itemize their roles because they do work in such close coordination.* [P09 I156]

In some cases, SB-82/833 program staff are also fully integrated into larger teams that are not SB-82/833 funded or perform support services that are then carried out by teams that are not SB-82/833 funded.

A final form of integration concerns ***collaboration between SB-82/833 programs in counties that received more than one type of SB-82/833 Triage Grant***. The extent of interaction and collaboration between SB-82/833 grants depends heavily on alignment between the specific characteristics of each program; some SB-82/833 programs have little or no overlap in clientele, type of setting, location, or core care processes with other SB-82/833 programs in their counties and therefore operate wholly independently. Some, however, actively coordinate with either Adult/TAY or School-County Collaborative Programs. Some Child/Youth programs have complimentary functions with respect to their Adult/TAY equivalents, allowing for collaborative efforts for developing and maintaining workflows. Child/Youth programs can benefit Adult/TAY programs by reducing the extent to which adult crisis programs are expected to engage in youth crises, which are often more time intensive as a result of the coordination necessary with families and the more limited set of mental health resources for youth. In some cases, Adult/TAY programs (especially those with a greater amount of funding) also provide support to Child/Youth programs by managing crisis access lines or filling gaps in staff coverage. Child/Youth and School-County Collaborative programs also report successes in facilitating new and mutually beneficial divisions of labor in their respective crisis care systems to ensure more accessible and appropriate care for youth:

Adding the [School-County Collaborative Program] it's basically cut down the calls [from schools] that actually go to our mobile crisis team down to next to nothing, so that team is now really freed up to respond to the most severe crisis situations in our community. …those two teams have worked really well together. And so, it's been nice to see that we're able to utilize our mobile crisis team a little bit more focused on the high end and have the [School-County Collaborative] team handle the school situations. And so, that's been one really nice benefit of this program getting up and running. [School-County Collaborative Program Lead: P22 I069]
…from the past, [schools] tended to call our more emergency services and say we have a child who's acting up in school, can you come and help us? And now we generally turn that over to the School-Collaborative clinicians and contact their supervisor and say, can you go out and assess the situation. And then if they need us, we will help them. [Child/Youth Program Lead: P11 I063]
…one of the things that we had seen last year, we were just starting to get this anecdotal evidence [that] the [Child/Youth Program] that is part of the County, they were… noting that they were finding the schools that had wellness centers were having a lower percentage of students being referred to them, but that when they were referred to them, that they were more likely to be hospitalized. So… we were able to kind of triage a little bit more appropriately on the ground… and then being able to refer to those higher levels of care when they were actually needing. [School-County Collaborative Program Lead: P18 I078]

Child/Youth and School-County Collaborative Programs also reported effective coordination and even co-response to major incidents in their communities.

Each of these configurations of relationships between SB-82/833 funded teams and non-SB-82/833-funded teams—SB-82/833 reliance on non-SB-82/833-funded teams, co-responding or blended teams, non-SB-82/833-funded team reliance on SB-82/833 teams, and collaboration between SB-82/833 programs—suggest that SB-82/833 programs are generally highly integrated into their social service settings. This integration occurs for a few intersecting reasons: ***1) they are designed to fill***

gaps in the social service system, 2) they require efficient and shared use of resources due to limited budgets, and 3) they entail a wide range of crisis care processes that are understood by their counties as best addressed collaboratively. While this level of integration complicates efforts to distinguish SB-82/833 program services and outcomes from those of the systems in which they are embedded, ***it is also a distinctive and unique advantage of such programs in enhancing and increasing the capacity of crisis care systems***. One of the opportunities created by this high level of integration is in strengthening mental health system by improving its networks and creating new means of coordination and communication for greater efficiency:

…it seemed like a lot of these programs and services were oftentimes overlapping and not clearly delineated and that… the pathways for students for accessing these different distinct programs was oftentimes blurring and confusing. And so… something we've also developed over the last two years is having meetings… with different mental health line staff from [other inner setting departments]. … So, getting everyone in the same room on a weekly basis, making sure that all the kids who are needing services are getting services, that we are also not duplicating services; really sort of just coordination of care type meetings and that I think has helped a lot. [Child/Youth Program Lead: P16 I084]
…the [SB-82/833] team and [inner setting department]…, we all work with families. …so we created a family engagement team, we meet monthly and talk about the trending needs that are going on in our community, any resources that are available in our community that we don't know about. We use the planner to build these files, so we have the resources at our fingertips, and we can reach out to each other: "hey, this family needs a mattress, do you know anybody?" [School-County Collaborative Program Lead: P10 I024]

While SB-82/833 programs report that they are generally satisfied with, benefit from, and enhance communication and coordination within their teams and social service settings, there are some factors that seem to impact the quality of networks and communication. One consideration is related to the significant variation in the level of centralization of the networks in which they are embedded as well as program size. On the one hand, smaller programs tend to be more centralized and have an easier time communicating and coordinating with their core team; however, due to their size they are also more likely to depend on other teams, over which they may have limited control, to accomplish their core program services and activities. For larger programs, especially those that are structurally complex, they often have an easier time with communication and coordination to the extent that they are more centralized (e.g., housed in a single location or are actively supervised by a central administrator). For larger and more complex programs that are more de-centralized, a greater degree of communication and coordination is required to maintain regular operations.

4.3.3 Organizational Culture and Climate

Findings on the organizational cultures and climates relevant to SB-82/833 program implementation involve 1) the ***compatibility***, or fit, of the program with both the culture and climate of the organization as well as existing workflows and systems in the organization, and 2) staff's perceptions of the ***relative priority*** of the program in its implementing and immediately proximate organization(s).

Compatibility

A first aspect of SB-82/833 programs' compatibility with its implementing and immediately proximate organization(s) is in the design of programs. Just as SB-82/833 programs are tailored to the needs of

their communities, program leads describe their ***design and tailoring to meet the needs of their social service systems and implementing organization(s)***. In addition to addressing the goals of the SB-82/833 Triage Grant program as a whole, programs were designed to meet a number of specific, identified needs in their respective social service settings that generally fit in one of the following categories:

- filling gaps in existing crisis services
- creating links between existing services and resources
- providing dedicated crisis and triage services for children and youth
- mitigating the absence of critical community mental health resources
- improving capacity for mental health services in schools
- improving the quality of linkages and handoffs
- creating capacity for insurance neutral, “no wrong door” services

Program leads provided details on how these needs were tied to the specific characteristics of their social service systems: that is, leads often described what specific deficiencies or gaps existed in their existing systems and how those distinct needs would be met by the components of their programs. Programs were therefore not merely intended to meet general, holistic goals with respect to the improvement of mental health crisis services but to meet the particular, often quite specific, needs of their systems (as well as communities). Program leads also provided details on ***how the design of their programs was aligned with their organizational missions, norms, and values***, further confirming that these programs were intended to fit with their inner settings, rather to conform to external standards that may not be appropriate or adaptive to their settings. Findings on networks and communications within the inner setting also support the notion that, while they experience some challenges and growing pains, programs are generally tailored to and fit within the workflows of their implementing organization(s).

Where there is ***greater variation in both compatibility with norms and values and existing workflows and systems is for programs whose immediate operations and workflows are carried out in (or housed by) organizations that are not traditionally oriented toward mental health*** (e.g., law enforcement, education, hospitals). In many cases, programs report strong compatibility in such norms and values:

They have a social services unit and so, I think partnering with us really does dovetail into their mission and vision. And I don’t think they see themselves as just policing, I think they see themselves kind of more holistic and their role in the community. So, I think that you know collaborating with us is natural. [Child/Youth Program Lead: P02 I096]
I think there’s clearly a recognition on campus… that, you know, in addition to like all the educational components of learning that… social emotional processes [are] such a big part of that, so I think there does seem to be a recognition that… these components go hand in hand and are very much integrated. [Child/Youth Program Lead: P16 I084]

Other programs, however, describe needing to overcome some tensions between their SB-82/833 programs and the core missions of their non-mental health settings:

> *…overall, I think everyone’s been really collaborative. And, it’s really hard to get people with a school lens sometimes to see why this lens is important to be in schools. I think there’s still some, some different opinions around how much does mental health need to be in schools. There definitely isn’t someone with mental health experience in district leadership teams, and that just means we have to be a little louder, push a little harder*

to make sure that voice… is being heard. [School-County Collaborative Program Lead: P18 I074]

Similarly, some programs, especially new, have experienced ***challenges in setting up workflows that align with the systems in non-mental health settings***, some of which were further disrupted by loss of regular access to these settings during the pandemic. As previously mentioned, additional work was sometimes necessary to resolve role ambiguities so that staff in their setting understood what function the program was designed to play, including how program staff were distinct from existing staff in related roles (such as the distinction between school counselors and crisis triage counselors). Issues of regulatory complexity, such as additional efforts required align HIPAA and FERPA requirement in school-based programs, also posed challenges to some programs as they attempted to develop workflows. In some cases, programs also had to tailor their program activities to fit the workflows of their settings to ensure that program activities complemented, rather than conflicted with, activities within such settings.

For programs that are set in multiple non-mental health sites (e.g., multiple schools, school districts, or hospitals), the extent of efforts needed to ensure compatibility were often either dependent on, or at least varied by, the particular site:

I mean… [site 1 and site 2] have always been a little bit more welcoming of the program, historically the [site 3] has been a little bit more difficult to work with, I guess for lack of a better term. They just, they operate differently. [Child/Youth Program Lead: P21 I059]
We know no two districts are the same and as we have experienced with [school district], no two schools within the same district are even the same. [Child/Youth Program Lead: P05 I089]
…every district is at a different place. [School-County Collaborative Program Lead: P18 I032]

A major factor described by program leads and staff explaining these differences is in the extent of buy-in from, and opportunities for communication with, setting staff and leadership:

I think that what we've learned through this project is that that's immensely important is to have leadership at a site being invested in mental health and open to looking at things in a new way and being open to even having mental health on campus and seeing that that it belongs in a school setting. [School-County Collaborative Program Staff: P18 I073]
But I think the school being involved was very helpful, so they can conceptualize how can they leverage this program, what processes do they already have in place, that this program can leverage with the school, so that it's not disjointed because I got the sense that they really want to sustain it and the need is there definitely: there's no question about that. But how can the school help support the program and vice versa, so that was really nice to see. [Child/Youth Program Lead: P05 I089]
…we also know that there are some administrators that are very hesitant to give us that control and so we have continued to allow administration to have the choice of how [program staff] receives the names and the needs of the students at the school. So, in some cases, the administration remains the gatekeeper and for that we will see those particular school sites, we have fewer number of unique students served. [Child/Youth Program Lead: P01 I010]

> *You're running up against… different ideas about how they want to run your school… I think most of them are really open to this, but some of the administrators play better with others than others do.* [Child/Youth Program Lead: P19 I091]

At the administrative level, several programs tied the extent of leadership buy-in to differences in administrative capacity between schools or school districts, noting better alignment and communication with sites that had sufficient administrative resources they could dedicated to mental or behavioral health as opposed to working with a point of contact juggling a wider range of responsibilities.

Finally, ***some of the variation in compatibility with non-mental health settings may be explained by program design: some programs deliberately chose sites with greater needs with respect to mental health, either related to the needs of the community as a whole or greater needs for support for mental health services at the particular site***. Such programs provide a critical role in introducing and enhancing attention to mental health needs in non-mental health settings, however they may require more resources and effort to achieve alignment in values as well as work within the existing workflows of the setting. Other programs, however, either deliberately selected sites because of their pre-existing compatibility with (or attention to) mental health or worked at sites with which they had already built relationships. Such programs often described this as a significant benefit for their ongoing program implementation. Both models—selecting sites based on greatest need and selecting sites based on existing fit and relationships—have advantages but their relative impacts on implementation also require consideration.

Relative Priority

SB-82/833 program leads and staff generally report that their programs are appropriately prioritized within their implementing organization(s). Some program leads and staff attested to a high level of priority placed on their programs, despite competing priorities during the pandemic:

> *It's definitely a priority. I mean kids are getting so much focus right now, our students, mental health in the schools. I mean so a lot of focus is being placed on children and with [program staff] being dedicated to this, it's our priority for us, most definitely. It's one of our top priorities.* [Child/Youth Program Lead: P19 I057]

> *I think it's a high priority. …I think it's taken off and we've made an impact, far deeper than they thought that we would. And the schools are even recognizing it and so now they're having even more and more requests than we can handle in terms of sites that want [program staff] and also want training. And so, I think they are making it a priority.* [School-County Collaborative Program Staff: P01 I037]

Several program leads were also realistic about the need to prioritize the program alongside other critical projects—especially given limited resources—though some specified that this did not mean that programs were necessarily deprioritized with their systems:

> *I run multiple contracts, so I try to prioritize them all, I mean equally. They all need their own love and support, and you know, I gotta do each one…* [Child/Youth Program Lead: P14 I013]

> *…they could have possibly more, maybe visibility, but I feel like they are… being prioritized in terms of just the communication, the coordination, and the involvement, even with follow up. You know, we're making sure that we're consulting with them just to keep them a part of the conversation after they've connected clients. So, they are really, I believe that they are important in our crisis program.* [Child/Youth Program Lead: P09 I156]

…we're committed to it; it is a priority. I just think it's really unfortunate that… in a time when there's so many other competing priorities that are really, really extremely relevant. And it's not that it's any less of a priority, it's just that there's so many other priorities that are competing with it. [Child/Youth Program Lead: P20 I034]
I don't know how it's prioritized over any other program necessarily… So, I don't know if it's necessarily prioritized, but… there isn't less focus on that than other programs in the department, so. And we definitely recognize the importance of it. [Child/Youth Program Lead: P21 I059]

Many program leads and staff also expressed that they felt that their program was appreciated by their partners, even if there was effort needed to overcome issues with compatibility and value alignment:

We think they love it. They've done press releases that they love it, they told [program lead's] team that they love it; they have been very positive. I know that the original [site leaders] were even more extreme in their positivity, I don't know if the latter group has been quite as enthusiastic, but they have been, they've touted the program again, they've done press releases, they've done joint kind of media sorts of things, and they continue to get really good kudos to the staff that are there. So, I think it's really been positive. [Child/Youth Program Lead: P02 I054]
I think that… especially the administration in the schools is just so grateful to have us. I mean that's what we've been hearing. Just last week we had a crisis situation at the very end of school and an administrator was dealing with it, but he was very grateful, it was really out of his realm and comfort zone and really professional skill level. And, he was able to give a warm handoff to the wellness center and we were able to address that appropriately and get the student the help that she needed. So, I think that this school, I mean this is the quote that's been said before is, "once you have a wellness center, you won't not have one." Because there's so much value to it and shifting of the culture is such a huge piece that. [School-County Collaborative Program Staff: P18 I073]
It feels like, from the feedback that I get, that they're happy with the program overall: mostly response time. They are super happy that someone is coming out. [Child/Youth Program Clinician: P14 I097]
…for [sites], they love the program. They really appreciate us being there, they appreciate us dealing with the kids and trying to move the kids off the [emergency department] beds as quick as possible. [Child/Youth Program Lead: P21 I059]
…at the end of the year I sent out a survey to the administrators asking you know, what was most helpful, what was least helpful, what would you like to see more of and consistently across the board, I think at all… sites, was "we need them here more." So that's the consensus that everybody sees the value and they want the service, but then there is this financial piece that's a barrier. [School-County Collaborative Program Lead: P01 I019]

As with compatibility, ***the greatest variation with respect to programs' relative prioritization was for programs set in non-mental health settings***. While programs generally felt that their contributions were recognized and appreciated, variations in compatibility with the values and norms of the setting sometimes translated into variations in how much priority was placed on their ongoing operations in these settings. For some programs, their lack of prioritization (and efforts to overcome it) is itself indirect evidence for how crucially needed their program is within that setting. While

constituting a barrier to implementation, therefore, it is simultaneously an illustration of how such programs contribute to their settings. The pandemic, in some cases, magnified these challenges as non-mental health settings such as schools and hospitals were operating under especially constrained circumstances and limited resources:

I think the hospitals, obviously they want to provide the best care they can, but they also want to prioritize care for the folks that need it the most. And a kid who's in a psychiatric crisis who is just waiting for an LPS bed, isn't necessarily the most appropriate person to be in an emergency department bed. [Child/Youth Program Lead: P21 I059]
I feel like our program or at least my schools, has really been put on the back burner. So, they don't really have, they haven't put our program or what I do as a big priority and they're really just trying to get kids to log in and attend classes and so, it's, they haven't really you know. I think the lack of time, not because they don't want to. Just lack of time and having other things on the top of their priority list as far as figuring out how we can deliver services or connect with the kids when they can't even get them to connect to class. So, I think it's been harder to reach them or get them to make this a priority because right now they're really scrambling for attendance in general. [School-County Collaborative Program Staff: P01 I037]
I think they're trying to figure it all out and focusing on maintaining their operation during COVID while protecting their staff, making sure that they don't have too many staff that test positive, so that they can't cover the shifts. You know, same thing that every organization is probably dealing with. [Child/Youth Program Lead: P02 I096]

SB-82/833 programs also described their ***engagement in work to overcome resistance, advertise their services, and get buy-in from leadership to ensure that they are properly prioritized and utilized within their settings***. While some of these activities were aimed at building broader partnerships and strengthening institutional relationships, they also included practical outreach efforts to ensure that relevant staff within organizations knew how to use SB-82/833 services and who to contact for information. Many programs were innovative in developing customized means of making the program a priority for settings, such as by hosting meet and greets to integrate staff into their settings, delivering individualized messages to organizational staff, preparing resources for mass distribution to organizational leadership and staff, proactively involving themselves in organizational activities and initiatives to raise the profile (and advertise the value) of their programs, making regular visits to sites to provide program updates, and spearheading new initiatives for changing the climate of the setting with respect to mental health. One program noted that having their staff already funded by the SB-82/833 Triage Grant program was a particular asset in these efforts:

Having the triage staff placed in these schools already funded gave us leverage. So we said to these principals, if you're going to have these services on your campus, this is what you have to give: you have to give time at your staff meetings, you have to you know, support our [program] teams, so we've got some more leverage at those sites. [School-County Collaborative Program Lead: P05 I065]

4.3.4 Readiness for Implementation

Findings on readiness for implementation involve the amount and quality of program ***leadership engagement*** with their SB-82/833 program and the ***resources*** that are made available to the program.

Leadership Engagement

Interviews with SB-82/833 program leadership indicate that ***program leads are well-informed about and generally very passionate about their SB-82/833 programs and teams***. In addition to appropriately prioritizing programs, program leads were generally described in positive terms by program staff, with some singled out for exceptional praise. Most programs have multiple leads that take on different administrative, supervisory, and clinical responsibilities based on their roles within the implementing organization(s) and their areas of personal expertise. Programs with a greater degree of structural and organizational complexity often have a correspondingly higher number of leads, requiring greater coordination to ensure smooth program implementation. Especially for programs that are operated by a different organization than the organization that received and administers the grant—as with some partnered programs or programs that contracted all or some of their services—there is often wide variation in the type and level of engagement each lead has with the day-to-day operations. Program lead interviews therefore provide insight into a variety of types of ways that program leads, both administrative and day-to-day, engage with and facilitate their SB-82/833 programs.

Program leads, both administrative and day-to-day, variously engage with staff, program inner settings (both implementing organization(s) and immediately proximate organizations), and program outer settings (including critical partner agencies and organizations and community resources). Engagement practices in these domains that are aimed at facilitating their SB-82/833 programs are summarized in **Table 14**.

Table 14. Leadership engagement practices to facilitate implementation

Domain	Practice
Engagement with staff	Managing and coordinating with staff
	Problem solving and eliminating barriers
	Actively collaborating to promote program co-ownership
	Mitigating strain and burnout
Engagement with program inner setting	Coordinating with leadership in other units
	Securing resources and funding
Engagement with program outer setting	Building and maintaining relationships with critical partner organizations
	Securing resources and funding

Leadership Engagement with Staff

Managing and coordinating with staff commonly occurs using regular meetings, supervisions, and informal support. Some leads describe particular efforts to ensure that they ***maintain regular***

channels of communication and are available to staff, especially given the demanding nature of crisis triage work:

…[program lead] is a very relational leader and so he is in constant contact with the team through meetings through you know just pulling up beside somebody's desk and just talking. [Child/Youth Program Lead: P16 I079]
They get called out to some very heavy things and so, sometimes they'll say, "this has been a tough call," and I'll say, "Okay, well when you finish up your call, then I want you to call me back, so we can de-brief at least for a little bit." And that, I think has really been helpful for the teams, I know it's incredibly helpful for me as kind of a line staff supervisor to stay grounded in the work that they're doing every day and kind of really have a good understanding of what they face on a day-to-day basis. So, that consultation piece has just really been something we fought to keep in the program because it is time consuming, it is disruptive, but it's really, really valuable. [Child/Youth Program Lead: P12 I222]

Some of the support provided entails ***working with staff to identify and solve concrete problems as well as remove broader barriers to program implementation***, which was appreciated by the staff in several programs:

If there is some barrier or obstacle that comes up or another agency partner is not cooperating or being responsive, [program lead] will help us to speak to whomever we need to speak to, so we can remove those barriers. [Child/Youth Program Staff: P11 I040]
My supervisor is really good too about creating space for us to prioritize the work and if we ever did run into challenges, they are there to sort of help like problem solve. Again, I don't feel like I've had it with the people I'm working with, but sometimes other clinicians might run into trouble with this a school district and then, that level will pop in or it sounds like sometimes there's been… confusion about each other's roles. And so, that level will pop in and try to figure it versus just leaving line staff to figure it out on their own. [School-County Collaborative Program Staff: P22 I053]
…it feels like… from [program lead], even on up to his supervisors for [implementing organization], they'll come down and evaluate the programs that they're running down here, and you know every time they come down there, they're asking, "you know what? What do you need? What can we do? How can we support you?" … You can tell it's not like an act like they are really invested in what they're doing so, that when you have that support from higher up, then it just makes you more motivated to do your job better. [Child/Youth Program Clinician: P14 I097]

For some leaders, support for staff also comes alongside ***efforts to ensure that program staff feel empowered through genuine, active collaboration to promote a sense of program co-ownership***. Many program leads made visible, often conscious, efforts to demonstrate to their program staff that they respect their expertise and consider their programs to be a collaborative effort:

I think it's a testament to [program leads'] leadership that they did include [program staff] so much… both, in decisions and in, "okay, that that system didn't work, let's create a new one." I think they felt very much that they've been a part of the process, that they have been part of the design, that they've been part of any corrections that have needed to be made. And so, I think when you do that rather than just kind of plunk people into something that's already in and say: "go." They've been able to have input into all of that and I think that that has really shown throughout the process and I think they have a lot of ownership of it because of it. [Child/Youth Program Lead: P02 I054]

…it's very much a low power differential and I think culturally even with [implementing organization], we lead with that because it definitely is a partnership. And I think that's what has made this whole group successful. [Child/Youth Program Lead: P05 I089]
I think the main thing is that we try to create that atmosphere here, you know, the work we do is tough, it's hard, but we're going to learn, we're going to make it a learning environment, we're going to help each other, and we, you know, together we can do this stuff; and I think we do a pretty good job of that. [Child/Youth Program Lead: P12 I060]
I have a very collaborative style and, you know, I don't implement things to staff. You know, we collaborate on them together and come up with a mutually beneficial goal. [Child/Youth Program Lead: P16 I079]
I believe our leadership is great. They're very supportive, they've always backed it up with everything that we need, we think they're very open. They have an open-door policy and they're very active in what we're doing, they know exactly what's going on, and our communication with them, I believe it's a great relationship with all of our leadership. [School-County Collaborative Program Staff: P10 I098]
[Program lead] respects us, and, trusts us and gives us tremendous liberty and has a lot of confidence in us. So, that's very empowering as a line staff person to be working for someone like that. [Child/Youth Program Staff: P11 I040]

A final form of engagement with staff that particularly facilitates program implementation is in ***efforts to mitigate strain and the risk of burnout for staff***. For some leaders, this was identified as a critical component of any crisis service staff management due to the intensity and proximity to crisis of such work. However, especially during the pandemic, when staff were simultaneously experiencing a global crisis while attempting to manage crises in their communities, some leadership placed a high emphasis on ensuring that self-care was part of their regular communications with staff:

…my sort of leadership style is really about sort of doing a couple of things to really mitigate and support self-care. One of them is really technical supervision, …having a dedicated time where you're able to sort of unpack and unload just the reality of what this work, the toll this work takes on you. Within the vein of that… I'm big on asking staff, "you know, I've noticed you haven't been off nine months, hey what's going on?" … So, really making it explicit that I expect staff to take care of themselves, that I expect staff to take time off, and to really help them look at, while you are a piece in the health and welfare of the student you serve, you are not the only piece. [Child/Youth Program Lead: P16 I079]
we're looking at schedules, what can we do, we're constantly talking about what can we do to keep our teams healthy and able to do this work. If we're not doing that, and as a leadership, I think that we are really missing the ball because that's our, I do my job, is to find ways to make sure that they can continue to do their work and to do it well. And so, if we don't talk about self-care, if we don't talk about burnout prevention, if we're not looking at that stuff then, and I think I'm doing them a disservice. [Child/Youth Program Lead: P12 I222]

Leadership Engagement with Inner Setting

Program lead engagement related to the implementing organization(s) and immediately proximate organizations is frequently aimed at ***building and sustaining strong networks within their organization(s) that facilitate program implementation***. Much of this takes the form of regular communication and coordination with leadership in other units to ensure that programs are

adequately understood and supported by the implementing organization(s), as well as that program activities are properly integrated into the larger workflows of these organizations and settings.

I have the ear of my division manager and so, any needs or concerns that come up, if [clinical supervisor] brings something up to me, I bring it up to the division manager and then the answer just runs back downhill. So, that's always been a very stable, very organized process for just gathering information, understanding resources. [Child/Youth Program Lead: P16 I079]
…we have a meeting every two weeks of our [program], kind of our leadership team, so… I joined that along with [other program lead], our analyst who helps with some of the implementation and data collection, and then we have representatives from school districts kind of the leadership team. That really is our core group that checks in about more bigger picture, how is the program going, what's new with program, if there's any problems of specific districts, or more recently we've been talking about sustainability of the positions and what do as we are looking towards the grant wrapping up and things like that. So, that's more of an upper level, bigger picture meeting that happens every couple of weeks. [School-County Collaborative Program Lead: P22 I069]
…as a program manager, I am on the executive team, so cabinet level, if you will, in our organization. And on that team are the… leads for different larger teams. On that is the director for our [immediately proximate organization]. So, we meet monthly as well. Our partnership with them, again, not to take it lightly, but it's been a partnership because we are the same big organization forever. It's just that assumed relationship of linkage and support. [School-County Collaborative Program Lead: P10 I049]

A particularly critical leadership engagement practice that comes from these coordination processes is ***work to secure resources and pursue funding for programs***, both to sustain ongoing operations and to plan for the end of the grant period.

…there is 100% commitment from me as the leader and I am the one who sort of makes decisions and allocates resources, so if something is communicated to me and it's in my wheelhouse to do it, it will get done. And if I can't do it, I would just keep kicking someone's door until they give it to you. [Child/Youth Program Lead: P16 I079]

Details of these funding and sustainability planning efforts are discussed in section 4.5.3.

Leadership Engagement with Outer Setting

Leadership engagement with external partners is largely centered on ***building and maintaining relationships with critical partners*** to translate ad hoc or informal relationships into more routinized, sometimes even formalized, partnerships. Given the inherently cosmopolitan, or partnered, nature of SB-82/833 programs, such relationships are rarely completely top-down, so leadership often act more as facilitators of, rather than the sole drivers of, partnership-building. As SB-82/822 program staff are often instrumental in both establishing and sustaining relationships with external partners, leadership engagement sometimes takes the form of providing support for those staff efforts, including providing resources and contacts that make such relationships possible or making sure that all appropriate parties are brought to the table for crucial cross-sector conversations, rather than allowing coordination to be siloed or restricted only to higher-level leadership. Similarly, leadership also facilitate program implementation by using their access to leadership networks to identify new resources and funding streams from outside of their implementing organization(s), including grant opportunities and community assets.

Available Resources

Findings here address available resources linked to programs' inner settings, that is, the resources made available by their implementing organization(s) and the other immediately proximate organizations in which program implementation is carried out, as well as resources available from the funding provided by the SB-82/833 Triage Grant program itself.

Several programs attribute the limits of available resources for their programs to broader, systemic deficiencies in funding and resources for mental health services and community assets for mental health in their counties and the state of California as a whole. To the extent that implementing organization(s) do not have sufficient resources at their disposal to fully meet the needs of their communities, limits in resources provided by implementing organizations are thus understood by many program leads as a function of those systemic deficiencies rather than allocation failures within their agencies and organizations. Discussions of inner setting resources with program leads in counties large and small are therefore often centered on work to overcome a general lack of available resources:

> *…you know these are all completely overstressed systems.* [Child/Youth Program Lead: P16 I084]

> *I don't think there's ever enough resources, especially for mental health in California, in any state. I mean… we always need more resources, but we try to pull from wherever we can and come up with solutions.* [Child/Youth Program Lead: P14 I013]

> *…we haven't had the ability to augment any of the programming and I definitely would not say that we have… sufficient or more than enough resources. We are just always really working hard across all of our programs to strategize and figure out how can we make things work, you know, how can we best serve, how do we prioritize our resources. So, I just think it's an ongoing kind of shuffling to make sure we're meeting kids needs and families' needs. But, you know, budget, budget challenges are very real.* [Child/Youth Program Lead: P09 I041]

Indeed, as one program lead noted, if their agency already had the internal resources to provide the services funded by the grant, they would not have applied for the grant in the first place.

Within these limits, program leads describe ***resources that implementing organizations do provide to support their SB-82/833 programs, most notably personnel in the form of administration and analysts, supplies and equipment needed for operations and service delivery, and infrastructural resources including facilities and data systems***. They also provide the linked services with which SB-82/833 programs are often embedded or otherwise integrated and without which many programs would be unable to operate, as discussed in sections 4.3.1 (Structural Characteristics) and 4.3.2 (Networks and Communication). While programs report that they are able to supply what they need to ensure that programs are able to operate, following the discussion of initial grant funding in section 4.1.1 (Descriptive Characteristics: Grant Funding], they note that these often constitute hidden costs of—and thus ongoing barriers to—running such programs, requiring considerable effort to sustain.

> *…as you know this is for personnel only. So, we do have to leverage other funding in our department to help support, you know, like client support, transportations, all those things that comes with the program. So both, you know, physical resources and also trainings.* [Child/Youth Program Lead: P09 I011]

The effort required to meet these needs also varies to the extent that, beyond systemic deficiencies in resources for menta health, counties vary widely in their available resources and therefore the resources they can provide to their SB-82/833 programs. Smaller counties, in particular, describe significant limits to their capacity to provide administrative personnel, data infrastructure, analysts and

research support, and quality assurance. For many of these programs, such functions are also performed by the same individuals operating the SB-82/833 program itself. Larger counties, on the other hand, may be able to depend on dedicated departments that perform these functions and more robust infrastructural resources to support them. While some larger counties also reported significant budget challenges and pressures on their health systems, they are still more likely to report having dedicated resources (however thinly stretched) that are not available in smaller counties.

Beyond the organizations that directly implement (and administer) SB-82/833 programs, the ***immediately proximate organization(s) that house many SB-82/833 programs, including partnered schools/school districts, hospitals, and law enforcement agencies, are also important sources of program resources***. While these organizations are often also reported to be "overly stretched," many program leads expressed appreciation for the efforts made by these partners to ensure that they had crucial resources, most notably appropriate and adequate space:

I mean space is a big one, so yeah, I mean we're guests on campus and they let us use the health center … when most folks check out the health center for the first time, they're like, "oh wow, this is… really fantastic that students have active access to this on a day-to-day basis." So, that's… a big resource. [Child/Youth Program Lead: P16 I084]
…schools have been really good about you know finding space, space for teams, from helping teams get what they need. [School-County Collaborative Program Lead: P22 I069]
…the schools, all the districts have provided things in space and collaboration. So, they've provided a lot of in-kind supports to make it happen, all of that costs a lot of money. I know in some other counties, they funded just the space, and the school district funds the staff. But, you know, I think they've been generous in that area. [School-County Collaborative Program Lead: P18 I032]

While the quality and extent of these resources often varied from site to site and the COVID-19 pandemic, in many cases, resulted in significant changes to or temporary elimination of space and resources, such in-kind contributions were necessary for the implementation of many SB-82/833 programs.

The ***biggest areas where program leads reported insufficient resources, either from their implementing and immediately proximate organizations or from the SB-82/833 Triage Grant program funding, were in personnel, both clinical and administrative***. **Table 15** summarizes responses to program survey questions on the adequacy of staffing for their SB-82/833 program activities and services. Leads from only eight of fourteen Phase 1 SB-82/833 programs agreed that their programs had adequate staff for its activities and services or for program administration and leads from only six programs agreed that their program had adequate staff for data coordination and reporting.

Table 15. Phase 1 program lead attitudes toward adequacy of program staffing (N=14)

Response	Count	%
This SB-82/833 program has adequate staff for its activities and services.		
Strongly Disagree	0	0.0
Disagree	3	21.4
Somewhat Disagree	1	7.1
Neither Agree nor Disagree	1	7.1
Somewhat Agree	2	14.3
Agree	5	35.7
Strongly Agree	1	7.1
Don't Know	1	7.1
This SB-82/833 program has adequate staff for program administration.		
Strongly Disagree	0	0.0
Disagree	3	21.4
Somewhat Disagree	2	14.3
Neither Agree nor Disagree	0	0.0
Somewhat Agree	2	14.3
Agree	4	28.6
Strongly Agree	2	14.3
Don't Know	1	7.1
This SB-82/833 program has adequate staff for data coordination and reporting.		
Strongly Disagree	1	7.1
Disagree	2	14.3
Somewhat Disagree	5	35.7
Neither Agree nor Disagree	0	0.0
Somewhat Agree	3	21.4
Agree	2	14.3
Strongly Agree	1	7.1
Don't Know	0	0.0

Interviews with program leads and staff provide details on these perceived challenges with staffing. While adaptations made to programs following funding cuts meant that they were still able to appropriately target both the goals of the SB-82/833 Triage Grant program and their local needs, they also left programs with very tight resources to do it. These limits, combined with challenges with staff stability in many programs and challenges associated with the pandemic, led many programs to describe their programs as insufficiently staffed:

> *I think there's just not enough. There's not enough of us, there's not enough resources for all the children who need.* [School-County Collaborative Program Staff: P10 I061]
> *And enough time, too. We run out of time really fast.* [School-County Collaborative Program Staff: P10 I098]

> *…we are very small team and [school] is a pretty massive campus.* [Child/Youth Program Lead: P16 I084]

…there is not a lot of… bodies there to cover the stuff that needs to happen. [Child/Youth Program Clinician: P11 I075]
I think what we've learned over this year is that the… clinicians and the school positions that we have, just aren't enough. They're very busy. They get a lot of referrals and, well, it's incredibly helpful, and it's been a great partnership. I think everyone feels like we're just kind of scratching the surface of what these staff can really provide to schools and students. [School-County Collaborative Program Lead: P22 I069]
There's days when we can't even get to everyone that the hospital wants us to see. [Child/Youth Program Clinician: P12 I076]

While programs were able to provide services despite these limits, doing so was described as a "struggle" which, for some providers, compounded the inherent challenges of crisis work. It also impacted how some teams operated, limiting the time available for consultations and supervision, case management and follow-up, and routine team coordination and check-ins. In addition to limited clinical personnel, many programs also described challenges related to the lack of funding for administration, operations, and data and evaluation efforts. While grateful for the program personnel funded by the grants, programs recognized that operating complex (though crucial) services is time and labor intensive, and more so when it also involves contract monitoring and evaluation commitments associated with a grant.

For programs in smaller and more rural counties, as well as some who received smaller grants, challenges related to limited resources for both clinical and administrative personnel were reported to be especially acute. Clinical staffing is often difficult for such programs to both maintain and balance given the combination of "limited resources and staff" and the inherent inconsistency of demand in crisis services:

…a lot of the times it's feast or famine and… it's hard to maintain staffing for when there's a lot of problems, and then what do you do when there's not a lot of problems. So, it's juggling: do we have enough resources or do we have too much resources for the current situation and how do we maintain that for our staff when there is a lot of problems. [Child/Youth Program Clinician: P19 I091]
…part of the grant is awesome, and I really like it. It's the part where we just get overwhelmed because we don't have enough staff to meet their need. And then you know, there are days when there aren't any kids in the hospital. Crisis is always like that. You know, it's up and down, and… some days, there is nothing to do because there are no kids in the hospital. So, of course, they fill their time with follow-ups and check-ins with the family and parents. [Child/Youth Program Lead: P11 I063]

Programs in smaller and rural counties also faced challenges in supplying adequate personnel for program administration, contract monitoring, and data and evaluation:

…[urban counties] have staff to do those things and we don't. We're wearing multiple hats and we have limited time. [Child/Youth Program Lead: P19 I091]
…looking back it would have been great for us to have a dedicated analyst to all of our grants, just specifically who knows them inside and out. And we've done the best we can, and my hat goes off to [county staff] especially, she's been amazing. But oftentimes it's super challenging because… she's in charge of contracts and other data reporting, and other things that are on her plate. And so, it stretches our staff pretty thin, and we don't have additional county funding just to add positions and that's where ideally, we would have some additional support for the grants. [Child/Youth Program Lead: P11 I069]

4.4 Individual Characteristics

Findings on the individual characteristics of the leads and staff implementing the programs include:

1. findings on staff's ***knowledge and beliefs about the program***
2. findings on staff's ***self-efficacy toward and engagement in their roles*** within it, including progress toward skilled and enthusiastic participation in the program.

By all accounts, child and youth crisis triage programs involve challenging work for both the program leads and staff. ***Staff often have heavy workloads*** for a variety of reasons including program complexity, unpredictable (and often intense) demand for services, challenges with staff turnover and gaps, and limited resources for personnel both due to cuts in triage grant funding as well as broader systemic challenges in securing funding (and generating revenue) for youth crisis services. An experienced and passionate program clinician, who left the position soon after this interview, laid out the dilemma:

> *…we were joking at the beginning… [that] my job is to make sure everybody in the county gets mental health services… it's been a silly manner. And so, I think that can feel very overwhelming and I have other counterparts in other crisis services, and it does feel like the work is insurmountable sometimes.* [Child/Youth Program Clinician: P20 I070]

Staff also work under particularly challenging conditions due to the nature of crisis work, which is often acutely time sensitive and intensive, involves high stakes, and entails exposure to "vicarious trauma" which, especially for staff with lived experience, may also mirror their own lived traumas.

