University of California, Los Angeles

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

Deliverable 12: Final Report and Recommendations

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

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Dedication

We are honored to dedicate this report to Kristin Hart, daughter of Karen Hart, one of California's leaders in mental health advocacy and member of our Advisory Board.

Kristin Elizabeth Hart was born in 1972 and diagnosed with schizophrenia at age 16. She struggled for years in and out of hospitals and residential placements. The last several years of her life, she was able to return to Monterey and live semi-independently in the community. After her return to Monterey, she spoke out at meetings, hearings, and conferences about ways to help youth and families who were struggling with mental health challenges before her passing in 1994. Her kindness, compassion, and nature to reach out and help others was an inspiration to everyone she encountered. She gave hope and strength to so many. An annual memorial award was established to honor a person in her community who most exemplifies her giving nature and outreach to others.

She always told us to feel free to talk about her illness and her journey if it would possibly help someone else.

Acknowledgement

We gratefully acknowledge the contributions of the many advisors who have guided us during the evaluation and who continue to shed light on our work through sharing their experiences and expertise. Our advisors have included, but are not limited to, our 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 of our public engagement activities.

We would also like to acknowledge the work of our past collaborators, Drs. Jeanne Miranda, Sheryl Kataoka, Monique Gill, and Mrs. Krystal Lloyd, who contributed to previous deliverables. We honor the work and legacy of Richard Van Horn, a revolutionary in the nation's approach to mental health and leader in developing the California Mental Health Services Act, who contributed to our evaluation prior to his passing.

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

Executive Summary

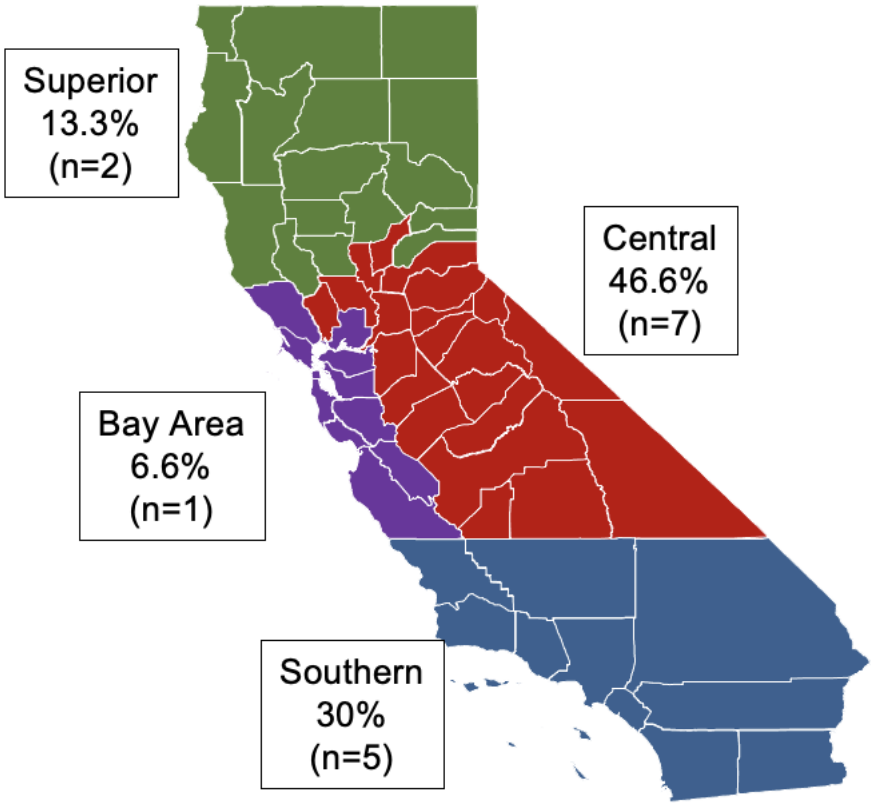
This report provides a detailed formative evaluation of 11 child and youth mental health crisis programs and four school-based child mental health programs across California, funded in 2018 by the Mental Health Wellness Act. These programs were implemented in 13 counties, of which two counties received funding for both Child/Youth and School-County Collaborative grants. The overarching goal of this formative evaluation was to understand the implementation of these programs. Across all phases, the main aims were: (1) to describe and assess program implementation activities, processes, and outcomes; and (2) to identify facilitators and barriers to program implementation. Together, achievement of these aims generated key lessons learned and evidence-based recommendations for future program implementation and evaluation. This executive summary includes background information (i.e., distribution of the grants, programs funded, evaluation approach), followed by major findings with corresponding key lessons learned and recommendations, and conclusion.

Background

In 2013, the California Senate passed the Investment in Mental Health Wellness Act (Senate Bill 82, or SB-82), which authorized the use of state Mental Health Services Act (MHSA) funds to expand capacity for county mental health crisis services. In 2016, Senate Bill 833 (SB-833) extended this mandate to include programs serving children and youth up to age 21. The SB-82/833 legislation allocated funds for counties to hire staff for mental health crisis triage to address a common gap in existing mental health care systems.

Mental health crisis triage is a multi-disciplinary team-based approach to assess and meet the needs of individuals experiencing mental health crises in the least restrictive manner. Priority is on client safety, timely assessment of mental health care needs, clinically indicated supports, and linkage to recovery-focused care. For children and youth, the emphasis is also on family-centered care and coordination of care with other child-serving care sectors, such as education, child welfare, and juvenile justice.

To meet the goal of increasing crisis triage personnel in California communities, the Mental Health Oversight and Accountability Commission (MHSOAC) administered a competitive Mental Health Crisis Triage grant program for counties. To apply, counties were asked to conduct a needs assessment on their existing service system and propose how and where they would integrate new crisis triage personnel. Counties were required to include a mix of clinical, case management, and peer/parent partner roles in their proposals. The first round of grants was awarded in 2014, with funding concluding at the end of a four-year period. During the second round in 2018, 11 Child/Youth and four School-County Collaborative grants were awarded in 13 counties (two counties received both types of grants). Both grant cycles funded pilot programs, supporting learning and growth around the expansion of state-funded mental health crisis triage services.



In addition, a statewide program evaluation was funded and participation of grant recipients was required in the second round of the grant program. The University of California, Los Angeles (UCLA) was awarded the contract to lead the formative evaluation for the 11 Child/Youth and four School-County Collaborative grants throughout California. Programs mostly served children ages 5-18 years and their families, but some programs extended their services beyond the age range. In general, programs that received Child/Youth grants were dedicated to delivering timely care during a child mental health crisis while programs supported by the School-County Collaborative grants focused on prevention and early intervention.

Throughout the entire project, the UCLA team used a community-partnered approach that integrated guidance from a Community Advisory Board that met every six months. At each stage, methods were revised, such as updating questions for key stakeholder interviews to address unanticipated changes (e.g., COVID-19, wildfires, civil unrest, workforce shortage, policy changes that impacted implementation) to continuously ensure community relevance. Preliminary findings were shared with community

members and the advisory board to stimulate two-way communication to deepen our understanding of the findings, provide potential explanations, and identify creative solutions. Likewise, earlier drafts of major findings, key lessons learned, and recommendations were revised in response to their collective wisdom and insight.

The formative evaluation used a mixed methods approach that included qualitative and quantitative data. Key stakeholder interviews with each program were regularly conducted during their implementation, using a purposive sample to ensure breadth of perspectives and roles. Quarterly program survey data that gathered information on number of children served, clinical characteristics and services delivered were nested in qualitative data that were roughly matched by time intervals. Other data sources included the original program grant proposals and revised descriptions following a reduction in their budgets, review of memoranda of understanding (MOUs), and county census data.

Major Findings, Key Lessons Learned, and Recommendations

Program Structure and Care Delivered

Finding 1: *SB-82/833 programs provided a variety of crisis triage approaches that were tailored to address their community needs and fill specific gaps in their mental health service system.*

- SB-82/833 Child/Youth and School-County Collaborative programs varied in their structure and components.
    - There were differences in their main setting, organization and operations, types of care, and care delivery.
- Six programs were based in schools or school wellness centers, four were

located at a program or county mental health office, three were primarily mobile crisis teams in the field or community, one in an emergency department, and one in a police department.