4.4.1 Knowledge and Beliefs about Programs

Despite these challenges, ***interviews with program leads and staff attest to a generally high degree of enthusiasm towards the programs and deep commitment to ensuring program success through their work***. Across the board, program leads express enthusiasm for investment in the programs they lead, with many also integrally involved in program design and ongoing execution. Although their direct involvement in and engagement with the programs varies, leads were generally able to articulate their support for the programs in some detail.

> *I see it perfectly aligned, critical in nature and it's been a tremendous support to just have the grant and just to have access to the extra clinician to be able to provide the aforementioned support. So, I couldn't see the world that we're working in without it, so yeah, I think it's been great.* [Child/Youth Program Lead: P16 I079]

> *You know, education and social-emotional sometimes live in two different buckets and then you add mental health. So, the way of really infusing all of these in these two sites has been really innovative.* [Child/Youth Program Lead: P05 I007]

The ***attitudes of program clinicians and staff toward their programs also were generally very positive***, emphasizing the positive contributions the programs were making to their respective social service systems and communities:

> *I might be a little biased, but I think it's a great program. I mean… we are able to provide services that we wouldn't have been able to provide in the past before this program. And it's done in a timely manner. And it's done... from a youth centric perspective where… that's all I do.* [Child/Youth Program Clinician: P14 I097]

I honestly think that it's amazing to have a program like this for clients and families. I have experience working… with troubled teenagers. And I think it's absolutely amazing to have a program like this that can kind of provide the services that are needed for this population that is so in need… This program makes it really easy for families who go to the hospital and stuff to get the services that they need, and I think that's amazing for the community. [Child/Youth Program Staff: P09 I117]

While staff in one program voiced some concerns with their program's structure, it was constructive in nature and aimed at improving their ability to achieve continuity of care, manage their workloads, and achieve core program goals. These concerns pointed to the staff's belief in the value of the services they were offering as well as the need for longer-term, dedicated funding to ensure that the benefits of these programs were available to as many students as possible without interruption. These staff indicated that they had appropriate channels to express this feedback and felt empowered to share it with their leads. Leads confirmed in interviews that they were aware of these concerns, which were closely linked to the impacts of the pandemic and the limited funding available to the program.

In addition to attitudes about the programs, interviews with program leads and staff also provided insight on staff's attitudes towards their own roles in the program. ***Program leads described their staff as dedicated and passionate about their jobs*** despite its challenges:

I mean crisis work isn't for everybody. You know, it's either you either like it, you can do it or, you want to stay as far away from it as possible. And so, everybody that works on the crisis team that does crisis in general loves doing what they do, and it shows. [Child/Youth Program Clinical Lead: P14 I013]
They are really committed, I mean they work, they work holidays, right because it's a 24/7 program. And between the two of them, they are very committed, and they are invested. They genuinely are seeking to help connect these families with support services and, it, their level of commitment is just really unmatched… [Child/Youth Program Lead: P09 I156]
They both have great attitudes… They are both behind the program 100%. [Child/Youth Program Lead: P11 I063]
…they really enjoy it, they like doing it, they understand the importance of it. [Child/Youth Program Lead: P21 I059]
She loves what she does, and we are all excited that she is so passionate about it. [Child/Youth Program Lead: P19 I057]
…they love their job and there is a bit of a pride that goes into implementing a brand-new program. [Child/Youth Program Lead: P02 I001]
I think the school staff is really committed and really motivated and really proud to be a part of the program. [School-County Collaborative Program Lead: P22 I039]

Interviews with staff themselves also evince this enthusiasm and dedication to their roles. Staff in several programs described requesting lateral transfers within their organizations in order to join the SB-82/833 programs and spoke effusively about their jobs:

I really appreciate this program and when I first learned about it, I really wanted to work here because of what they were doing, what was happening here, and it's not something that's done many other places. [Child/Youth Program Staff: P09 I103]
Yeah, well they're going to have to drag me kicking and screaming out of my job 'cause I love it. [Child/Youth Program Clinician: P14 I097]
I'm really passionate in my position. I love my job [Child/Youth Program Staff: P19 I021]

4.4.2 Self-Efficacy, Skills, and Engagement

Many ***program clinicians and staff also expressed confidence in their own skills and fit with the program***, often linked to their prior experiences, both professional and lived:

…I've been doing this for so long that it doesn't nerve me, and I know who to call. [Child/Youth Program Clinician: P21 I099]
…the original grant writer knew me and my skillset and that I was willing to do this. And so, it has taken on the way that I kind of like to work which is a little bit of everything and as many people as possible. And I have experience in a lot of different settings of care and I have a good understanding of how the systems work. [Child/Youth Program Clinician: P20 I070]

While the attitudes of the staff that were interviewed may not represent the full range of attitudes held towards SB-82/833 programs and their roles, it provides some indication that insufficient passion, fit, or self-efficacy is not an adequate explanation for staff turnover in SB-82/833 programs. Indeed, ***some staff that expressed significant and seemingly genuine passion for their roles in interviews left their programs within weeks or months***.

Program leads also provided details on not just the passion of program staff, but the particular ***strengths and skills they bring to their roles***, crediting much of the successes of their programs to the individuals carrying out the work on the ground:

…[it] wasn't just "oh we have the service," we have [program staff] doing the service… So, really small counties, you've got to get a talented, committed, passionate, smart staff person… because resources are so small." [Child/Youth Program Lead: P19 I012]
I think anybody can have the contract. I think it comes down to the staff and the people doing it. And I mean… we're lucky to have [program staff] because [program staff] is amazing at his job and makes everything else easier because he's so personable, and the kids like him, and he knows how to ease the situation in a crisis [Child/Youth Program Lead: P14 I013]
They are innovative, they are extremely innovative, they are flexible. The kids and family wellness is truly a priority. They will go above and beyond because they have passion for what they do. So, we have people that are dedicated, that work hard, and that go above and beyond in circumstances that sometimes it would be easier to take a step back and they step forward. [School-County Collaborative Program Lead: P01 I010]
…they've been really phenomenal in coming out with a lot of great questions. …I don't think that this program would've went well in the way it was designed and launched without having their involvement because without clinicians and advocates voicing their opinions even if it was in a disagreement, it wouldn't be successful at all. [Child/Youth Program Lead: P05 I089]

Particular strengths of SB-82/833 program staff that were mentioned by multiple program leads included their adaptability during the COVID-19 pandemic, proactivity, open-mindedness and willingness to try new things to support youth and family needs, comfort working in crisis environments, high level of professional skills (in the specific aspects of crisis care, both technical and interpersonal), extensive knowledge of and ability to navigate community resources, valuable professional and lived experiences, ability to appropriately engage youth and families of different cultures, and their skills in teamwork and coordination.

Interviews also provided insight into ***how program leads and staff engage and champion their programs***. Several program leads (and staff) describe working long hours with few breaks or vacations, making themselves available after-hours and outside of scheduled shifts, advocating the program within the implementing organization, and acting as "ambassadors" to critical partners. One program lead was even singled out by the staff in their county's other SB-82/833 program, so exceptional was their engagement with and advocacy for the program(s). For program staff, program championing also involved assuming de facto leadership roles within their programs, choosing to take on particularly challenging caseloads, creating new custom resources for their programs, and independently initiating new internal evaluation efforts to enhance program implementation. These often entailed efforts well beyond the normal expectations associated with their role or beyond the scope of their respective job descriptions:

…the two clinicians… I always get confused that they're clinicians because it always seems like they take such a leadership role; they share things with each other all the time… it's like [a] "how are we as a team becoming successful, what is it that you're doing that I'm not doing that I should be doing?" sort of thing [Child/Youth Program Lead: P05 I089]
They get concerned about having to take a day off. They want to be there. They want to be the one to provide the service. They want to make sure services are being provided and appropriate connections are being made. Like I said, they are very, very committed. [Child/Youth Program Lead: P09 I156]

While many programs describe themselves as team efforts and many have multiple dedicated leaders who are critical to program implementation, ***some rely heavily on a single champion to carry the implementation***. These individuals were particularly critical to smaller program teams and those in less resourced, smaller counties. Another noteworthy set of champions are staff in implementing organizations, often leadership and analysts, that are not formally assigned to or funded by the SB-82/833 program but provide very significant and often critical support to the programs.

Despite the outsized role than champions play in many SB-82/833 programs, these individuals are also not exempt from turnover; indeed, ***multiple programs lost a champion over the course of their first years of implementation***. While the reasons for each individual's departure likely vary (at least one retired, others may have taken new jobs), ***the impacts of these losses were acutely felt by their programs: disrupting program operations and constituting major losses to programs' institutional knowledge and social capital***. This further supports the lesson that staff in crisis triage programs require significant support in order to sustain the level of commitment necessary to do such challenging work, as programs still need to work to retain even their most invested staff, and also that programs need proactively work to ensure that if (or when) they lose their champion, the impacts are minimized as much as possible.

4.5 Implementation Processes

Findings on implementation processes both build and expand on previous findings to highlight some of the processes that are most critical to program implementation, including:

1. findings on how programs ***simplified implementation*** by reorganizing teams and staff roles
2. findings on ***executing programs flexibly*** to ensure that they maintained fidelity to SB-82/833 Triage Grant program goals as well as to their identified local needs while adapting to changing contexts

3. findings on programs' ***funding, revenue generation, and program sustainability planning***
4. findings on programs' work to ***track and reflect on their progress*** towards internal and external program targets

Detailed analyses and data tables on program lead survey items on programs' ***funding, revenue generation, and program sustainability planning*** by program maturation, school-based status, and urban/rural county can be found in Appendix C [section C.2, tables 38–41].

4.5.1 Simplification

Although program adaptation involves many types of efforts to make program implementation easier, ***a major practice that programs engage in to simplify, and thus facilitate, the execution of their programs is refining their divisions of labor***. At the organizational level, this is accomplished in part through efforts to resolve role ambiguity, as described in section 4.2.2 (Cosmopolitanism: Challenges Related to Partnerships, Facilitators of Partnerships). In also occurs within programs as teams reorganize, make adjustments to their staff allocations and schedules, and refine and redefine their internal roles.

Some augmenting programs reported that ***SB-82/833 Triage Grant funding directly facilitated these efforts for their existing teams, allowing them to add staff positions and reimagine how their existing teams were structured***, both in relation to other inner setting units (such as adult crisis intervention programs), outer setting partners (such as programs that respond to schools), as well as internally. As one School-County Collaborative program lead explained, re-envisioning their team structure was adaptive both for internal improvement and also to build capacity for program sustainment given the short-term nature of the funding:

> *We've reorganized since getting the grant, on purpose, to blend our team—this prevention and intervention team—for more effective and efficient systems, as well as sustainability, to be honest. Instead of getting a fund and [doing] one thing, and then if [the funding] goes away, then that one thing goes away– so, blending.* [P10 I049]

Some augmenting programs also noted that SB-82/833 Triage Grant program funding for additional staff made it possible to improve the mix of roles in their organization and on their team, allowing some clinicians to focus more on their primary clinical responsibilities or freeing up staff to focus more on program development and building relationships with critical partners:

> *…with [program clinician] coming on and filling this crisis clinician role, it's given, in particular myself and [implementing organization clinician], greater capacity to spend time with these program administrators.* [Child/Youth Program Lead: P16 I084]

While programs often still struggled with staff turnover and workload, for some programs grant funding made it possible to at least mitigate existing deficiencies in staff capacity and better integrate the staff resources that existed. At least one program, however, expressed the desire for greater flexibility in how to use SB-82/833 funding, noting that staff would benefit from a rotating crisis position more than having a single clinician assigned to all crises.

Some programs also improved their service capacity and efficacy by making adjustments to their staff allocations and schedules based on internal progress tracking and monitoring. In some cases, adjustments were made by necessity, as staff turnover and gaps required remaining staff to be reassigned, as possible, ensure maximal coverage. Adjustments were also made, however, to adapt to evolving understandings of program demand and need. This was especially important in programs whose resources and funding were not sufficient to ensure continuous staffing and needed to optimize staff schedules in light of those limits:

> *…my youth crisis worker used to work on Sundays 'cause we thought Sundays would be a good day, but it wasn't. And then, we moved them to Monday 'cause we saw Mondays fit in, now they work Friday… afternoon into evening for that overlap because Fridays are usually busy now. So, we're always like looking at the data. Well, can we do different? How can we help? More?* [Child/Youth Program Lead: P14 I013]

A major area of continual refinement for SB-82/833 programs, especially new programs that were earlier in learning their settings and understanding their demand, was in defining and distinguishing roles. While these efforts were sometimes aimed at resolving ambiguities, for some teams they were also aimed at improving program efficacy and efficiency as they better understood the range of needs their program needed to meet and at what volumes. Some programs started with less defined divisions of labor and, over time, worked to identify what staff roles were more appropriate for certain tasks and which staff had more or less capacity to take on additional responsibilities. How these roles were redefined therefore varied by the needs, challenges, and capacities of individual programs. For some, it took the form of shifting tasks from more to less specialized roles, for some it simply involved differentiating roles to impose some specialization for the sake of streamlining:

> *I think in the beginning we sort of had more similar, like we were sort of tag teaming and things, and so, now I think we're looking at my work as being more of a clinical support work. And the navigator actually also happens to be an LCSW, but she's not in the role of using that. So, and she might be more like… connecting to resources, so for helping connect with… private therapists like she might do more of the linkage to that.* [School-County Collaborative Program Staff: P22 I053]

4.5.2 Executing

The extent to which programs were executed according to plan was most obviously affected by the COVID-19 pandemic, which prompted numerous adaptations that were unlikely to have been carried out, at least in the form that they did, during the grant period. Even under more normal circumstances, program adaptability is not in inherent opposition to fidelity: indeed, executing a program according to plan often requires making adaptations that permit fidelity in outcome, if not process. ***Despite the unprecedented changes faced by SB-82/833 programs, on the whole this remained true: despite changes in needs and demands, new modalities of service and coordination, exceptional challenges and occasional new opportunities, programs were, on the whole, able to strategically adapt to execute the types of programs they had planned prior to the pandemic***. This is not without qualification: program execution for many programs was, by self-report, likely profoundly impacted in terms of the *quantity* of services delivered compared to previous expectations, the *depth* of some services (as a result of a variety of conditions described throughout this report), and the *timing* of some program operations (particularly hiring). The majority of programs, however, were able to deliver the types of services and care processes they had planned in the types of settings, however modified, they intended during the first years of the grant period.

This overall conclusion was reflected in interviews with program leads and staff as well as in responses to the Program Lead Survey. **Table 16** summarizes responses of Phase 1 program leads to two questions addressing the extent to which programs were delivered as intended and as proposed. All but two program leads agreed in some capacity (somewhat agree, agree, and strongly agree) that their programs had been carried out as originally intended and as described in their revised scopes of work.

Table 16. Phase 1 program lead attitudes toward program execution (N=14)

Response	Count	%
This SB-82/833 program has been carried out as originally intended.		
Strongly Disagree	0	0.0
Disagree	0	0.0
Somewhat Disagree	1	7.1
Neither Agree nor Disagree	1	7.1
Somewhat Agree	2	14.3
Agree	5	35.7
Strongly Agree	5	35.7
This SB-82/833 program has been implemented as described in the triage grant proposal/revised scope of work.		
Strongly Disagree	0	0.0
Disagree	0	0.0
Somewhat Disagree	1	7.1
Neither Agree nor Disagree	1	7.1
Somewhat Agree	1	7.1
Agree	6	42.9
Strongly Agree	5	35.7

The two Phase 1 exceptions were both Child/Youth programs, one of which had received SB-82/833 Triage Grant program funding for one clinician and was unable to sustain the position after that program clinician left, and one of which experienced lengthy delays in hiring at one proposed site. By both implementing organizations' accounts, delays were at least partially a result of the pandemic. For the first program, the sole clinician left in February 2020 and the county initially re-classified existing staff to fill the role. After that clinician also left the county, a hiring freeze implemented during the pandemic combined with the time-limited nature of the role resulted in a decision to leave the position vacant and, later, to attempt to re-allocate the role to align with the MHSSA grant awarded to that county. For the second program, it was designed to be set in two school districts and experienced a lengthy delay contracting and hiring in one district, which was also impacted by the pandemic as well as difficulties recruiting properly licensed and experienced staff.

All Phase 2 Child/Youth programs were also significantly delayed in their intended operations, first by a county decision to shift from directly provided to contracted services and then, by county action to delay implementation. The initial delay due to the shift to contracted services meant that program approval aligned with the start of the pandemic, shifting the timeline for program start to the end of 2020.

For the remaining Phase 1 programs, ***the most significant barriers to delivering their programs as planned included reductions in funding, challenges with hiring and staff turnover, and challenges during the COVID-19 pandemic***. While some of these barriers impacted program execution in specific areas—such as whether a particular type of role could be deployed as originally intended or the volume of services that could be provided in a particular setting—programs were able to describe how they overcame these challenges to deliver services that still fit the aims of their programs and the goals of the SB-82/833 Triage Grant program. One Child/Youth Program lead emphasized, though, that accomplishing this was no small feat:

> *…although I think we've been really successful in doing this, it is a struggle, and it continues to be a struggle.* [Child/Youth Program Lead: P09 I022]

As described in section 4.1.1 (Descriptive Characteristics: Grant Funding), ***while programs felt that they had been successful in re-scaling their programs, there were some aftereffects of funding cuts on how programs were executed***. This was likely at least partially because mental health service programs are harder to operate when they have less resources, regardless of timing or program design. That is, one barrier may simply have been that the funding was lower and therefore less proportional to need, requiring programs to make hard choices about what aspects of their programs to prioritize when resources were limited. For some programs, this impacted how they carried out their programs:

> *we don't have as many outreach workers as we hoped that we had to go to outreach schools, outreach other groups– the connections that we wanted to make.* [Child/Youth Program Lead: P12 I060]

> *the downside of… [high demand for services] is that I think one of the other hopes we had for our staff was to do some of the prevention work, whether that's meeting with school staff or parents and providing psychoeducation. Or, providing some of that kind of consultation and training that was a part of what we envisioned them being able to do at some point. I don't believe we've done as much of that as we originally hoped we would. But that's still a part of the program that I would say… we anticipate… doing more of in the future.* [School-County Collaborative Program Lead: P22 I069]

There is also some evidence that the reductions themselves were barriers, as some programs had already began planning their operations, working with partners, and making commitments to both their implementing organization(s) and partners on what their programs were going to provide. Programs that were envisioned at a large scale can be—and certainly were—scaled back while still addressing their core aims, but the effort requiring to achieve that fit on an ongoing basis is likely to be greater than had the programs been originally scaled more appropriately. Program leads and staff attested to the ongoing impacts of these changes:

> *I think it was planned out to be a little different or a little larger in the beginning and um, we do still struggle a little with that piece.* [Child/Youth Program Clinician: P11 I075]

Challenges related to funding and funding cuts were, in some programs, further exacerbated by the challenges hiring staff and adjusting to staff turnover described in section 4.3.1 (Structural Characteristics: Team Stability), which impacted some program's ability to execute their programs as intended by reducing staff capacity and, in some cases, delaying operations. For structurally complex programs with teams located in multiple regions or sites, losing staff or experiencing challenges in hiring staff necessarily meant that programs were at least temporarily unable to execute their programs as planned. To the extent that programs were already understaffed (or at least minimally staffed) relative to their intended program aims, gaps in staffing and delays in hiring placed further strain on programs.

The final major challenge faced by Phase 1 programs in delivering their programs as intended was ***maintaining fidelity despite COVID***. While details on the adaptations and innovations made by programs are outlined in section 4.2.3 (Adaptation during the COVID-19 Pandemic), interviews also provided a bigger picture view of the extent to which program leads and staff felt that their programs had been executed as planned, despite those challenges, because they were able to adapt:

> *…COVID's effect has been, I mean it has affected, of course, how we deliver service and probably then our numbers on the numbers of services. I mean we are working,*

what feels like probably to our team, four times as hard to try to scrounge-up [referrals], right. I mean it's just a lot of work. [School-County Collaborative Program Lead: P01 I010]
…with having to adjust with where our schools are at and meeting them where they're at, you know the plan that we had ready to roll out had to be modified obviously. [School-County Collaborative Program Lead: P10 I207]
I think the only thing is… in all those areas, we've made progress because of figuring out the protocols to replace… our COVID interventions and so we have made progress, we have continued to provide services. If anything, we made, I think better collaborations because you just do that when things are harder sometimes. And so, I don't think it interrupted our program at all, if not it strengthened [it]. [Child/Youth Program Staff: P19 I021]
Yeah, we maintained a high level, high number of face-to-face contacts, even in the early days of COVID, in terms of crisis response and I would even say moderate level crisis responses. We didn't close doors too much. [Child/Youth Program Lead: P19 I105]
…our folks continued their work, they just did it virtually instead of obviously being on campus. So, you know, I definitely think during those times, you, there's, you know, they're not serving as many students because it's so convenient for students to walk in and come right, right in during those times, but they're always available. [School-County Collaborative Program Lead: P18 I073]

4.5.3 Funding, Revenue, and Sustainability Planning

For SB-82/833 programs, ***a significant component of program planning concerns efforts toward funding stability***, which is a function of the availability of sufficient funding to support program operations over a defined period of time. Since SB-82/833 grants funding was highly variable, reduced between initial award and the official start of program implementation, and explicitly short-term in nature, SB-82/833 programs are generally unstable with respect to funding. Further, since grant funding was not, for all programs, sufficient to sustain the programs that they proposed in their initial applications and because the requirement to develop a plan to financially sustain programs through external sources following the end of the grant period was built into the grant process, a critical component of SB-82/833 program implementation is efforts toward *achieving* funding stability. Programs therefore take ongoing action to accomplish stability by 1) securing additional funding or generating revenue, as needed, to support ongoing operations and 2) developing plans for transitioning their programs to new funding and revenue sources for sustainment after the end of the grant period.

Patchwork Funding

While two Phase 1 SB-82/833 programs report that they fund their programs using SB-82/833 Triage Grant program funding alone, the rest currently rely on additional sources of funding or revenue to sustain their programs. **Table 17** summarizes how many additional sources of funding and revenue Phase 1 programs reported using in the Program Lead Survey; while six programs rely on only one additional source of funding or revenue, another six programs rely on between two and five additional sources. **Table 18** reports the sources of revenue and funding used by programs to sustain their ongoing operations by the number of Phase 1 programs that report using it; billing Medi-Cal is the

most commonly used source of additional revenue, used by 71% of Phase 1 programs, with MHSA and county funds the second and third most common sources of additional funds, respectively.

Table 17. Phase 1 programs by number of additional sources of funding or revenue (N=14)

Number of Sources	Count	%
None	2	14.3
1 Additional Source	6	42.9
2 Additional Sources	2	14.3
3 Additional Sources	1	7.1
4 Additional Sources	1	7.1
5 Additional Sources	2	14.3
		100

Table 18. Number of Phase 1 programs using each additional source of funding or revenue (N=14)

Response	Count	% of Programs
What funding or revenue streams, if any, is your county's SB-82/833 program currently using to supplement SB-82/833 grant funding?		
Billing Medi-Cal	10	71.4
Billing private insurance	1	7.1
Private grant funds	1	7.1
Donor funds/Philanthropy	1	7.1
County funds	4	28.6
School/School District funds	2	14.3
State funds (DHCS)	1	7.1
State funds (MHSA)	6	42.9

Interviews with program leads provide additional context for understanding how programs use these additional sources of funding and revenue, including the challenges they pose to program implementation. While some programs structure their funding according to specific models for combining funding sources (e.g., braiding, blending), a more relevant distinction with respect to impact on implementation is that, ***for many programs, funding and revenue efforts are best understood as "patchworking," that is, ongoing efforts to combine multiple, individually insufficient, elements out of (ever changing) necessity rather than strategic vision***. Indeed, in the absence of adequate, predictable, and long-term funding and revenue sources, programs' attempts to strategize are often fruitless, especially as circumstances change. As one Child/Youth program lead explained:

> *I think that's the only way that this program can survive because, you know, this is kind of like, I call it a bridge money funding to help us to get the work done. But we can't… completely rely on this alone. So, we definitely have to… look for every opportunity to leverage resources.* [P09 I011]

For many programs, patchworking began at the start of implementation as funding cuts disrupted the preparations they were already making to initiate their programs. Multiple programs described

needing to supplement their reduced funding with other sources, which delayed or created barriers to their early implementation processes:

> *…when the grants were cut, but we didn't want to cut our services, so we had to go back to our community and ask for local MHSA dollars to try to keep the grant as it was originally designed. It was a lot of work to try to—and when I say community that includes even in our own infrastructure of our county system, not just community people, it was kind of both. And so I want to make sure that we are very clear that that was probably from our perspective one of the challenges that we've had to kind of get over.* [School-County Collaborative Program Lead: P18 I074]

While this patchworking was itself a barrier to implementation of some programs, programs also described barriers to being able to combine certain sources of funding, leaving some in a double bind wherein they needed additional sources of funding and revenue to sustain their programs but found that the use of one source of funding potentially threatened their use of others. To the extent that programs must, for example, navigate prohibitions on supplanting funding or commit to keeping certain funding elements pure, there was often an element of path dependency whereby decisions made under a certain set of options potentially constrained their future options. With a landscape of future options that are generally unpredictable to program leads, this meant that decisions around funding and revenue were sometimes fraught: in a constant tension between present necessity and the specter of unintended consequences. Once established, programs also described specific challenges related to maintaining several sources of funding, including effort to align their programs with the goals and outcomes of multiple grants and the additional administrative demands from balancing multiple contracts, billing systems, and reporting requirements. These patchworked funding structures also often still left gaps, which were especially challenging for programs that were providing insurance neutral services (especially in schools) and could not rely on reimbursement for certain types of program components or clients. Another source of gaps stems from the need to depend on multiple short-term or otherwise unpredictable sources of funding, which are not always well-aligned.

Sustainability Planning

In addition to efforts to stabilize their ongoing program funding by patchworking available sources of funding and revenue, programs also reported on their progress toward planning for the sustainment of their programs at the end of the SB-82/833 Triage Grant program period. Program leads from twelve of the fourteen Phase 1 programs agreed that their implementing organization or agency is actively supporting the SB-82/833 program in identifying ways to replace program funding after the end of the grant period. As of May 2021, program leads from nine of fourteen Phase 1 programs at least somewhat agreed that there was a sustainability plan in place to replace SB-82/833 grant funds. Of the nine program leads reporting some sustainability plan in place, eight also agreed that they were confident that their SB-82/833 program would be sustained after the grant period ends and one neither agreed nor disagreed. For the remaining five Phase 1 programs, three program leads disagreed that they were confident in their program's sustainment and two neither agreed nor disagreed (see **Table 19**).

Table 19. Phase 1 program lead attitudes toward sustainability planning (N=14)

Response	Count	%
The implementing organization/agency is actively supporting the SB-82/833 program in identifying ways to replace program funding after the end of the grant period.		
Strongly Disagree	0	0.0
Disagree	1	7.1
Somewhat Disagree	1	7.1
Neither Agree nor Disagree	0	0.0
Somewhat Agree	0	0.0
Agree	6	42.9
Strongly Agree	6	42.9
There is currently a sustainability plan in place to replace SB-82/833 grant funds.		
Strongly Disagree	1	7.1
Disagree	3	21.4
Somewhat Disagree	1	7.1
Neither Agree nor Disagree	0	0.0
Somewhat Agree	4	28.6
Agree	5	35.7
Strongly Agree	0	0.0
I am confident that this SB-82/833 program will be sustained after the grant period ends.		
Strongly Disagree	1	7.1
Disagree	1	7.1
Somewhat Disagree	1	7.1
Neither Agree nor Disagree	3	21.4
Somewhat Agree	3	21.4
Agree	3	21.4
Strongly Agree	2	14.3

Program leads also provided insight on the sources of funding and revenue that were either included in or under consideration in their sustainability planning, summarized in **Table 20**. As with efforts to supplement funding and revenue on an ongoing basis, the most commonly cited source of sustainability revenue is billing Medi-Cal (79% of programs planning/considering), followed by MHSA funding (57% of programs planning/considering) and county or school/school district funding (36% of programs planning/considering each). Many programs were also considering numerous funding and revenue options as part of their planning, as summarized in **Table 21**.

Table 20. Number of Phase 1 programs considering each source of sustainability funding or revenue (N=12)		
Response	**Count**	**%**
What funding or revenue streams, if any, is your county's SB-82/833 program currently using to supplement SB-82/833 grant funding?		
Billing Medi-Cal	11	78.6
Billing private insurance	2	14.3
Private grant funds	2	14.3
Donor funds/Philanthropy	2	14.3
County funds	5	35.7
Municipal funds	1	7.1
School/School District funds	5	35.7
State funds (DHCS)	2	14.3
State funds (MHSA)	8	57.1
State funds (Other)	4	28.6
Federal funds (e.g., SAMHSA)	2	14.3
Mental health block grant	1	7.1
Increasing general funds	2	14.3
Local Control Funding Formula	1	7.1

Table 21. Phase 1 programs by number of sustainability funding or revenue sources considered (N=14)		
Number of Sources	**Count**	**%**
None	2	14.3
1–2 Sources	4	28.6
3–4 Sources	5	35.7
5–6 Sources	2	14.3
Over 6 Sources	1	7.1
		100

Although nine programs reported at least some form of sustainability plan in place as of May 2021, only two were described in concrete terms: one for a program that is currently funded for less than one FTE position and one for a program that had an external sustainability plan in place from the start of their program. Other ***program leads described sustainability planning as "challenging" or "daunting," citing and expanding on many of the same challenges related to patchwork funding their programs***. As one program lead explained it:

> *These are highly complicated systems and require local agency involvement and workgroups to determine what is the best fit for the local context. This is not a one size fits all process but rather takes time to develop with partners to meet the needs of children in the community.* [School-County Collaborative Program Lead: P18 I032]

Programs described a variety of avenues they were pursuing to determine the feasibility of the options they had under consideration: conducting meetings with community partners, holding workgroups, seeking new grant opportunities, offering contracted services to partners, exploring new Medi-Cal billing systems, approaching MHSA steering committees, soliciting funding from county

agencies, working with consultants, and determining the feasibility of program re-alignment to other grants or funded units. The COVID-19 pandemic, however, complicated these efforts because, as the program lead explained:

> *…we haven't been able to do much of anything towards sustainability because we've been in survivability.* [School-County Collaborative Program Lead: P18 I032]

Program leads also described some practical challenges related to the specific funding and revenue sources they were considering, many of which mirrored their concerns in ongoing funding of their programs: ***few options were expected to be adequate to support their programs, predictable over time, or reliable for long-term sustainment***. Program leads also expressed how these challenges applied to some of the most commonly available (and indeed most considered) options: short-term grant funding, Medi-Cal reimbursement, community MHSA funds, and other local funding sources (such as county, LCFF funding, LEA/school district, or school funds).

Challenges related to short-term grant funding applied both to the SB-82/833 Triage Grant program as well as to efforts toward future grant funding. Several program leads described a frustrating short-term grant-funded program cycle: funding is sufficient to get a program started but not for enough time to develop a robust plan for long-term sustainment:

> *We get the grant, we put it together, and then the grant money goes away and then the program goes away*. [Child/Youth Program Lead: P20 I034]

Program leads noted that it takes time to build the types of relationships and buy-in from partners (both in and outside of the implementing organization) that could potentially be used to sustain programs permanently. A further dilemma for programs that are starting with a short-term funding commitment is that their time-limited grant period may actually inhibit the establishment of those relationships in the first place since partners are wary about programs disappearing at inopportune moments. As discussed in section 4.2.3 (Adaptation during the COVID-19 Pandemic), the pandemic exacerbated this dilemma for some programs as it added both an additional challenge for developing the kinds of relationships needed for long-term program sustainment and created a much more uncertain budget landscape for funding. While the SB-82/833 Triage Grant program extension was helpful for some programs with unspent funds, the extension did not reduce this challenge for programs that had been successful in remaining fully operational throughout the pandemic; most programs had been able to keep their operations going, though not necessarily in ways that promoted sustainability planning. Program leads also described other challenges related to the use of short-term grant funding for program sustainment, including their labor intensiveness both to apply for and manage. This may disproportionately impact the counties that need resources the most, as they already have fewer resources to devote to lengthy application processes and fewer staff with extensive skills and experience at grant writing. Finally, several program leads expressed concerns around long-term dependency on a series of short-term grants which, while sometimes necessary to the extent that permanent funding is unavailable, creates both insecurity and logistical dilemmas for program management. Jumping from one grant to another, especially when there are gaps between grants, creates challenges for staff allocation, as roles cannot be easily moved between agency budgets and grants. They also create challenges with maintaining program and staff continuity, exacerbating existing staff turnover.

Another option for program sustainment, indeed the most widely considered among SB-82/833 programs, is Medi-Cal reimbursement for services. Program leads described ***several major limitations to the use of Medi-Cal to generate revenue***, including its limited client penetration and covered services. A high priority for many programs is to provide insurance neutral services, which cannot be supported through Medi-Cal reimbursement. This is especially challenging for programs in schools who aim to provide services to all students regardless of insurance and programs in counties

with lower Medi-Cal eligibility rates. For such programs, ensuring program sustainability may come at the cost of removing a safety net for clients that currently benefit from universally available services:

> *…the needs are still there but the Medi-Cal eligibility is not.* [Child/Youth Program Lead: P02 I054]

Programs also note that Medi-Cal itself is not well-suited to supported certain types of programs. Since Medi-Cal does not cover staffing, it will always need to be braided with other funding sources, but the ***limitations on what services are billable to Medi-Cal also exclude (or heavily restrict) many of the target care processes and activities that SB-82/833 programs are aimed at providing, including prevention, outreach, linkage and follow-up, and system navigation***. School-based programs are especially oriented toward services and activities that cannot be billed. Indeed, this lack of alignment is often by design to the extent that SB-82/833 programs are aimed at filling gaps in the service system left by existing Medi-Cal billable programs in their counties. (For at least one program, this issue goes a step further in that their county does not want them to bill Medi-Cal even for the services that are technically eligible due to "unintended consequences" on other contracted services in the county.)

Table 22 reports the percentage of program services that program leads estimate are eligible for billing to Medi-Cal; two program leads estimate that none of their program services are billable to Medi-Cal (one due to Medi-Cal eligibility, one due to county policy), five program leads estimate that 50% or less of their services are billable, five program leads estimate that between 51% and 90% of their services are billable, and two program leads did not know what percentage of their services could be billed to Medi-Cal. Of the four program leads that either estimated that they could bill none of their services to Medi-Cal or didn't know what percentage of services could be billed to Medi-Cal, three also did not agree that there was a sustainability plan in place for their programs or have confidence in the sustainment of their programs (the fourth both has a pre-existing sustainability plan and is not approved by their county to bill Medi-Cal for SB-82/833 services).

Table 22. Estimated Medi-Cal billing eligibility for Phase 1 programs (N=14)

Response	Count	%
Based on your current understanding, please select the percentage of services and activities delivered by your program that can be billed to Medi-Cal		
None	2[1]	14.3
1–10%	1	7.1
11–20%	1	7.1
21–30%	0	0.0
31–40%	2	14.3
41–50%	1	7.1
51–60%	3	21.4
61–70%	1	7.1
71–80%	0	0.0
81–90%	1	7.1
91–100%	0	0.0
Don't Know	2	14.3
		100.0

[1]One program notes that Medi-Cal eligible SB-82/833 services may not be billed by county policy.

Further, some program leads indicated that changes in program demand and service delivery during ***the COVID-19 pandemic had inhibited their ability to gauge how many program services were eligible for billing or the rate at which they could expect to bill for them*** under non-pandemic circumstances. While Medi-Cal is likely to remain critical to sustainability planning for many SB-82/833 programs, program leads indicated that it is only a partial solution for many programs. However, blending Medi-Cal revenue with grants or other funding sources can also result in the same dilemma to the extent that such sources also require a minimum percentage of Medi-Cal billing that is, in fact, the same gap they need additional resources to fill.

An additional option for programs hoping to augment grants or revenue are funding sources such as local MHSA funds, county funds, LCFF funding, and LEA/school district or school funds. Like grants, ***program leads describe these sources as often scarce and difficult to predict or plan around***. While MHSA funds are important to mental health services in many counties, program leads report that the use of such funds are highly competitive within counties, short-term requests may disrupt the community planning process, and less affluent counties are disadvantaged given the structure of the funds. For local funding sources such as county or educational/school funds, budget uncertainty due to the COVID-19 pandemic has left programs without, or unable to predict, certain funding options they had hoped to draw on in their sustainability planning.

Interviews indicate that many ***program leads are concerned not merely with the financial aspects of sustainability planning but with ensuring that their sustainability planning is really compatible with program efficacy, continuity of care, and equity***; that is, that their efforts actually achieve *substantive* program sustainment, not just funding at the expense of program integrity or funding for the sake of funding. To this end, programs showed significant interested in expanding their resources for effective sustainability planning. To some extent, the SB-82/833 Triage Grant program created opportunities for this by providing spaces (such as workgroups) for them to discuss shared challenges and potential solutions. Leads from two School-County Collaborative programs, for example, began collaborating around sustainability planning based on the connections made through the SB-82/833 Triage Grant program. Other programs also expressed interest in greater opportunities for support around sustainability planning:

> *I know that the grant funders will offer like technical assistance and stuff like that, but's it's almost like another level of technical assistance that's needed… like, the grant funder actually hires some consultants or something like that to say, we are actually going to go into the county and help you figure out, right, how… and really actively work with you on developing a real sustainability plan…* [Child/Youth Program Lead: P20 I034]

While programs described substantial effort around sustainability planning, some expressed that they felt that programs would be more likely to be sustained were they to have better opportunities, and more time, to understand and explore what options were available.

4.5.4 Progress Tracking and Reflecting

There is a high level of variation in programs' capacity to collect and maintain data necessary for tracking progress, both internally and to support external evaluations and mandatory data reporting. While programs were engaged in efforts to track their own services and progress towards program aims as well as reflect on that progress, the types of efforts they engage in vary widely as did their ease and regularity. For many programs, ***data collection and reporting constitute a significant***

burden that is linked to access to resources (especially staff capacity), differences in the quality of county and site data infrastructure, organizational and regulatory complexity, as well as complications from the pandemic. In some cases, programs were able to compensate for challenges, for example overcoming limitations of their county data infrastructure or data system linkages by investing greater staff time into informal tracking. For some programs, however, these challenges compounded each other, as several programs lacked adequate staff time for data collection and progress tracking in addition to working with inadequate data infrastructure, juggling multiple systems, and disruptions to regular access to data systems during the pandemic.

Internal Progress Tracking and Reflecting

Programs reported a ***variety of internal progress tracking efforts used to guide and improve their program implementation***. Program leads in all but two of the programs in operation for the majority of the grant period at least somewhat agreed that progress toward SB-82/833 program goals are tracked and evaluated regularly (see **Table 23**). While interviews with program leads and staff described how many of their internal tracking efforts required adaptation due to the pandemic, many expressed satisfaction and pride in their efforts to understand how their programs were progressing, despite wide variation in capacity. As one program lead attested:

> *Always trying to do what we can to, you know. We're, we're really data driven here, so we look at the data and see what we're doing.* [Child/Youth Program Lead: P14 I013]

Examples of internal progress tracking practices used by SB-82/833 programs include encounter logs used to determine the extent to which programs meet internal targets, summaries of services and activities prepared for distribution to stakeholders to show program reach and impacts within their program settings, reports to leadership in the implementing organization, reports to maintain compliance with parties to whom they bill or from whom they receive funding, fidelity tracking using standardized tools (especially for certain school-based programs), and satisfaction and impact surveys for their stakeholders and clients. In some programs, individual staff engage in specialized data tracking to inform their service delivery. As with other aspects of the pandemic, programs also worked to adapt their existing practices to accommodate changes in access to their usual tracking tools and streamline processes for staff facing changes to their normal workflows.

Programs leads and staff also described the extent to which they were able reflect, individually and as a team, on the progress of their programs. These efforts can include internal debriefing, review of available data, and efforts to synthesize what they have learned into strategies for action. With the exception of one program that was not in operation for most of the grant period, program leads for every SB-82/833 program at least somewhat agreed that their staff had regular opportunities to debrief and reflect on program progress (see Table 23). For many programs, this took place primarily through regular team meetings and individual supervisions with staff. The challenges of the pandemic and need for frequent adjustment and adaptation also constituted a context in which reflection took place, however it simultaneously impacted some programs' ability to engage in more sustained, higher-level reflection and strategy since programs were focused on managing rapidly evolving and immediate challenges. ***To the extent that programs were in "survival mode" as the pandemic played out, extensive reflection was not always possible.***

Table 23. Phase 1 program lead attitudes toward progress tracking and reflection (N=14)

Response	Count	%
Progress toward SB-82/833 program goals is tracked and evaluated regularly		
Strongly Disagree	0	0.0
Disagree	1	7.1
Somewhat Disagree	0	0.0
Neither Agree nor Disagree	1	7.1
Somewhat Agree	2	14.3
Agree	8	57.1
Strongly Agree	2	14.3
The SB-82/833 staff have regular opportunities to debrief and reflect on program progress.		
Strongly Disagree	0	0.0
Disagree	0	0.0
Somewhat Disagree	0	0.0
Neither Agree nor Disagree	1	7.1
Somewhat Agree	0	0.0
Agree	5	35.7
Strongly Agree	8	57.1

Challenges Related to Data Collection and Coordination

Programs experienced several major challenges to data collection and coordination related to limited resources for data management, variation in data infrastructure and capacity across counties, impacts of organizational and regulatory complexity on data management, and participation in the external evaluation.

Resources

Many programs reported that they do not have adequate resources or dedicated staff for data coordination, meaning that the burden of data management and collection either falls on the same staff who are supposed to be delivering services or on staff that are not assigned to (or funded by) the SB-82/833 program. In such cases, internal data collection and program tracking efforts are often scaled and designed to limit the burden on providers, who are already likely to have heavy workloads. Especially in programs which must also compensate for limited data infrastructure or work with multiple tracking systems, these efforts take time from staff who may also have important clinical and service responsibilities. Program leads from only five of the Phase 1 programs at least somewhat agreed that their program had been allocated adequate resources for data coordination and infrastructure, with several noting that the SB-82/833 Triage Grant program was not designed to provide such resources (see **Table 24**).

Table 24. Phase 1 program lead attitudes toward resource allocation for data coordination and infrastructure (N=14)		
Response	**Count**	**%**
This SB-82/833 program has been allocated adequate resources for data coordination and infrastructure.		
Strongly Disagree	1	7.1
Disagree	1	7.1
Somewhat Disagree	4	28.6
Neither Agree nor Disagree	3	21.4
Somewhat Agree	1	7.1
Agree	4	28.6
Strongly Agree	0	0.0

Variations in Organizational Infrastructure

While some implementing organizations, especially larger and more urban counties, have relatively robust data infrastructures on which programs can build, other programs either lack such resources or are housed in organizations, such as schools, without significant health data infrastructures. ***Data infrastructure and capacity varies widely by county and even by program site***. Some implementing organizations have well-developed data systems and/or dedicated research or evaluation units, while others have no organizational support for data management or legacy systems that are onerous to access and use. This wide variation means that programs start on an uneven playing field with respect to internal data tracking and ability to participate in external evaluation efforts:

We had… an adult triage grant in the first round and when we went to MHSOAC meeting, I was amazed by the level of expertise on staff at, with the larger urban areas; they have an entire evaluation team and that's all they do. Whereas here, I'm the evaluator with about 19 contracts… I'm in charge of a Wellness Center with four staff and so this is just one of many, many things. [Child/Youth Program Lead: P19 I012]
So, [we have] one person who's… administering the entire system for both the children's and adults' sides. So, whenever I want anything for our EHR, it's a huge ask because I got one person administering the entire system. [Child/Youth Program Lead: P20 I034]
I think we have the best research team of just about any county around. [Child/Youth Program Lead: P12 I060]
…our office has a research department, we do the evaluation in house. [Child/Youth Program Lead: P05 I058]
…we have our own internal quality assurance department. [Child/Youth Program Lead: P21 I059]

Organizational and Regulatory Complexity

The extent to which programs operate within and between multiple organizations (e.g., mental and behavioral health agencies, offices of education, school districts and schools, law enforcement agencies, hospitals) and the variation in the policies, procedures, and regulations within those organizations adds an additional challenge for data collection and progress tracking. ***Navigating multiple systems, which generally cannot interface for infrastructural or regulatory reasons,***

makes it difficult for programs to access data that would be valuable for service delivery and care coordination, internal quality improvement purposes, as well as for the formative and summative evaluations. Even in counties with integrated systems of care, which facilitate coordination across social service units, data systems are not always integrated or designed to be easily accessible for programs that operate across sectors.

…there's just wide variation of the data we have access to. [Child/Youth Program Lead: P01 I010]
…there are three different, potentially four different data bases where students where data could come in. [Child/Youth Program Lead: P16 I080]
I think right now we don't have systems that talk to each other across the county… there's definitely the ability to share information, um between but there's no systems that just talk to each other or pull data from multiple systems and then combine that at this point. [Child/Youth Program Lead: P20 I100]

For most programs, the lack of integration between systems combined with the cross-sector complexity of the services they provide results in major deficiencies in their ability to connect client data with data from external agencies, such as schools, law enforcement, and other mental health service agencies to improve client care.

Challenges Related to External Evaluations

While each of the data collection challenges previously discussed affect programs' abilities to track their own progress, they also impacted programs' capacity to participate in data collection and management for the external evaluations. Programs were generally very willing—even enthusiastic—to contribute to a better understanding of program implementation statewide, but several factors made this participation challenging for many, if not most, Phase 1 programs. A first challenge was that the lack of funding to support data collection was compounded by SB-82/833 Triage Grant program terms that required programs to participate in external evaluations without compensation for those additional efforts. While programs expressed that they understood, and indeed often valued, external efforts to better understand crisis triage program challenges, successes, and outcomes, it was very difficult to do so with the resources available:

Unfortunately, here, it falls on our analyst, who quite honestly, they are strapped with all of our other contracts and the other needs throughout the county, so, it's definitely a huge lift on our existing staff. [School-County Collaborative Program Lead: P22 I069]
I'm not sure what elements we're going to be tracking, again because it is a very small grant and we want to make sure that we are getting enough data… And, in mass these grants are, are improving the crisis system and leading to better outcomes, but we want to make sure it is a reasonable amount for the amount of money that we're getting. [Child/Youth Program Lead: P16 I080]
I just want to add to that it's not just funding to operate the program, it's also for the data, outcomes, and all of that. I think the support for that piece is critical. So, I know [county analyst], you can speak to that, but I definitely think we need support for that as well. [Child/Youth Program Lead: P09 I011]

Even for programs with robust data infrastructures, providing data for an external evaluation could still pose challenges since many systems are not necessarily intended or designed for mass extraction of certain types of data elements. Additionally, many data elements that are important for understanding program outcomes are not stored electronically due to the time intensity of data entry for the program team. Data elements available to programs are therefore often those collected for existing internal

tracking and evaluation efforts or proximate to other routine processes requiring data, such as those used in billing, required for mandatory reporting or auditing, or tied to services provided by their counties.

A final challenge is that programs did not know in advance what data elements would be requested for the summative and formative evaluations, as the plan was for the evaluators to work with programs to determine what data elements were available and adapt the evaluation to their systems. While some program leads expressed appreciation for efforts to ensure that program evaluation was customized to their programs' characteristics and data availability, not having a definite understanding of what elements might be expected made it harder for them to determine how to structure their own data collection activities at the start of their program implementation. Many programs expressed concerns that they may be "under-collecting" data or collecting different elements than would be expected and would not be able to pivot if necessary:

We are collecting what we are collecting, but I fear that something will be put in place and we won't be able to go back and get that information. [Child/Youth Program Lead: P14 I095]
…it would be very difficult if certain data elements were really desired or requested or required, it would be very difficult if not impossible to go back in time and get that information without having designed the tools to do so ahead of time. [Child/Youth Program Lead: P09 I022]

These challenges were exacerbated by changes to the overall structure of the evaluation, which further delayed requests for data for the formative and summative evaluations. ***Recommendations from program leads included building in time prior to program start to work through evaluation requirements and data requests, providing funding support for the time involved in evaluation-related activities, and orienting evaluations toward data sources that do not require strict standardization (such as narratives)***.

4.6 Goals, Activities, and Proximal Outcomes

Interviews with program staff and leads provide valuable insight on how program implementation is oriented toward SB-82/833 Triage Grant program goals as well as their engagement in target program activities that are intended to meet those goals. While the proximal outcomes of those activities will be examined in more detail in the final report using data that are still being collected, this section also discusses some considerations, identified in the thematic analysis, that are relevant to the interpretation of data on these proximal outcomes.

Detailed analyses and data tables on program lead survey items on programs' perceived suitability for and effectiveness at each ***Triage Grant program goal*** by program maturation, school-based status, and urban/rural county can be found in Appendix C [section C.3, tables 42–45].

4.6.1 Triage Grant Program Goals

These findings address how program implementation addresses the overarching intention and goals of the SB-82/833 Triage Grant program, including their alignment with SB-82/833 program goals, how they are factored into ongoing implementation, and considerations that potentially impact their ability to achieve them. Overall, ***programs engage in a variety of activities that both address and fit with the goals of the SB-82/833 Triage Grant Program***. Moreover, while Child/Youth programs and School-County Collaborative programs have some distinct SB-82/833 Triage Grant program goals, ***many Child/Youth programs show evidence of addressing School-County Collaborative grant***

goals and vice versa, attesting to the wide range of potential impacts of these programs on child mental health crisis systems. Both types of programs demonstrate significant flexibility in aligning the SB-82/833 Triage Grant Program goals with their community and system needs, leading to a set of programs that are both ***heterogeneous in their care targets and services and yet coherently tied together around broader-level aims and goals***.

Expand Crisis Prevention and Treatment Services

The overall intention of the SB-82/833 Triage Grant program, for both Child/Youth and School-County programs, is to expand crisis prevention and treatment services by providing crisis intervention, crisis stabilization, mobile crisis support, and intensive case management and linkage to services across care sectors. Per the findings on program characteristics, ***SB-82/833 programs report targeting care processes across the full crisis care continuum that address these goals***, although the specific areas programs focus on vary.

Other previously reported findings also indicate that program activities are oriented toward *expansion* of options for crisis prevention and treatment. Survey responses from program leads provide further support for these findings.

Programs address expanding crisis prevention and treatment services:

1) ***By filling specific gaps in their service systems and service settings***, as reflected in the findings on Program Characteristics, Cosmopolitanism, and Networks and Communication. All SB-82/833 programs expand prevention and treatment services within or across care sectors in some way whether they are new or augmenting. While the details of how they do so vary, every Phase 1 SB-82/833 program does *one or more* of the following:

Introduce dedicated child crisis services to provide appropriate, youth-centric care	*There's a lot of clinicians on the adult side who really just don't have that experience and so, they, when a child presents, they really feel kind of out of their element and don't know necessarily how to respond or know what's normal behavior versus really concerning behavior. So, having clinicians who truly have that clinician's lens and that training and expertise is really helpful and appropriately responding.* [Child/Youth Program Lead: P11 I069]
Expand the geographic reach of child crisis services to underserved regions	*…being a rural county, that mobile aspect to where we're reaching people that not necessarily, we would have never seen, or youth that would have never gotten services. So, we're reaching those.* [Child/Youth Program Lead: P19 I021]
	…it would in some ways be a lot easier to say all of our staff work out of [principal city]… but that really does limit our ability to serve students who are pretty isolated and already are in regions of the county that don't have a lot of services. And so it's something that we are really proud of that we're reaching some of the underserved and kind of hardest to reach schools in our region. [School-County Collaborative Program Lead: P22 I069]
Expand the settings or sites at which mental health crisis services are available in their communities	*…the reason we went after the grant and I was so passionate about it is we don't have any LPS beds for adolescents in [county]; we don't have any crisis residential; we don't have any crisis stabilization; we don't really have any crisis facilities for youth in [county]. So, what happens if a client goes into crisis or is placed on*

	a 5585 hold, they sit in the emergency departments until we can find an LPS bed for them. … So, we have kids who are sometimes sitting in an [emergency department] in mental health crisis for days. [Child/Youth Program Lead: P21 I059]
	…if you are just thinking about the triage staff and the role they serve, not every school in our district has that and that really provided the social-emotional support that a lot of schools were missing. I mean that was not a service we could provide to every student like we did at these two school that we are talking about today. [Child/Youth Program Lead: P05 I056]
Provide services to youth and families with significant barriers, or would not otherwise have access, to mental health services	*I think that system itself of having a mental health professional on campus that is not just for Medi-Cal reimbursement billing, but it's really for any student regardless of financial situation, regardless of whether they meet medical necessity or not. That just means support, whether one-time support or a few times or whether we are looking for long term support in which we can hand them off to a support, service provider, has been really successful. We have a lot of really nice success stories because of that.* [School-County Collaborative Program Lead: P01 I010]
	…it's so critical because in our county… there are so many students who would not have access to mental health care if it weren't for our programs, truly. [School-County Collaborative Program Lead: P18 I073]
Increase the timeliness of crisis response	*…the feedback that we're getting from the people that we're responding to, mainly schools, is that our response time has been much improved and that we're actually getting out in a more timely manner, which the enhanced staffing of the grant allows us to be able to do given just the nature of our area. It goes small communities to rural and it's a lot of area to cover, so with the extra people we have, um, an improved ability to reach people in a more timely manner.* [Child/Youth Program Lead: P14 I097]
Increase the capacity of existing service(s) that were not sufficient to meet need or demand	*…this grant, has really brought in resources to try to function as a conduit or interface between those programs. And so, the schools, many of the schools that you guys are talking about already had a PBIS system in place, but it didn't have the robustness of reaching out to community resources like you're talking about. It didn't have the robustness of having parent partners like you are talking about. And it didn't have the relationships as solid with the mental health services that are there.* [School-County Collaborative Program Lead: P10 I088]
	…just having the additional staff person has made our capacity for drop-in much more consistent than it was last year. Last year… essentially whenever someone was out, whether it be for sick leave or vacation or something like that, we oftentimes would not have any backup coverage because of the long-term therapy that we were also simultaneously supporting. So, we've just been able to just much more consistently provide care to students, which has just been really helpful. [Child/Youth Program Lead: P16 I084]

Program leads for every program at least somewhat agreed that the activities and services of their SB-82/833 program are suitable for addressing needs that are not adequately met by other mental health programs in this county/community. All but one program lead, for a program that was not in operation for most of the grant period, also at least somewhat agreed that their program was also *effective* in addressing such needs. Program leads also overwhelmingly agreed that their programs were both suitable for and effective at expanding crisis prevention, response, and treatment services in their communities. Of the programs in operation for most of the grant period, only two leads did not at least somewhat agree that their programs were suitable or effective for expanding crisis response services, both of which were school-based programs that do not provide acute crisis response services. Similarly, the only four programs that did not agree that their program expanded crisis *treatment* services in their communities were the same two school-based programs, which do not directly provide mental health treatment, a crisis response-focused Child/Youth program that noted additional treatment resources are needed in their county, and a Child/Youth program that responded, "Don't Know."

2) ***By their efforts to identify and respond to specific unmet needs in their communities, including those of underserved communities, related to crisis services***, as reflected in the findings on Needs of Patients and Communities. Program leads for all thirteen Phase 1 programs in operation during the majority of the grant period also at least somewhat agreed that their programs were both suitable for and effective at expanding access to mental health services in unserved or underserved communities.

3) ***By engaging in partnerships to ensure that existing services and resources are better linked and utilized***, as reflected in the findings on Cosmopolitanism and Networks and Communication. Program leads for all but one of the thirteen Phase 1 programs in operation during the majority of the grant period also at least somewhat agreed that their programs were both suitable for and effective at strengthening coordination or relationship building within the implementing organization. Only program lead, in a program that contracts its services, responded "Don't Know."

Increase Client Wellness

Programs address increasing client wellness by providing crisis services that are targeted to the specific mental health needs of their communities, as reflected in the findings in section 4.2.1 (Needs of Patients and Communities). Client wellness is also an identified priority and regular area of discussion in program workgroups, with program leads sharing details on how their program activities and services are designed to improve the wellness of youth and families, not just deliver services as such. Both workgroups and interviews attest to the high level of investment in client wellness evinced by program leads and staff, especially as the COVID-19 pandemic posed new threats to the wellness of youth, families, and communities. A program lead of a Child/Youth program perfectly exemplified this attitude when describing the goals of the program he supervises:

> *And it also sort of provides a safe place for students and families to come to get information about sort of what are some next steps to just reduce stigma and access… care. I mean as you know stigma is a big challenge, especially in Black and brown communities. It just provides a safe place for students to come in and have a conversation and to understand what the next steps might be for getting ongoing mental health support, you know, looking at it from a trauma-informed lens, really helping families and kids understand the impact of trauma, you know, and how we can sort of support them to navigate those experiences, so that they can get healing, you know,*

> *build into their health and wellness and move on to become, you know, whatever it is they were designed to be in life.* [P16 I079]

Leads and staff in SB-82/833 programs worked to refine their understandings of what was necessary not merely to refine their operations but to ensure that those operations were aimed at improving mental health outcomes and overall wellness.

The overwhelming majority of program leads in the thirteen Phase 1 programs in operation during the majority of the grant period at least somewhat agreed that the activities and services of their SB-82/833 program are both suitable for and have been effective at increasing client wellness, with only one responding, "Don't Know."

Decrease Unnecessary Hospitalizations

Decreasing unnecessary hospitalizations and associated costs is a SB-82/833 Triage Grant program goal for Child/Youth Crisis programs. Unnecessary hospitalizations are defined as a hospitalization where crisis intervention is indicated, but which could be better served by a lower (i.e., less invasive) service, such as a crisis residential program. The overwhelming majority of program leads at least somewhat agreed that the activities and services of their SB-82/833 program are suitable for and effective at reducing unnecessary psychiatric hospitalizations and associated costs. The only exceptions were one School-County Collaborative program lead that responded that this goal is not applicable to their program, which does not target acute crisis intervention or response, and the lead for a program that was not in operation for most of the grant period.

While not all SB-82/833 programs provide acute crisis intervention or response, ***both Child/Youth and School-County Collaborative programs provide services and activities that could contribute, either directly or indirectly, to reducing unnecessary hospitalizations in at least one of the following ways:***

1) ***By providing preventative care aimed at reducing the incidence of mental health crisis.***

2) ***By providing early intervention services aimed at identifying needs or crises before the escalate to the point where hospitalization is considered.***

> *We have the school grant staff [that] are really building those relationships, and teachers and administrators now, I think they feel like they have somewhere where they can lift up concerns or issues. So, I think attending to things earlier on, it might prevent someone from escalating to the need where they maybe previously would have escalated and ended up in an emergency room or more of a crisis call.* [School-County Collaborative Program Lead: P11 I069]

3) ***By providing plentiful, age-appropriate crisis services that improve the quality and depth of child crisis response to de-escalate crisis situations.***

> *…one of the numbers that we have seen changed since I've started here is about the hospitalizations… There were youth coming in regularly to get hospitalized for their first psychiatric admission that had zero mental health care. So, and when we're talking about linkage it is not only about after crisis but now we see far fewer children who are getting their first psychiatric hospitalization who have never had any outpatient mental health.* [Child/Youth Program Lead: P20 I070]

> *…we've gotten a lot of positive feedback from the school so far, just in terms of how quickly we are able to get there and then be able to collaborate with the school staff and*

then get parents on board and we've been able to have more diversions than hospitalizations, just in the short time that we've had this up and running. [Child/Youth Program Clinician: P14 I097]
And in the past when [emergency departments] would get a child up there, their full focus was just we need to get 'em out of here, they don't belong here. And now they're working so much better with us and they're respecting our opinion and we're just, we're like, we're killin' 'em with the relationships. We're just all over the safety plans and helping them understand that kids don't have to be hospitalized, that we can come up with ways to support them with their families. [Child/Youth Program Clinician: P11 I063]

4) By addressing the unnecessary use of emergency departments for mental health crises.

…we were really looking… [to] find a way to prevent kids from going into crisis and then if they did go into crisis and end up in the [emergency department], we wanted to try to get them out of the emergency department as quickly as possible either through intensive um, crisis stabilization in the [emergency department] and safety planning or finding a bed for them as quick as possible. So that was kind of the impetus for how we wrote the grant, with that dedicated people whose sole job was to work with kids in the [emergency department] to move them on as quickly as we could. [Child/Youth Crisis Program Lead: P21 I059]
…when we first started doing this, we saw a [young child] on… [multiple] consecutive holds in an emergency room bed with people coming in who've been shot, people having heart attacks and dying, adults with mental health illnesses that are very crude, and yelling and screaming, and threatening. And this kid sat through… consecutive holds which is… 12 days in an emergency room seeing all that stuff and that broke my heart to hear that. So, to be able to go in there and make interventions, break a hold, get him out of there, get him to more appropriate care helps— and for the doctors and nurses to know that kid was sitting there for that many days and not knowing what to do with the child. I mean… they know what to do if the kid has a broken arm, they know what to do if they have an earache, they don't know what to do for a [young child] feeling suicidal. So, you know, it's just slowly changing culture everywhere that we go. [Child/Youth Crisis Program Lead: P12 I060]
I think another thing that just kind of speaks to the collaborative effort with the county and, and [implementing organization] too, and COVID, is a few weeks back we had a minor that was on a hold and he wasn't getting placed 'cause… he had COVID. And he was pretty much being isolated in a room. ... He was going to have to sit in the emergency room for another 10 or 12 days. And he, at the time, without extra services, he wasn't safe to send home either. …so [the program] being able to get those things in place allowed him to be able to go home. And… the amount of people that were involved in hustling and getting it done all within, like, you know, a 36-hour, 24-hour period. I mean, he was home… Yeah, I think that's not getting done without this program in place, so. [Child/Youth Crisis Program Lead: P14 I097]

As discussed in section 4.2.2 (Cosmopolitanism: Connections to Community Assets for Mental Health), in the absence of accessible, appropriate treatment resources, such as crisis residential services, crisis stabilization units, mental health emergency or urgent care centers, and even readily accessible outpatient clinics, emergency departments are likely to continue to be overutilized for mental health crises. SB-82/833 programs also draw attention to this problem, highlighting the importance of ensuring that appropriate alternative resources are available:

We need more psychiatric hospitals to take people to get help so they're not stuck in emergency rooms. I think that would help the burden. I mean we help, but if there's nowhere for us to take people, we're kinda stuck. People are still going to be stuck in emergency rooms and that's… just going to add to their stress. Right now, that's the only I can think of, that's what I hear from our stakeholders, law enforcement, from the hospitals are just… there's nowhere to take people. [Child/Youth Program Clinician: P12 I076]
One of the issues that we have had is that any kids that are non-binary or trans, it's really hard to place them… out of county because they have to have a private room according to hospital policy. And nobody wants to give up that other bed, so they are sitting in our emergency rooms. [Child/Youth Program Lead: P11 I063]

Programs also provide valuable insights on other contexts that lead to unnecessary emergency department usage for mental health crises, including county policies, law enforcement practices, and broader dynamics of unnecessary emergency department utilization. In one county, a Child/Youth program clinician reports that the only way to initiate a necessary psychiatric hospitalization is through emergency departments. A Child/Youth clinician in another county also explained that law enforcement often uses emergency departments for mental health crises when they are unwilling to wait long periods for crisis response, suggesting that increasing mobile crisis response times would decrease the likelihood that a mental health crisis is handled through the emergency department. The clinician in that program also described seasonal variation in inappropriate emergency department usage, with extreme weather linked to greater diversion to emergency departments.

Reduce Unnecessary Law Enforcement Involvement

Reducing unnecessary law enforcement involvement and law enforcement cost is a SB-82/833 Triage Grant program goal for Child/Youth Crisis programs. Since programs vary in the crisis care processes they target and services they deliver, they also vary in the extent to which their services are likely to interact with law enforcement or impact law enforcement involvement in mental health crises. The overwhelming majority of program leads at least somewhat agreed that the activities and services of their SB-82/833 program are both suitable for and effective at reducing unnecessary law enforcement involvement and law enforcement cost. The only exceptions were one School-County Collaborative program lead that responded that this goal is not applicable to their program, one Child/Youth program lead that neither agreed nor disagreed, and the lead for a program that was not in operation for most of the grant period.

Some SB-82/833 programs, including several School-County Collaborative programs, provide services that are most likely to result in indirect impacts on law enforcement involvement, while others work directly with law enforcement or provide services that are targeted at reducing the burden on law enforcement for mental health response (see section 4.2.2 [Cosmopolitanism: Advantages of Partnerships]). One Child/Youth program is housed at a municipal police department, another Child/Youth program has a team co-located at a local sheriff's department, at least one School-County Collaborative program has programming that they deliver in partnership with a sheriff's department, and at least two programs are part of agencies that deliver mental health trainings to law enforcement. Many other programs, both school-based and not school-based, interact with law enforcement more informally or on an as needed basis. These programs also describe efforts to develop relationships with law enforcement but do so in less structured or formalized ways.

SB-82/833 programs provide services and activities that could contribute, either directly or indirectly, to reducing unnecessary law enforcement involvement—or improving their involvement when it occurs and/or is required—in at least one of the following ways:

1) ***By working to prevent the need for law enforcement involvement through parent trainings, preventive crisis services, social-emotional learning, and positive behavioral supports in schools.***

2) ***By providing an alternative to law enforcement involvement when mental health crises occur*** (also see section 4.2.2 [Cosmopolitanism: Advantages of Partnerships]).

So, now instead of a sheriff's deputy being the first response to a kid in crisis on the campus, they can call [program staff] …one of the concerns from the schools was about kids: the Sheriff's Office has a protocol where if you ride in the back of the car, you go in handcuffs. So, you are getting kids handcuffed and put in the back of the sheriff's vehicle for transport for further evaluation at the hospital, so I think we've managed to avoid that. [Child/Youth Program Lead: P19 I091]
…we do briefing presentations very frequently. My senior clinical therapist is very dedicated to trying to make sure we hit all of our sheriff and local law enforcement stations monthly to remind them of the program and remind them how to use the program. So, we really strongly encourage that if they have a call or service that's more mental health or behavioral health nature, that they call us out. [Child/Youth Program Lead: P12 I222]
…we recently have an MOU with probation, so there's been a few instances where [program clinician's] been contacted by probation and she's provided some crisis assessment and de-escalation for probation youth as well. [Child/Youth Program Lead: P20 I026]
I mean, most officers are reluctant to write holds in this area just because of the fact that they don't have training like we do. So, the majority of the times, we are getting calls to go do it for law enforcement. But if we are all tied up and we're busy with other calls, then they will. [Child/Youth Program Lead: P14 I097]

3) ***By improving law enforcement's understanding of mental health to improve the quality of their participation in mental health crisis response when it occurs and/or is necessary*** (also see section 4.2.2 [Cosmopolitanism: Advantages of Partnerships]).

What's really happening… when we get there, the officers want to learn from us, what we're doing, why we're doing it, and they oftentimes stay and see the call through because they see it as a learning experience. So, the chiefs weren't thinking about it that way, but the officers were thinking about it that way. So, that sort of is what's come out of it, is that a lot of police officers and sheriffs are better prepared to deal with mental health situations because they see how we do it, they watch how we do it, and then they can always call us for help too. So, I think a really good byproduct came out of that which is learning. [Child/Youth Program Lead: P12 I060]
Because the culture is: police officer, sheriff, school, whoever, they see the issue, in their minds identify it as behavioral health, and their thought was this person needs to be placed on a hold or this person needs to go to a hospital or go to jail. And that was the culture forever, so to turn around and say that's actually the last thing you want to do… You know, most people don't want to hear it, so, you really have to start changing culture. And then you have to have a lot of success. … I mean we just have to change everyone's culture when they think about behavioral health crisis and we're doing that, I

mean we are spending a lot of time doing that. And we feel like we are making some really good traction, so, it needs to happen in other places too. [Child/Youth Program Lead: P12 I060]
…a lot of credit goes to the [Child/Youth Program] grant that [county agency] has, because our staff have just really built positive relationships with the officers who come out with the [Child/Youth Program]. We had an incident recently where… one of our staff had to call 911 for a 5150 assessment and the [Child/Youth Program] was off. But because they know that [local law enforcement] is embedded with [Child/Youth Program], they felt like some of the walls were already broken down on how to talk that officer and they knew obviously these officers have some understanding of mental health, and the importance of how we're talking to this student because they let the [Child/Youth Program] be part of their department. So, that's really helped. [School-County Collaborative Program Lead: P18 I016]

4) By providing options for co-response with law enforcement to promote de-escalation and appropriate crisis response.

We have a couple of [city] police officers that were very involved with kids not getting trafficked and they are super involved with that. And then, they've got us on speed dial when they've got one of these kids, so we work closely with them to find an alternative for some of those situations. [Child/Youth Program Lead: P11 I063]
We're frequently contacted by law enforcement to come out and assist if they're not sure or if they feel like it's gray. They'll often call us not only for this, the youth piece, but for what [program lead] was speaking to, the mental health evaluation team. We get frequent contacts from law enforcement. [Child/Youth Program Clinician: P14 I097]
So, when a kid acted up, let's just say it was a normal kid who's acting up, throwing a tantrum they would call the school resource officer because schools have a zero tolerance now for anything. Anything out of the ordinary in the way of learning, they involve a crime, they involve law enforcement, whatever. So, we start building really good relationships with the school resource officers knowing that they're now like the hub of the school. So, there's times now when the school resource officer will just call us directly, we'll come out and help them make an intervention, get the kid back in the class without even having to involve too much of the principal, the teachers, the parents or anybody sometimes or other times, we do bring them all in. [Child/Youth Program Lead: P12 I060]

Programs also draw attention to situations where law enforcement involvement is either necessary or where it is presently required but not necessarily indicated given the situation (that is, where unnecessary law enforcement involvement could be reduced through policy changes). A major area of law enforcement involvement in many counties concerns 5585 involuntary detention holds which often involve law enforcement because 1) the crisis itself involves a threat to safety to which law enforcement have been called in to respond, 2) law enforcement are empowered to write such holds by county policy, or 3) law enforcement are not permitted to write such holds and must coordinate with county behavioral health when they encounter a situation in which a hold might be indicated. Where law enforcement is unable to write holds, a program lead describes this is a significant factor in increasing their interactions with law enforcement:

…if the youth [in crisis] is in the community, then law enforcement has to call us to come do the evaluation and write the hold. So, we're always in contact with the different police departments and our Sheriff Department. [Child/Youth Program Lead: P21 I059]

While policies regulating whether or not law enforcement can write holds may not directly affect the frequency of law enforcement involvement in mental health crises as such, they are an important element of context to explain *how* law enforcement is differentially involved in mental health crises by county.

Law enforcement may also be required to be involved in holds to the extent that policies exist that mandate their participation; one school-based program, for example, reported that local policies require law enforcement to dispatch the ambulance for 5585 holds:

> *I mean ideally, I think we could call for an ambulance… because I'm writing the holds. I don't need the police officer to write the hold. That I could, you know, have a direct connection with the EMT and we wouldn't need the police officer.* [Child/Youth Program Clinician: P16 I064]

In such cases, the clinician described their role as one of "harm reduction":

> *…for me clinically knowing that I have to involve a police officer… in a hold while I'm working to prepare the student for… what will happen as we're moving through the process, it's, you know— I try to use the information that I've learned from doing holds before to provide a more trauma-informed experience for the young person. To sort of say, you know, "the police officer now has to come in here and speak with you for a moment and has to, you know, has to search your backpack" and that… might be really scary… whatever sort of I think is going to come up around that. But just to prepare them 'cause it's worse if you're sitting there and all of a sudden a police officer's searching your backpack and you didn't know that was coming.* [Child/Youth Program Clinician: P16 I064]

A final consideration related to the involvement and role of law enforcement in SB-82/833 crisis programs concerns law enforcement response to the increased attention to, and criticism of, police violence toward people and communities of color as well as broader debates about law enforcement involvement in communities. Staff in two programs described changes they observed in the willingness of law enforcement, and even medical transport, to respond to mental health crises:

> *I know there was a situation where we had someone that was actually on a hold, and an evaluator had gone out and seen them. And the person was unwilling to go and so, typically in a situation like that, we would call law enforcement to come help us with transportation. And in this particular incident, they weren't going to facilitate that, which would have meant them going and probably putting somebody in handcuffs and transporting them in the vehicle.* [Child/Youth Program Clinician: P14 I097]

> *We had somebody that we put on hold, they would run in their house and close their door and knowing that law enforcement was going to come in there and get them. And we were there standing with the hold, and law enforcement would drive away. So, they couldn't do anything. So, now we have a hold, what do we do? So those are tough because we can't force entry into the home. And if we get the name of the officer, we document everything we need to document, we made an attempt, we tried. There're times that we've had to just walk away with with a hold in hands which is scary for us, legally.* [Child/Youth Program Clinician: P12 I060]

Increase Access to Mental Health Services and Supports through School-Community Partnerships

Increasing access to a continuum of mental health services and supports through school-community partnerships is a SB-82/833 Triage Grant program goal for School-County Collaborative programs. Despite significant variations in the care processes and services provided by each School-County Collaborative program, each is structured by active, ongoing formal partnerships with local education agencies, such as county offices of education, SELPAs, and school districts. Program leads in all four School-County Collaborative programs, as well as all four school-based and/or school-focused Child/Youth programs, at least somewhat agreed that the activities and services of their SB-82/833 program was suitable for and effective at increasing access to a continuum of mental health services and supports in schools as well as in developing new or strengthening existing school-community partnerships for mental health. Additionally, one other Child/Youth program agreed that their program was suitable for and effective at increasing access to mental health supports in schools and three other Child/Youth programs agreed that their program was suitable for and effective at increasing developing new or strengthening existing school-community partnerships for mental health.

Each School-County Collaborative program describes specific enhancements to school mental health services that are tied to these partnerships; that is, program leads and staff do not merely describe the introduction of new mental health supports in schools as such, but also new methods of integrating mental health supports and community resources into the operations and culture of educational agencies and schools. One program lead for a School-County Collaborative program encapsulated that attitude when describing the intentions of the program in his county:

> *Because each community is different and each community has different resources, and each school is different that has different resources. So, you know, the strength of the program I think is collaboration and one of the barriers is when people think that it's [just] a mechanism to deliver mental health. And I don't think that's the intention of this… project and the OAC, the new legislation, or really anything I think I've seen from the governor lately. So, you know, I don't know. I guess I get excited about the collaboration.* [School-County Collaborative Program Lead: P18 I032]

This perspective was shared by other program leads and staffs in both the School-County Collaborative programs as well as the two school-based Child/Youth programs; indeed, they often described extensive efforts to ensure that their services were not siloed and that their operational reach extended into community supports that were not otherwise leveraged in school settings. As described in section 4.1.1 (Descriptive Characteristics: Care Processes and Services) and section 4.2.2 (Cosmopolitanism), school-based programs generally targeted a wide range of care processes by integrating an impressively diverse array of agency, school, and community resources. In doing so, every School-County Collaborative or school-based program addressed increasing access to a continuum of mental health services and supports through school-community partnerships in at least one of three ways:

1) By offering services that didn't previously exist at schools

> *…for the elementary schools and middle schools this is all brand new, they haven't had anything like this before.* [School-County Collaborative Program Lead: P18 I016]

> *…we didn't have anything like it, and so, the grant enabled us to start a brand-new program and offer a brand-new service.* [School-County Collaborative Program Lead: P22 I069]

And then, just being an extra layer of support… most schools, they have access to a school psychologist or school counselor, but they are missing that mental health piece. And so, when we've done our surveys like at the end of this second year, the first school cycle, a lot of the feedback was, you know, having this instant immediate access to a mental health person was invaluable. [School-County Collaborative Program Lead: P01 I019]

2) By increasing the reach and intensity of services at schools

…looking at the data that we've been collecting and, this was surprising to me, but… it's probably been helpful is that our staff, our teams have averaged I think 7 to 8 interventions or points of contact with families once they get a referral. So, I think when we originally wrote the grant, we were thinking they would intervene and then help connect to a long-term service and then step out of it. And I don't think we really imagined, we didn't know how long that would take, but it's in some ways, our [SB-82/833 program] teams are staying connected a little bit longer just to make sure that the families do engage in the other referred services and if that takes a while that they are staying connected and still providing interventions, so that the families aren't left with, without any kind of support. [School-County Collaborative Program Lead: P22 I069]
…yes, we started as a PBIS team, we still are, right, providing that technical assistance support. But I think that's really developed our relationship with our folks; they know who we are, they know who to contact. Right, it's something we still push out there, hey, you know solidify with our newsletters, our PBIS [programming], our parent [engagement]. I mean, just really trying to push our resources and support, but I think that's been really the foundation of this team has been the ability to know who we are, what we do. It always goes back to that marketing component with our entire organization right, how do we push out those supports, how do they reach us. [School-County Collaborative Program Lead: P10 I033]

3) By doing the above using a partnered approach—integrating community and agency resources—to offer greater depth of care

…the part that's really working for the school grant is that the clinician goes there, they meet with the family, when they can develop a safety plan, they come back, we get them hooked up with services, we have a children family team meeting, we get the school involved, we get everybody that needs to be involved, we get them a doctor, a clinician, a case manager, and hope for stability. And um, a lot of times it's working really well. So, that part of the grant is awesome, and I really like it. [Child/Youth Program Lead: P11 I063, describing integration with School-County program]
I would say too, in regards to the partnerships, even though there's always been good relationships between the various levels, I was at [school site] for five years and until [program staff] got there, I didn't know a lot of things existed. And so, it really opened options up for our families and our students and in ways that you know most administrators aren't trained in. And so, we don't know what to reach out to, but with the wellness center and staff that was provided for us, it really bridged that connection and strengthened the relationships between the different agencies and in a more meaningful way. [School Administrator at School-County Collaborative Program Site: P18 I048]
…there's all these different providers and it can be very siloed and that's not the way families work, you know. Like we, we work that way as an agency, um but really to provide the best services and I think, I especially see this with younger kids where there

really isn't a separation like here is your physical health, here's your mental health, here's your academic functioning, like those are not several separate entities, like there are so intertwined that in the way our agencies are set up: you have a very specific role and you provide this role. But not everyone's… talking to each other and it's sort of up to the family to try to pull that together and that could be overwhelming. So, I really do like [School-County Collaborative program], that I feel like you can look at that bigger and not just the level [of] family… like providing support to the people that are providing the support. So, just thinking about all the levels that you need to support for this to be a healthy community. [School-County Collaborative Program Clinician: P22 I053]
…the grant is a little more concerned with mental health and I think that sometimes those things are spoken of separately as opposed to integrated. And I that um, this team has done a really good job of integrating those two and then you add education, right. You know, education and social-emotional sometimes live in two different buckets and then you add mental health. So, the way of really infusing all of these in these two sites has been really innovative. [Child/Youth Program Lead: P05 I007]
So, we really try to kind of bridge the gap also between the school setting and the mental health. …whenever we do send a referral, you know, oftentimes, they get lost or we don't know what happened with that student. So, we try to have collaborative meetings at least monthly with the county mental health providers. Make sure you know, if we submitted a referral or if the school submitted a referral, identify those referrals and talk to the county mental health about if they reached out, did they scheduled an assessment, if not, what were the barriers to that, what could we do to support that and connect with the family to make sure that student is going to get an assessment. So, that is another thing, a big part of what we do. [School-County Collaborative Program Staff: P02 I020]
People are coming our way. Our community services assistant is really good at making those connections; she attends all of the… virtual community events here. But, just getting our name out there, so people are starting to reach back out to us and saying, "hey, we have this family in need." It's all about relationship and connection. [School-County Collaborative Program Staff: P10 I024]

Develop Crisis Response Systems on School Campuses

Developing coordinated and effective crisis response systems on school campuses when mental health crises arise is a SB-82/833 Triage Grant program goal for School-County Collaborative programs. Program leads in every School-County Collaborative program as well as every school-based and/or school-focused Child/Youth program at least somewhat agreed that their program is both suitable for and effective at developing coordinated and effective crisis response systems on school campuses when mental health crises arise. Additionally, three other Child/Youth program leads also agreed that their programs were suitable for and effective at developing such systems. One non-school-based Child/Youth program noted that their program was not effective in this area due to "limited staffing," which meant that "greater response to schools for youth in crisis was not possible." In total, eleven of the thirteen Phase 1 programs in operation for the majority of the grant period at least somewhat agreed that their programs addressed this goal.