- Over half of grantees used funds to establish new units within their service system and the others used their funds to add crisis triage personnel to an existing unit.
- Programs provided a wide array of mental health care, spanning prevention, early intervention, acute crisis services, treatment, referral, care coordination, and community outreach.
- Acute crisis services, referrals, and care coordination were the most commonly implemented care processes as well as a focus of the majority of programs.
- Six of fifteen programs also included prevention, early intervention, treatment, and/or community outreach as priority areas.
- Most programs targeted at least three care processes, with programs based in schools especially engaged in integrating multiple types of care processes.
- Most SB-82/833 programs were complex.
    - Programs had different configurations of personnel, organizational units, and administration.
    - Delivery of care often involved multiple teams, varying sectors, and complicated regulatory environments.

Key Lessons Learned:

- Child mental health crisis triage shows promise for filling major gaps in mental health service systems.
- The additional resources for child mental health crisis triage enable counties to introduce new services and increase access to services for under-resourced populations.
- Child mental health crisis triage acts as an effective bridge across the care continuum—from prevention to acute crisis response to linkage to long-term care.
- There are inherent trade-offs when child mental health crisis interventions are

tailored to community needs and local mental health service systems.

- Each program brought a unique set of complexities that also posed implementation challenges.
- Comparisons between programs, even when awarded the same type of contract, were limited in the program evaluation.

Recommendations:

1. Programs would benefit from more time to design, plan, and ramp up prior to service delivery.
    a. Additional time should be provided for new programs and those providing a wide range of services in complex organizations.
    b. The planning phase could include developing tailored, local solutions to address common and program-specific barriers to implementation.
    c. Time should be protected to allow programs to learn from other counties deploying similar programs and personnel and share information about statewide opportunities that may mutually support their programs.
    d. Leadership and staff workgroups would be particularly beneficial at this stage to identify common challenges and solutions across counties.
2. Programs would benefit from incentivizing early and greater involvement in the evaluation design.
    a. Variation in programs, including their complexity, should be factored into the approach to measure implementation and compare program outcomes.
3. A mixed methods approach that contextualizes quantitative data from a variety of crisis triage programs with insights from individuals directly involved in program implementation is well suited to evaluate program implementation over time.
4. Future grant programs would benefit from technical consultation during the development of the Request for Proposals and selection process to build in capacity to test differences in outcomes between programs with shared characteristics (e.g., rural vs. urban, child inpatient psychiatric beds in county vs. not).

Barriers to Effective Program Delivery

Finding 2: *SB-82/833 programs faced many challenges that affected the delivery of child mental health crisis services in the community.*

- Programs identified challenges and strived to address the substantial need for child mental health services, better access for children and families, culturally appropriate care (especially for minoritized racial and ethnic communities), and care responsive to structural racism within communities and social service systems.
- Significant barriers to implementation included availability of community mental health resources, such as child inpatient psychiatric beds, crisis stabilization units, crisis residential facilities, and outpatient clinics with urgent care capacity.
- Lack of child mental health providers was a common barrier.
    - Qualified clinicians and staff were not available or insufficient in number to support effective recovery-focused care in some communities.
- Early funding cuts to the Mental Health Crisis Triage grant programs affected program implementation.
    - The volume and type of services, number of sites, mix of staff roles, and number of geographic units were reduced.
    - In-kind, often hidden, contributions were made to successfully execute their programs.
- Especially for school-based programs, challenges included maintaining multiple teams, coordinating across several agencies, and navigating between public school district and county mental health agency regulations.
- Following the onset of the COVID-19, the need for child mental health crisis

services substantially rose while barriers to program implementation increased.

- Barriers included increased strain on staff, lost time continually re-adjusting to an ever-changing landscape, new challenges to building and sustaining partnerships, increased uncertainty around future funding, and loss of access to critical resources.

Key Lessons Learned:

- Pilot child mental health crisis triage programs can mitigate but not solve systemic deficiencies in their community mental health services infrastructure or disparities in care that were exacerbated following the onset of the COVID-19 pandemic.
- Crisis triage personnel can provide critical short-term support and linkage, but are not equipped or resourced to provide extensive care coordination, long-term outpatient care or intensive services (e.g., care in a specialized care facility).