Prior to the pandemic, program efforts toward developing coordinated and effective crisis response systems on school campuses were often aimed at ensuring that effective referral systems were in place and that these referral systems were known to and utilized by appropriate parties both in and outside of school settings. In some cases, these crisis response systems involved coordination

between School-County Collaborative and Child/Youth grants to develop a more efficient and organized division of labor within the response system. For some School-County Collaborative programs these efforts also involving providing support for schools to track and understand their interventions to improve effectiveness in existing systems. While many of these systems were strained or altered by the COVID-19 pandemic school closures, one of the most noteworthy contributions that many School-County Collaborative and school-based Child/Youth programs made was in their active participation in new pandemic-initiated crisis response initiatives, especially related to identifying student population needs, reaching out to students who were "virtually truant," and establishing new procedures and trainings related to risk assessment on remote platforms.

School-County Collaborative or school-based programs addressed developing coordinated and effective crisis response systems on school campuses when mental health crises arise in at least three ways:

1) By providing the capacity and coordination for new referral and tracking systems to be put in place, both prior to and during the COVID-19 pandemic

…from all the feedback I've heard from administrators, from schools, um, is that they're really just thrilled to have some presence and kind of know who to call when there is a crisis. [School-County Collaborative Program Lead: P22 I069]
A huge component of it is using universal screening for behaviors and so, for the school districts, and building the capacity of in the school districts, at their entry point when they're ready… to do universal screening for behaviors for internalizing and externalizing… so [education agencies] in building their capacity to help educate them on what to do next on students who might have lower-level behaviors that they could address earlier instead of just an individual counseling referral for every kid and having them learn and identify when it is they might use that as a support and then utilizing… our clinical support as well. [School-County Collaborative Program Lead: P10 I049]

2) By providing resources and support to ensure that existing systems are used more appropriately and effectively

We have a… tracking tool that we train our school on… Keeping track of how they're utilizing and quite frankly formalizing those systems of support, so, we absolutely know that interventions are done all the time on campus. We're trying to help them de-stigmatize intervention so they're not being reactive and really have something in place for when students need that support, they're able to start something with the students to keep track of the information and how successful that student has been and or if the intervention itself needs help. Because it's not always the student, it's the intervention in which it's getting implemented. They're not doing it with fidelity or they're actually just doing it wrong and so we're helping them keep track of that to make those decisions. [School-County Collaborative Program Lead: P10 I049]
So, we will be reviewing, you know a set of students every week or every other week to give them access to services, monitor how those services are happening, make referrals to community providers, make internal referral services at school, tracking those services and either increasing if a student needs more or exiting from services because you shouldn't be in some of these things, it's not a life sentence you know, you shouldn't have to do some programs forever. [School-County Collaborative Program Lead: P18 I032]

3) By using these referral systems to ensure that major crises in schools are addressed in a timely and appropriate manner

…what we've found over this first year really is that um, the, number one the schools greatly appreciate having having um, staff that are in their regions that are available that they can call when there is a student in crisis um, they've really valued developing their relationships and working closely with our teams and our regions. [School-County Collaborative Program Lead: P22 I069]
So, [crisis situation] was kind of a perfect collaboration of all the people involved including our doctor and nurse and the [School-County Collaborative program] and it all turned out for the best. … But it did work out really well and those connections that they were able to do with the school were things that we wouldn't really be able to do. We are more connected to law enforcement, emergency rooms, that kind of thing. So, it was kind of perfect. [Child/Youth Program Lead: P11 I063]
Just last week we had a crisis situation at the very end of school and an administrator was dealing with it, but he was very grateful, it was really out of his realm and comfort zone and really professional skill level. And, he was able to give a warm handoff to the wellness center and we were able to um, address that appropriately and get the student the help that she needed. So, I think that this school, I mean this is the quote that's been said before is, once you have a wellness center, you won't not have one. Because there's, there's so much value to it and shifting of the culture is such a huge piece that. [School-County Collaborative Program Lead: P18 I073]

Engage Parents and Caregivers

Engaging parents and caregivers in supporting their child's social-emotional development and building family resilience is a SB-82/833 Triage Grant program goal for School-County Collaborative programs. Program leads in every School-County Collaborative program at least somewhat agreed that their program is both suitable for and effective at engaging parents and caregivers in supporting their child's social-emotional development and building family resilience. Program leads for one school-based, two school-focused, and five other Child/Youth programs also at least somewhat agreed that their programs were suitable for and effective at engaging parents and caregivers (the one school-based Child/Youth program lead who responded "Don't Know" is in a program that contracts its direct services). In total, twelve of the thirteen Phase 1 programs in operation for the majority of the grant period at least somewhat agreed that their programs addressed this goal.

Parent engagement is a frequently described component of all School-County Collaborative programs and most other school-based and school-focused Child/Youth programs. For all programs that provide acute crisis intervention services, this engagement is often carried out through parental involvement in care and safety planning, such as through family team meetings. However, ***programs providing a wide variety of care processes also describe separate efforts to provide outreach, training, support, and resources to parents and caregivers beyond immediate interactions in the course of discrete crises***. Especially during the COVID-19 pandemic, as described in section 4.2.3 (Adaptation during the COVID-19 Pandemic: Challenge, Innovation, and Opportunity), many programs were actively involved in developing new modes of engaging parents and caregivers: producing informational resources for parents and caregivers on detecting mental health needs, using social media to outreach to parents and caregivers, running remote support and activity groups, and providing remote trainings to help parents and caregivers support youth during remote schooling and (later) adjusting with school re-openings. Several programs described a high level of need among parents and caregivers for engagement and support during the pandemic and

worked hard to leverage increasing awareness about mental health among some parents and caregivers to both meet this increased need and encourage continued utilization of mental health resources for their children in the future.

I also want to add that these two ladies were instrumental in our engagement process because, so as a team we developed a process and a protocol for reaching out to families for students who were not engaging in the in the material like we would like to see, and they were a part of that tiered system. And they worked so hard to reach out to families and engage families and figure out what, what the barriers were to them accessing and so, that only a few filtered up to needing more intensive support, but they were a key part of that process during distance learning [School Administrator at School-County Collaborative Program Site: P18 I048]
…so that's where some districts have really appreciated us being able to come in and re-define that school-parent relationship and help get the parent involved back involved in that student. And in doing so and building relationships with parents, there's times that we discover other needs whether food-related, you know, heat-related, whatever the case may be. And so, being able to troubleshoot that and link them with other additional resources is a really important piece as well. [School-County Collaborative Program Lead: P01 I010]
So, we provide parent trainings. We provide resources for parents in need, any family in need actually, you don't have to be a parent, we'll provide any resource that you might need. So, we go out to the different school sites, um, and do parent trainings at school sites and also, if somebody is in need at a school site, we will go out and with meet them and accommodate whatever resources they might need. [School-County Collaborative Program Lead: P10 I098]
It might be working with a family specifically to connect them to other resources in the community, if it's maybe more of a family stressor that maybe led to the youth acting out some, but that could be connecting a parent with um, job resources or housing resources or other. So, it's kind of a varied, depending on what the crisis is and what the student and family needs those navigators and parent support coaches could be, um, they're not just making a single referral to one agency per say. It could be really varied as far as what each youth and family are really needing to be stabilized. [School-County Collaborative Program Lead: P22 I069]
I just heard… really, really positive feedback about the trauma trainings that [program staff] has provided. Our supervisor over… our recruitment for foster parents and resource parents, noted that we had incredible turnout at those events and not only of foster parents who are newer—that tends to be who shows up to trainings. She also noted that we had parents who've adopted children from the foster care system who have really sort of been off our radar for quite some time. But… really found that the topic was so relevant to them, that they're raising children who've experienced significant trauma, that they attended and really had positive feedback. [Child/Youth Program Lead: P20 I067]

Reduce Special Education Placement and School/Community Removal

Reducing the number of children placed in special education for emotional disturbance or removed from school and community due to their mental health needs is a SB-82/833 Triage Grant program goal for School-County Collaborative programs. Of the SB-82/833 Triage Grant program goals for School-County Collaborative programs, this was the most challenging for most programs of any grant

type to address due to the severe disruptions to educational systems that occurred during the COVID-19 pandemic. Previously described disruptions to school systems for identifying need were compounded by disruptions to the delivery of special education services as well as to school discipline procedures. To the extent that programs intended to work directly with special education or to intervene on the use of discipline in schools, such efforts were often significantly altered under remote schooling. Many school-based programs were still able to work towards changing the culture in these areas, but noted that these efforts were unlikely to be visible according to standard metrics given the massive disruptions to special education and school discipline systems.

Program leads in three of the four School-County Collaborative programs at least somewhat agreed that their program is both suitable for and effective at reducing the number of children placed in special education for emotional disturbance or removed from school and community due to their mental health needs. One School-County Collaborative program noted that this goal was not applicable to their program since they do not deliver direct services in schools. One other Child/Youth program reported that their program activities are suitable for and effective in this area. In total, only four programs of either grant type at least somewhat agreed that their programs were suited for and effective at reducing special education placement or removal from schools/communities due to mental health needs.

Although not all programs were either designed to meet this goal or believed they had been able to address it extensively, interviews with some programs' leads and staff did address specific actions that could address utilization of special education and school discipline:

1) ***By tracking special education utilization to understand how and when it may be disproportionately used for minoritized students or students with mental health needs***

2) ***By working with school staff in special education to improve their knowledge of and access to mental health resources***

One of the things in collaboration with special ed department, they really weren't well-versed in sort of the mental health world and which services were available and how do you make referrals, what's the difference between a client that has Medi-Cal and private insurance. So, we've been sort of answering questions, sort of helping them better understand what makes community mental health different from someone with private insurance and begin to see how we can identify kids earlier in the pipeline that might benefit from mental health services, that's one. [Child/Youth Program Lead: P16 I079]

3) ***By tracking school discipline to understand how and when it may be disproportionately used for minoritized students or students with mental health needs***

4) ***By working with school staff to improve systems and cultures in school discipline before the COVID-19 pandemic***

I'll say too that a lot of, pre-shutdown, a lot of our data looked very promising just since… all of these [program services] have been brought on. It was really depressing actually when everything basically was nullified, but our suspension data, our academic data—attendance wasn't quite there if I remember correctly, but the, those other two data points we're looking very promising prior to the shutdown. [School-County Collaborative Program Lead: P18 I048]
…the assistant principals tend to take on more of the disciplinary and handling behavioral referrals, and so both of our triage clinicians worked really closely with them to find—so, before COVID-19, when there was more behavior referrals—but like how do

> *we respond to those without them just being suspensions, what are other supports that we can provide. And then… that hasn't had to be such a focus since we've been distance learning there's not, as far as I know, not like behavioral referrals. ... So, but that was a really, even in just the short months they were there, there was starting to be a huge shift in that conversation, like not every behavioral referral has to be a suspension, which I think was an attempt.* [Child/Youth Program Lead: P05 I056]

Finally, several programs raised considerations related to special education, including fears that school closures and trauma during the COVID-19 pandemic would result in large increases in need for and/or utilization of special education in the upcoming years. Another program lead connected special education utilization to insufficient resources for meeting existing mental health needs, noting that increasing the capacity to detect mental health needs in schools without sufficient resources to provide long-term, robust services to address those needs would likely result in long-term overutilization of special education as an alternative.

4.6.2 Target Program Activities and Proximal Program Outcomes

This section describes how findings on program implementation address target activities and provide important preliminary considerations for future measurement and interpretation of their corresponding proximal program outcomes. ***As with the SB-82/833 Triage Grant program goals, the specific ways that programs engage in these target activities are customized to their particular system structure and community needs***.

Cultivate Partnerships

Following the findings in sections 4.1.2 (Complexity), 4.2.2 (Cosmopolitanism), and 4.3.2 (Networks and Communication), current evidence indicates that cultivating partnerships, both in and outside of implementing organizations and program settings, is a major way that programs address their own program goals as well as SB-82/833 Triage Grant program goals. ***While the COVID-19 pandemic had variable effects on the formation of new partnerships and sustainment of existing partnerships, present evidence strongly points to the ongoing importance of these partnerships to program implementation***.

The corresponding proximal program outcomes proposed in the evaluation plan for cultivating partnerships are the number and type of new memoranda of understanding (MOUs) and the number of inter-disciplinary team meetings to capture the creation of new and the sustainment of existing partnerships, respectively. Qualitative data, however, suggest how these metrics require contextualization to accurately represent the ways that programs practically cultivate partnerships. Focusing on MOUs to address new partnerships may inadvertently prioritize formal partnerships over the informal partnerships and relationships that program leads and staff emphasize in describing their work. Since highly complex and extensively networked programs are unlikely to have the time and resources to formalize agreements with every agency or organization with whom they have important ongoing collaborative relationships and, moreover, the disruptions of the COVID-19 pandemic likely inhibited the development of new MOUs even where they might otherwise have been pursued, the number of MOUs likely underestimates the true extent of new partnerships. This is also true for tracking cultivation of existing partnerships using inter-disciplinary team meetings, which may underrepresent the extent to which such relationships are sustained by ongoing direct coordination outside of the formal context of meetings. Finally, tracking the number and type of MOUs and number of inter-disciplinary team meetings will require supplementation to capture important relational

elements of partnership, that is, the complex interlinkages that programs often describe as the real assets to their programs.

Integrate Program Teams

Current evidence suggests that ***programs are engaged in activities to integrate their program teams in support of both SB-82/833 Triage Grant Program goals and their own program goals, but encounter some barriers to doing so***. The corresponding proximal program outcomes proposed in the evaluation plan for integrating their program teams include three markers of team integration: 1) development of new communication channels within the implementing organization, 2) changes in hiring or staff allocation, and 3) task shifting over time. Findings in section 4.3.2 (Networks and Communication) and section 4.3.4 (Readiness for Implementation: Leadership Engagement) indicate that programs are engaged in the development of new communication channels within their organizations and findings in section 4.2.3 (Adaptation during COVID-19: Challenge, Innovation, and Opportunity) also indicate how these lines of communication were both challenged by and, in some cases, enhanced during the pandemic. Findings in section 4.5.1 (Simplification) address how programs adjust their staff allocation and reorganize tasks to better integrate their teams. All three markers of team integration, however, are affected by findings in section 4.3.1 (Structural Characteristics: Team Stability), which suggest that improvements in team integration that program make may be offset by staff turnover and gaps as well as challenges hiring qualified staff when turnover occurs.

Linkage of Agency/School Supports and Referrals

Current evidence suggests that ***SB-82/833 programs are engaged in activities to link clients to supports and referrals appropriate to their service settings***. Eleven of the fourteen Phase 1 SB-82/833 programs indicated in the Data Coordinator Survey that “Referral” is one of their program’s target areas and that they provide referrals and linkage as one of their services. In interviews, both Child/Youth and School-County Collaborative programs described a wide variety of supports, both mental health and non-mental health, to which they refer youth and families. Some of these supports include the organizations and agencies identified in the findings in section 4.2.2 (Cosmopolitanism). The corresponding proximal program outcomes proposed in the evaluation plan for linkage of agency/school supports are the number and type of links made. Interviews have expanded our understanding of how referrals and linkages are made, suggesting that programs may have limited ability to track whether or not referrals result in completed linkages. These challenges are related to limitations of data infrastructure and data system integration discussed in the findings in section 4.5.4 (Progress Tracking and Reflection). Additionally, findings in section 4.2.3 (COVID-19 Pandemic: Changes in Community Needs) indicate that many programs may have increased their linkages to resources related to basic needs during the pandemic.

Deliver Crisis Prevention and Intervention Services to Clients

Current evidence suggests that ***SB-82/833 programs are actively working to deliver crisis prevention and intervention services to clients***. While these services were expected to be especially relevant to Child/Youth programs, most School-County Collaborative programs also provide direct services to students in schools. Only one program does not provide direct services as part of its SB-82/833 program, but provides direct support and other system enhancements to the units in its organization that do provide prevention and intervention services. The corresponding proximal program outcomes proposed in the evaluation plan for delivering crisis prevention and

intervention services to clients are number and type of services delivered. Interviews and direct feedback from programs on survey development have provided the evaluation team with a richer understanding of the overall types of services provided by programs and suggest that quantitative accounting of services (whether aggregated in the program survey or via extraction from client-level data sources) will not comprehensively capture all services delivered by programs. Following findings in section 4.5.4 (Progress Tracking and Reflection), extant program service data sources are likely to systematically underreport services that are either not routinely documented, not billable, provided in certain non-mental health settings (such as classrooms), and non-clinical (such as case management or follow-up). Some of these types of services are discussed, and thus can be documented, using qualitative data but will not be possible to comprehensively quantify. Counts of services delivered will also need to be contextualized in light of major sources of disruptions to service delivery, most notably the COVID-19 pandemic. Moreover, programs brought to light program or county-specific considerations that could impact service delivery figures, including seasonal and weather-based trends.

Deliver Mental Health Trainings and Activities

Current evidence suggests that many ***SB-82/833 programs are actively working to deliver mental health trainings and activities within their program and other sites***. As expected, these activities are especially relevant to School-County Collaborative programs, though all school-based programs and some other Child/Youth programs also provide such activities. Several Child/Youth programs intended to deliver more activities, such as psychoeducational programming and trainings for parents and caregivers or prevention-based activities, but either reduced their emphasis after funding cuts or found that their resources were already strained delivering their core crisis response and intervention services. As described in findings in section 4.2.3 (COVID-19 Pandemic: Changes in Community Needs), some school-based programs also described increased needs for preventive and universal supports for students as well as greater demand for trainings and support for teachers and school staff. The corresponding proximal program outcomes proposed in the evaluation plan for delivering mental health trainings and activities are number and type of trainings and activities delivered. Similar to number and types of services delivered, interviews suggest that trainings and activities are likely to be underreported, especially to the extent that activities are not already routinely documented by programs. Some of these types of activities are discussed, and thus can be documented, using qualitative data but may be difficult to accurately quantify.

4.7 Implementation Outcomes

Previously described findings and survey responses suggest preliminary conclusions around the acceptability, appropriateness, feasibility, fidelity, penetration, and sustainability of programs through mid-2021.

Detailed analyses and data tables on program lead survey items on each implementation outcome by program maturation, school-based status, and urban/rural county can be found in Appendix C [section C.4, tables 46–49].

4.7.1 Acceptability

Program acceptability entails the extent to which the service or program is perceived by staff and leads as satisfactory. Findings in section 4.4.1 (Knowledge and Beliefs about Programs) indicate that ***program acceptability is generally quite high***, with only a few indications of significant concerns

among staff about how their programs are designed. While findings in sections 4.1.2 (Complexity) and 4.2.2 (Cosmopolitanism) indicate that SB-82/833 programs are in many ways challenging to deliver, program leads and staff suggest that programs are satisfactory even to the extent that they are challenging. Indeed, ***many of the most highly prioritized aspects of SB-82/833 programs—such as bridging gaps, building relationships both in and outside of the implementing organization(s), extensive county or site penetration—also make them more challenging to deliver***. Responses to the Program Lead Survey provide further confirmation that program leads consider their programs satisfactory: leads from all thirteen of the fourteen Phase 1 SB-82/822 programs in operation for the majority of the grant period at least somewhat agreed with at least two of three statement measuring program acceptability:

The design of this SB-82/833 program is appealing
The components of this SB-82/833 program meet my approval.
I would suggest this SB-82/833 program to other counties/communities.

Most program leads at least somewhat agreed with all three statements, only two program leads agreed with two of the three statements. One qualified their disagreement with the statement on program design response by noting that the limited scope of the staff role funded by the SB-82/833 Triage Grant program "impacted the persons job satisfaction and the workflow of the broader team," which further supports a previous finding in section 4.1.3 (Adaptability) on programs' desire for flexibility in their funded programs.

There are few major challenges to program acceptability identified in the present findings. Challenges related to the limits of program adaptability (see section 4.1.3 [Adaptability]) and strain on program staff (see section 4.2.3 [Adaptation during COVID-19: Challenge, Innovation, and Opportunity] and section 4.3.1 [Team Stability]) are presently among the most likely barriers to acceptability.

4.7.2 Appropriateness

Appropriateness refers to the relevance or fit of the program to its context, which can include community and organizational contexts. Findings on how programs are tailored to their outer and inner settings indicate that ***SB-82/833 programs are generally considered highly appropriate for meeting and adapting to the needs of their communities*** (see section 4.2.1 [Needs of Patients and Communities] and section 4.2.3 [COVID-19 Pandemic: Changes in Community Needs]) ***and building and enhancing partnerships within and outside of their implementing organizations*** (see section 4.2.2 [Cosmopolitanism], section 4.3.1 [Structural Characteristics: Social Architecture], and section 4.3.2 [Networks and Communication]). Programs also generally fit within the organizations that implement them and work to overcome challenges in fit with partners in other sectors (see section 4.3.3 [Organizational Culture and Climate: Compatibility]), which constitutes part of their perceived appropriateness to program leads and staff implementing them. Responses to the Program Lead Survey provide further confirmation that program leads consider their programs appropriate for their outer and inner settings, respectively; all program leads for Phase 1 programs in operation for the majority of the grant period at least somewhat agreed with the following statements:

This SB-82/833 program is fitting for the needs of children and families in this county/community.
This SB-82/833 program is a good match for my organization/agency.

Findings on the extent to which program activities align with and address SB-82/833 Triage Grant program goals (see section 4.6.1 [Triage Grant Program Goals]) also support the conclusion that SB-82/833 programs are generally appropriate for providing the types of dedicated child crisis triage services envisioned by the funder.

There are few major challenges to program appropriateness identified in the present findings. A potential barrier to appropriateness concerns the extent to which sustainability planning may transition SB-82/833 programs to funding sources that reduce their ability to provide services that are well-tailored to their community needs and the gaps in their existing service systems (see section 4.5.3 [Funding, Revenue, and Sustainability Planning]).

4.7.3 Feasibility

The feasibility of a program refers to the extent to which a program can be executed successfully by the implementing organization and/or within a particular setting. Findings suggest that, ***while SB-82/833 programs are generally feasible in principle, they face several barriers to feasibility in their execution***. For especially complex and cosmopolitan programs, the number of partners involved certainly impacted program feasibility to the extent that they faced barriers (such as regulatory challenges or external leadership buy-in) that either delayed implementation or took effort away from program operations (see sections 4.1.2 [Complexity] and 4.2.2 [Cosmopolitanism]). Following the conclusions on program acceptability, however, overcoming these challenges in an effort to introduce mental health services to new settings is also among the higher priorities of many programs.

The biggest barriers to feasibility for SB-82/833 programs, however, concern the availability of necessary resources, including funding, access to critical community assets for mental health, and access to sufficient staff. For many programs, adjustments to their programs made in response to SB-82/833 Triage Grant program funding cuts made their programs more difficult to deliver, as they sought to ensure that their programs continued to meet their initial proposed goals, as well as SB-82/833 Triage Grant program goals, despite significant reductions in their funding (see section 4.1.1 [Descriptive Characteristics: Grant Funding]). Efforts to patchwork sources of funding to increase the resources available to programs was somewhat successful for mitigating this challenge for some programs, but also impacted program feasibility to the extent that such efforts disrupted early program implementation planning for these programs (see section 4.5.3 [Patchwork Funding]). Compounding limited funding for program implementation were deficiencies in critical community assets for mental health in some counties, which created additional complications in service delivery and linkage for many programs (see section 4.2.2 [Cosmopolitanism: Community Assets]). A final major challenge concerning program feasibility regards challenges with maintaining sufficient staff and staff stability; some programs were already working with very limited staff, which were then further overextended in programs that experienced challenges retaining and hiring staff (see section 4.3.1 [Structural Characteristics: Team Stability] and section 4.3.4 [Readiness for Implementation: Available Resources]). ***Major factors that offset these challenges and thus made programs feasible (indeed possible) to deliver are the adaptability and high level of engagement of many program leads and staff***, including some staff at the implementing organization that were not formally assigned to or funded by the SB-82/833 Triage Grant program (see section 4.1.3 [Adaptability] and section 4.4.2 [Self-Efficacy, Skills, and Engagement]).

Responses to the Program Lead Survey provide further perspective on program leads' attitudes toward the feasibility of their programs. All but one of the thirteen programs leads for Phase 1 programs in operation for the majority of the grant period at least somewhat agreed that their program was "implementable as proposed" (one lead, for a program that experienced delays at one program site, neither agreed nor disagreed). Eleven of the thirteen programs leads for Phase 1 programs in operation for the majority of the grant period also at least somewhat agreed that their program "is easy to implement." The two program leads that disagreed are both from complex school-based programs, which faced significant challenges related to program complexity and staffing. Two other

program leads who did agree, provided additional context to their answers. One program lead, for a School-County Collaborative program, agreed but provided an insightful comment:

> *While I strongly agree, creating and developing collaboration and new collaboration is not "easy". It requires long-term strategic planning, memorandums of understanding (backed by strong relationships), communication agreements, and shared vision. I firmly believe this is the work that must happen, but it is not just something on paper and requires integrated leadership, training, and coaching.* [P18 I032]

The lead for a school-based Child/Youth program also noted that the structure of the grant made it hard to create satisfactory work conditions for staff. These results suggest that school-based programs may have particular challenges related to ensuring that their programs are feasible to implement that warrant consideration.

4.7.4 Fidelity

The fidelity of program implementation refers to the extent to which the program has been implemented in accordance with plan or the intents of its designers. Findings on the extent to which programs were delivered as planned, and the adaptations necessary to do so, suggest that programs were, with a few exceptions, generally able to maintain fidelity. ***The biggest barrier to fidelity was most likely the effects of the COVID-19 pandemic, which significantly changed program demand, access to service settings, and methods of service delivery for many programs***. As with feasibility, the biggest facilitators of fidelity were the adaptability of programs as well as the dedication and engagement of leads and staff (see section 4.1.3 [Adaptability], section 4.3.4 [Readiness for Implementation: Leadership Engagement], and section 4.4.2 [Self-Efficacy, Skills, and Engagement]). However, despite the extensive impacts of the pandemic, fidelity was impacted more in form than in substance; ***adaptations made over the course of implementation were perceived by program leads and staff as generally sufficient to ensure that programs still provided intended services and addressed intended aims, even as the specifics of execution varied from what had been expected prior to the pandemic***. Many programs reported that they were able to make adaptations that allowed them to implement their services with close to fidelity in quality, especially those that provide field based/mobile crisis services. Others were able to provide services with at least reasonable fidelity in quality via telehealth, even as the technical aspects of care may have been easier to support than interpersonal care.

Beyond the effects of the pandemic, significant barriers to program fidelity were extensions of the challenges around feasibility, such as complexity, funding, community assets, and staffing. While programs felt that they were generally able to overcome these challenges, some programs did experience delays in implementation, some minor and a couple quite significant. As reported in the findings in section 4.5.2 (Executing), all but two Phase 1 program leads at least somewhat agreed with the statements capturing fidelity:

This SB-82/833 program has been carried out as originally intended.
This SB-82/833 has been implemented as described in the triage grant proposal/revised scope of work.

As previously described, the two program leads that did not agree were from a program that experienced contract and hiring delays with an external program site and from a program that suspended operations due to staffing and pandemic-related challenges.

4.7.5 Penetration

Findings on program penetration, or the extent to which programs are integrated into their organizational contexts, suggest that penetration varies significantly across programs. **Some programs are extremely integrated with other service teams in their organization** either because they work with other inner setting teams to coordinate their services, provide direct support to the operations of other inner setting teams, or because SB-82/833 funded staff are part of broader teams that are not funded by the SB-82/833 Triage Grant program (see section 4.3.1 [Structural Characteristics: Social Architecture] and section 4.3.2 [Networks and Communication]). Leads and staff described efforts to ensure that programs were well-integrated into their setting, such as through regular meetings, leadership engagement activities, and outreach within the implementing organizations. ***For programs that are set in non-mental health settings, however, the extent of penetration into those settings varies more***, as described in the findings in section 4.2.2 (Cosmopolitanism) and section 4.3.3 (Organizational Culture and Climate).

The biggest barriers to integration into these settings involve the extent of leadership buy-in and administrative capacity for partnerships in the proximate organization(s) (see section 4.3.3 [Compatibility]). While ***staff and leadership engagement likely mitigated those challenges***, findings suggest the importance of having available time to dedicate to communication and relationship-building. Therefore, limited resources (especially staff and leadership time) may be a barrier to program penetration. A second major barrier to penetration was the COVID-19 pandemic to the extent that it both took time away from and, for some programs, directly inhibited efforts toward overcoming barriers to compatibility with their partners (though some programs found the reverse was true). Despite challenges, program leads from all thirteen Phase 1 programs agreed that their program was "integrated into the regular operations of the organization and/or setting(s) it operates in."

4.7.6 Sustainability

Sustainability broadly refers to the extent to which a program is (or can be) maintained over time. Findings indicate that programs have a noteworthy mix of barriers to and facilitators of their sustainment over time. ***Major facilitators of program sustainability include their adaptability, the extent to which they are adequately prioritized by their implementing organization(s) and supported by leadership in their organizations*** (see section 4.1.3 [Adaptability], section 4.2.3 [Adaptation during COVID-19: Challenge, Innovation, and Opportunity], section 4.3.3 [Relative Priority], and section 4.3.4 [Leadership Engagement]). Programs' embeddedness in both outer setting partnerships and inner setting networks have mixed effects on sustainability; for some programs, the strength of these relationships is likely to facilitate future sustainment, as they provide both material and operational support to program implementation. However, for programs with barriers to building these relationships, especially programs housed by non-mental health settings, those same barriers may also inhibit future program sustainment (see section 4.2.2 [Cosmopolitanism] and section 4.3.2 [Networks and Communication]).

The most impactful barriers to program sustainability, however, center on resources: program sustainability will be low to the extent that programs lack stable resources necessary to sustain their operations on an ongoing basis (see section 4.1.1 [Descriptive Characteristics: Grant Funding], section 4.2.2 [Community Assets], section 4.3.4 [Readiness for Implementation: Available Resources], and section 4.5.3 [Patchwork Funding]) or are unable to secure adequate, predictable, and reliable alternative sources of funding and revenue following the end of the SB-82/833 Triage Grant program (see section 4.5.3 [Funding, Revenue, and Sustainability Planning]). Since many SB-

82/833 programs experience several challenges related to resources, which often compound each other, programs may find that without solutions their program operations become more challenging to sustain over time. Limited staff time and infrastructure and resources for data collection, progress tracking, and evaluation also make it harder for programs to identify areas needing improvement, which would promote more effective adaptation (see section 4.5.4 [Progress Tracking and Reflecting]). Besides having direct impacts on program operations, inadequacy in resources—especially staff time—may also either inhibit the continued development of the relationships that programs depend on for sustainment or, prevent them from being able to develop such relationships to increase their sustainability. Moreover, some of the most available options for financial sustainability are either temporary or require programs to make changes that may reduce their appropriateness.

5. Early Lessons Learned

The findings in this report provide some early key lessons learned from program implementation to date, including preliminary recommendations for enhancing the implementation of similar programs in the future.

1. SB-82/833 programs make noteworthy contributions to mental health services in their counties and communities.
   - Programs are designed and implemented to ***increase access*** to youth mental health by:
     - filling gaps in the existing child mental health services system
     - tailoring their programs to better understand and meet the needs of youth, including those in underserved communities
     - building stronger inter- and intra-agency partnerships and relationships
     - expanding mental health resources in sectors, especially education, that are critical to youth mental health
   - SB-82/833 programs are taking actions to ***improve the quality*** of mental health crisis services for youth in their communities by:
     - providing more age-appropriate and specialized crisis services for youths from dedicated child-focused clinicians and staff
     - having specialized and experienced mental health clinicians and staff coordinate and deliver crisis services, rather than relying on non-specialized staff (such as law enforcement or school counselors) at the frontlines of mental health care
     - increasing program capacity so that staff in different roles can focus on their own areas of specialization
   - SB-82/833 programs ***expand mental health and crisis services in schools*** by:
     - providing services and activities across the care continuum, including significant preventive and universal supports
     - integrating mental health into the culture of schools and school districts
     - actively working to overcome existing obstacles to collaboration across the behavioral health and educational sectors

2. SB-82/833 programs are heterogeneous and unique, in part because of the wide range of care processes involved in crisis triage, but largely because they are specifically tailored to the needs of their communities and service systems. Their value is likely a direct function of that fit. Given their heterogeneity and wide scope of activities, programs are therefore likely to benefit from ***flexibility in how their programs are designed and executed*** to ease their efforts aligning contractual obligations with the needs of their communities, implementing organization, staff, and partnered organizations. This flexibility would also enhance adaptation and allow programs to apply lessons learned more effectively during implementation.

3. Some of these major advantages of SB-82/833 programs—including their operation across multiple care processes on the crisis continuum, integration with teams both in and outside of their organizations, and partnerships across sectors—also make them more challenging to deliver. Programs would likely benefit from support directed toward these unique advantages and their corresponding challenges.
   - Given programs' level of specialization, complexity, involvement in partnerships, and tailoring to community needs, they may benefit from ***more time to design, plan, and ramp up their programs prior to the start of service delivery*** as well as support during that time to ensure that major barriers can be overcome. Ensuring that potential grantees have adequate time to conduct thorough needs assessments, develop their proposals with

stakeholders, and solicit potential partners prior to RFP deadlines may reduce unnecessary delays and enhance the feasibility of proposed programs. Once grants are awarded, programs may also benefit from time and support to learn and manage regulatory systems, initiate and build relationships with critical partners, and establish a progress tracking framework and strategies (especially if an external evaluation is involved).

- Since the success of most SB-82/833 programs depend on extensive, ongoing coordination between organizations, both to build critical relationships and manage contractual and regulatory compliance, ***additional administrative resources may be appropriate*** to support these efforts. This could include direct funding for administration or providing experts to provide direct, individualized consultation and support in key areas such as program design and implementation, sustainability planning, data infrastructure and management.
- Programs would likely benefit from ***additional support for developing effective partnerships in sectors relevant to their programs***. To the extent that specialized resources for support do not already exist, programs would likely benefit from access to venues to develop and share best practices for partnering with emergency departments/hospitals, police departments, and schools.
- Given the number and type of partners with which many SB-82/833 programs work, formalized partnerships may be most appropriate when initiated organically and tailored to need rather than administratively or bureaucratically mandated, which can add additional burden to programs on top of the coordination they are already engaged in.

4. SB-82/833 programs face ***challenges in ensuring that they have access to adequate resources*** to allow them to implement their programs and focus on program goals without straining their personnel. Programs implementation may be easier and more efficient to the extent that these resource needs are better met or that they have access to opportunities to learn about how to obtain such resources.
    - Programs are likely to benefit from ***increased clinical and other service staffing*** to make workloads more manageable and reduce the likelihood of staff burnout. Increased staffing would also make it possible for programs to increase the diversity of their staff and therefore provide more culturally appropriate care, offer services in needed languages, and reflect a more diverse set of lived experiences. Additional staffing would also ensure that staff have sufficient time for reflection and participation in higher-level improvements to their programs.
    - SB-82/833 program implementation would likely benefit from ***access to more robust community assets for child mental health in their counties***, such as youth psychiatric inpatient beds, crisis stabilization units, crisis residential programs, mental health urgent care clinics, and outpatient treatment resources. While SB-82/833 programs add value to service systems whether or not these assets are available, their efforts toward program goals would likely be more effective to the extent that they are less focused on compensating for absent resources.
    - Programs would likely benefit from ***more stable, predictable, and long-term funding opportunities***. Programs are likely to be more effective at providing core services and building sustained partnerships to the extent that they are less reliant on patchworking multiple sources of short-term, unpredictable funding and/or revenue. Such efforts may further deplete the limited administrative resources of programs and shifting to revenue sources that do not adequately cover the types of services and activities they provide may incentivize shifts in programs' priorities to what is billable rather than what is most appropriate for their communities and service systems. Access to longer-term funding options would also reduce programs' vulnerability to external disruptions (ranging from

large-scale disruptions, such as the COVID-19 pandemic, to local conditions such as temporary changes in budgets, natural disasters, or social disruptions) that are challenging to adjust to within a narrow funding window. Longer-term funding would also provide adequate time for programs to meet their higher-order goals, such as building robust, long-term relationships and establishing proof of concept to secure community funding. Especially given the ambitions of many programs to transform their service systems and build new cross-sector partnerships, for such programs to have a reasonable possibility of sustainment they may need more extended support to build the foundations on which that support is possible.

- Where programs would benefit from more resources than are immediately available (whether due to funding cuts, systemic factors, or even external shocks such as the COVID-19 pandemic), ***programs may need more learning opportunities to increase their capacity to close resource gaps***. This could include more opportunities for sharing lessons and support between programs as well as making trainings, individualized support, or consultation available to programs and their staff.
- To the extent that resources for child mental health services remain scarce relative to need, it may be advantageous to ***ensure that grant-funded programs are appropriately scaled to the resources available***, especially if funding is reduced. While SB-82/833 programs were generally able to provide the types of services they set out to, grant programs may be more effective to the extent that they fully fund more modest proposed programs rather than more ambitious programs that are systematically under-resourced.

5. Especially given limited staffing and resources and the inherent challenges of crisis work, SB-82/833 program implementation would benefit from ***support to develop strategies to reduce or mitigate the effects of staff turnover***.
    - Many programs would benefit from more systematic efforts to assess staff workload, detect signs of burnout, and work with staff to address issues before they progress. Additional clinical and service personnel would help ensure that staff are not overworked. Many programs would also benefit from ensuring that remuneration for positions is competitive, which may involve action at the county level. Other improvements to work conditions may also improve crisis triage programs, such as allowing crisis triage responsibilities to be shared or rotated to reduce individual burden.
    - Since some amount of turnover in staff is inevitable (retirements, medical or family leave, etc.), programs would benefit from the development of mechanisms to sustain resources, relationships, partnerships when staff turnover occurs. This is more possible where staffing and administrative resources are sufficient, and both administrative and service staff have adequate time to reflect on and document their work.

6. School-based programs, both Child/Youth and School-County Collaborative, have some special considerations that affect, and should be addressed, in grant program design and program execution.
    - ***School-based programs, in particular, may benefit from additional time between grant award and the expected start of services*** especially if they need to develop contracts and build relationships with school districts, hire staff in schools, establish a defined division of labor with existing school staff, or establish new workflows in schools. Since some programs are aimed at introducing mental health services to schools that are otherwise inexperienced, such programs would likely benefit from additional support toward achieving school readiness, including built in time to get buy-in from school/school district leadership, existing counselors, and teachers. Programs would also likely benefit from time to plan their outreach efforts toward students and families.

- ***Alignment of grant funding with the school year would ease implementation of school-based programs***. Some programs benefitted from time to plan their programs in advance of the school year; ideally, planning time should be aligned such that the program is ready to start when a school year begins and major transitions (such as grant sunset) do not occur mid-year.
- ***School-based programs may need additional support developing strategies to navigate between the data and regulatory systems that prevail in the mental health and educational sectors***. Navigating between HIPAA and FERPA compliance, in particular, was a challenge for several school-based programs and existing guidance may not be tailored to school-based programs that include both school and behavioral health staff.

7. For all SB-82/833 programs, a final lesson learned is that many of the challenges they face in implementation—providing services in multiple care processes and settings, building relationships and partnerships, overcoming cross-sector challenges, managing limited state and county resources—are also illustrative of the need for such programs for creating more whole and integrated crisis support systems.

6. Limitations

6.1 Evaluation Design

The main limitations of the evaluation are related to the trade-offs made in the study design and methods to accommodate the heterogeneity of program types, program start-dates and duration, care processes delivered, and unanticipated onset of the COVID-19 pandemic. Thus, programs vary in their capacity to report data and the types of data reported. To address this, missing data that are not relevant to the program will continue to be identified and missing data appropriately excluded from denominators will be noted. Ongoing quantitative data analysis will provide more detail on the extent and reasons for as well as issues of data quality given the aggregated and self-reported nature of the data obtained from programs. In addition, the revised evaluation is limited to program-level data and will not include client level proximal or distal outcomes.

As described in previous deliverables and section 4.6.2 (Target Program Activities and Proximal Program Outcomes), some program activities may be underestimated using quantitative data from the survey. During start-up, some Child/Youth Programs provided services for clients prior to setting up administrative mechanisms to collect data. Some activities and proximal outcomes are also not routinely documented or are provided in settings to which programs have limited access to data. Further, some standardized measures, such as those for partnerships, will not capture informal practices. Thus, findings will likely be conservative and will be reported as such to further reinforce the potential greater reach of the programs. Qualitative data will be used both to understand these limitations and provide additional data sources for these elements.

Another potential limitation concerns the variation in program reach, as most programs are funded on a county basis but may operate in and service a narrower geographic area. While the formative nature of the evaluation reduces the impact this variation has on our intended aims, we collect both qualitative and quantitative data on the extent of reach to ensure that our treatment of proximal outcomes does not directly compare the outputs of programs with dissimilar reach.

6.2 Preliminary Findings

All the findings in this midpoint progress report should be understood as preliminary pending additional data collection, cleaning, and analysis. As analysis of the data previously collected is still ongoing, findings are subject to revision in later deliverables as issues of data quality and availability are identified and analytic techniques are refined.

For the supplemental analysis of the Program Lead Survey (Appendix C), results and tables are constructed using a conservative recoding of respondent agreement that may underestimate agreement with attitudinal survey elements. These results should also be put into the context of a very small population surveyed (administrative program leads). Future data analysis will include surveys from a larger number of program leads, but will still need to be understood in relation to the small population.

6.3 COVID-19

The study design does not allow for examining the direct impact of the COVID-19 pandemic, but the evaluation of the program implementation sets the findings within this context. The evaluation incorporates COVID-19 as a major context, including by establishing COVID-19 study time intervals,

revising our interview guides to address the impact of COVID-19 on services, and adding questions about COVID-19 to our workgroup meetings. We monitor key policy changes at the county level (school closures, stay at home orders) and county-level public health data (case rates, hospitalization rates, death rates) to facilitate data interpretation.

With respect to our preliminary thematic findings related to the COVID-19 pandemic, findings are intended to reflect the perceptions of stakeholders on impacts such as changes in mental health need rather than conclusive assessments of impact. These findings are consistent with, and indeed complement, emerging studies suggesting increasing mental health need and substance use, need for intervention, or shifting in clinical severity and stressors (e.g., new-onset or worsening of suicidal ideation, concerns about loss of family/friends, social distancing, or public events such as demonstrations) (Choi et al., 2020; Czeisler et al., 2020; Galea et al., 2020; Lee, 2020; Pfefferbaum & North 2020; Volkow, 2020; Wang et al., 2020; Xie et al., 2020; Yao et al., 2020). In addition, we note that our findings cannot conclusively assess, though they support, existing concerns that COVID-19 has increased existing disparities for minoritized groups in both COVID-19 outcomes such as infection rate and mortality, and COVID-19 related outcomes such as eviction, access to digital resources, school attendance, and unemployment, while increasing concerns about deeply entrenched existing issues such as structural racism and limited access for some groups to health services including mental health services (Braithwaite & Warren, 2020; Chowkwanyun & Reed, 2020; Couch, Fairlie, & Xu, 2020; Kohli & Blume, 2020; McClure, et al., 2020; Yancy, 2020).

In terms of the impact of COVID-19 on the program evaluation plan and activities, the pandemic has resulted in significant practical adjustments, such as shifting all evaluation staff to remote work, holding meetings with county stakeholders via Zoom, and dedicating significant workforce hours to revising the evaluation plan and tracking pandemic-related confounders. With SB 82/833 staff working under especially challenging conditions, and often working remotely as well, there have also been intermittent delays in their responses to our requests for information or data.

7. Workplan

For the purposes of the workplan, the formative evaluation has been divided into six main areas of focus: stakeholder engagement, interviews, program survey, case studies, other data sources, and reports. The workplan timeline is in **Table 25**, explained in this section.

7.1 Stakeholder Engagement

The main objective for stakeholder engagement is to collaboratively work together with our program partners and other stakeholders to inform and guide our progress and ensure the relevance of our findings. This will be accomplished through a variety of forms including meetings, webinars, and newsletters throughout the formative evaluation.

7.1.1. Stakeholder Advisory Board

Since filling all positions on the Stakeholder Advisory Board, we will continue to meet quarterly throughout the duration of the formative evaluation. The next scheduled meeting is July 27, 2021.

7.1.2 Data Coordinator's Workgroup

We will continue to discuss topics related to data infrastructure and county updates on a quarterly basis. The next scheduled meeting is October 14, 2021.

7.1.3 School-County Workgroup

The School-County Collaborative programs and school-based Child/Youth programs will continue to meet monthly to discuss program and evaluation updates. The next scheduled meeting is August 5, 2021, though this may be rescheduled pending the next Triage Collaboration meeting.

7.1.4 Child Workgroup

The non-school-based Child/Youth programs will continue to meet monthly for program and evaluation updates. The next scheduled meeting is July 23, 2021.

7.1.5 Webinars

To date, we have hosted two webinars and plan to host another to share our preliminary findings.

7.1.6 Triage Collaboration Meetings

The MHSOAC hosts quarterly Triage Collaboration meetings that span Adult/TAY, Child/Youth, and School-County Collaborative SB-82/833 programs. The evaluation team is grateful to be present at these meetings to learn more about our county partners and their programs.

7.1.7 Newsletters

Newsletters are distributed about twice a year or as needed. The last issue was disseminated in April 2021 and our next issue is scheduled for October 2021.

7.2 Interviews

Interviews are the primary source of our qualitative data, providing us with a rich narrative of implementation progress. To meet this objective, the evaluation team creates semi-structured interview guides, recruits stakeholders, conducts interviews, produces transcriptions, and conducts subsequent thematic coding and analysis.

7.2.1 Interview Guides

Semi-structured interview guides will continue to be developed and refined in advance of each round of interviews, overlapping recruitment of stakeholders and scheduling of interviews.

7.2.2 Recruit Stakeholders

Program leads have been identified in each program and will be contacted via email to identify stakeholders from other sampling groups, such as site or agency staff. Members of the appropriate sampling group are contacted, and an interview time is scheduled. This will continue to occur prior to each round of bi-annual interviews.

7.2.3 Interviews

We will continue to interview stakeholders from the SB-82/833 programs every six months and at the end of their respective grant periods. The last round of Phase 1 Child/Youth program interviews will end in November 2021, the last round of School-County Collaborative program interviews will end in November 2022, and the last round of Phase 2 Child/Youth program interviews will end in July 2023.

7.2.4 Transcription

Evaluation staff will continue to produce transcripts of the interviews when audio recordings are available. Transcription software is used to produce initial transcripts, then staff proofread the transcript while listening to the audio recording to ensure accuracy and insert timestamps. These will continue to occur following each interview period.

7.2.5 Coding and Analysis

Coding and analysis of interview transcripts began in April 2021 and will continue following each new round of interviews. The codebook is refined throughout the analysis, which will be ongoing throughout the evaluation.

7.3 Program Survey

The program survey is the primary source of our quantitative data, providing us with aggregate data on services delivered, client characteristics, program activities, and attitudes on program implementation. This survey was created and tailored with the collaboration of our county partners and will continue to be used throughout the evaluation.

7.3.1 Create Program Survey

The program survey was created between January and March 2021. We will refine the survey for our Phase 2 Child Crisis Intervention programs in July 2021.

7.3.2 Pilot Period

The pilot period for Phase 1 and School-County programs took place between March and April 2021. Evaluation staff met with each program to tailor the survey to their specific programs as best as possible. We meet with the program leads of the Phase 2 programs regularly and will discuss the survey during those meetings.

7.3.3 Survey Data Collection

Data collection for the Data Coordinator section of the survey began on April 12, 2021, and data collection for the Program Lead section of the survey began on April 15, 2021, both for the Phase 1 and School-County programs only. Data collection for the Phase 2 programs will begin once the survey and appropriate data transfer agreements are finalized. The Data Coordinator section collects aggregate data by calendar quarters, and therefore data collection will be ongoing throughout the evaluation. The Program Lead Survey will be repeated once at the end of the grant period.

7.3.4 Analysis

We are receiving and cleaning data throughout the evaluation since data will continue to flow in from program partners. Subject to data quality, full analyses of our program survey data will be possible at the end of each grant period.

7.4 Case Studies

Case studies will be conducted for the four School-County Collaborative programs to support a “road map” for integrated, effective, and sustainable school county collaboratives.

7.4.1 Case Study Data Collection

We began assessing our extant data for use in case studies of the four School-County Collaborative programs and identifying areas where additional data collection may be needed. Additional data will include publicly available datasets, program and school records when available, and structured conversations in our School-County Workgroup.

7.4.2 Analysis

The codebook for our thematic analysis includes both thematic and content elements that are particularly relevant to school-county partnerships. The results of our broader thematic analysis will be used to identify additional codes to support the construction of fuller case narratives. Case study analyses are scheduled to begin in December 2022.

7.5 Other Data Sources

Other data sources, such as publicly available datasets, will be used as available to supplement our primary data.

7.5.1 Exploration of Data Sources

Exploration of data sources has been ongoing since early in the evaluation and will continue through late 2022.

7.5.2 Data Collection

Some data has already been extracted from publicly available datasets. We plan to continue collecting data from other data sources through late 2022.

7.5.3 Analysis

Pending final data collection of other data sources, we anticipate beginning analyses of other data sources in December 2022.

7.6 Reports

The evaluation team will continue to complete quarterly progress report deliverables, other deliverables, and monthly updates on the evaluation for the MHSOAC. The draft final report will be completed in tandem with our last round of interviews with the Phase 2 Child Crisis Intervention programs. As such, we will have preliminary analyses done in the draft final report and final analyses in the final report. All prior areas of focus are based around the timeline for when reports are due per the contract.

Table 25. Work plan timeline

	2019								2020												2021												2022												2023										
	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N
																															Child grants end (Ph.1)												School grants end												Child grants end (Ph.2)
Stakeholder Engagement																																																							
Stakeholder Advisory Board																		*			*																																		
Data Coordinator's Workgroup																		*																																					
School-County Workgroup							*		*	*																																													
Child Workgroup																							*																																
Webinars																			*																																				
Triage Collaboration meetings													*			*																																							
Newsletters																		*	*																																				
Interviews																																																							
Create interview guide																																																							
Recruit stakeholders																																																							
Interviews																																																							
Transcriptions																																																							
Coding and analysis																*	*	*	*	*	*	*	*																																
Program Survey																																																							
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Other Data Sources																																																							
Exploration of data sources																																																							
Prospective data collection																																																							
Analysis																																																							
Reports																																																							
Deliverables																																																							

*Signifies scheduling conflicts or unforeseen delays.

8. Conclusion

This report summarizes the progress made thus far in the statewide formative evaluation of SB-82/833 Child/Youth and School-County Collaborative Triage programs. Preliminary findings are considered and summarized to provide a provisional understanding of program implementation. With the collaborative efforts of our program partners and the MHSOAC, we will continue to expand on our preliminary findings and include additional themes and findings that emerge over the course of the evaluation.

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Appendix A

Stakeholder Feedback and Responses

Date	Source	Feedback	Response
5/2/19	*Quarterly Triage Collaboration Meeting*	The evaluation team noticed wide variation in data infrastructure maturation and development. The UC Evaluation team introduced the idea of a data learning collaborative at the Sacramento meeting and programs agreed this would be beneficial.	In collaboration with UC Davis, we created a Data Coordinator's Workgroup for grantees across Adult/TAY, Child/Youth and School-County Collaborative programs to discuss data availability and infrastructure.
6/3/19	*Data Coordinator's Workgroup*	Programs were at different stages in creating their encounter forms and expressed a desire to see encounter forms from other programs.	In Box, we created a shared resources folder for programs to share measures, encounter forms, and other items programs wish to share with each other.
8/8/19	*Data Coordinator's Workgroup*	School-County Collaborative programs expressed a desire to have a workgroup separate from the larger workgroup to discuss their program implementation in a smaller, more focused space.	We created the School-County Workgroup, extending the invitation to all programs based in schools.
10/3/19	*School-County Workgroup*	Programs desired to have an electronic method to share items with each other.	In Box, we created a folder for programs to share documents, measures and other items with each other.
11/14/19	*Data Coordinator's Workgroup*	As programs changed and adapted during early implementation, they wished to hear more about progress from other programs.	Workgroup meetings now start with program updates to learn early implementation lessons from other programs.
12/5/19	*School-County Workgroup*	Programs think interviews conducted twice a year will be feasible for their staff.	The evaluation team will schedule qualitative interviews twice a year as planned.
1/9/20	*Data Coordinator's Workgroup*	Programs wished to nominate stakeholders for the project's Stakeholder Advisory Board.	Evaluation team reviewed nominated stakeholders and included some in the Board.
4/3/20	*Stakeholder Advisory Board Meeting*	A few stakeholders prefer in-person meetings over Zoom meetings.	The team will revisit interest and feasibility of an in-person Stakeholder Advisory Board meeting in the future.
5/7/20	*School-County Workgroup*	Program partners requested a REDCap tutorial to better understand how to navigate the software.	Our team provided a REDCap tutorial for all programs to have their relevant questions answered.
6/4/20	*School-County Workgroup*	As program staff worked to understand how to input their data in REDCap, they found it would be helpful to extend the REDCap pilot period.	We extended the pilot period to September as staff were on summer vacation and needed more time to familiarize themselves with REDCap.

7/16/20	*School-County Workgroup*	Stakeholders discussed language to replace "at-risk" in the REDCap survey and shared with us how language should be more equitable and mindful.	A stakeholder shared the language suggestions and how language should not blame children for being in positions rather shift responsibility to institutions putting the children in these situations.
7/16/20	*School-County Workgroup*	During REDCap pilot period, staff shared the need for more responses for a question regarding frequency of meetings.	The REDCap survey was edited to include the feedback.
7/16/20	*School-County Workgroup*	Programs requested longer workgroup meetings to be able to discuss more items and to continue learning from each other.	We adjusted calendar invites from an hour to an hour and a half. Programs have the freedom to shorten meetings.
7/16/20	*Stakeholder Advisory Board Meeting*	A stakeholder shared how their personal experience relates to the importance of the entire evaluation and their lifelong advocacy for mental health resources in California.	The final report will be dedicated in memory of the stakeholder's family member.
7/16/20	*Stakeholder Advisory Board Meeting*	Stakeholders wish for the evaluation teams to be mindful of the impact the pandemic is having on programs with respect to geography and setting.	The evaluation team used this feedback to interpret COVID-19 pandemic specific excerpts in the analysis of interviews.
7/16/20	*Stakeholder Advisory Board Meeting*	Stakeholders suggest determining mechanisms to measure unmet needs where programs are being implemented during the pandemic.	The team will explore using Census Bureau pandemic questions and census tract data to understand if this is quantifiable for the evaluation.
7/16/20	*Stakeholder Advisory Board Meeting*	Stakeholders wish for the evaluation to recognize how program response to the pandemic will vary as well as their county's specific response to the pandemic.	The team continues to adapt the evaluation to evaluate the changing needs of the programs.
8/13/20	*School-County Workgroup*	A program requested a second REDCap tutorial for their team to better understand how to use the software for data entry.	We contacted the REDCap university contact to inquire about another REDCap tutorial. Ultimately, we provided a recording of the previous tutorial to the program.
9/3/20	*School-County Workgroup*	A program requested more response options for a few questions to better describe their program activities.	We added more response options to our REDCap pilot survey.
11/12/20	*Data Coordinator's Workgroup*	Child grantees suggested a separate workgroup similar to that of the smaller School-County Workgroup to discuss program specific topics.	We created the Child Workgroup for programs to provide updates, work together, and share facilitators and barriers.

12/10/20	*School-County Workgroup*	Program partners agreed to share previous workgroup notes with the MHSOAC. They believe the notes will provide the MHSOAC with lessons learned and rich discussion.	We will share workgroup notes with the MHSOAC after program partners review and approve notes.
1/14/21	*Data Coordinator's Workgroup*	Programs shared this meeting clarified lingering questions and helped them understand the current evaluation timeline.	We will continue to hold workgroups with the intention of keeping programs informed and in communication with each other.
1/22/21	*Child Workgroup*	Programs expressed gratitude for the workgroup space, especially during these challenging times.	We will continue creating a space where programs share mutual strengths during this time.
2/26/21	*Child Workgroup*	Programs wish to have equity as a topic of discussion during future meetings and feel this group makes them feel less isolated in the work they do.	We recognize this is a space for more than program specific topics and we continue to create space for programs to form relationships.
3/4/21	*School-County Workgroup*	Program partners expressed concern over the change in evaluation contract scope and how that would affect data entry.	We assured the programs the MHSOAC will use the data to inform their portion of the evaluation.
3/4/21	*School-County Workgroup*	Programs stressed the administrative burden imposed by data collection and entry for the evaluation.	Our team continues to be mindful of data asks as we continue to refine our data collection.
3/4/21	*School-County Workgroup*	Program partners agreed it would be helpful to have MHSOAC staff join the next workgroup call.	We invited our MHSOAC partners to the next meeting.
3/4/21	*School-County Workgroup*	Program partners suggest our evaluation team use websites, monthly reports, road map quarterly reports, and newsletters as data sources.	Our team will consider these data sources for the evaluation.
4/1/21	*School-County Workgroup*	Program partners suggested additional response options for our survey.	We added additional response options to better describe program sustainability, service setting, staff development, and staff turnover.
4/8/21	*Data Coordinator's Workgroup*	Some programs shared the ability to provide the number of unduplicated clients across the span of the grant.	The evaluation teams will ask for this data in the last survey sent out to programs.
4/23/21	*Child Workgroup*	Programs call each other outside of the workgroup to learn about different funding sources they could potentially use as sustainability may require multiple funding streams.	We recognize these workgroups provide programs the ability to continue collaborative conversations outside of the workgroup setting.
4/27/21	*Stakeholder Advisory Board Meeting*	Stakeholders advised avoiding the use of the language "new normal" in reference to life during the ongoing pandemic.	Our team will share this with our evaluation partners and recognize the importance of continuing to be mindful of language used during times of crisis.

4/27/21	*Stakeholder Advisory Board Meeting*	Stakeholders express concern for children and families returning to school as well as the anticipated needs clinicians will need to triage.	The evaluation team will explore these concerns in the next round of qualitative interviews.
4/27/21	*Stakeholder Advisory Board Meeting*	Stakeholders expressed difficulty in finding contact information for the SB-82 funded programs in their region. They recommend support be accessible to all those in need.	The evaluation team provided them with the website of the triage program in their area with relevant contact information.
4/27/21	*Stakeholder Advisory Board Meeting*	Stakeholders shared that in past projects developing programs, quantitative data was easier to collect but it did not capture the stories captured in qualitative data.	We recognize the importance of qualitative and quantitative data and are using a mixed-methods approach in this evaluation.
4/27/21	*Stakeholder Advisory Board Meeting*	A stakeholder stressed the value of including statements from clients and families utilizing the SB-82 services.	While it would be desirable to include client experiences, it is not feasible for this evaluation. Nevertheless, interviews with stakeholders are used to capture stories about clients and families.
4/27/21	*Stakeholder Advisory Board Meeting*	Stakeholder recommends exploring how telehealth and virtual meetings have affected relationship building.	Our team will look for this in the analysis of telehealth codes and we will explore this in our future interviews.
5/13/21	*School-County Workgroup*	Program partners expressed great interest in testifying before the legislature to share their program narratives.	We will relay this valuable information to the MHSOAC.
5/13/21	*School-County Workgroup*	Staff are growingly concerned with data collection burden, especially burden placed on staff not funded by the grant.	We will include this data in our qualitative analysis.
5/13/21	*School-County Workgroup*	Programs think quantitative data is valuable, but they want to make sure their program stories are equally as important to the evaluation.	We recognize this to be important to the program partners and will include rich qualitative data in our evaluation.
6/17/21	*School-County Workgroup*	Programs feel tracking the financial impact of the grant would be beneficial for their own evaluations.	We will explore how to support programs in their own evaluations.
6/17/21	*School-County Workgroup*	Programs would like evaluation feedback.	We will revisit this request after the midpoint report.
7/1/21	*School-County Workgroup*	Programs feel they benefit from monthly learning collaborative meetings over larger structured meetings. Programs are in frequent contact to discuss mutual challenges and facilitators.	We will continue to hold workgroups throughout the duration of the evaluation. The workgroup provides a space for cross program learning and relationship building.

Appendix B

Definitions of Framework and Logic Model Domains and Constructs

Domain I: SB-82/833 Program Characteristics Features of SB-82/833 programs that might influence implementation.	
Construct	**Definition(s)**
Descriptive Characteristics	The basic features of the program and its interventions that provide context for, and may also impact, the course of implementation
Complexity	The perceived difficulty of implementing the program
Adaptability	The degree to which the program can be adapted, tailored, refined, or reinvented to meet local needs
Domain II: Outer Setting The external contexts in which SB-82/833 is carried out, including both county/community contexts and broader national/global contexts.	
Construct	**Definition**
Needs of Patients and Communities	The extent to which patient and community needs are known and prioritized by the program, including the barriers and facilitators to understanding and meeting those needs
Cosmopolitanism	The extent to which programs are connected to other organizations in their communities/county
Domain III: Inner Setting (Organization/Agency/Setting) Features of the implementation organization that might influence implementation of SB-82/833 programs.	
Construct	**Definition**
Structural Characteristics:	Structural characteristics of the implementing organization
Social Architecture	The functional division of labor within the organization and how the program is positioned within it
Team Stability	The extent to which teams remain stable and staff remain in their roles for an adequate amount of time without excessive turnover
Networks and Communications	The nature and quality of social networks and quality of formal and informal communications within the implementing organization(s)
Organizational Culture and Climate:	Norms, values, and basic assumptions of the implementing organization(s)
Compatibility	The extent to which the program fits the organizational culture and climate and existing workflows and systems in the implementing organization(s)
Relative Priority	Stakeholders' perceptions of the priority of the program within the implementing organization(s)
Readiness for Implementation:	Tangible and immediate indicators of organizational commitment to the program
Leadership Engagement	The extent to which leadership in the implementing organization(s) are committed to and involved in program implementation
Available Resources	The level of resources dedicated to program implementation

Domain IV: Individual Characteristics (i.e., Program Staff) Characteristics of staff involved in implementation that might influence implementation of SB-82/833 interventions.	
Construct	**Definition**
Knowledge and Beliefs	Staff perceptions of and attitudes toward intervention
Self-Efficacy	Staff belief about their capabilities to deliver intervention
Staff Engagement	Staff progress toward skilled and enthusiastic engagement in the program
Domain V: Implementation Processes Strategies involved in implementing the program that might influence outcomes of SB-82/833 interventions.	
Construct	**Definition**
Planning:	Strategies for implementation
Stakeholder Consideration	Efforts to consider stakeholder needs and perspectives
Tailoring	Tailoring of program to appropriate subgroups
Simplification	Strategies used to simplify program execution
Executing	Carrying out the program according to plan
Progress Tracking	Tracking progress towards goals and milestones
Reflecting	Reflecting and debriefing about program progress and experiences
Domain VI: SB-82/833 Triage Grant Program Goals	
	Definition
Overall Intention	***Expand crisis prevention and treatment services*** by providing crisis intervention, crisis stabilization, mobile crisis support, and intensive case management and linkage to services across care sectors
Main Specified Outcomes:	
Child/Youth AND School-County	- Increase client and/or student wellness
Child/Youth	- Decrease unnecessary hospitalizations and associated costs - Reduce unnecessary law enforcement involvement and law enforcement cost
School-County	- Increase access to a continuum of mental health services and supports through school-community partnerships - Develop coordinated and effective crisis response systems on school campuses when mental health crises arise - Engage parents and caregivers in supporting their child's social-emotional development and building family resilience - Reduce the number of children placed in special education for emotional disturbance or removed from school and community due to their mental health needs

Domains VII and IX: Target Program Activities and Proximal Program Outcomes Program-level activities that are anticipated to meet SB-82/833 Triage Grant program goals.		
Target Program Activity	**Definition**	**Proximal Program Outcome**
Cultivate partnerships	- Building relationships for collaboration between program and other relevant community agencies	- Number and type of MOUs - Number of interdisciplinary team meetings
Integrate program teams	- Expanding, adapting, shifting internal staff roles	Markers of Team Integration: - New communication channels - Changes in staff allocation and task shifting
Linkage of agency/school supports and referrals	- Linking clients to appropriate supports and referrals	- Number and type of linkages and referrals
Deliver crisis prevention and intervention services to clients	- Carrying out crisis prevention and intervention services	- Number and type of services and trainings delivered
Deliver mental health trainings and activities	- Carrying out mental health trainings and activities	- Number and type of services and trainings delivered

Appendix C
Supplementary Analysis of Program Lead Survey

This section provides a supplementary preliminary analysis of data from the first round of the Program Lead Survey, featuring selected elements related to the outer setting, inner setting, implementation processes, SB-82/833 Triage Grant program goals, and implementation outcomes. All attitudinal items reported in this section used a 1–7 Likert scale where 1=strongly disagree, 2=disagree, 3=somewhat disagree, 4=neither agree nor disagree, 5=somewhat agree, 6=agree, 7=strongly agree. Unless otherwise specified, the tables in this section reflect the number and proportion of administrative leads that reported “agree” or “strongly agree.” This is intended to conservatively, rather than comprehensively, summarize agreement. Where data are missing due to “Not applicable” or “Don’t know” responses, percentages reported are based on the number of programs that provided a substantive response.

C.1 Outer and Inner Setting

Table 26 summarizes the number and proportion of programs that reported agree or strongly agree with indicators of implementation for needs of patients and communities, cosmopolitanism, team stability, relative priority, and leadership engagement by type of triage grant, **Table 27** presents these by program maturation, **Table 28** by school-based status, and **Table 29** by urban/rural county.

C.1.1 Needs of Patients and Communities

For indicators related to addressing needs of patients and communities, all programs reported high agreement (agree or strongly agree) with at least one indicator. Of the Child/Youth programs (n=10), 90% (n=9) reported that their program was suitable and effective in addressing needs that are not adequately met by other mental health programs in their county or community. Most (n=9; 90%) also agreed or strongly agreed their program was suitable for expanding access to mental health services in unserved or underserved communities, and 80% (n=8) also agreed or strongly agreed that their program was effective in this task. Among the School-County Collaborative programs, all (n=4; 100%) agreed or strongly agreed with all four indices of addressing community and patient needs.

C.1.2 Cosmopolitanism

For indicators related to strengthening partnerships, almost all programs (n=13; 92.9%) agreed or strongly agreed with at least one indicator. Of the programs contracted through the Child/Youth grant (n=9), 90% agreed or strongly agreed with at least one indicator, and all School-County Collaborative programs (n=4; 100%) agreed or strongly agreed with at least one of these implementation indices. Among the Child/Youth programs (n=10), 77.8% (n=7) agreed or strongly agreed that their program was suitable as well as effective for strengthening coordination or relationship building within the implementing organization. Most Child/Youth programs (n=9; 90%) agreed or strongly agreed that their program was suitable for developing or strengthening partnerships with other mental health and social service agencies, but only 60% (n=6) agreed or strongly agreed that their program was effective in this task. Among the School-County Collaborative programs (n=4), all agreed or strongly agreed that their program was suitable for strengthening coordination or relationship building within the implementing organization but only three out of the four programs agreed or strongly agreed that their program was effective in doing so. For developing or strengthening partnerships with other

mental health and social service agencies, all programs (n=4; 100%) endorsed that their program was suitable as well as effective.

C.1.3 Team Stability

Slightly more than one-half of all programs (n=8; 57.1%) agreed or strongly agreed that their SB-82/833 program has stable staffing with limited gaps, turnover, or leaves.

Table 30 summarizes the impacts of staff turnover, gaps, or leaves on SB-82/833 programs among all programs and by grant type, **Table 31** does so by program maturation, **Table 32** by school-based status, and **Table 33** by urban/rural. The most frequent impact was change in the range or quality of services, impacting 42.9% (n=6) of all programs, 40% (n=4) of Child/Youth programs, and 50% (n=2) of School-County Collaborative programs. The second most common impacts were increase in staff case load (n=4; 28.6%), reduction in staff morale (n=4; 28.6%), loss of professional expertise (n=4; 28.6%), and loss of institutional knowledge (n=4; 28.6%). In addition, among all programs (n=14), two (14.3%) reported cessation of elimination of services, outsourcing services to another unit or community partner, increase in staff work hours, and reduction in staff productivity. Among Child/Youth programs (n=10), the second most common impact was increase in staff case load (n=3; 30%) followed by outsourcing services to another unit or community partner (n=2; 20%), reduction in community access to non-crisis-related services (n=2; 20%), reduction in staff morale (n=2; 20%), loss of professional expertise (n=2; 20%), loss of clinical expertise (n=2; 20%), and loss of institutional knowledge (n=2; 20%). Among School-County Collaborative programs (n=4), 50% (n=2) also reported reduction in community access to mental health services, reduction in staff productivity, reduction in staff morale, loss of professional expertise, loss of clinical expertise, and loss of institutional knowledge.

On average, all programs reported 3.2 (SD±3.4) impacts, Child/Youth programs reported an average of 2.7 (SD±2.7) impacts, and School-County Collaborative programs reported 4.3 (SD±4.9) impacts related to staff turnover, gaps, and leaves. Overall, 46.2% (n=6) of the programs reported three or more impacts attributed to staff turnover, gaps, and leaves. More than 40% of Child/Youth programs (n=4; 44.4%) and 50% (n=2) of School-County Collaborative programs reported three or more impacts related to staff turnover, gaps, and leaves.

Table 34 summarizes the proportion of programs by grant type that rated the impact of staff instability as moderate-severe and severe for each impact, **Table 35** does so by program maturation, **Table 36** by school-based mental health services status, and **Table 37** by urban/rural. Among all programs that reported each impact, the impact was reported as severe for cessation or elimination of services (n=2; 100%), change in the range or quality of services (n=4; 66.7%), outsourcing services to another unit or community partner (n=2; 100%), reduction in community access to mental health services (n=2; 66.7%), reduction in community access to non-crisis-related services (n=1; 33.3%), increase in staff work hours (n=2; 100%), increase in staff case load (n=3; 75%), reduction in staff productivity (n=1; 50%), reduction in staff morale (n=2; 50%), loss of professional expertise (n=3; 75%), loss of clinical expertise (n=3; 75%), and loss of institutional knowledge (n=2; 50%). Additional programs that reported each impact reported it as moderate in the following areas: reduction in community access to mental health services (additional n=1), increase in staff case load (additional n=1), reduction in staff productivity (additional n=1), reduction in staff morale (additional n=2), loss of professional expertise (additional n=1), and temporary gaps in services (n=1). Among Child/Youth programs, severe impact was reported for all of the impacts reported by at least one program. Moderate impact was reported by an additional one program for each of the following: increase in staff loads, reduction

in staff morale, loss of professional expertise, loss of clinical expertise, loss of institutional knowledge and temporary gaps in services.

Among School-County Collaborative programs, nine impacts were rated in the severe range and one additional program reported moderate impact for reduction in community access to mental health services, reduction in staff productivity, and reduction in staff morale. When examining impact of staff instability by school-based program, program maturation, and urban/rural status there were little qualitative differences. Details are summarized in Tables 35–37 below.

C.1.4 Relative Priority

When inquired about relative priority of their SB-82/833 program (see Tables 26–29), only 50% (n=7) agreed or strongly agreed it was a top priority for their organization or agency, but all (n=14; 100%) endorsed that the program was appropriately prioritized within the organization or setting it operates in. Among School-County Collaborative programs, only one agreed or strongly agreed that their SB-82/833 program was a top priority for their organization or agency.

C.1.5 Leadership Engagement

In contrast, perceived leadership engagement was high (see Tables 26–29). All programs (n=14; 100%) agreed or strongly agreed that their SB-82/833 program was actively supported by leadership in their organization or agency, and almost all (n=13; 92.9%) agreed or strongly agreed that their program was supported by leadership outside the implementing organization(s).

C.1.6 Available Resources

More than three-fourths of the programs (n=10; 76.9%) agreed or strongly agreed with at least one indicator related to resources (see Tables 26–29), but endorsement of individual indicators was lower. Among all programs (n=14), only 35.7% (n=5) agreed or strongly agreed that their program had been allocated adequate resources for activities and services, 50% (n=7) agreed or strongly agreed that their program was allocated adequate resources for program administration, and only 28.6% (n=4) agreed or strongly agreed that resources from the SB-82/833 program were adequate for data coordination and infrastructure. When assessing adequacy of staffing, less than one-half of the programs agreed or strongly agreed the SB-82/833 program had adequate staff for activities and services (n=6; 46.2%) and program administration (n=6; 46.2%), and only three programs (21.4%) agreed or strongly agreed that the program provided adequate staff for data coordination and reporting. Among the School-County Collaborative programs, none agreed or strongly agreed that resources and staff from the SB-82/833 program were adequate for data coordination and infrastructure or reporting.