Recommendations:

1. The scope, reach, and capacity of child mental health crisis triage programs should be accounted for in any attempt to assess program outcomes.
2. Programs would benefit from regular opportunities to exchange information about adaptations in implementing programs, creative solutions, and outside resources that may mitigate shared challenges.
3. Future program evaluations should build in capacity to adjust for workforce shortage and availability of child mental health resources (e.g., inpatient psychiatric beds, residential child mental health crisis services, urgent outpatient child mental health care) when assessing implementation and examining differences in clinical outcomes.

Facilitators to Effective Program Delivery

Finding 3: *Adaptability, partnerships, and leadership engagement were major facilitators of program implementation by helping programs work through significant challenges.*

- Programs that believed they had sufficient capacity (e.g., resources) and authority (e.g., leadership role) to adapt their operations and be flexible in their approach were more successful in overcoming implementation barriers and addressing challenges in real-time.
    - In contrast, programs were generally less able to overcome challenges when they lacked the capacity to adapt due to factors outside of their control (e.g., few resources, administrative or regulations) or perceived adaptation was beyond their authority to implement.
- Willingness to adapt, including proactive efforts to identify challenges, was critical to the programs that reported greatest success in implementation.
- For some programs, strong organizational partnerships (pre-existing and new) gave personnel greater options when determining possible courses of action in response to obstacles.
- A common goal driving partnerships was to have a long-term impact on linkages across sectors.
    - Successful administrative approaches included (1) creating and sustaining durable formal partnerships, (2) enabling practical cross-sector workflows, and/or (3) creating more integrated social service systems.
- Facilitators of effective partnerships included strong leadership engagement on the part of partners.
    - Successful mechanisms included (1) leaders directly advocating for the

program or actively working to secure supplemental resources, (2) co-location and institutional embeddedness (e.g., crisis triage personnel in a school or police department), (3) formal partnerships to facilitate information sharing and bypass bureaucratic and policy barriers (e.g., MOUs, service agreements), and (4) formation of routine and reliable communication channels between partners and all levels of leadership.

- SB-82/833 programs were more likely to be successful if tightly embedded in the organizations and had personnel that was coordinated with other units in their organizations.
    - In contrast, some programs housed in non-mental health agency sites (e.g., schools, hospitals, police departments) had varying experiences with being aligned with their setting's mission.
- Some programs described extensive work to ensure that program implementation was successful, such as ongoing outreach, information gathering, and rapport-building operations with other units at their site.
- Following the onset of the COVID-19 pandemic, programs were highly innovative, as evidenced by rapid uptake of telehealth and changes in care delivery to address disruptions to program settings, referral sources, youth and family engagement, and in-person team coordination.
    - Perspectives on the utilization and efficacy of telehealth to deliver child mental health crisis serves were mixed. Some programs found the use of telehealth facilitated access to care while others reported that in-person sessions were necessary to develop a therapeutic relationship with children and their families.

Key Lessons Learned:

- Capacity for adaptation and flexibility, especially during a public health and social crisis, are key facilitators for SB-82/833 program implementation.
- Organizational partnerships are a major way that programs successfully reduce barriers to access to mental health services.
- Successful programs depend on active, consistent engagement of partners at the

level of leadership, and strong formal partnerships and coordination in place.

Recommendations:

1. Support and enhance active communication channels between the grant funder and grantee to interpret contract terms, and thereby clarify the types of adaptations that programs may use.
2. Funded programs should proactively report challenges to the grant funder to open a dialogue focused on potential adaptations and if approved, explore contract revisions as needed.
3. Crisis triage programs may require additional forms of support to develop and sustain organizational and community partnerships.
    a. Examples are protected staff time to (1) advocate for the program within their site, (2) identify appropriate community partners, and (3) build and maintain collaborative relationships based on shared goals.

Child Mental Health Care Workforce-related Barriers and Facilitators

Finding 4: *Successful programs depend on experienced and dedicated personnel to overcome significant workforce challenges and limited organizational resources.*

- Challenges maintaining their workforce was a common barrier to implementation for programs.
- Contributors to staff turnover included stresses related to the nature and structure of dedicated crisis roles, prevailing public sector mental health compensation, and work conditions.