Table 26. Implementation indices for outer and inner setting constructs among total sample of programs and by grant type							
		Overall *(N=14)*		**Child/Youth** *(N=10)*		**School-County** *(N=4)*	
	Analytic N	*Agree/ Strongly Agree[a] N(%)*	*M±SD*	*Agree/ Strongly Agree[a] N(%)*	*M±SD*	*Analytic N*	*M±SD*
Outer Setting							
Address Community and Patient Needs							
The activities and services of this SB-82/833 program are:							
suitable for addressing needs that are not adequately met by other mental health programs in this county/community.	14	13(92.9)	6.4±0.6	9(90.0)	6.4±0.7	4(100.0)	6.5±0.6
effective in addressing needs that are not adequately met by other mental health programs in this county/community.	14	13(92.9)	6.4±0.9	9(90.0)	6.4±1.0	4(100.0)	6.5±0.6
suitable for expanding access to mental health services in unserved or underserved communities.	14	13(92.9)	6.4±0.6	9(90.0)	6.3±0.7	4(100.0)	6.8±0.5
effective on expanding access to mental health services in unserved or underserved communities.	14	12(85.7)	6.1±0.9	8(80.0)	5.9±0.9	4(100.0)	6.8±0.5
% Agree/Strongly Agree and Overall Mean	14	14(100.0)	6.4±0.6	10(100.0)	6.3±0.6	4(100.0)	6.7±0.3
Strengthening Partnerships (Cosmopolitanism)							
This SB-82/833 program is:							
suitable for strengthening coordination or relationship building within the implementing organization.	13	11(84.6)	6.3±0.9	7(77.8)	6.0±1.0	4(100.0)	7.0±0.0
effective in strengthening coordination or relationship building within the implementing organization.	13	10(76.9)	6.2±1.0	7(77.8)	6.0±1.0	3(75.0)	6.5±1.0
suitable for developing or strengthening partnerships with other mental health and social service agencies.	14	13(92.9)	6.6±0.6	9(90.0)	6.4±0.7	4(100.0)	7.0±0.0
effective in developing or strengthening partnerships with other mental health and social service agencies.	14	10(71.4)	6.0±1.1	6(60.0)	5.7±1.2	4(100.0)	6.8±0.5
% Agree/Strongly Agree and Overall Mean	13	13(92.9)	6.3±0.8	9(90.0)	6.1±0.9	4(100.0)	6.8±0.4

Inner Setting							
Team Stability							
This SB-82/833 program has stable staffing with limited gaps, turnover, or leaves.	14	8(57.1)	4.8±2.1	6(60.0)	4.8±2.0	2(50.0)	4.8±2.6
Relative Priority							
This SB-82/833 program is:							
a top priority for my organization/agency.	14	7(50.0)	5.6±1.2	6(60.0)	5.6±1.3	1(25.0)	5.5±1.0
appropriately prioritized within the organization or setting it operates in.	14	14(100.0)	6.3±0.5	10(100.0)	6.3±0.5	4(100.0)	6.3±0.5
% Agree/Strongly Agree and Overall Mean	14	14(100.0)	5.9±0.8	10(100.0)	6.0±0.8	4(100.0)	5.9±0.8
Leadership Engagement							
This SB-82/833 program is actively supported by leadership:							
in my organization/agency.	14	14(100.0)	6.7±0.5	10(100.0)	6.7±0.5	4(100.0)	6.8±0.5
outside the implementing organization(s).	14	13(92.9)	6.2±0.8	9(90.0)	6.2±0.9	4(100.0)	6.3±0.5
% Agree/Strongly Agree and Overall Mean	14	14(100.0)	6.5±0.6	10(100.0)	6.5±0.6	4(100.0)	6.5±0.4
Resources							
This SB-82/833 program has been allocated adequate resources for:							
activities and services.	14	5(35.7)	5.0±1.3	4(40.0)	5.1±1.4	1(25.0)	4.8±1.3
program administration.	14	7(50.0)	4.9±1.8	5(50.0)	4.6±2.0	2(50.0)	5.8±1.0
data coordination and infrastructure.	14	4(28.6)	4.0±1.6	4(40.0)	4.4±1.7	0(0.0)	3.0±0.8
This SB-82/833 program has adequate staff for:							
activities and services.	13	6(46.2)	4.6±1.8	4(44.4)	4.3±1.9	2(50.0)	5.3±1.7
program administration.	13	6(46.2)	4.6±1.9	4(44.4)	4.3±1.8	2(50.0)	5.3±2.4
data coordination and reporting.	14	3(21.4)	3.9±1.8	3(30.0)	4.4±1.8	0(0.0)	2.5±1.0
% Agree/Strongly Agree and Overall Mean	13	10(76.9)	4.6±1.1	7(77.8)	4.7±1.2	3(75.0)	4.4±0.9

Table 27. Implementation indices for outer and inner setting constructs among total sample of programs and by program maturation							
		Overall *(N=14)*		**New** *(N=8)*		**Augmenting** *(N=6)*	
	Analytic N	*Agree/ Strongly Agree[a] N(%)*	*M±SD*	*Agree/ Strongly Agree[a] N(%)*	*M±SD*	*Analytic N*	*M±SD*
Outer Setting							
Address Community and Patient Needs							
The activities and services of this SB-82/833 program are:							
suitable for addressing needs that are not adequately met by other mental health programs in this county/community.	14	13(92.9)	6.4±0.6	7(87.5)	6.4±0.7	6(100.0)	6.5±0.5
effective in addressing needs that are not adequately met by other mental health programs in this county/community.	14	13(92.9)	6.4±0.9	8(100.0)	6.6±0.5	5(83.3)	6.2±1.2
suitable for expanding access to mental health services in unserved or underserved communities.	14	13(92.9)	6.4±0.6	7(87.5)	6.5±0.8	6(100.0)	6.3±0.5
effective on expanding access to mental health services in unserved or underserved communities.	14	12(85.7)	6.1±0.9	8(100.0)	6.5±0.5	4(66.7)	5.7±1.0
% Agree/Strongly Agree and Overall Mean	14	14(100.0)	6.4±0.6	8(100.0)	6.5±0.4	6(100.0)	6.2±0.7
Strengthening Partnerships (Cosmopolitanism)							
This SB-82/833 program is:							
suitable for strengthening coordination or relationship building within the implementing organization.	13	11(84.6)	6.3±0.9	7(87.5)	6.5±0.8	4(80.0)	6.0±1.2
effective in strengthening coordination or relationship building within the implementing organization.	13	10(76.9)	6.2±1.0	6(75.0)	6.4±0.9	4(80.0)	5.8±1.1
suitable for developing or strengthening partnerships with other mental health and social service agencies.	14	13(92.9)	6.6±0.6	7(87.5)	6.6±0.7	6(100.0)	6.5±0.5
effective in developing or strengthening partnerships with other mental health and social service agencies.	14	10(71.4)	6.0±1.1	6(75.0)	6.1±1.1	4(66.7)	5.8±1.2
% Agree/Strongly Agree and Overall Mean	13	13(92.9)	6.3±0.8	7(87.5)	6.4±0.8	6(100.0)	6.1±1.0

Inner Setting							
Team Stability							
This SB-82/833 program has stable staffing with limited gaps, turnover, or leaves.	14	8(57.1)	4.8±2.1	5(62.5)	5.1±2.1	3(50.0)	4.3±2.3
Relative Priority							
This SB-82/833 program is:							
a top priority for my organization/agency.	14	7(50.0)	5.6±1.2	3(37.5)	5.5±1.1	4(66.7)	5.7±1.4
appropriately prioritized within the organization or setting it operates in.	14	14(100.0)	6.3±0.5	8(100.0)	6.3±0.5	6(100.0)	6.3±0.5
% Agree/Strongly Agree and Overall Mean	14	14(100.0)	5.9±0.8	8(100.0)	5.9±0.7	6(100.0)	6.0±0.9
Leadership Engagement							
This SB-82/833 program is actively supported by leadership:							
in my organization/agency.	14	14(100.0)	6.7±0.5	8(100.0)	6.8±0.5	6(100.0)	6.7±0.5
outside the implementing organization(s).	14	13(92.9)	6.2±0.8	8(100.0)	6.4±0.5	5(83.3)	6.0±1.1
% Agree/Strongly Agree and Overall Mean	14	14(100.0)	6.5±0.6	8(100.0)	6.6±0.4	6(100.0)	6.3±0.8
Resources							
This SB-82/833 program has been allocated adequate resources for:							
activities and services.	14	5(35.7)	5.0±1.3	3(37.5)	5.1±1.0	2(33.3)	4.8±1.7
program administration.	14	7(50.0)	4.9±1.8	4(50.0)	5.4±1.2	3(50.0)	4.3±2.4
data coordination and infrastructure.	14	4(28.6)	4.0±1.6	1(12.5)	3.6±1.3	3(50.0)	4.5±2.0
This SB-82/833 program has adequate staff for:							
activities and services.	13	6(46.2)	4.6±1.8	3(37.5)	4.8±1.7	3(50.0)	4.4±2.2
program administration.	13	6(46.2)	4.6±1.9	4(50.0)	4.9±2.0	2(40.0)	4.2±2.0
data coordination and reporting.	14	3(21.4)	3.9±1.8	1(12.5)	3.6±1.6	2(33.3)	4.2±2.1
% Agree/Strongly Agree and Overall Mean	13	10(76.9)	4.6±1.1	6(75.0)	4.6±0.9	4(80.0)	4.8±1.5

Table 28. Implementation indices for outer and inner setting constructs among total sample of programs and by school-based status

		Overall *(N=14)*		**School-based** *(N=6)*		**Non-school-based** *(N=8)*	
	Analytic N	*Agree/ Strongly Agree[a] N(%)*	*M±SD*	*Agree/ Strongly Agree[a] N(%)*	*M±SD*	*Analytic N*	*M±SD*
Outer Setting							
Address Community and Patient Needs							
The activities and services of this SB-82/833 program are:							
suitable for addressing needs that are not adequately met by other mental health programs in this county/community.	14	13(92.9)	6.4±0.6	6(100.0)	6.3±0.5	7(87.5)	6.5±0.8
effective in addressing needs that are not adequately met by other mental health programs in this county/community.	14	13(92.9)	6.4±0.9	6(100.0)	6.3±0.5	7(87.5)	6.5±1.1
suitable for expanding access to mental health services in unserved or underserved communities.	14	13(92.9)	6.4±0.6	6(100.0)	6.7±0.5	7(87.5)	6.3±0.7
effective on expanding access to mental health services in unserved or underserved communities.	14	12(85.7)	6.1±0.9	6(100.0)	6.5±0.5	6(75.0)	5.9±1.0
% Agree/Strongly Agree and Overall Mean	14	14(100.0)	6.4±0.6	6(100.0)	6.5±0.4	8(100.0)	6.3±0.7
Strengthening Partnerships (Cosmopolitanism)							
This SB-82/833 program is:							
suitable for strengthening coordination or relationship building within the implementing organization.	13	11(84.6)	6.3±0.9	6(100.0)	6.7±0.5	5(71.4)	6.0±1.2
effective in strengthening coordination or relationship building within the implementing organization.	13	10(76.9)	6.2±1.0	5(83.3)	6.5±0.8	5(71.4)	5.9±1.1
suitable for developing or strengthening partnerships with other mental health and social service agencies.	14	13(92.9)	6.6±0.6	6(100.0)	6.7±0.5	7(87.5)	6.5±0.8
effective in developing or strengthening partnerships with other mental health and social service agencies.	14	10(71.4)	6.0±1.1	5(83.3)	6.3±0.8	5(62.5)	5.8±1.3
% Agree/Strongly Agree and Overall Mean	13	13(92.9)	6.3±0.8	6(100.0)	6.6±0.5	7(87.5)	6.1±1.0

Inner Setting							
Team Stability							
This SB-82/833 program has stable staffing with limited gaps, turnover, or leaves.	14	8(57.1)	4.8±2.1	3(50.0)	4.7±2.3	5(62.5)	4.9±2.2
Relative Priority							
This SB-82/833 program is:							
a top priority for my organization/agency.	14	7(50.0)	5.6±1.2	3(50.0)	5.7±0.8	4(50.0)	5.5±1.4
appropriately prioritized within the organization or setting it operates in.	14	14(100.0)	6.3±0.5	6(100.0)	6.2±0.4	8(100.0)	6.4±0.5
% Agree/Strongly Agree and Overall Mean	14	14(100.0)	5.9±0.8	6(100.0)	5.9±0.6	8(100.0)	5.9±0.9
Leadership Engagement							
This SB-82/833 program is actively supported by leadership:							
in my organization/agency.	14	14(100.0)	6.7±0.5	6(100.0)	6.7±0.5	8(100.0)	6.8±0.5
outside the implementing organization(s).	14	13(92.9)	6.2±0.8	6(100.0)	6.2±0.4	7(87.5)	6.3±1.0
% Agree/Strongly Agree and Overall Mean	14	14(100.0)	6.5±0.6	6(100.0)	6.4±0.4	8(100.0)	6.5±0.7
Resources							
This SB-82/833 program has been allocated adequate resources for:							
activities and services.	14	5(35.7)	5.0±1.3	2(33.3)	5.0±1.1	3(37.5)	5.0±1.5
program administration.	14	7(50.0)	4.9±1.8	3(50.0)	5.7±0.8	4(50.0)	4.4±2.2
data coordination and infrastructure.	14	4(28.6)	4.0±1.6	1(16.7)	3.8±1.5	3(37.5)	4.1±1.8
This SB-82/833 program has adequate staff for:							
activities and services.	13	6(46.2)	4.6±1.8	3(50.0)	5.2±1.5	3(42.9)	4.1±2.0
program administration.	13	6(46.2)	4.6±1.9	3(50.0)	5.0±2.1	3(42.9)	4.3±1.9
data coordination and reporting.	14	3(21.4)	3.9±1.8	1(16.7)	3.5±1.8	2(25.0)	4.1±1.9
% Agree/Strongly Agree and Overall Mean	13	10(76.9)	4.6±1.1	4(66.7)	4.7±0.9	6(85.7)	4.6±1.3

Table 29. Implementation indices for outer and inner setting constructs among total sample of programs and by urban/rural

		Overall (N=14)		Urban (N=11)		Rural (N=3)	
	Analytic N	*Agree/ Strongly Agree[a] N(%)*	*M±SD*	*Agree/ Strongly Agree[a] N(%)*	*M±SD*	*Analytic N*	*M±SD*
Outer Setting							
Address Community and Patient Needs							
The activities and services of this SB-82/833 program are:							
suitable for addressing needs that are not adequately met by other mental health programs in this county/community.	14	13(92.9)	6.4±0.6	10(90.9)	6.4±0.7	3(100.0)	6.7±0.6
effective in addressing needs that are not adequately met by other mental health programs in this county/community.	14	13(92.9)	6.4±0.9	10(90.9)	6.4±0.9	3(100.0)	6.7±0.6
suitable for expanding access to mental health services in unserved or underserved communities.	14	13(92.9)	6.4±0.6	10(90.9)	6.3±0.6	3(100.0)	7.0±0.0
effective on expanding access to mental health services in unserved or underserved communities.	14	12(85.7)	6.1±0.9	9(81.8)	6.0±0.9	3(100.0)	6.7±0.6
% Agree/Strongly Agree and Overall Mean	14	14(100.0)	6.4±0.6	11(100.0)	6.3±0.6	3(100.0)	6.8±0.3
Strengthening Partnerships (Cosmopolitanism)							
This SB-82/833 program is:							
suitable for strengthening coordination or relationship building within the implementing organization.	13	11(84.6)	6.3±0.9	8(80)	6.1±1.0	3(100.0)	7.0±0.0
effective in strengthening coordination or relationship building within the implementing organization.	13	10(76.9)	6.2±1.0	7(70)	6.0±1.1	3(100.0)	6.7±0.6
suitable for developing or strengthening partnerships with other mental health and social service agencies.	14	13(92.9)	6.6±0.6	10(90.9)	6.5±0.7	3(100.0)	7.0±0.0
effective in developing or strengthening partnerships with other mental health and social service agencies.	14	10(71.4)	6.0±1.1	7(63.6)	5.8±1.2	3(100.0)	6.7±0.6
% Agree/Strongly Agree and Overall Mean	13	13(92.9)	6.3±0.8	10(90.9)	6.1±0.9	3(100.0)	6.8±0.3

Inner Setting							
Team Stability							
This SB-82/833 program has stable staffing with limited gaps, turnover, or leaves.	14	8(57.1)	4.8±2.1	7(63.6)	5.1±1.9	1(33.3)	3.7±2.9
Relative Priority							
This SB-82/833 program is:							
a top priority for my organization/agency.	14	7(50.0)	5.6±1.2	5(45.5)	5.4±1.1	2(66.7)	6.3±1.2
appropriately prioritized within the organization or setting it operates in.	14	14(100.0)	6.3±0.5	11(100.0)	6.2±0.4	3(100.0)	6.7±0.6
% Agree/Strongly Agree and Overall Mean	14	14(100.0)	5.9±0.8	11(100.0)	5.8±0.7	3(100.0)	6.5±0.9
Leadership Engagement							
This SB-82/833 program is actively supported by leadership:							
in my organization/agency.	14	14(100.0)	6.7±0.5	11(100.0)	6.6±0.5	3(100.0)	7.0±0.0
outside the implementing organization(s).	14	13(92.9)	6.2±0.8	10(90.9)	6.1±0.8	3(100.0)	6.7±0.6
% Agree/Strongly Agree and Overall Mean	14	14(100.0)	6.5±0.6	11(100.0)	6.4±0.6	3(100.0)	6.8±0.3
Resources							
This SB-82/833 program has been allocated adequate resources for:							
activities and services.	14	5(35.7)	5.0±1.3	3(27.3)	4.8±1.4	2(66.7)	5.7±0.6
program administration.	14	7(50.0)	4.9±1.8	6(54.5)	5.0±1.9	1(33.3)	4.7±1.5
data coordination and infrastructure.	14	4(28.6)	4.0±1.6	4(36.4)	4.3±1.7	0(0.0)	3.0±1.0
This SB-82/833 program has adequate staff for:							
activities and services.	13	6(46.2)	4.6±1.8	6(60.0)	5.0±1.8	0(0.0)	3.3±1.5
program administration.	13	6(46.2)	4.6±1.9	6(60.0)	5.3±1.6	0(0.0)	2.3±0.6
data coordination and reporting.	14	3(21.4)	3.9±1.8	3(27.3)	4.4±1.6	0(0.0)	2.0±1.0
% Agree/Strongly Agree and Overall Mean	13	10(76.9)	4.6±1.1	7(70.0)	5.0±1.0	3(100.0)	3.5±0.3

Table 30. Impact of staff instability for SB-82/833 triage grant programs among total sample of programs and by grant type

	Analytic N	**Overall** *(N=14)* *N(%)*	**Child/Youth** *(N=10)* *N(%)*	**School-County** *(N=4)* *N(%)*
Staff Instability				
Impacts on SB-82/833 program occurred as a result of staff turnover, gaps, or leaves:	14			
Cessation/elimination of services		2(14.3)	1(10.0)	1(25.0)
Change in the range or quality of services		6(42.9)	4(40.0)	2(50.0)
Outsource		2(14.3)	2(20.0)	0(0.0)
Reduction in community access to mental health services		3(21.4)	1(10.0)	2(50.0)
Reduction in community access to non-crisis-related services		3(21.4)	2(20.0)	1(25.0)
Increase in staff work hours		2(14.3)	2(20.0)	0(0.0)
Increase in staff case load		4(28.6)	3(30.0)	1(25.0)
Reduction in staff productivity		2(14.3)	0(0.0)	2(50.0)
Reduction in staff morale		4(28.6)	2(20.0)	2(50.0)
Hire temporary worker(s)				
Substitution of permanent staff with volunteers, students, trainees or interns				
Loss of professional expertise		4(28.6)	2(20.0)	2(50.0)
Loss of clinical expertise		4(28.6)	2(20.0)	2(50.0)
Loss of institutional knowledge		4(28.6)	2(20.0)	2(50.0)
Other (Temporary gaps in services)		1(7.1)	1(10.0)	0(0.0)
NA				
Do not know		1(7.1)	1(10.0)	0(0.0)
Mean # of Impacts	13	3.2±3.4	2.7±2.7	4.3±4.9
0		5(38.5)	3(33.3)	2(50.0)
1		1(11.1)	1(1.1)	0(0.0)
2		1(11.1)	1(1.1)	0(0.0)
≥3		6(46.2)	4(44.4)	2(50.0)

Table 31. Impact of staff instability for SB-82/833 triage grant programs among total sample of programs and by program maturation

	Analytic N	**Overall** *(N=14)* *N(%)*	**New** *(N=8)* *N(%)*	**Augmenting** *(N=6)* *N(%)*
Staff Instability				
Impacts on SB-82/833 program occurred as a result of staff turnover, gaps, or leaves:	14			
Cessation/elimination of services		2(14.3)	1(12.5)	1(16.7)
Change in the range or quality of services		6(42.9)	4(50.0)	2(33.3)
Outsource		2(14.3)	0(0.0)	2(33.3)
Reduction in community access to mental health services		3(21.4)	3(37.5)	0(0.0)
Reduction in community access to non-crisis-related services		3(21.4)	3(37.5)	0(0.0)
Increase in staff work hours		2(14.3)	0(0.0)	2(33.3)
Increase in staff case load		4(28.6)	2(25.0)	2(33.3)
Reduction in staff productivity		2(14.3)	2(25.0)	0(0.0)
Reduction in staff morale		4(28.6)	2(25.0)	2(33.3)
Hire temporary worker(s)				
Substitution of permanent staff with volunteers, students, trainees or interns				
Loss of professional expertise		4(28.6)	3(37.5)	1(16.7)
Loss of clinical expertise		4(28.6)	3(37.5)	1(16.7)
Loss of institutional knowledge		4(28.6)	3(37.5)	1(16.7)
Other (Temporary gaps in services)		1(7.1)	1(12.5)	0(0.0)
NA				
Do not know		1(7.1)	0 (0.0)	1(16.7)
Mean # of Impacts	13	3.2±3.4	3.4±3.9	2.8±2.8
0		5(38.5)	3(37.5)	2(40.0)
1		1(7.7)	1(12.5)	0(0.0)
2		1(7.7)	1(12.5)	0(0.0)
≥3		6(46.2)	3(37.5)	3(60.0)

Table 32. Impact of staff instability for SB-82/833 triage grant programs among total sample of programs and by school-based status

	Analytic N	**Overall** *(N=14)* *N(%)*	**School-based** *(N=6)* *N(%)*	**Non-school-based** *(N=8)* *N(%)*
Staff Instability				
Impacts on SB-82/833 program occurred as a result of staff turnover, gaps, or leaves:	14			
Cessation/elimination of services		2(14.3)	1(16.7)	1(12.5)
Change in the range or quality of services		6(42.9)	3(50.0)	3(37.5)
Outsource		2(14.3)	0(0.0)	2(25.0)
Reduction in community access to mental health services		3(21.4)	3(50.0)	0(0.0)
Reduction in community access to non-crisis-related services		3(21.4)	2(33.3)	1(12.5)
Increase in staff work hours		2(14.3)	0(0.0)	2(25.0)
Increase in staff case load		4(28.6)	2(33.3)	2(25.0)
Reduction in staff productivity		2(14.3)	2(33.3)	0(0.0)
Reduction in staff morale		4(28.6)	2(33.3)	2(25.0)
Hire temporary worker(s)				
Substitution of permanent staff with volunteers, students, trainees or interns				
Loss of professional expertise		4(28.6)	3(50.0)	1(12.5)
Loss of clinical expertise		4(28.6)	3(50.0)	1(12.5)
Loss of institutional knowledge		4(28.6)	3(50.0)	1(12.5)
Other (Temporary gaps in services)		1(7.1)	0(0.0)	1(12.5)
NA				
Do not know		1(7.1)	0(0.0)	1(12.5)
Mean # of Impacts	13	3.2±3.4	4.0±4.4	2.4±2.4
0		5(38.5)	3(50.0)	2(28.6)
1		1(7.7)	0(0.0)	1(14.3)
2		1(7.7)	0(0.0)	1(14.3)
≥3		6(46.2)	3(50.0)	3(42.9)

Table 33. Impact of staff instability for SB-82/833 triage grant programs among total sample of programs and by urban/rural				
	Analytic N	**Overall** *(N=14) N(%)*	**Urban** *(N=11) N(%)*	**Rural** *(N=3) N(%)*
Staff Instability				
Impacts on SB-82/833 program occurred as a result of staff turnover, gaps, or leaves:	14			
Cessation/elimination of services		2(14.3)	1(9.1)	1(33.3)
Change in the range or quality of services		6(42.9)	4(36.4)	2(66.7)
Outsource		2(14.3)	1(9.1)	1(33.3)
Reduction in community access to mental health services		3(21.4)	2(18.2)	1(33.3)
Reduction in community access to non-crisis-related services		3(21.4)	3(27.3)	0(0.0)
Increase in staff work hours		2(14.3)	1(9.1)	1(33.3)
Increase in staff case load		4(28.6)	2(18.2)	2(66.7)
Reduction in staff productivity		2(14.3)	1(9.1)	1(33.3)
Reduction in staff morale		4(28.6)	2(18.2)	2(66.7)
Hire temporary worker(s)				
Substitution of permanent staff with volunteers, students, trainees or interns				
Loss of professional expertise		4(28.6)	3(27.3)	1(33.3)
Loss of clinical expertise		4(28.6)	3(27.3)	1(33.3)
Loss of institutional knowledge		4(28.6)	3(27.3)	1(33.3)
Other (Temporary gaps in services)		1(7.1)	1(9.1)	0(0.0)
NA				
Do not know		1(7.1)	1(9.1)	0(0.0)
Mean # of Impacts	13	3.2±3.4	2.7±3.2	4.7±4.5
0		5(38.5)	4(40.0)	1(33.3)
1		1(7.7)	1(10.0)	0(0.0)
2		1(7.7)	1(10.0)	0(0.0)
≥3		6(46.2)	4(40.0)	2(66.7)

Table 34. Moderate-severe and severe impact of staff stability on SB-82/833 triage grant programs among total sample of programs and by grant type

		Overall *(N=14)*			Child/Youth *(N=10)*			School-County *(N=4)*		
	Analytic N	*Moderate-Severe[a] N(%)*	*Severe[b] N(%)*	*M±SD*	*Moderate-Severe N(%)*	*Severe N(%)*	*M±SD*	*Moderate-Severe N(%)*	*Severe N(%)*	*M±SD*
How much impacted program implementation										
Cessation/elimination of services	2	2 (100.0)	2 (100.0)	6.5±0.7	1 (100.0)	1 (100.0)	7.0±0.0	1 (100.0)	1 (100.0)	6.0±0.0
Change in the range or quality of services	6	4 (66.7)	4 (66.7)	5.3±1.9	3 (75.0)	3 (75.0)	5.8±1.9	1 (50.0)	1 (50.0)	4.5±2.1
Outsource services to another unit or community partner	2	2 (100.0)	2 (100.0)	7.0±0.0	2 (100.0)	2 (100.0)	7.0±0.0	0	0	0.0±0.0
Reduction in community access to mental health services	3	3 (100.0)	2 (66.7)	5.3±1.2	1 (100.0)	1 (100.0)	6.0±0.0	2 (100.0)	1 (50.0)	5.0±1.4
Reduction in community access to non-crisis-related services	3	1 (33.3)	1 (33.3)	4.0±1.7	1 (50.0)	1 (50.0)	4.5±2.1	0 (0.0)	0 (0.0)	3.0±0.0
Increase in staff work hours	2	2 (100.0)	2 (100.0)	6.5±0.7	2 (100.0)	2 (100.0)	6.5±0.7	0	0	0.0±0.0
Increase in staff case load	4	4 (100.0)	3 (75.0)	6.0±0.8	3 (100.0)	2 (66.7)	5.7±0.6	1 (100.0)	1 (100.0)	7.0±0.0
Reduction in staff productivity	2	2 (100.0)	1 (50.0)	6.0±1.4	0	0	0.0±0.0	2 (100.0)	1 (50.0)	6.0±1.4
Reduction in staff morale	4	4 (100.0)	2 (50.0)	5.5±0.6	2 (100.0)	1 (50.0)	5.5±0.7	2 (100.0)	1 (50.0)	5.5±0.7
Hire temporary worker(s)	0	0	0	0.0±0.0	0	0	0.0±0.0	0	0	0.0±0.0
Substitution of permanent staff with volunteers, students, trainees or interns	0	0	0	0.0±0.0	0	0	0.0±0.0	0	0	0.0±0.0
Loss of professional expertise	4	4 (100.0)	3 (75.0)	6.0±0.8	2 (100.0)	1 (50.0)	5.5±0.7	2 (100.0)	2 (100.0)	6.5±0.7
Loss of clinical expertise	4	4 (100.0)	3 (75.0)	6.0±0.8	2 (100.0)	1 (50.0)	5.5±0.7	2 (100.0)	2 (100.0)	6.5±0.7
Loss of institutional knowledge	4	3 (75.0)	2 (50.0)	5.3±1.7	2 (100.0)	1 (50.0)	5.5±0.7	1 (50.0)	1 (50.0)	5.0±2.8
Other (Temporary gaps in services)	1	1 (100.0)		5.0±0.0	1 (100.0)		5.0±0.0	0		0.0±0.0
Other 2	0	0	0	0.0±0.0	0	0	0.0±0.0	0	0	0.0±0.0

[a]Moderate to severe impact corresponds to a score of at least 4 or higher (4-7) on a 1-7 Likert scale with 4 corresponding to moderate and 7 corresponding to severe.
[b]Severe impact corresponds to score of 6-7.

Table 35. Moderate-severe and severe impact of staff stability on SB-82/833 triage grant programs among total sample of programs and by program maturation

		Overall *(N=14)*			**New** *(N=8)*			**Augmenting** *(N=6)*		
	Analytic N	*Moderate-Severe[a] N(%)*	*Severe[b] N(%)*	*M±SD*	*Moderate-Severe N(%)*	*Severe N(%)*	*M±SD*	*Moderate-Severe N(%)*	*Severe N(%)*	*M±SD*
How much impacted program implementation										
Cessation/elimination of services	2	2(100.0)	2(100.0)	6.5±0.7	1(100.0)	1(100.0)	6.0±0.0	1(100.0)	1(100.0)	7.0±0.0
Change in the range or quality of services	6	4(66.7)	4(66.7)	5.3±1.9	2(50.0)	2(50.0)	4.8±2.1	2(100.0)	2(100.0)	6.5±0.7
Outsource services to another unit or community partner	2	2(100.0)	2(100.0)	7.0±0.0	0	0	0.0±0.0	2(100.0)	2(100.0)	7.0±0.0
Reduction in community access to mental health services	3	3(100.0)	2(66.7)	5.3±1.2	3(100.0)	2(66.7)	5.3±1.2	0	0	0.0±0.0
Reduction in community access to non-crisis-related services	3	1(33.3)	1(33.3)	4.0±1.7	1(33.3)	1(33.3)	4.0±1.7	0	0	0.0±0.0
Increase in staff work hours	2	2(100.0)	2(100.0)	6.5±0.7	0	0	0.0±0.0	2(100.0)	2(100.0)	6.5±0.7
Increase in staff case load	4	4(100.0)	3(75.0)	6.0±0.8	2(100.0)	1(50.0)	6.0±1.4	2(100.0)	2(100.0)	6.0±0.0
Reduction in staff productivity	2	2(100.0)	1(50.0)	6.0±1.4	2(100.0)	1(50.0)	6.0±1.4	0	0	0.0±0.0
Reduction in staff morale	4	4(100.0)	2(50.0)	5.5±0.6	2(100.0)	1(50.0)	5.5±0.7	2(100.0)	1(50.0)	5.5±0.7
Hire temporary worker(s)	0	0	0	0.0±0.0	0	0	0.0±0.0	0	0	0.0±0.0
Substitution of permanent staff with volunteers, students, trainees or interns	0	0	0	0.0±0.0	0	0	0.0±0.0	0	0	0.0±0.0
Loss of professional expertise	4	4(100.0)	3(75.0)	6.0±0.8	3(100.0)	3(100.0)	6.3±0.6	1(100.0)	0(0.0)	5.0±0.0
Loss of clinical expertise	4	4(100.0)	3(75.0)	6.0±0.8	3(100.0)	3(100.0)	6.3±0.6	1(100.0)	0(0.0)	5.0±0.0
Loss of institutional knowledge	4	3(75.0)	2(50.0)	5.3±1.7	2(66.7)	2(66.7)	5.3±2.1	1(100.0)	0(0.0)	5.0±0.0
Other (Temporary gaps in services)	1	1(100.0)		5.0±0.0	1(100.0)		5.0±0.0	0		0.0±0.0
Other 2	0	0	0	0.0±0.0	0	0	0.0±0.0	0	0	0.0±0.0

[a]Moderate to severe impact corresponds to a score of at least 4 or higher (4-7) on a 1-7 Likert scale with 4 corresponding to moderate and 7 corresponding to severe.
[b]Severe impact corresponds to score of 6-7.

Table 36. Moderate-severe and severe impact of staff stability on SB-82/833 triage grant programs among total sample of programs and by school-based status

		Overall *(N=14)*			**School-based** *(N=6)*			**Non-school-based** *(N=8)*		
	Analytic N	*Moderate-Severe[a] N(%)*	*Severe[b] N(%)*	*M±SD*	*Moderate-Severe N(%)*	*Severe N(%)*	*M±SD*	*Moderate-Severe N(%)*	*Severe N(%)*	*M±SD*
How much impacted program implementation										
Cessation/elimination of services	2	2(100.0)	2(100.0)	6.5±0.7	1(100.0)	1(100.0)	6.0±0.0	1(100.0)	1(100.0)	7.0±0.0
Change in the range or quality of services	6	4(66.7)	4(66.7)	5.3±1.9	2(66.7)	2(66.7)	5.3±2.1	2(66.7)	2(66.7)	5.3±2.1
Outsource services to another unit or community partner	2	2(100.0)	2(100.0)	7.0±0.0	0	0	0.0±0.0	2(100.0)	2(100.0)	7.0±0.0
Reduction in community access to mental health services	3	3(100.0)	2(66.7)	5.3±1.2	3(100.0)	2(66.7)	5.3±1.2	0	0	0.0±0.0
Reduction in community access to non-crisis-related services	3	1(33.3)	1(33.3)	4.0±1.7	1(50.0)	1(50.0)	4.5±2.1	0	0	3.0±0.0
Increase in staff work hours	2	2(100.0)	2(100.0)	6.5±0.7	0	0	0.0±0.0	2(100.0)	2(100.0)	6.5±0.7
Increase in staff case load	4	4(100.0)	3(75.0)	6.0±0.8	2(100.0)	1(50.0)	6.0±1.4	2(100.0)	2(100.0)	6.0±0.0
Reduction in staff productivity	2	2(100.0)	1(50.0)	6.0±1.4	2(100.0)	1(50.0)	6.0±1.4	0	0	0.0±0.0
Reduction in staff morale	4	4(100.0)	2(50.0)	5.5±0.6	2(100.0)	1(50.0)	5.5±0.7	2(100.0)	1(50.0)	5.5±0.7
Hire temporary worker(s)	0	0	0	0.0±0.0	0	0	0.0±0.0	0	0	0.0±0.0
Substitution of permanent staff with volunteers, students, trainees or interns	0	0	0	0.0±0.0	0	0	0.0±0.0	0	0	0.0±0.0
Loss of professional expertise	4	4(100.0)	3(75.0)	6.0±0.8	3(100.0)	3(100.0)	6.3±0.6	1(100.0)	0(0.0)	5.0±0.0
Loss of clinical expertise	4	4(100.0)	3(75.0)	6.0±0.8	3(100.0)	3(100.0)	6.3±0.6	1(100.0)	0(0.0)	5.0±0.0
Loss of institutional knowledge	4	3(75.0)	2(50.0)	5.3±1.7	2(66.7)	2(66.7)	5.3±2.1	1(100.0)	0(0.0)	5.0±0.0
Other (Temporary gaps in services)	1	1(100.0)	0	5.0±0.0	0	0	0.0±0.0	1(100.0)	0	5.0±0.0
Other 2	0	0	0	0.0±0.0	0	0	0.0±0.0	0	0	0.0±0.0

[a]Moderate to severe impact corresponds to a score of at least 4 or higher (4-7) on a 1-7 Likert scale with 4 corresponding to moderate and 7 corresponding to severe.
[b]Severe impact corresponds to score of 6-7.

Table 37. Moderate-severe and severe impact of staff stability on SB-82/833 triage grant programs among total sample of programs and by urban/rural

		Overall *(N=14)*			**Urban** *(N=11)*			**Rural** *(N=3)*		
	Analytic N	*Moderate-Severe[a] N(%)*	*Severe[b] N(%)*	*M±SD*	*Moderate-Severe N(%)*	*Severe N(%)*	*M±SD*	*Moderate-Severe N(%)*	*Severe N(%)*	*M±SD*
How much impacted program implementation										
Cessation/elimination of services	2	2(100.0)	2(100.0)	6.5±0.7	1(100.0)	1(100.0)	7.0±0.0	1(100.0)	1(100.0)	6.0±0.0
Change in the range or quality of services	6	4(66.7)	4(66.7)	5.3±1.9	2(50.0)	2(50.0)	5.0±2.3	2(100.0)	2(100.0)	6.0±0.0
Outsource services to another unit or community partner	2	2(100.0)	2(100.0)	7.0±0.0	1(100.0)	1(100.0)	7.0±0.0	1(100.0)	1(100.0)	7.0±0.0
Reduction in community access to mental health services	3	3(100.0)	2(66.7)	5.3±1.2	2(100.0)	1(50.0)	5.0±1.4	1(100.0)	1(100.0)	6.0±0.0
Reduction in community access to non-crisis-related services	3	1(33.3)	1(33.3)	4.0±1.7	1(33.3)	1(33.3)	4.0±1.7	0	0	0.0±0.0
Increase in staff work hours	2	2(100.0)	2(100.0)	6.5±0.7	1(100.0)	1(100.0)	6.0±0.0	1(100.0)	1(100.0)	7.0±0.0
Increase in staff case load	4	4(100.0)	3(75.0)	6.0±0.8	2(100.0)	1(50.0)	5.5±0.7	2(100.0)	2(100.0)	6.5±0.7
Reduction in staff productivity	2	2(100.0)	1(50.0)	6.0±1.4	1(100.0)	0(0.0)	5.0±0.0	1(100.0)	1(100.0)	7.0±0.0
Reduction in staff morale	4	4(100.0)	2(50.0)	5.5±0.6	2(100.0)	1(50.0)	5.5±0.7	2(100.0)	1(50.0)	5.5±0.7
Hire temporary worker(s)	0	0	0	0.0±0.0	0	0	0.0±0.0	0	0	0.0±0.0
Substitution of permanent staff with volunteers, students, trainees or interns	0	0	0	0.0±0.0	0	0	0.0±0.0	0	0	0.0±0.0
Loss of professional expertise	4	4(100.0)	3(75.0)	6.0±0.8	3(100.0)	2(66.7)	5.7±0.6	1(100.0)	1(100.0)	7.0±0.0
Loss of clinical expertise	4	4(100.0)	3(75.0)	6.0±0.8	3(100.0)	2(66.7)	5.7±0.6	1(100.0)	1(100.0)	7.0±0.0
Loss of institutional knowledge	4	3(75.0)	2(50.0)	5.3±1.7	2(66.7)	1(33.3)	4.7±1.5	1(100.0)	1(100.0)	7.0±0.0
Other (Temporary gaps in services)	1	1(100.0)		5.0±0.0	1(100.0)		5.0±0.0	0		0.0±0.0
Other 2	0	0	0	0.0±0.0	0	0	0.0±0.0	0	0	0.0±0.0

[a]Moderate to severe impact corresponds to a score of at least 4 or higher (4-7) on a 1-7 Likert scale with 4 corresponding to moderate and 7 corresponding to severe.
[b]Severe impact corresponds to score of 6-7.

C.2 Implementation Processes

C.2.1 Funding, Revenue, and Sustainability Planning

Table 38 summarizes additional funding and revenue sources used to supplement the SB-82/833 programs and anticipated funding and revenue sources to sustain the program by type of triage grant, **Table 39** by program maturation, **Table 40** by school-based status, and **Table 41** by urban/rural.