- Negative impacts from workforce shortage included changing the services programs could provide, placing additional burden on remaining staff, and reducing programs' institutional knowledge and networks.
- Administrative barriers to recruit and hire staff included availability of only short-term positions, provider shortages (both regional and linked to licensure requirements), and processing delays related to the COVID-19 pandemic.
- Even among well-resourced programs, staff time for workforce development was limited and/or constrained in both state and local mental health systems.
- The resources needed for administration and data coordination (i.e., not direct care) often exceeded the program's organization capacity to fund these activities. This strain will likely increase as adherence to behavioral health quality measures are mandated to be reported by state Medicaid agencies in 2024.
- These challenges were especially acute for smaller and more rural counties.
- Despite the high workloads and the stressful nature of crisis intervention, providers generally expressed positive attitudes toward program quality, and passion and enthusiasm for their work.
- A major facilitator of successful program implementation was heavy reliance on experienced and dedicated personnel willing to go beyond the scope of their personal responsibilities to ensure program success.
    - For some programs, this included extensive contributions from organizational personnel not funded by the SB-82/833 grant.

Key Lessons Learned:

- SB-82/833 programs benefit from hiring more experienced staff with a high degree of personal dedication to their work, which may mitigate challenges with staff turnover and gaps.
- Efforts to identify and address signs of staff burnout are attributed to the success of many programs, especially when staff views workloads as acceptable and programs adapt roles when needed.
- Reliance on staff not funded by the grant may suggest a need for additional forms of support or specific staffing commitments from counties as a pre-condition of

their award.

Recommendations:

1. Programs should prioritize experienced and committed staff members who live in the communities they serve, have a deep understanding of the community, and can leverage formal and informal social networks in delivery of their care.
2. Programs should provide incentives and increase training to recruit and retain staff, particularly in rural areas.
3. Programs would benefit from the development of mechanisms to sustain resources, services, relationships, and partnerships to prepare for staff turnover and workforce gaps.

Sustainability

Finding 5: *SB-82/833 pilot programs faced significant barriers related to sustainability, including challenges in identifying alternative sources of revenue for direct clinical care and funding for data collection and reporting.*

- The SB-82/833 Mental Health Crisis Triage grant program only funded crisis triage personnel.
- Multiple programs described 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 15 SB-82/833 programs, an average of 2.3 funding sources were reported to supplement Triage Grant funding.
- Among the nine SB-82/833 programs with a sustainability plan, an average of 3.2

funding sources were reported.

- Both patch working funding and sustainability planning required significant effort and programs faced systemic challenges related to the lack of adequate, predictable, and reliable support for mental health services.
- For many programs, data collection and reporting posed a significant burden.
    - Contributing factors were (1) lack of resources (especially staff capacity), (2) differences in the quality of county and site data infrastructure, (3) organizational and regulatory challenges, and (4) unforeseen complications related to the COVID-19 pandemic.

Key Lessons Learned:

- Program activities not related to direct care (e.g., documentation, data collection) are the most difficult to implement, suggesting a need for additional planning or supports to ensure that data, fiscal, administrative, and regulatory obligations do not take staff time away from service delivery.
- Securing adequate, reliable, and long-term funding sources to support implementation and growth of their promising pilot programs is a challenge for most programs.

Recommendations:

1. Sustainability plans should specify funding sources for direct clinical care and services that are required for implementation but cannot be billed to Medi-Cal.
2. From the beginning of the grant application process, sources for future sustainability should be identified.
3. Technical assistance should be provided to programs early to identify appropriate revenue sources and how to access them to prepare for implementation of their sustainability plans.
4. Resources, particularly protected staff time, should be provided to programs to enable them advocate within their communities and counties for long-term funding, at the start of the grant and over time.

Conclusion

Crisis triage programs show great promise for addressing known gaps in the mental health service system. These programs are an effective bridge to community supports to ensure that youth and families receive timely, adequate, and appropriate care when they are experiencing crisis. Important barriers to and facilitators of SB-82/833 program implementation included the characteristics and complexity of programs, longstanding deficiencies within child mental health care systems, program adaptability, organizational partnerships, leadership engagement, and challenges related to workforce and program sustainment. Nevertheless, SB-82/833 programs were successful to the extent that they tailored crisis triage to meet the specific needs of their sites and communities and adapted continually as challenges arose. Supporting the specific needs of crisis triage programs and personnel through active leadership and partnerships, and cultivating an experienced and dedicated team, will ensure that these programs remain successful despite the structural challenges they face. Communities would benefit from committing long-term, stable resources to ensure that crisis triage services are available and well integrated into their mental health service systems, including embedded within schools. As child mental health care delivery shifts to a population health approach guided by the principles of CalAIM, this formative evaluation brings key insights into program implementation across the care continuum in schools and community-based mental health crisis programs for children and youth.

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Introduction

The California Mental Health Services Accountability and Oversight Commission (MHSOAC)'s Mental Health Crisis Triage grant program was established as part of the Investment in Mental Health Wellness Act passed by the California legislature in 2013 (Senate Bills 82 and 833, or SB-82/833). These bills aimed to increase capacity for and access to mental health crisis services by allocating funding for additional crisis triage personnel in key community settings such as hospitals and schools. This report summarizes a multi-year, statewide formative evaluation of programs receiving Child/Youth and School-County Collaborative grants in the second round of this grant program. It tells the statewide story of the pilot programs that received personnel funding through this grant program by examining the implementation of all eleven Child/Youth and four School-County Collaborative Mental Health Crisis Triage programs from the grant start in 2018 to the end of their grant cycles between 2021 and 2023.

The design of this formative evaluation allowed commonly shared, broad features *across* programs to be identified while also allowing flexibility to accommodate differences *between* the programs, including differences in how the programs were designed and operated as well as in the communities they served. Likewise, to address wide variation in data sources, infrastructure, and capacity across counties, we used a flexible, mixed methods approach to data collection and analysis in collaboration with our program partners. Findings and recommendations in this report are based primarily on in-depth analyses of multiple cycles of interviews with purposively selected individuals involved in program implementation, supplemented by program survey data and informed by a wide breadth of program and community partners. The formative evaluation also adopted a community partnered approach 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.

The most successfully implemented 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 ways of delivering crisis triage services that were tailored to their communities demonstrated that crisis triage is not one-size-fits-all**. Important barriers to and facilitators of SB-82/833 program implementation addressed in this report include:

1. the characteristics and complexity of the programs receiving grant funds
2. longstanding challenges within child mental health care systems
3. program adaptability, organizational partnerships, and leadership engagement
4. workforce challenges and strengths
5. challenges related to long-term program sustainment.

The barriers and challenges to which they adapted also form the basis of recommendations for future crisis triage programs and considerations for interpreting data on program outcomes.

Background

Mental Health Services Act (MHSA)

California voters passed Proposition 63—the Mental Health Services Act (MHSA)—in 2004, which created a fund to expand California's mental health service system by assessing a 1% tax on taxable personal income over $1 million. This unique mechanism funds nearly 25% of the public mental health system in California, with the vast majority spent directly by counties through local planning processes. The California Mental Health Services Oversight and Accountability Commission (MHSOAC) was established in 2005 as an independent commission charged with a wide range of responsibilities related to MHSA implementation, ranging from oversight of MHSA spending by counties to administrative authority over designated state-led mental health funding initiatives.

Investment in Mental Health Wellness Act (SB-82 and SB-833)

In 2013, the California Senate passed Senate Bill 82 (SB-82)—known as the Investment in Mental Health Wellness Act—appropriating a portion of MHSA funds to be made available to counties to expand their capacity for mental health crisis services. Following public concerns that the funding could be limited to the adult crisis continuum of care only, Senate Bill 833 (SB-833) was passed in 2016 to enact a grant program for child and youth crisis services alongside those for adults.

The overall objective of SB-82/833 is to improve the continuum of mental health crisis services in California communities by expanding:

1. mobile crisis response teams
2. crisis stabilization services
3. crisis residential treatment beds
4. crisis triage personnel.

Following the direction of the legislature, the California Health Facilities Financing Authority (CHFFA) and the MHSOAC each established grant funding opportunities for counties. CHFFA's grant program funded the development of new mobile crisis response, crisis stabilization, and crisis residential programs. The MHSOAC's SB-82/833 Mental Health Crisis Triage grant program, on the other hand, was charged with allocating funding for at least 600 new crisis triage personnel across the state.