Supplemental Funding and Revenue Sources

More than 70% of SB-82/833 programs (n=10; 71.4%) used funding from Medi-Cal to supplement their triage grant funding. Among the Child/Youth programs (n=10), 80% (n=8) supplemented their program's funding with revenue collected from Medi-Cal billing and one program used revenue collected from private insurance billing. One-half (n=5; 50%) of the Child/Youth programs reported that 51% or more of the services and activities delivered by their program were billed to Medi-Cal. Among the School-County Collaborative programs, one-half (n=2; 50%) supplemented their program using funds from Medi-Cal.

In addition, more than one quarter of all SB-82/833 programs (n=4; 28.6%) supplemented their program using county funds, and 14.3% (n=2) combined financial support with school or school district funds. Among Child/Youth programs, only 20% (n=2) supplemented their funding with county funds. For School-County Collaborative programs (n=4), 50% (n=2) reported supplementing their program with county funds and 50% (n=2) supplemented their program with funding from the school or school district. Among state-level funding sources, funding from the MHSA for other projects was the most common supplemental funding source. More than one-third of programs (n=6; 42.9%) reported using MHSA funding to supplement their SB-82/833 programs. Of the Child/Youth programs, 40% (n=4) supplemented their program with MHSA funds. Among School-County Collaborative programs (n=4), one supplemented their program using funds from the State of California Department of Healthcare Services (DHCS) and two (50%) combined their program funding with MHSA funds from another project. Among School-County Collaborative programs (n=4), one program supplemented their SB-82/833 program with funds from a private foundation and/or donor.

Overall, an average of 2.3 (SD±1.6) funding and revenue sources were used to supplement SB-82/833 Triage Grant funding. Child/Youth programs were supplemented with an average of 1.8 (SD±1.1) funding sources and School-County Collaborative programs supplemented their funding by an average of 3.7 (SD ±2.3) funding sources.

Sustainability Funding and Revenue Sources

Among programs that reported having a sustainability plan in place (n=9), 88.9% (n=8) reported that their sustainability plan includes Medi-Cal. Among Child/Youth programs with a sustainability plan in place (n=6), 100% (n=6) anticipate billing Medi-Cal and one program will include billing private insurance as part their sustainability plan. Among School-County Collaborative programs with a sustainability plan in place (n=3), 66.7% (n=2) intend to bill Medi-Cal to sustain their SB-82/833 program. Only one Child/Youth program anticipates using county funds to help sustain their program. Of the School-County Collaborative programs with sustainability plans in place (n=3), 66.7% (n=2) plan to use county funds and 100% (n=3) plan to use funding from their school or school district to sustain their program. The most frequently reported state funding source to sustain SB-82/833 programs was MHSA funds. Two-thirds of the programs with a sustainability plan in place (n=6;

66.7%) plan to use MHSA funds to sustain their program, which includes five Child/Youth programs (83.3%) and one School-County Collaborative program. Funds from DHCS and/or general funds were reported by one School-County Collaborative program to be part of their sustainability plan. In addition, funds from a private foundation and/or donor and/or local control funding formula were reported to be part of a sustainability plan for one School-County Collaborative program.

Overall, an average of 3.2 (SD±1.8) funding sources are included in a sustainability plan among the programs that reported having a sustainability plan in place (n=9). Child/Youth programs include an average of 2.7 (SD±0.8) funding sources and School-County Collaborative programs include an average of 4.3 (SD±2.9) funding sources in their sustainability plans.

Among the funding sources considered for programs that reported that they did not yet have a sustainability plan in place (n=5), the most common funding or revenue sources under consideration were Medi-Cal (n=3; 60.0%) and MHSA (n=3; 60.0%).

Table 38. Distribution of funding sources for SB-82/833 triage grant programs (n=14) and their sustainability plans among total sample of programs and by grant type			
	Overall[a] *(n=14)* *N*[a]*(%)*	**Child/Youth** *(n=10)* *N(%)*	**School-County** *(n=4)* *N(%)*
Funding or revenue streams currently used to supplement SB-82/833 grant funding			
Health Insurance			
Medi-Cal	10(71.4)	8(80.0)	2(50.0)
Private	1(7.1)	1(10.0)	0(0.0)
Public			
Municipal			
County	4(28.6)	2(20.0)	2(50.0)
School/School District	2(14.3)	0(0.0)	2(50.0)
State			
DHCS	1(7.1)	0(0.0)	1(25.0)
MHSA	6(42.9)	4(40.0)	2(50.0)
General funds			
Other	1(7.1)	1(10.0)	0(0.0)
Federal (e.g., SAMHSA)			
Mental health block grant			
Private			
Private foundation	1(7.1)	0(0.0)	1(25.0)
Donor	1(7.1)	0(0.0)	1(25.0)
Other			
Other 1			
Other 2			
NA	2(14.3)	1(10.0)	1(25.0)
Do not know			
Mean # of additional funding sources	2.3±1.6	1.8±1.1	3.7±2.3
Services and activities delivered by the program and billed to Medi-Cal			
None	2(14.3)	1(10.0)	1(25.0)
1–10%	1(7.1)	0(0.0)	1(25.0)
11–20%	1(7.1)	0(0.0)	1(25.0)
21–30%			
31–40%	2(14.3)	1(10.0)	1(25.0)
41–50%	1(7.1)	1(10.0)	0(0.0)
51–60%	3(21.4)	3(30.0)	0(0.0)
61–70%	1(7.1)	1(10.0)	0(0.0)
71–80%			
81–90%	1(7.1)	1(10.0)	0(0.0)
91–100%			
NA			
Do not know	2(14.3)	2(20.0)	0(0.0)

	Overall[a] *(n=9)* *N[a](%)*	**Child/Youth** *(n=6)* *N(%)*	**School-County** *(n=3)* *N(%)*
Funding source(s) your current sustainability plan includes[b]:			
Health Insurance			
Medi-Cal	8(88.9)	6(100.0)	2(66.7)
Private	1(11.1)	1(16.7)	0(0.0)
Public			
Municipal			
County	3(33.3)	1(16.7)	2(66.7)
School/School District	3(33.3)	0(0.0)	3(100.0)
State			
DHCS	1(11.1)	0(0.0)	1(33.3)
MHSA	6(66.7)	5(83.3)	1(33.3)
General funds	1(11.1)	0(0.0)	1(33.3)
Other	3(33.3)	3(50.0)	0(0.0)
Federal (e.g., SAMHSA)			
Mental health block grant			
Private			
Private foundation	1(11.1)	0(0.0)	1(33.3)
Donor	1(11.1)	0(0.0)	1(33.3)
Other			
Other 1 (Local Control Funding Formula)	1(11.1)	0(0.0)	1(33.3)
Other 2			
NA			
Do not know			
Mean # of additional funding sources	3.2±1.8	2.7±0.8	4.3±2.9
	Overall[a] *(n=5)* *N[a](%)*	**Child/Youth** *(n=4)* *N(%)*	**School-County** *(n=1)* *N(%)*
Funding source(s) considered when developing a sustainability plan[c]:			
Health Insurance			
Medi-Cal	3(60.0)	2(50.0)	1(100.0)
Private	1(20.0)	0(0.0)	1(100.0)
Public			
Municipal	1(20.0)	0(0.0)	1(100.0)
County	2(40.0)	1(25.0)	1(100.0)
School/School District	2(40.0)	1(25.0)	1(100.0)
State			
DHCS	1(20.0)	0(0.0)	1(100.0)
MHSA	3(60.0)	2(50.0)	1(100.0)
General funds	1(20.0)	0(0.0)	1(100.0)
Other	1(20.0)	0(0.0)	1(100.0)
Federal (e.g., SAMHSA)	2(40.0)	1(25.0)	1(100.0)
Mental health block grant	1(20.0)	0(0.0)	1(100.0)
Private			
Private foundation	1(20.0)	0(0.0)	1(100.0)
Donor	1(20.0)	0(0.0)	1(100.0)

Other			
Other 1			
Other 2			
NA	1(20.0)	1(25.0)	0(0.0)
Do not know	1(20.0)	1(25.0)	0(0.0)

[a]Number of funding sources may exceed the total number of programs because more than one funding source may be reported per program
[b]Question only applies to programs that report having a sustainability plan in place.
[c]Question only applies to programs that do not report having a sustainability plan in place.

Table 39. Distribution of funding sources for SB-82/833 triage grant programs (n=14) and their sustainability plans among total sample of programs and by program maturation

	Overall[a] *(n=14)* *N[a](%)*	**New** *(n=8)* *N(%)*	**Augmenting** *(n=6)* *N(%)*
Funding or revenue streams currently used to supplement SB-82/833 grant funding			
Health Insurance			
Medi-Cal	10(71.4)	5(62.5)	5(83.3)
Private	1(7.1)	0(0.0)	1(16.7)
Public			
Municipal			
County	4(28.6)	2(25.0)	2(33.3)
School/School District	2(14.3)	2(25.0)	0(0.0)
State			
DHCS	1(7.1)	1(12.5)	0(0.0)
MHSA	6(42.9)	4(50.0)	2(33.3)
General funds			
Other	1(7.1)	1(12.5)	0(0.0)
Federal (e.g., SAMHSA)			
Mental health block grant			
Private			
Private foundation	1(7.1)	1(12.5)	0(0.0)
Donor	1(7.1)	1(12.5)	0(0.0)
Other			
Other 1			
Other 2			
NA	2(14.3)	1(12.5)	1(16.7)
Do not know			
Mean # of additional funding sources	2.3±1.6	2.4±1.9	2.0±1.2
Services and activities delivered by the program and billed to Medi-Cal			
None	2(14.3)	1(12.5)	1(16.7)
1–10%	1(7.1)	1(12.5)	0(0.0)
11–20%	1(7.1)	1(12.5)	0(0.0)
21–30%			
31–40%	2(14.3)	2(25.0)	0(0.0)
41–50%	1(7.1)	1(12.5)	0(0.0)
51–60%	3(21.4)	0(0.0)	3(50.0)
61–70%	1(7.1)	1(12.5)	0(0.0)
71–80%			
81–90%	1(7.1)	0(0.0)	1 (16.7)
91–100%			
NA			
Do not know	2(14.3)	1(12.5)	1(16.7)

	Overall[a] *(n=9)* *N[a](%)*	**New** *(n=4)* *N(%)*	**Augmenting** *(n=5)* *N(%)*
Funding source(s) your current sustainability plan includes[b]:			
Health Insurance			
Medi-Cal	8(88.9)	4(100.0)	4(80.0)
Private	1(11.1)	0(0.0)	1(20.0)
Public			
Municipal			
County	3(33.3)	2(50.0)	1(20.0)
School/School District	3(33.3)	3(75.0)	0(0.0)
State			
DHCS	1(11.1)	1(25.0)	0(0.0)
MHSA	6(66.7)	3(75.0)	3(60.0)
General funds	1(11.1)	1(25.0)	0(0.0)
Other	3(33.3)	1(25.0)	2(40.0)
Federal (e.g., SAMHSA)			
Mental health block grant			
Private			
Private foundation	1(11.1)	1(25.0)	0(0.0)
Donor	1(11.1)	1(25.0)	0(0.0)
Other			
Other 1 (Local Control Funding Formula)	1(11.1)	1(25.0)	0(0.0)
Other 2			
NA			
Do not know			
Mean # of additional funding sources	3.2±1.8	3.6±2.3	2.8±1.0
	Overall[a] *(n=5)* *N[a](%)*	**New** *(n=3)* *N(%)*	**Augmenting** *(n=2)* *N(%)*
Funding source(s) considered when developing a sustainability plan[c]:			
Health Insurance			
Medi-Cal	3(60.0)	3(100.0)	0(0.0)
Private	1(20.0)	1(33.3)	0(0.0)
Public			
Municipal	1(20.0)	1(33.3)	0(0.0)
County	2(40.0)	2(66.7)	0(0.0)
School/School District	2(40.0)	2(66.7)	0(0.0)
State			
DHCS	1(20.0)	1(33.3)	0(0.0)
MHSA	3(60.0)	3(100.0)	0(0.0)
General funds	1(20.0)	1(33.3)	0(0.0)
Other	1(20.0)	1(33.3)	0(0.0)
Federal (e.g., SAMHSA)	2(40.0)	2(66.7)	0(0.0)
Mental health block grant	1(20.0)	1(33.3)	0(0.0)
Private			
Private foundation	1(20.0)	1(33.3)	0(0.0)
Donor	1(20.0)	1(33.3)	0(0.0)

Other			
Other 1			
Other 2			
NA	1(20.0)	0(0.0)	1(50.0)
Do not know	1(20.0)	0(0.0)	1(50.0)

[a]Number of funding sources may exceed the total number of programs because more than one funding source may be reported per program

[b]Question only applies to programs that report having a sustainability plan in place.

[c]Question only applies to programs that do not report having a sustainability plan in place.

Table 40. Distribution of funding sources for SB-82/833 triage grant programs (n=14) and their sustainability plans among total sample of programs and by school-based status

	Overall[a] *(n=14)* *N*[a]*(%)*	**School-based** *(n=6)* *N(%)*	**Non-school-based** *(n=8)* *N(%)*
Funding or revenue streams currently used to supplement SB-82/833 grant funding			
Health Insurance			
Medi-Cal	10(71.4)	3(50.0)	7(87.5)
Private	1(7.1)	0(0.0)	1(12.5)
Public			
Municipal			
County	4(28.6)	2(33.3)	2(25.0)
School/School District	2(14.3)	2(33.3)	0(0.0)
State			
DHCS	1(7.1)	1(16.7)	0(0.0)
MHSA	6(42.9)	4(66.7)	2(25.0)
General funds			
Other	1(7.1)	0(0.0)	1(12.5)
Federal (e.g., SAMHSA)			
Mental health block grant			
Private			
Private foundation	1(7.1)	1(16.7)	0(0.0)
Donor	1(7.1)	1(16.7)	0(0.0)
Other			
Other 1			
Other 2			
NA	2(14.3)	1(16.7)	1(12.5)
Do not know			
Mean # of additional funding sources	2.3±1.6	2.8±2.0	1.9±1.2
Services and activities delivered by the program and billed to Medi-Cal			
None	2(14.3)	1(16.7)	1(12.5)
1–10%	1(7.1)	1(16.7)	0(0.0)
11–20%	1(7.1)	1(16.7)	0(0.0)
21–30%			
31–40%	2(14.3)	1(16.7)	1(12.5)
41–50%	1(7.1)	0(0.0)	1(12.5)
51–60%	3(21.4)	0(0.0)	3(37.5)
61–70%	1(7.1)	0(0.0)	1(12.5)
71–80%			
81–90%	1(7.1)	1(16.7)	0(0.0)
91–100%			
NA			
Do not know	2(14.3)	1(16.7)	1(12.5)

	Overall[a] *(n=9)* *N[a] (%)*	School-based *(n=4)* *N (%)*	Non-school-based *(n=5)* *N (%)*
Funding source(s) your current sustainability plan includes[b]			
Health Insurance			
Medi-Cal	8(88.9)	3(75.0)	5(100.0)
Private	1(11.1)	0(0.0)	1(20.0)
Public			
Municipal			
County	3(33.3)	2(50.0)	1(20.0)
School/School District	3(33.3)	3(75.0)	0(0.0)
State			
DHCS	1(11.1)	1(25.0)	0(0.0)
MHSA	6(66.7)	2(50.0)	4(80.0)
General funds	1(11.1)	1(25.0)	0(0.0)
Other	3(33.3)	0(0.0)	3(60.0)
Federal (e.g., SAMHSA)			
Mental health block grant			
Private			
Private foundation	1(11.1)	1(25.0)	0(0.0)
Donor	1(11.1)	1(25.0)	0(0.0)
Other			
Other 1 (Local Control Funding Formula)	1(11.1)	1(25.0)	0(0.0)
Other 2			
NA			
Do not know			
Mean # of additional funding sources	3.2±1.8	3.8±2.6	2.8±0.8
	Overall[a] *(n=5)* *N[a] (%)*	**School-based** *(n=4)* *N (%)*	**Non-school-based** *(n=1)* *N (%)*
Funding source(s) considered when developing a sustainability plan[c]			
Health Insurance			
Medi-Cal	3(60.0)	2(100.0)	1(33.3)
Private	1(20.0)	1(50.0)	0(0.0)
Public			
Municipal	1(20.0)	1(50.0)	0(0.0)
County	2(40.0)	1(50.0)	1(33.3)
School/School District	2(40.0)	2(100.0)	0(0.0)
State			
DHCS	1(20.0)	1(50.0)	0(0.0)
MHSA	3(60.0)	2(100.0)	1(33.3)
General funds	1(20.0)	1(50.0)	0(0.0)
Other	1(20.0)	1(50.0)	0(0.0)
Federal (e.g., SAMHSA)	2(40.0)	1(50.0)	1(33.3)
Mental health block grant	1(20.0)	1(50.0)	0(0.0)
Private			
Private foundation	1(20.0)	1(50.0)	0(0.0)
Donor	1(20.0)	1(50.0)	0(0.0)

Other			
Other 1			
Other 2			
NA	1(20.0)	0(0.0)	1(33.3)
Do not know	1(20.0)	0(0.0)	1(33.3)

[a]Number of funding sources may exceed the total number of programs because more than one funding source may be reported per program
[b]Question only applies to programs that report having a sustainability plan in place.
[c]Question only applies to programs that do not report having a sustainability plan in place.

Table 41. Distribution of funding sources for SB-82/833 triage grant programs (n=14) and their sustainability plans among total sample of programs and by urban/rural

	Overall[a] *(n=14)* *N*[a]*(%)*	**Urban** *(n=11)* *N(%)*	**Rural** *(n=3)* *N(%)*
Funding or revenue streams currently used to supplement SB-82/833 grant funding			
Health Insurance			
Medi-Cal	10(71.4)	7(63.6)	3(100.0)
Private	1(7.1)	1(9.1)	0(0.0)
Public			
Municipal			
County	4(28.6)	3(27.3)	1(33.3)
School/School District	2(14.3)	2(18.2)	0(0.0)
State			
DHCS	1(7.1)	1(9.1)	0(0.0)
MHSA	6(42.9)	6(54.5)	0(0.0)
General funds			
Other	1(7.1)	1(9.1)	0(0.0)
Federal (e.g., SAMHSA)			
Mental health block grant			
Private			
Private foundation	1(7.1)	1(9.1)	0(0.0)
Donor	1(7.1)	1(9.1)	0(0.0)
Other			
Other 1			
Other 2			
NA	2(14.3)	2(18.2)	0(0.0)
Do not know			
Mean # of additional funding sources	2.3±1.6	2.6±1.7	1.3±0.6
Services and activities delivered by the program and billed to Medi-Cal			
None	2(14.3)	2(18.2)	0(0.0)
1–10%	1(7.1)	1(9.1)	0(0.0)
11–20%	1(7.1)	1(9.1)	0(0.0)
21–30%			
31–40%	2(14.3)	1(9.1)	1(33.3)
41–50%	1(7.1)	0(0.0)	1(33.3)
51–60%	3(21.4)	2(18.2)	1(33.3)
61–70%	1(7.1)	1(9.1)	0(0.0)
71–80%			
81–90%	1(7.1)	1(9.1)	0(0.0)
91–100%			
NA			
Do not know	2(14.3)	2(18.2)	0(0.0)

	Overall[a] *(n=9)* *N[a](%)*	Urban *(n=7)* *N(%)*	Rural *(n=2)* *N(%)*
Funding source(s) your current sustainability plan includes[b]			
Health Insurance			
Medi-Cal	8(88.9)	6(85.7)	2(100.0)
Private	1(11.1)	1(14.3)	0(0.0)
Public			
Municipal			
County	3(33.3)	3(42.9)	0(0.0)
School/School District	3(33.3)	3(42.9)	0(0.0)
State			
DHCS	1(11.1)	1(14.3)	0(0.0)
MHSA	6(66.7)	5(71.4)	1(50.0)
General funds	1(11.1)	1(14.3)	0(0.0)
Other	3(33.3)	2(28.6)	1(50.0)
Federal (e.g., SAMHSA)			
Mental health block grant			
Private			
Private foundation	1(11.1)	1(14.3)	0(0.0)
Donor	1(11.1)	1(14.3)	0(0.0)
Other			
Other 1 (Local Control Funding Formula)	1(11.1)	1(14.3)	0(0.0)
Other 2			
NA			
Do not know			
Mean # of additional funding sources	3.2±1.8	3.6±1.9	2.0±0.0
	Overall[a] *(n=5)* *N[a](%)*	**Urban** *(n=4)* *N(%)*	**Rural** *(n=1)* *N(%)*
Funding source(s) considered when developing a sustainability plan[c]			
Health Insurance			
Medi-Cal	3(60.0)	2(50.0)	1(100.0)
Private	1(20.0)	0(0.0)	1(100.0)
Public			
Municipal	1(20.0)	0(0.0)	1(100.0)
County	2(40.0)	1(25.0)	1(100.0)
School/School District	2(40.0)	1(25.0)	1(100.0)
State			
DHCS	1(20.0)	0(0.0)	1(100.0)
MHSA	3(60.0)	2(50.0)	1(100.0)
General funds	1(20.0)	0(0.0)	1(100.0)
Other	1(20.0)	0(0.0)	1(100.0)
Federal (e.g., SAMHSA)	2(40.0)	1(25.0)	1(100.0)
Mental health block grant	1(20.0)	0(0.0)	1(100.0)
Private			
Private foundation	1(20.0)	0(0.0)	1(100.0)
Donor	1(20.0)	0(0.0)	1(100.0)

Other			
Other 1			
Other 2			
NA	1(20.0)	1(25.0)	0(0.0)
Do not know	1(20.0)	1(25.0)	0(0.0)

[a]Number of funding sources may exceed the total number of programs because more than one funding source may be reported per program

[b]Question only applies to programs that report having a sustainability plan in place.

[c]Question only applies to programs that do not report having a sustainability plan in place.

C.3 SB-82/833 Triage Grant Goals

Table 42 summarizes the number and proportion of programs that agreed or strongly agreed on their programs' suitability for and effectiveness at SB-82/833 Triage Grant program goals by type of triage grant, **Table 43** does so by program maturation, **Table 44** by school-based status, and **Table 45** by urban/rural. Although some SB-82/833 Triage Grant program goals are aimed only at Child/Youth or School-County Collaborative programs (as specified in the subheadings of Tables 42–45), questions on all goals were asked to leads from every program to ensure that we did not exclude contributions made by programs beyond their grant type. As a result, for some survey items reported, the denominator may be less than the total number of programs because programs reported that the survey item did not apply (e.g., K-12 student wellness for Child/Youth programs).

C.3.1 Expand Crisis Prevention and Treatment Services

For the goal to expand crisis prevention and treatment services, all Child/Youth and School-County Collaborative programs agreed or strongly agreed with at least one indicator. Almost all programs (n=13; 92.9%) agreed or strongly agreed that the activities and services provided by their SB-82/833 program were both suitable and effective for addressing needs that were not adequately met by other mental health programs in their county or community, and also suitable for expanding access to mental health services in unserved or underserved communities. In addition, 85.7% (n=12) agreed or strongly agreed that the activities and services provided were effective in expanding access to mental health services. Most (n=13; 92.9%) also agreed or strongly agreed that the activities and services provided were suitable for expanding crisis prevention services in the community, and 76.9% (n=10) agreed or strongly agreed their program was effective in this task. In addition, 84.6% (n=11) agreed or strongly agreed that their program was suitable for expanding crisis response services in their community and 69.2% (n=9) agreed or strongly agreed that their programs were effective in doing so. Further, 83.3% (n=10) programs agreed or strongly agreed that their program was suitable for expanding crisis treatment services in the community and two-thirds (n=8; 66.7%) agreed or strongly agreed that their programs were effective in meeting this goal.

Among School-County Collaborative programs (n=4), all agreed or strongly agreed the activities and services of their SB-82/833 programs were suitable and effective in addressing needs that were not adequately met by other mental health programs in their county or community as well as suitable and effective for expanding access to mental health services. Three-fourths of the School-County Collaborative programs (n=3; 75%) agreed or strongly agreed their programs were suitable and effective in expanding crisis prevention services in their community as well as suitable for expanding crisis response services. One-half of the School-County Collaborative programs (n=2; 50%) agreed or strongly agreed that their programs were effective in expanding crisis response services in the community. Further, three-fourths of the School-County Collaborative programs (n=3; 75%) agreed or strongly agreed their program was suitable and effective in expanding crisis treatment services in their community.

C.3.2 Increase Client Wellness

For the goal of increasing client wellness, all programs agreed or strongly agreed with at least one indicator. Most (n=12; 92.3%) agreed or strongly agreed their SB-82/833 program was suitable for increasing client wellness or effective in increasing client wellness. Among Child/Youth programs, 88.9% (n=8) agreed or strongly agreed their programs were suitable and effective in increasing client wellness, and all School-County Collaborative programs agreed or strongly agreed their programs

were suitable and effective in increasing client wellness. Among the School-County Collaborative programs, all agreed their program was suitable and effective in increasing K-12 student wellness.

C.3.3 Decrease Unnecessary Hospitalizations

Among Child/Youth programs, all (n=10, 100%) agreed or strongly agreed the activities and services provided by their SB-82/833 program were suitable for reducing unnecessary psychiatric hospitalizations and costs, and 90% (n=9) agreed or strongly agreed their programs were effective in accomplishing this task. Although this goal was aimed at Child/Youth programs, one-third of responding School-County Collaborative programs (n=1, 33.3%) agreed or strongly agreed their programs were suitable and effective for this goal.

C.3.4 Reduce Unnecessary Law Enforcement Involvement and Costs

More than three-fourths of the programs (n=10; 76.9%) agreed or strongly agreed their program was suitable for reducing unnecessary law enforcement involvement and costs, and 69.2% (n=9) were reported to be effective in this task. Among Child/Youth programs, 80% (n=8) agreed or strongly agreed their program was suitable for reducing unnecessary law enforcement involvement and costs, and 70% (n=7) agreed or strongly agreed their programs were effective in this task. Among School-County Collaborative programs, two-thirds (n=2; 66.7%) agreed or strongly agreed the activities and services for their SB-82/833 program were suitable and effective for reducing unnecessary law enforcement involvement and costs.

C.3.5 Increase Access to Mental Health Services and Supports through School-Community Partnerships

Among School-County Collaborative programs, all (n=4; 100%) programs agreed or strongly agreed that the activities and services for their SB-82-833 program were suitable and effective in increasing access to a continuum of mental health services and supports in schools as well as for developing new or strengthening existing school-community partnerships for mental health.

C.3.6 Develop Crisis Response Systems on School Campuses

For School-County Collaborative programs, all (n=4; 100%) agreed or strongly agreed the activities and services of their SB-82/833 program were suitable and effective in developing coordinated and effective crisis response systems on school campuses when mental health crises arise.

C.3.7 Engage Parents and Caregivers

Among School-County Collaborative programs, all (n=4; 100%) agreed or strongly agreed that the activities and services of their SB-82/833 program were suitable and effective in engaging parents and caregivers in supporting their child’s social-emotional development and building family resilience.

C.3.8 Reduce Special Education Placement and School/Community Removal

Among School-County Collaborative programs, two-thirds (n=2; 66.7%) agreed or strongly agreed

that the activities and services provided by their SB-82/833 program were suitable and effective in reducing the number of children placed in special education for emotional disturbance or removed from school and community due to their mental health.

Table 42. SB-82/833 triage grant program goals among total sample of programs and by grant type

		Overall *(N=14)*		**Child/Youth** *(N=10)*		**School-County** *(N=4)*	
	Analytic N	*Agree/ Strongly Agree N(%)*	*M±SD*	*Agree/ Strongly Agree N(%)*	*M±SD*	*Agree/ Strongly Agree N(%)*	*M±SD*
SB-82/833 Triage Grant Program Goals							
Expand crisis prevention and treatment services							
The activities and services of this SB-82/833 program are:							
suitable for addressing needs that are not adequately met by other mental health programs in this county/community.	14	13(92.9)	6.4±0.6	9(90.0)	6.4±0.7	4(100.0)	6.5±0.6
effective in addressing needs that are not adequately met by other mental health programs in this county/community.	14	13(92.9)	6.4±0.9	9(90.0)	6.4±1.0	4(100.0)	6.5±0.6
suitable for expanding access to mental health services in unserved or underserved communities.	14	13(92.9)	6.4±0.6	9(90.0)	6.3±0.7	4(100.0)	6.8±0.5
effective in expanding access to mental health services in unserved or underserved communities.	14	12(85.7)	6.1±0.9	8(80.0)	5.9±0.9	4(100.0)	6.8±0.5
suitable for expanding crisis prevention services in the community.	14	13(92.9)	6.5±0.7	10(100.0)	6.5±0.5	3(75.0)	6.5±1.0
effective in expanding crisis prevention services in the community.	13	10(76.9)	6.3±1.0	7(77.8)	6.2±1.1	3(75.0)	6.5±1.0
suitable for expanding crisis response services in the community.	13	11(84.6)	6.0±1.6	8(88.9)	6.3±0.7	3(75.0)	5.3±2.9
effective in expanding crisis response services in the community.	13	9(69.2)	5.7±1.7	7(77.8)	6.0±1.0	2(50.0)	5.0±2.8
suitable for expanding crisis treatment services in the community.	12	10(83.3)	5.8±1.9	7(87.5)	6.1±1.4	3(75.0)	5.0±2.7
effective in expanding crisis treatment services in the community.	12	8(66.7)	5.3±1.8	5(62.5)	5.5±1.4	3(75.0)	5.0±2.7
% Agree/Strongly Agree and Overall Mean[a]	12	14(100.0)	6.1±0.9	10(100.0)	6.2±0.7	4(100.0)	6.0±1.3

Increase client wellness							
(Goal for all programs)							
The activities and services of this SB-82/833 program are:							
suitable for increasing client wellness.	13	12(92.3)	6.5±0.7	8(88.9)	6.3±0.7	4(100.0)	6.8±0.5
effective in increasing client wellness.	13	12(92.3)	6.4±0.9	8(88.9)	6.2±1.0	4(100.0)	6.8±0.5
% Agree/Strongly Agree and Overall Mean[a]	13	13(100.0)	6.4±0.7	9(100.0)	6.3±0.8	4(100.0)	6.8±0.5
(Goal for School-County programs)							
The activities and services of this SB-82/833 program are:							
suitable for increasing K-12 student wellness.	9	8(88.9)	6.3±1.0	4(80.0)	5.8±1.1	4(100.0)	7.0±0.0
effective in increasing K-12 student wellness.	9	7(77.8)	6.0±1.2	3(60.0)	5.4±1.3	4(100.0)	6.8±0.5
% Agree/Strongly Agree and Overall Mean[a]	9	8(88.9)	6.2±1.1	4(80.0)	5.6±1.1	4(100.0)	6.9±0.3
Decrease unnecessary hospitalizations and costs							
(Goal for Child/Youth programs)							
The activities and services of this SB-82/833 program are:							
suitable for reducing unnecessary psychiatric hospitalizations and costs.	13	11(84.6)	6.2±0.7	10(100.0)	6.4±0.5	1(33.3)	5.3±0.6
effective in reducing unnecessary psychiatric hospitalizations and costs.	13	10(76.9)	6.2±1.0	9(90.0)	6.3±0.9	1(33.3)	5.7±1.2
% Agree/Strongly Agree and Overall Mean[a]	13	11(84.6)	6.2±0.8	10(100.0)	6.4±0.7	1(33.3)	5.5±0.9
Reduce unnecessary law enforcement involvement and costs							
(Goal for Child/Youth programs)							
The activities and services of this SB-82/833 program are:							
in my organization/agency.	13	10(76.9)	6.2±1.0	8(80.0)	6.2±1.0	2(66.7)	6.3±1.2
outside the implementing organization(s).	13	9(69.2)	6.1±1.2	7(70.0)	6.0±1.2	2(66.7)	6.3±1.2
% Agree/Strongly Agree and Overall Mean[a]	13	10(76.9)	6.2±1.1	8(80.0)	6.1±1.1	2(66.7)	6.3±1.2
Increase access to a continuum of mental health services and supports through school-community partnerships							
(Goal for School-County programs)							
The activities and services of this SB-82/833 program are:							

suitable for increasing access to a continuum of mental health services and supports in schools.	12	10(83.3)	6.2±0.9	6(75.0)	5.8±0.9	4(100.0)	7.0±0.0
effective in increasing access to a continuum of mental health services and supports in schools.	11	9(81.8)	6.1±1.1	5(71.4)	5.6±1.1	4(100.0)	7.0±0.0
suitable for developing new or strengthening existing school-community partnerships for mental health.	12	11(91.7)	6.5±0.7	7(87.5)	6.3±0.7	4(100.0)	7.0±0.0
effective in developing new or strengthening existing school-community partnerships for mental health.	12	10(83.3)	6.3±1.0	6(75.0)	5.9±1.0	4(100.0)	7.0±0.0
% Agree/Strongly Agree and Overall Mean[a]	11	11(100.0)	6.3±0.7	7(100.0)	6.0±0.7	4(100.0)	7.0±0.0
Develop a coordinated and effective crisis response systems on school campuses when mental health crises arise							
(Goal for School-County programs)							
The activities and services of this SB-82/833 program are:							
suitable for developing coordinated and effective crisis response systems on school campuses when mental health crises arise.	13	10(76.9)	6.2±0.8	6(66.7)	5.8±0.7	4(100.0)	7.0±0.0
effective in developing coordinated and effective crisis response systems on school campuses when mental health crises arise.	13	11(84.6)	5.9±1.2	7(77.8)	5.7±1.3	4(100.0)	6.5±0.6
% Agree/Strongly Agree and Overall Mean[a]	13	12(92.3)	6.0±0.9	8(88.9)	5.7±0.8	4(100.0)	6.8±0.3
Engage parents and caregivers in supporting their child's social-emotional development and building family resilience							
(Goal for School-County programs)							
The activities and services of this SB-82/833 program are:							
suitable for engaging parents and caregivers in supporting their child's social-emotional development and building family resilience.	13	11(84.6)	6.4±0.8	7(77.8)	6.1±0.8	4(100.0)	7.0±0.0
effective in engaging parents and caregivers in supporting their child's social-emotional development and building family resilience.	13	10(76.9)	6.2±1.0	6(66.7)	5.8±1.0	4(100.0)	7.0±0.0
% Agree/Strongly Agree and Overall Mean[a]	13	11(84.6)	6.3±0.8	7(77.8)	5.9±0.8	4(100.0)	7.0±0.0

Reduce the number of children placed in special education for emotional disturbance or removed from school and community due to their mental health needs							
(Goal for School-County programs)							
The activities and services of this SB-82/833 program are:							
suitable for reducing the number of children placed in special education for emotional disturbance or removed from school and community due to their mental health.	9	4(44.4)	5.0±1.7	2(33.3)	4.5±1.8	2(66.7)	6.0±1.0
effective in reducing the number of children placed in special education for emotional disturbance or removed from school and community due to their mental health.	9	3(33.3)	4.8±1.6	1(16.7)	4.2±1.6	2(66.7)	6.0±1.0
% Agree/Strongly Agree and Overall Mean[a]	9	4(44.4)	4.9±1.6	2(33.3)	4.3±1.6	2(66.7)	6.0±1.0

[a]For goals with multiple indicators, overall means are calculated using only programs that answered questions on all indicators, and overall percentages reflect agreement on at least one indicator.