SB-82/833 Mental Health Crisis Triage Grant Program

The MHSOAC's SB-82/833 Mental Health Crisis Triage grant program sought proposals from counties throughout California to fund personnel for crisis triage, including targeted case management and linkage to service for individuals needing intervention. Following the broad aims of SB-82, the Request for Applications (RFA) for this grant program called for proposals meeting the needs of the local mental health crisis service system as well as meeting designated grant program objectives.

The goals of the Child/Youth grant program included:

1. improving client wellness and experience while reducing costs
2. increasing crisis triage personnel at various points of access in the community
3. reducing unnecessary psychiatric hospitalizations
4. reducing recidivism and unnecessary law enforcement involvement in mental health crisis.

For School-County Collaborative grants, goals included:

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

The first round of SB-82/833 Mental Health Crisis Triage personnel grants spanned 2014 to 2017, with evaluations conducted internally by each grantee. Feedback suggested an external statewide evaluation would more comprehensively and accurately tell the story of these programs. The MHSOAC partnered with research teams at the University of California, Davis (UCD) and the University of California, Los Angeles (UCLA) to carry out a three-pronged evaluation of the second round of Triage grants. UCD led the formative evaluation of adult and transitional age youth (TAY) programs and UCLA led the formative evaluation of Child/Youth and School-County Collaborative programs, summarized in this report. The MHSOAC led a summative evaluation of Adult/TAY, Child/Youth, and School-County Collaborative program outcomes.

SB-82/833 Child/Youth and School-County Collaborative Programs

The eleven Child/Youth and four School-County Collaborative programs that received awards in the second round of the SB-82/833 Mental Health Crisis Triage grant program

began operating (that is, utilizing the personnel hired for crisis triage) between October 2018 and November 2020. Programs had different components and structures based on the characteristics of the existing service systems in their respective counties and the specific needs of their communities. Despite differences in program components and structure, however, all programs were required to include a staff mix of three roles:

1. clinical
2. case management
3. peer or parent/caregiver partner

Programs also operated in a variety of different settings, including where their personnel were based and where in the community their services were delivered. Within these settings, programs varied in their relationship to their existing service systems: seven programs were formed as new units within their service system and seven programs augmented or expanded an existing unit in their crisis service system.

Consistent with their mandate to provide mental health crisis triage, these programs provided a wide array of services and activities spanning prevention, early intervention, acute crisis services, treatment, referral, care coordination, and community outreach. Acute crisis services, referrals, and care coordination were the three most common services provided, with each targeted by most programs. Six of fifteen programs also targeted prevention, early intervention, treatment, and/or community outreach. Most programs targeted at least three care processes, with programs based in schools especially engaged in offering multiple types of care processes.

2. Formative Evaluation Aims and Logic Model

What is a formative evaluation?

A formative evaluation is a rigorous effort to understand what factors influence progress in implementing a particular initiative, in this case the use of grant-funded crisis triage personnel to expand mental health crisis services in California communities. Formative evaluations involve data collection on processes *prior to* and *over the course of* the implementation of an initiative to understand **how it has been carried out and what factors may have served as barriers to or facilitators of implementation**. While formative evaluations are often used to understand the implementation of a single intervention (for example, a particular treatment or assessment instrument) we used this approach to evaluate a broader set of interventions that were implemented across counties/programs to achieve common goals.

Why use a formative evaluation?

Formative evaluations can provide useful feedback for health service systems by helping understand how their initiatives are carried out in the real world and what contexts affect their execution and effectiveness. Findings from formative evaluations are particularly useful for:

1. **understanding the local context of implementation**, including whether a program addresses an important local need, local conditions that might affect its delivery, and adaptations that were made to fit those local needs and conditions
2. **providing details on implementation activities and program operations**, especially where there is variation expected in program design and execution
3. **documenting progress in implementation**, including major barriers and facilitators that they encounter and work done to streamline and optimize implementation.

Understanding these factors is important because they can be used to: **assist in interpreting main program outcomes** (e.g., in a summative evaluation), **inform the generation of recommendations for future efforts** in similar sites or systems, and **understand the perspectives of individuals involved in implementation.**

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

The aims of this evaluation were focused on **describing the process of program implementation and adaptation over time**, from proposal to initial implementation through transition to full implementation and, hopefully, maturity.