Table 43. SB-82/833 triage grant program goals among total sample of programs and by program maturation

		Overall *(N=14)*		**New** *(N=8)*		**Augmenting** *(N=6)*	
	Analytic N	*Agree/ Strongly Agree N(%)*	*M±SD*	*Agree/ Strongly Agree N(%)*	*M±SD*	*Agree/ Strongly Agree N(%)*	*M±SD*
SB-82/833 Triage Grant Program Goals							
Expand crisis prevention and treatment services							
The activities and services of this SB-82/833 program are:							
suitable for addressing needs that are not adequately met by other mental health programs in this county/community.	14	13(92.9)	6.4±0.6	7(87.5)	6.4±0.7	6(100.0)	6.5±0.5
effective in addressing needs that are not adequately met by other mental health programs in this county/community.	14	13(92.9)	6.4±0.9	8(100.0)	6.6±0.5	5(83.3)	6.2±1.2
suitable for expanding access to mental health services in unserved or underserved communities.	14	13(92.9)	6.4±0.6	7(87.5)	6.5±0.8	6(100.0)	6.3±0.5
effective in expanding access to mental health services in unserved or underserved communities.	14	12(85.7)	6.1±0.9	8(100.0)	6.5±0.5	4(66.7)	5.7±1.0
suitable for expanding crisis prevention services in the community.	14	13(92.9)	6.5±0.7	7(87.5)	6.5±0.8	6(100.0)	6.5±0.5
effective in expanding crisis prevention services in the community.	13	10(76.9)	6.3±1.0	6(75.0)	6.5±0.9	4(80.0)	6.0±1.2
suitable for expanding crisis response services in the community.	13	11(84.6)	6.0±1.6	5(71.4)	5.6±2.1	6(100.0)	6.5±0.5
effective in expanding crisis response services in the community.	13	9(69.2)	5.7±1.7	4(57.1)	5.4±2.1	5(83.3)	6.0±1.1
suitable for expanding crisis treatment services in the community.	12	10(83.3)	5.8±1.9	5(71.4)	5.1±2.3	5(100.0)	6.6±0.5
effective in expanding crisis treatment services in the community.	12	8(66.7)	5.3±1.8	4(57.1)	4.9±2.1	4(80.0)	6.0±1.2
% Agree/Strongly Agree and Overall Mean[a]	12	14(100.0)	6.1±0.9	8(100.0)	6.0±1.0	6(100.0)	6.3±0.8

Increase client wellness							
(Goal for all programs)							
The activities and services of this SB-82/833 program are:							
suitable for increasing client wellness.	13	12(92.3)	6.5±0.7	7(87.5)	6.5±0.8	5(100.0)	6.4±0.5
effective in increasing client wellness.	13	12(92.3)	6.4±0.9	8(100.0)	6.6±0.5	4(80.0)	6.0±1.2
% Agree/Strongly Agree and Overall Mean[a]	13	13(100.0)	6.4±0.7	8(100.0)	6.6±0.6	5(100.0)	6.2±0.8
(Goal for School-County programs)							
The activities and services of this SB-82/833 program are:							
suitable for increasing K-12 student wellness.	9	8(88.9)	6.3±1.0	5(83.3)	6.5±1.2	3(100.0)	6.0±0.0
effective in increasing K-12 student wellness.	9	7(77.8)	6.0±1.2	5(83.3)	6.3±1.2	2(66.7)	5.3±1.2
% Agree/Strongly Agree and Overall Mean[a]	9	8(88.9)	6.2±1.1	5(83.3)	6.4±1.2	3(100.0)	5.7±0.6
Decrease unnecessary hospitalizations and costs							
(Goal for Child/Youth programs)							
The activities and services of this SB-82/833 program are:							
suitable for reducing unnecessary psychiatric hospitalizations and costs.	13	11(84.6)	6.2±0.7	5(71.4)	6.0±0.8	6(100.0)	6.3±0.5
effective in reducing unnecessary psychiatric hospitalizations and costs.	13	10(76.9)	6.2±1.0	5(71.4)	6.1±0.9	5(83.3)	6.2±1.2
% Agree/Strongly Agree and Overall Mean[a]	13	11(84.6)	6.2±0.8	5(71.4)	6.1±0.8	6(100.0)	6.3±0.8
Reduce unnecessary law enforcement involvement and costs							
(Goal for Child/Youth programs)							
The activities and services of this SB-82/833 program are:							
in my organization/agency.	13	10(76.9)	6.2±1.0	5(71.4)	6.3±1.0	5(83.3)	6.2±1.2
outside the implementing organization(s).	13	9(69.2)	6.1±1.2	5(71.4)	6.3±1.0	4(66.7)	5.8±1.5
% Agree/Strongly Agree and Overall Mean[a]	13	10(76.9)	6.2±1.1	5(71.4)	6.3±1.0	5(83.3)	6.0±1.3
Increase access to a continuum of mental health services and supports through school-community partnerships							
(Goal for School-County programs)							
The activities and services of this SB-82/833 program are:							

suitable for increasing access to a continuum of mental health services and supports in schools.	12	10(83.3)	6.2±0.9	6(85.7)	6.6±0.8	4(80.0)	5.6±0.9
effective in increasing access to a continuum of mental health services and supports in schools.	11	9(81.8)	6.1±1.1	6(100.0)	6.8±0.4	3(60.0)	5.2±1.1
suitable for developing new or strengthening existing school-community partnerships for mental health.	12	11(91.7)	6.5±0.7	6(85.7)	6.6±0.8	5(100.0)	6.4±0.5
effective in developing new or strengthening existing school-community partnerships for mental health.	12	10(83.3)	6.3±1.0	6(85.7)	6.6±0.8	4(80.0)	5.8±1.1
% Agree/Strongly Agree and Overall Mean[a]	11	11(100.0)	6.3±0.7	6(100.0)	6.8±0.4	5(100.0)	5.8±0.6
Develop a coordinated and effective crisis response systems on school campuses when mental health crises arise							
(Goal for School-County programs)							
The activities and services of this SB-82/833 program are:							
suitable for developing coordinated and effective crisis response systems on school campuses when mental health crises arise.	13	10(76.9)	6.2±0.8	5(62.5)	6.1±1.0	5(100.0)	6.2±0.4
effective in developing coordinated and effective crisis response systems on school campuses when mental health crises arise.	13	11(84.6)	5.9±1.2	7(87.5)	6.0±1.3	4(80.0)	5.8±1.1
% Agree/Strongly Agree and Overall Mean[a]	13	12(92.3)	6.0±0.9	7(87.5)	6.1±1.0	5(100.0)	6.0±0.7
Engage parents and caregivers in supporting their child's social-emotional development and building family resilience							
(Goal for School-County programs)							
The activities and services of this SB-82/833 program are:							
suitable for engaging parents and caregivers in supporting their child's social-emotional development and building family resilience.	13	11(84.6)	6.4±0.8	6(85.7)	6.6±0.8	5(83.3)	6.2±0.8
effective in engaging parents and caregivers in supporting their child's social-emotional development and building family resilience.	13	10(76.9)	6.2±1.0	6(85.7)	6.4±0.8	4(66.7)	5.8±1.2
% Agree/Strongly Agree and Overall Mean[a]	13	11(84.6)	6.3±0.8	6(85.7)	6.5±0.8	5(83.3)	6.0±0.9

Reduce the number of children placed in special education for emotional disturbance or removed from school and community due to their mental health needs							
(Goal for School-County programs)							
The activities and services of this SB-82/833 program are:							
suitable for reducing the number of children placed in special education for emotional disturbance or removed from school and community due to their mental health.	9	4(44.4)	5.0±1.7	2(40.0)	4.8±1.9	2(50.0)	5.3±1.5
effective in reducing the number of children placed in special education for emotional disturbance or removed from school and community due to their mental health.	9	3(33.3)	4.8±1.6	2(40.0)	4.8±1.9	1(25.0)	4.8±1.5
% Agree/Strongly Agree and Overall Mean[a]	9	4(44.4)	4.9±1.6	2(40.0)	4.8±1.9	2(50.0)	5.0±1.4

[a]For goals with multiple indicators, overall means are calculated using only programs that answered questions on all indicators, and overall percentages reflect agreement on at least one indicator.

Table 44. SB-82/833 triage grant program goals among total sample of programs and by school-based status

		Overall *(N=14)*		**School-based** *(N=6)*		**Non-school-based** *(N=8)*	
	Analytic N	*Agree/ Strongly Agree N(%)*	*M±SD*	*Agree/ Strongly Agree N(%)*	*M±SD*	*Agree/ Strongly Agree N(%)*	*M±SD*
SB-82/833 Triage Grant Program Goals							
Expand crisis prevention and treatment services							
The activities and services of this SB-82/833 program are:							
suitable for addressing needs that are not adequately met by other mental health programs in this county/community.	14	13(92.9)	6.4±0.6	6(100.0)	6.3±0.5	7(87.5)	6.5±0.8
effective in addressing needs that are not adequately met by other mental health programs in this county/community.	14	13(92.9)	6.4±0.9	6(100.0)	6.3±0.5	7(87.5)	6.5±1.1
suitable for expanding access to mental health services in unserved or underserved communities.	14	13(92.9)	6.4±0.6	6(100.0)	6.7±0.5	7(87.5)	6.3±0.7
effective in expanding access to mental health services in unserved or underserved communities.	14	12(85.7)	6.1±0.9	6(100.0)	6.5±0.5	6(75.0)	5.9±1.0
suitable for expanding crisis prevention services in the community.	14	13(92.9)	6.5±0.7	5(83.3)	6.5±0.8	8(100.0)	6.5±0.5
effective in expanding crisis prevention services in the community.	13	10(76.9)	6.3±1.0	5(83.3)	6.5±0.8	5(71.4)	6.1±1.2
suitable for expanding crisis response services in the community.	13	11(84.6)	6.0±1.6	4(80.0)	5.4±2.5	7(87.5)	6.4±0.7
effective in expanding crisis response services in the community.	13	9(69.2)	5.7±1.7	3(50.0)	5.2±2.5	6(75.0)	6.0±1.1
suitable for expanding crisis treatment services in the community.	12	10(83.3)	5.8±1.9	4(80.0)	5.2±2.4	6(85.7)	6.1±1.5
effective in expanding crisis treatment services in the community.	12	8(66.7)	5.3±1.8	4(80.0)	5.2±2.4	4(57.1)	5.4±1.5
% Agree/Strongly Agree and Overall Mean[a]	12	14(100.0)	6.1±0.9	6(100.0)	6.0±1.1	8(100.0)	6.2±0.7

Increase client wellness							
(Goal for all programs)							
The activities and services of this SB-82/833 program are:							
suitable for increasing client wellness.	13	12(92.3)	6.5±0.7	6(100.0)	6.7±0.5	6(85.7)	6.3±0.8
effective in increasing client wellness.	13	12(92.3)	6.4±0.9	6(100.0)	6.7±0.5	6(85.7)	6.1±1.1
% Agree/Strongly Agree and Overall Mean[a]	13	13(100.0)	6.4±0.7	6(100.0)	6.7±0.5	7(100.0)	6.2±0.8
(Goal for School-County programs)							
The activities and services of this SB-82/833 program are:							
suitable for increasing K-12 student wellness.	9	8(88.9)	6.3±1.0	4(100.0)	7.0±0.0	4(80.0)	5.8±1.1
effective in increasing K-12 student wellness.	9	7(77.8)	6.0±1.2	4(100.0)	6.8±0.5	3(60.0)	5.4±1.3
% Agree/Strongly Agree and Overall Mean[a]	9	8(88.9)	6.2±1.1	4(100.0)	6.9±0.3	4(80.0)	5.6±1.1
Decrease unnecessary hospitalizations and costs							
(Goal for Child/Youth programs)							
The activities and services of this SB-82/833 program are:							
suitable for reducing unnecessary psychiatric hospitalizations and costs.	13	11(84.6)	6.2±0.7	3(50.0)	5.8±0.8	8(100.0)	6.4±0.5
effective in reducing unnecessary psychiatric hospitalizations and costs.	13	10(76.9)	6.2±1.0	3(50.0)	6.0±1.0	7(87.5)	6.3±1.0
% Agree/Strongly Agree and Overall Mean[a]	13	11(84.6)	6.2±0.8	3(50.0)	5.9±0.9	8(100.0)	6.3±0.7
Reduce unnecessary law enforcement involvement and costs							
(Goal for Child/Youth programs)							
The activities and services of this SB-82/833 program are:							
in my organization/agency.	13	10(76.9)	6.2±1.0	4(80.0)	6.4±0.9	6(75.0)	6.1±1.1
outside the implementing organization(s).	13	9(69.2)	6.1±1.2	4(80.0)	6.4±0.9	5(62.5)	5.9±1.4
% Agree/Strongly Agree and Overall Mean[a]	13	10(76.9)	6.2±1.1	4(80.0)	6.4±0.9	6(75.0)	6.0±1.2
Increase access to a continuum of mental health services and supports through school-community partnerships							
(Goal for School-County programs)							
The activities and services of this SB-82/833 program are:							

suitable for increasing access to a continuum of mental health services and supports in schools.	12	10(83.3)	6.2±0.9	6(100.0)	6.8±0.4	4(66.7)	5.5±0.8
effective in increasing access to a continuum of mental health services and supports in schools.	11	9(81.8)	6.1±1.1	6(100.0)	6.8±0.4	3(60.0)	5.2±1.1
suitable for developing new or strengthening existing school-community partnerships for mental health.	12	11(91.7)	6.5±0.7	6(100.0)	6.8±0.4	5(83.3)	6.2±0.8
effective in developing new or strengthening existing school-community partnerships for mental health.	12	10(83.3)	6.3±1.0	6(100.0)	6.8±0.4	4(66.7)	5.7±1.0
% Agree/Strongly Agree and Overall Mean[a]	11	11(100.0)	6.3±0.7	6(100.0)	6.8±0.4	5(100.0)	5.8±0.6
Develop a coordinated and effective crisis response systems on school campuses when mental health crises arise							
(Goal for School-County programs)							
The activities and services of this SB-82/833 program are:							
suitable for developing coordinated and effective crisis response systems on school campuses when mental health crises arise.	13	10(76.9)	6.2±0.8	6(100.0)	6.7±0.5	4(57.1)	5.7±0.8
effective in developing coordinated and effective crisis response systems on school campuses when mental health crises arise.	13	11(84.6)	5.9±1.2	6(100.0)	6.3±0.5	5(71.4)	5.6±1.5
% Agree/Strongly Agree and Overall Mean[a]	13	12(92.3)	6.0±0.9	6(100.0)	6.5±0.4	6(85.7)	5.6±0.9
Engage parents and caregivers in supporting their child's social-emotional development and building family resilience							
(Goal for School-County programs)							
The activities and services of this SB-82/833 program are:							
suitable for engaging parents and caregivers in supporting their child's social-emotional development and building family resilience.	13	11(84.6)	6.4±0.8	4(80.0)	6.6±0.9	7(87.5)	6.3±0.7
effective in engaging parents and caregivers in supporting their child's social-emotional development and building family resilience.	13	10(76.9)	6.2±1.0	4(80.0)	6.6±0.9	6(75.0)	5.9±1.0
% Agree/Strongly Agree and Overall Mean[a]	13	11(84.6)	6.3±0.8	4(80.0)	6.6±0.9	7(87.5)	6.1±0.8

Reduce the number of children placed in special education for emotional disturbance or removed from school and community due to their mental health needs							
(Goal for School-County programs)							
The activities and services of this SB-82/833 program are:							
suitable for reducing the number of children placed in special education for emotional disturbance or removed from school and community due to their mental health.	9	4(44.4)	5.0±1.7	2(50.0)	5.5±1.3	2(40.0)	4.6±1.9
effective in reducing the number of children placed in special education for emotional disturbance or removed from school and community due to their mental health.	9	3(33.3)	4.8±1.6	2(50.0)	5.5±1.3	1(20.0)	4.2±1.8
% Agree/Strongly Agree and Overall Mean[a]	9	4(44.4)	4.9±1.6	2(50.0)	5.5±1.3	2(40.0)	4.4±1.8

[a]For goals with multiple indicators, overall means are calculated using only programs that answered questions on all indicators, and overall percentages reflect agreement on at least one indicator.

Table 45. SB-82/833 triage grant program goals among total sample of programs and by urban/rural

		Overall *(N=14)*		**Urban** *(N=11)*		**Rural** *(N=3)*	
	Analytic N	*Agree/ Strongly Agree N(%)*	*M±SD*	*Agree/ Strongly Agree N(%)*	*M±SD*	*Agree/ Strongly Agree N(%)*	*M±SD*
SB-82/833 Triage Grant Program Goals							
Expand crisis prevention and treatment services							
The activities and services of this SB-82/833 program are:							
suitable for addressing needs that are not adequately met by other mental health programs in this county/community.	14	13(92.9)	6.4±0.6	10(90.9)	6.4±0.7	3(100.0)	6.7±0.6
effective in addressing needs that are not adequately met by other mental health programs in this county/community.	14	13(92.9)	6.4±0.9	10(90.9)	6.4±0.9	3(100.0)	6.7±0.6
suitable for expanding access to mental health services in unserved or underserved communities.	14	13(92.9)	6.4±0.6	10(90.9)	6.3±0.6	3(100.0)	7.0±0.0
effective in expanding access to mental health services in unserved or underserved communities.	14	12(85.7)	6.1±0.9	9(81.8)	6.0±0.9	3(100.0)	6.7±0.6
suitable for expanding crisis prevention services in the community.	14	13(92.9)	6.5±0.7	10(90.9)	6.5±0.7	3(100.0)	6.7±0.6
effective in expanding crisis prevention services in the community.	13	10(76.9)	6.3±1.0	7(70.0)	6.2±1.1	3(100.0)	6.7±0.6
suitable for expanding crisis response services in the community.	13	11(84.6)	6.0±1.6	8(80.0)	5.8±1.8	3(100.0)	6.7±0.6
effective in expanding crisis response services in the community.	13	9(69.2)	5.7±1.7	6(60.0)	5.5±1.9	3(100.0)	6.3±0.6
suitable for expanding crisis treatment services in the community.	12	10(83.3)	5.8±1.9	7(77.8)	5.6±2.1	3(100.0)	6.3±0.6
effective in expanding crisis treatment services in the community.	12	8(66.7)	5.3±1.8	5(55.6)	5.1±2.1	3(100.0)	6.0±0.0
% Agree/Strongly Agree and Overall Mean[a]	12	14(100.0)	6.1±0.9	11(100.0)	6.0±1.0	3(100.0)	6.6±0.1

Increase client wellness							
(Goal for all programs)							
The activities and services of this SB-82/833 program are:							
suitable for increasing client wellness.	13	12(92.3)	6.5±0.7	9(90.0)	6.4±0.7	3(100.0)	6.7±0.6
effective in increasing client wellness.	13	12(92.3)	6.4±0.9	9(90.0)	6.3±0.9	3(100.0)	6.7±0.6
% Agree/Strongly Agree and Overall Mean[a]	13	13(100.0)	6.4±0.7	10(100.0)	6.4±0.7	3(100.0)	6.7±0.6
(Goal for School-County programs)							
The activities and services of this SB-82/833 program are:							
suitable for increasing K-12 student wellness.	9	8(88.9)	6.3±1.0	5(83.3)	6.2±1.2	3(100.0)	6.7±0.6
effective in increasing K-12 student wellness.	9	7(77.8)	6.0±1.2	4(66.7)	5.7±1.4	3(100.0)	6.7±0.6
% Agree/Strongly Agree and Overall Mean[a]	9	8(88.9)	6.2±1.1	5(83.3)	5.9±1.2	3(100.0)	6.7±0.6
Decrease unnecessary hospitalizations and costs							
(Goal for Child/Youth programs)							
The activities and services of this SB-82/833 program are:							
suitable for reducing unnecessary psychiatric hospitalizations and costs.	13	11(84.6)	6.2±0.7	9(90.0)	6.2±0.6	2(66.7)	6.0±1.0
effective in reducing unnecessary psychiatric hospitalizations and costs.	13	10(76.9)	6.2±1.0	8(80.0)	6.2±1.0	2(66.7)	6.0±1.0
% Agree/Strongly Agree and Overall Mean[a]	13	11(84.6)	6.2±0.8	9(90.0)	6.2±0.8	2(66.7)	6.0±1.0
Reduce unnecessary law enforcement involvement and costs							
(Goal for Child/Youth programs)							
The activities and services of this SB-82/833 program are:							
in my organization/agency.	13	10(76.9)	6.2±1.0	7(70.0)	6.0±1.1	3(100.0)	7.0±0.0
outside the implementing organization(s).	13	9(69.2)	6.1±1.2	6(60.0)	5.8±1.2	3(100.0)	7.0±0.0
% Agree/Strongly Agree and Overall Mean[a]	13	10(76.9)	6.2±1.1	7(70.0)	5.9±1.1	3(100.0)	7.0±0.0
Increase access to a continuum of mental health services and supports through school-community partnerships							
(Goal for School-County programs)							
The activities and services of this SB-82/833 program are:							

suitable for increasing access to a continuum of mental health services and supports in schools.	12	10(83.3)	6.2±0.9	8(88.9)	6.3±0.7	2(66.7)	5.7±1.5
effective in increasing access to a continuum of mental health services and supports in schools.	11	9(81.8)	6.1±1.1	7(87.5)	6.3±1.0	2(66.7)	5.7±1.5
suitable for developing new or strengthening existing school-community partnerships for mental health.	12	11(91.7)	6.5±0.7	8(88.9)	6.4±0.7	3(100.0)	6.7±0.6
effective in developing new or strengthening existing school-community partnerships for mental health.	12	10(83.3)	6.3±1.0	7(77.8)	6.2±1.1	3(100.0)	6.3±0.6
% Agree/Strongly Agree and Overall Mean[a]	11	11(100.0)	6.3±0.7	8(100.0)	6.4±0.7	3(100.0)	6.1±0.9
Develop a coordinated and effective crisis response systems on school campuses when mental health crises arise							
(Goal for School-County programs)							
The activities and services of this SB-82/833 program are:							
suitable for developing coordinated and effective crisis response systems on school campuses when mental health crises arise.	13	10(76.9)	6.2±0.8	8(80.0)	6.2±0.8	2(66.7)	6.0±1.0
effective in developing coordinated and effective crisis response systems on school campuses when mental health crises arise.	13	11(84.6)	5.9±1.2	8(80.0)	5.7±1.3	3(100.0)	6.7±0.6
% Agree/Strongly Agree and Overall Mean[a]	13	12(92.3)	6.0±0.9	9(90.0)	6.0±0.9	3(100.0)	6.3±0.6
Engage parents and caregivers in supporting their child's social-emotional development and building family resilience							
(Goal for School-County programs)							
The activities and services of this SB-82/833 program are:							
suitable for engaging parents and caregivers in supporting their child's social-emotional development and building family resilience.	13	11(84.6)	6.4±0.8	9(90.0)	6.4±0.7	2(66.7)	6.3±1.2
effective in engaging parents and caregivers in supporting their child's social-emotional development and building family resilience.	13	10(76.9)	6.2±1.0	8(80.0)	6.1±1.0	2(66.7)	6.3±1.2
% Agree/Strongly Agree and Overall Mean[a]	13	11(84.6)	6.3±0.8	9(90.0)	6.3±0.8	2(66.7)	6.3±1.2

Reduce the number of children placed in special education for emotional disturbance or removed from school and community due to their mental health needs							
(Goal for School-County programs)							
The activities and services of this SB-82/833 program are:							
suitable for reducing the number of children placed in special education for emotional disturbance or removed from school and community due to their mental health.	9	4(44.4)	5.0±1.7	4(66.7)	5.3±2.0	0(0.0)	4.3±0.6
effective in reducing the number of children placed in special education for emotional disturbance or removed from school and community due to their mental health.	9	3(33.3)	4.8±1.6	3(50.0)	5.0±2.0	0(0.0)	4.3±0.6
% Agree/Strongly Agree and Overall Mean[a]	9	4(44.4)	4.9±1.6	4(66.7)	5.2±1.9	0(0.0)	4.3±0.6

[a]For goals with multiple indicators, overall means are calculated using only programs that answered questions on all indicators, and overall percentages reflect agreement on at least one indicator.

C.4 Implementation Outcomes

Table 46 summarizes the implementation outcomes among the total sample of programs by theoretical construct and by grant type, **Table 47** does so by program maturation, **Table 48** by school/not school, and **Table 49** by urban/rural. In this section, an implementation outcome is classified as reported to be achieved if a program lead reports agree or strongly agree with the implementation outcome. Within a construct (e.g., acceptability), there may be more than one indicator. A summary score, including the number and percentage of programs who report agree or strongly agree on at least one indicator and the combined mean rating is summarized for each construct.

C.4.1 Acceptability

Almost all programs (n=13; 92.9%) agreed or strongly agreed with at least one indicator of acceptability. Of the Child/Youth programs (n=10), 90% (n=9) reported high acceptability (agreed or strongly agreed) on at least one indicator, 90% (n=9) agreed or strongly agreed that they would suggest the SB-82/833 program to other counties or communities, 80% (n=8) agreed or strongly agreed that the SB-82/833 program met their approval, and 70% (n=7) agreed or strongly agreed with the statement that the SB-82/833 program was appealing. Among the four School-County Collaborative programs, all (n=4; 100%) endorsed high acceptability on all indices.

C.4.2 Appropriateness

Almost all programs (n=13; 92.9%) agreed or strongly agreed with at least one indicator of appropriateness. Among the Child/Youth programs (n=10), 90% (n=9) agreed or strongly agreed that the program fit the needs of children and families in their county or community, and 70% (n=7) agreed or strongly agreed that their program was a good match for their organization or agency. Among the School-County Collaborative programs, all (n=4, 100%) reported high appropriateness (agreed or strongly agreed) on both indicators.

C.4.3 Feasibility

More than three-fourths of the programs (n=11; 78.6%) agreed or strongly agreed with at least one indicator of feasibility, but only 50% (n=7) agreed or strongly agreed that the SB-82/833 program was easy to implement. The Child/Youth (n=5; 50%) and School-County Collaborative programs (n=2; 50%) were also equally divided between agree/strongly agree or not on whether the SB-82/833 program was easy to implement. In addition, among the Child/Youth programs (n=10), 70% (n=7) agreed or strongly agreed that their program was implementable as proposed, and all School-County Collaborative programs (n=4; 100%) agreed or strongly agreed that the SB-82/833 program was implementable as proposed.

C.4.4 Fidelity

Most programs (n=12; 85.7%) agreed or strongly agreed with at least one indicator of fidelity to the SB-82/833 program. Among Child/Youth programs, 70% (n=7) agreed or strongly agreed that the program had been carried out as originally intended, and 70% (n=7) agreed or strongly agreed that the program had been implemented as described in the triage grant proposal or revised scope of work. Among the School-County Collaborative programs, three-fourths (n=3; 75%) agreed or strongly

agreed that their program had been carried out as originally intended and all (n=4; 100%) agreed or strongly agreed that their program had been implemented as described in the triage grant proposal or revised scope of work.

C.4.5 Penetration

Most programs (n=12; 85.7%) agreed or strongly agreed with the statement that activities and services of their SB-82/833 program were integrated into the regular operations of the organization and/or setting(s) in which they operate. Among the Child/Youth programs, 90% (n=9) agreed or strongly agreed with this statement and among the School-County Collaborative programs, three-fourths (n=3; 75%) agreed or strongly agreed.

C.4.6 Sustainability

Slightly more than 70% (n=10; 71.4%) agreed or strongly agreed with at least one indicator of sustainability, but only one-third (n=5; 35.7%) to one-half of the programs (n=7; 50%) agreed or strongly agreed with an individual indicator. Anticipated sustainability of the SB-82/833 programs was less optimistic. Among the Child/Youth programs, only four (40%) programs agreed or strongly agreed with the statement that the SB-82/833 program is possible to implement with the funding provided by the SB-82-833 grant. One-half of the programs (n=5) agreed or strongly agreed that the SB-82/833 program can be sustained during the grant period using only the funding provided by the SB-82/833 Triage Grant program and that they were confident that this SB-82-833 program will be sustained after the grant period ends. Among the School-County Collaborative programs, three (75%) agreed or strongly agreed that their SB-82/833 program was possible to implement with the funding provided by the triage grant, but only one (25%) agreed or strongly agreed that their SB-82/833 program can be sustained solely on this funding and none agreed or strongly agreed with having confidence that their program will be sustained after the grant period ends.

Table 46. Implementation outcomes among total sample of programs and by grant type

		Overall (N=14)		Child/Youth (N=10)		School-County (N=4)	
	Analytic N	*Agree/ Strongly Agree N(%)*	*M±SD*	*Agree/ Strongly Agree N(%)*	*M±SD*	*Agree/ Strongly Agree N(%)*	*M±SD*
Implementation Outcomes							
Acceptability							
The design of this SB-82/833 program is appealing	14	11(78.6)	6.3±1.3	7(70.0)	6.0±1.5	4(100.0)	7.0±0.0
The components of this SB-82/833 program meet my approval	14	12(85.7)	6.1±1.0	8(80.0)	5.8±1.0	4(100.0)	7.0±0.0
I would suggest this SB-82/833 program to other counties/communities	14	13(92.9)	6.4±0.9	9(90.0)	6.2±0.9	4(100.0)	7.0±0.0
% Agree/Strongly Agree and Overall Mean	14	13(92.9)	6.3±1.0	9(90.0)	6.0±1.0	4(100.0)	7.0±0.0
Appropriateness							
This SB-82/833 program is:							
fitting for the needs of children and families in this county/community	14	13(92.9)	6.6±0.8	9(90.0)	6.5±1.0	4(100.0)	7.0±0.0
a good match for my organization/agency	14	11(78.6)	6.4±1.0	7(70.0)	6.1±1.1	4(100.0)	7.0±0.0
% Agree/Strongly Agree and Overall Mean	14	13(92.9)	6.5±0.9	9(90.0)	6.3±1.0	4(100.0)	7.0±0.0
Feasibility							
This SB-82/833 program is:							
implementable as proposed	14	11(78.6)	6.1±1.1	7(70.0)	5.9±1.2	4(100.0)	6.5±0.6
easy to implement	14	7(50.0)	5.2±1.6	5(50.0)	5.3±1.5	2(50.0)	5.0±2.2
% Agree/Strongly Agree and Overall Mean	14	11(78.6)	5.6±1.2	7(70.0)	5.6±1.3	4(100.0)	5.8±1.3
Fidelity							
This SB-82/833 program has:							
been carried out as originally intended	14	10(71.4)	5.9±1.2	7(70.0)	5.7±1.3	3(75.0)	6.3±1.0
been implemented as described in the triage grant proposal/revised scope of work	14	11(78.6)	5.9±1.2	7(70.0)	5.7±1.3	4(100.0)	6.5±0.6

% Agree/Strongly Agree and Overall Mean	14	12(85.7)	5.9±1.2	8(80.0)	5.7±1.3	4(100.0)	6.4±0.8
Penetration							
The activities and services of this SB-82/833 program are integrated into the regular operations of the organization and/or setting(s) it operates in	14	12(85.7)	6.4±0.7	9(90.0)	6.3±0.7	3(75.0)	6.5±1.0
Sustainability							
This SB-82/833 program is possible to implement with the funding provided by the SB-82/833 grant	14	7(50.0)	5.2±1.7	4(40.0)	4.9±1.5	3(75.0)	6.0±2.0
This SB-82/833 program can be sustained during the grant period using only the funding provided by the SB-82/833 grant	14	6(42.9)	4.0±2.3	5(50.0)	4.3±2.3	1(25.0)	3.3±2.5
I am confident that this SB-82/833 program will be sustained after the grant period ends	14	5(35.7)	4.6±1.8	5(50.0)	4.7±2.1	0(0.0)	4.5±1.0
% Agree/Strongly Agree and Overall Mean	14	10(71.4)	4.6±1.4	7(70.0)	4.6±1.6	3(75.0)	4.6±1.3

Table 47. Implementation outcomes among total sample of programs and by program maturation

		Overall *(N=14)*		New *(N=8)*		Augmenting *(N=6)*	
	Analytic N	*Agree/ Strongly Agree N(%)*	*M±SD*	*Agree/ Strongly Agree N(%)*	*M±SD*	*Agree/ Strongly Agree N(%)*	*M±SD*
Implementation Outcomes							
Acceptability							
The design of this SB-82/833 program is appealing	14	11(78.6)	6.3±1.3	8(100.0)	7.0±0.0	3(50.0)	5.3±1.6
The components of this SB-82/833 program meet my approval	14	12(85.7)	6.1±1.0	8(100.0)	6.6±0.5	4(66.7)	5.5±1.2
I would suggest this SB-82/833 program to other counties/communities	14	13(92.9)	6.4±0.9	8(100.0)	6.8±0.5	5(83.3)	6.0±1.1
% Agree/Strongly Agree and Overall Mean	14	13(92.9)	6.3±1.0	8(100.0)	6.8±0.3	5(83.3)	5.6±1.1
Appropriateness							
This SB-82/833 program is:							
fitting for the needs of children and families in this county/community	14	13(92.9)	6.6±0.8	8(100.0)	7.0±0.0	5(83.3)	6.2±1.2
a good match for my organization/agency	14	11(78.6)	6.4±1.0	7(87.5)	6.6±0.7	4(66.7)	6.0±1.3
% Agree/Strongly Agree and Overall Mean	14	13(92.9)	6.5±0.9	8(100.0)	6.8±0.4	5(83.3)	6.1±1.2
Feasibility							
This SB-82/833 program is:							
implementable as proposed	14	11(78.6)	6.1±1.1	7(87.5)	6.1±1.0	4(66.7)	6.0±1.3
easy to implement	14	7(50.0)	5.2±1.6	4(50.0)	4.9±1.9	3(50.0)	5.7±1.2
% Agree/Strongly Agree and Overall Mean	14	11(78.6)	5.6±1.2	7(87.5)	5.5±1.4	4(66.7)	5.8±1.2
Fidelity							
This SB-82/833 program has:							
been carried out as originally intended	14	10(71.4)	5.9±1.2	6(75.0)	5.9±1.4	4(66.7)	5.8±1.2
been implemented as described in the triage grant proposal/revised scope of work	14	11(78.6)	5.9±1.2	6(75.0)	5.9±1.4	5(83.3)	6.0±1.1

% Agree/Strongly Agree and Overall Mean	14	12(85.7)	5.9±1.2	7(87.5)	5.9±1.3	5(83.3)	5.9±1.1
Penetration							
The activities and services of this SB-82/833 program are integrated into the regular operations of the organization and/or setting(s) it operates in	14	12(85.7)	6.4±0.7	6(75.0)	6.3±0.9	6(100.0)	6.5±0.5
Sustainability							
This SB-82/833 program is possible to implement with the funding provided by the SB-82/833 grant	14	7(50.0)	5.2±1.7	5(62.5)	5.4±1.9	2(33.3)	5.0±1.4
This SB-82/833 program can be sustained during the grant period using only the funding provided by the SB-82/833 grant	14	6(42.9)	4.0±2.3	3(37.5)	3.6±2.6	3(50.0)	4.5±2.0
I am confident that this SB-82/833 program will be sustained after the grant period ends	14	5(35.7)	4.6±1.8	1(12.5)	4.6±1.2	4(66.7)	4.7±2.5
% Agree/Strongly Agree and Overall Mean	14	10(71.4)	4.6±1.4	5(62.5)	4.5±1.4	5(83.3)	4.7±1.6

Table 48. Implementation outcomes among total sample of programs and by school-based status

		Overall *(N=14)*		**School-based** *(N=6)*		**Non-school-based** *(N=8)*	
	Analytic N	*Agree/ Strongly Agree N(%)*	*M±SD*	*Agree/ Strongly Agree N(%)*	*M±SD*	*Agree/ Strongly Agree N(%)*	*M±SD*
Implementation Outcomes							
Acceptability							
The design of this SB-82/833 program is appealing	14	11(78.6)	6.3±1.3	5(83.3)	6.3±1.6	6(75.0)	6.3±1.2
The components of this SB-82/833 program meet my approval	14	12(85.7)	6.1±1.0	6(100.0)	6.7±0.5	6(75.0)	5.8±1.2
I would suggest this SB-82/833 program to other counties/communities	14	13(92.9)	6.4±0.9	6(100.0)	6.8±0.4	7(87.5)	6.1±1.0
% Agree/Strongly Agree and Overall Mean	14	13(92.9)	6.3±1.0	6(100.0)	6.6±0.8	7(87.5)	6.0±1.0
Appropriateness							
This SB-82/833 program is:							
fitting for the needs of children and families in this county/community	14	13(92.9)	6.6±0.8	6(100.0)	6.8±0.4	7(87.5)	6.5±1.1
a good match for my organization/agency	14	11(78.6)	6.4±1.0	4(66.7)	6.3±1.0	7(87.5)	6.4±1.1
% Agree/Strongly Agree and Overall Mean	14	13(92.9)	6.5±0.9	6(100.0)	6.6±0.7	7(87.5)	6.4±1.1
Feasibility							
This SB-82/833 program is:							
implementable as proposed	14	11(78.6)	6.1±1.1	5(83.3)	6.0±1.1	6(75.0)	6.1±1.1
easy to implement	14	7(50.0)	5.2±1.6	3(50.0)	4.7±2.2	4(50.0)	5.6±1.1
% Agree/Strongly Agree and Overall Mean	14	11(78.6)	5.6±1.2	5(83.3)	5.3±1.5	6(75.0)	5.9±1.0
Fidelity							
This SB-82/833 program has:							
been carried out as originally intended	14	10(71.4)	5.9±1.2	4(66.7)	5.7±1.5	6(75.0)	6.0±1.1
been implemented as described in the triage grant proposal/revised scope of work	14	11(78.6)	5.9±1.2	5(83.3)	5.8±1.5	6(75.0)	6.0±1.1

% Agree/Strongly Agree and Overall Mean	14	12(85.7)	5.9±1.2	5(83.3)	5.8±1.5	7(87.5)	6.0±1.0
Penetration							
The activities and services of this SB-82/833 program are integrated into the regular operations of the organization and/or setting(s) it operates in	14	12(85.7)	6.4±0.7	4(66.7)	6.2±1.0	8(100.0)	6.5±0.5
Sustainability							
This SB-82/833 program is possible to implement with the funding provided by the SB-82/833 grant	14	7(50.0)	5.2±1.7	4(66.7)	5.8±1.6	3(37.5)	4.8±1.7
This SB-82/833 program can be sustained during the grant period using only the funding provided by the SB-82/833 grant	14	6(42.9)	4.0±2.3	2(33.3)	3.3±2.5	4(50.0)	4.5±2.1
I am confident that this SB-82/833 program will be sustained after the grant period ends	14	5(35.7)	4.6±1.8	1(16.7)	4.7±1.0	4(50.0)	4.6±2.3
% Agree/Strongly Agree and Overall Mean	14	10(71.4)	4.6±1.4	4(66.7)	4.6±1.3	6(75.0)	4.6±1.6

Table 49. Implementation outcomes among total sample of programs and by urban/rural

		Overall *(N=14)*		**Urban** *(N=11)*		**Rural** *(N=3)*	
	Analytic N	*Agree/ Strongly Agree N(%)*	*M±SD*	*Agree/ Strongly Agree N(%)*	*M±SD*	*Agree/ Strongly Agree N(%)*	*M±SD*
Implementation Outcomes							
Acceptability							
The design of this SB-82/833 program is appealing	14	11(78.6)	6.3±1.3	8(72.7)	6.1±1.4	3(100.0)	7.0±0.0
The components of this SB-82/833 program meet my approval	14	12(85.7)	6.1±1.0	9(81.8)	6.1±1.1	3(100.0)	6.3±0.6
I would suggest this SB-82/833 program to other counties/communities	14	13(92.9)	6.4±0.9	10(90.9)	6.4±0.9	3(100.0)	6.7±0.6
% Agree/Strongly Agree and Overall Mean	14	13(92.9)	6.3±1.0	10(90.9)	6.2±1.1	3(100.0)	6.7±0.4
Appropriateness							
This SB-82/833 program is:							
fitting for the needs of children and families in this county/community	14	13(92.9)	6.6±0.8	10(90.9)	6.5±0.9	3(100.0)	7.0±0.0
a good match for my organization/agency	14	11(78.6)	6.4±1.0	8(72.7)	6.3±1.1	3(100.0)	6.7±0.6
% Agree/Strongly Agree and Overall Mean	14	13(92.9)	6.5±0.9	10(90.9)	6.4±1.0	3(100.0)	6.8±0.3
Feasibility							
This SB-82/833 program is:							
implementable as proposed	14	11(78.6)	6.1±1.1	8(72.7)	6.0±1.2	3(100.0)	6.3±0.6
easy to implement	14	7(50.0)	5.2±1.6	6(54.5)	5.5±1.5	1(33.3)	4.3±2.1
% Agree/Strongly Agree and Overall Mean	14	11(78.6)	5.6±1.2	8(72.7)	5.7±1.3	3(100.0)	5.3±1.2
Fidelity							
This SB-82/833 program has:							
been carried out as originally intended	14	10(71.4)	5.9±1.2	8(72.7)	5.8±1.3	2(66.7)	6.0±1.0
been implemented as described in the triage grant proposal/revised scope of work	14	11(78.6)	5.9±1.2	8(72.7)	5.8±1.3	3(100.0)	6.3±0.6

% Agree/Strongly Agree and Overall Mean	14	12(85.7)	5.9±1.2	9(81.8)	5.8±1.3	3(100.0)	6.2±0.8
Penetration							
The activities and services of this SB-82/833 program are integrated into the regular operations of the organization and/or setting(s) it operates in	14	12(85.7)	6.4±0.7	9(81.8)	6.3±0.8	3(100.0)	6.7±0.6
Sustainability							
This SB-82/833 program is possible to implement with the funding provided by the SB-82/833 grant	14	7(50.0)	5.2±1.7	5(45.5)	5.0±1.8	2(66.7)	6.0±1.0
This SB-82/833 program can be sustained during the grant period using only the funding provided by the SB-82/833 grant	14	6(42.9)	4.0±2.3	5(45.5)	3.9±2.4	1(33.3)	4.3±2.1
I am confident that this SB-82/833 program will be sustained after the grant period ends	14	5(35.7)	4.6±1.8	3(27.3)	4.5±1.8	2(66.7)	5.3±2.1
% Agree/Strongly Agree and Overall Mean	14	10(71.4)	4.6±1.4	7(63.6)	4.5±1.5	3(100.0)	5.2±1.2