The specific aims are:

1. **To describe and assess selected program implementation activities, processes, and outcomes across the course of the grant.**
    1a. To examine variation in implementation (e.g., by program type, region, new or augmenting, urban or rural, and relevant sociodemographic and contextual factors).
    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.**
    2a. To examine variation in facilitators and barriers to implementation (e.g., by program type, region, new or augmenting, urban or rural, and relevant sociodemographic and contextual factors).
    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 Community Engagement Activities

Collaboration with our county partners and other community engagement activities continuously informed our progress in meeting the aims of the evaluation. Our community partnered approach was carried out through the following activities:

2.2.1 Community Partner Advisory Board

Our initial Community Partner Advisory Board, which included Richard Van Horn, Karen Hart, Felica Jones, and other community partners, met April 3, 2020 and July 17, 2020. The board was expanded in 2021 by soliciting additional nominations through program partners, our newsletter, and organizations focused on underserved mental health groups.

The expanded Community Partner Advisory Board includes 10 community partners, 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. The 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 met quarterly until October 31, 2023, discussing the landscape of mental health in their communities and informing the evaluation. During the evaluation, one of our community partners and lifelong leaders in mental health advocacy, Richard Van Horn, passed away.

2.2.2 Program Workgroups

Early in the evaluation, program personnel encouraged the creation of regular workgroups to share common challenges, solutions, and lessons learned. A quarterly Data Coordinator's Workgroup began meeting in June 2019 to understand data capacity and infrastructure issues across counties as well as identify potential data collection strategies for the evaluation. As discussions progressed, personnel from School-County Collaborative and school-based Child/Youth programs requested an additional workgroup to tackle some of the distinctive challenges of operating school-oriented programs. A monthly School Workgroup therefore began meeting in October 2019. In January 2021, a monthly Child Workgroup was also formed as a space for Child/Youth programs to discuss progress with their programs.

SB-82/833 program leads and personnel were invited to attend the workgroups as feasible for their schedules and workgroup meeting frequencies were adjusted, as needed, to accommodate our partners. As the programs progressed, so did the formats of the workgroups; our meetings shifted from structured to semi-structured to allow programs greater room for cross-program collaboration. Following this collaboration and relationship-building, programs reported meeting independently of the workgroup to work together to address sustainability challenges and expressed their gratitude for the space to share narratives and support each other through program implementation.

2.2.3 Evaluation Communication and Public Engagement

In collaboration with our UC Davis and MHSOAC evaluation partners, evaluation newsletters were circulated to our program partners in October 2019, March 2020, November 2020, April 2021, December 2021, and May 2022.

We also hosted three webinars to communicate our progress to the public: one focused on crisis literature reviews (November 25, 2019), one focused on the evaluation plan (May 21, 2020), and one presenting evaluation findings (September 14 and 15, 2023). The evaluation team also presented preliminary progress and findings at MHSOAC Triage Collaboration meetings held quarterly throughout the grant period.

As part of our community-partnered approach, the evaluation team has documented actionable input received from our partners as well as the public at large. A summary of feedback and 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 used in the formative evaluation is made up of nine domains that specify:

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

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 used in the analysis can be found in **Appendix B.**

Contexts and Factors Influencing Implementation

To identify important contexts and factors that influence implementation, we drew 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 adaptations of these 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 the program itself that might influence how it was implemented, such as its setting(s), component(s), and basic structure. Other important program characteristics 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 refers to the external contexts in which the program was carried out, which 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** were known and prioritized by the program and the extent to which programs were connected to or **partnered with other organizations** in their communities.

Inner Setting

The inner setting of implementation refers to features of the implementing organization that might influence implementation of the program, which includes the **functional division of labor within the organization** and how the program was positioned within it, the **stability of the workforce**, the **compatibility of the program with its organizational culture**, and the **extent of leadership engagement** with the program.

Individual Characteristics

Individual characteristics are factors related to the particular individuals who are involved in implementation, most notably the leadership and personnel of the programs. Important considerations related to the individual characteristics of the individuals involved in implementation include their perceptions of and **attitudes toward the program and its components** and 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 was the **planning** of the program, which can include efforts to consider community needs and perspectives in developing the program, **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 was carried out according to plan. This can include whether or not the intended interventions were delivered, their quality, and their timing or intensity. It can also include the extent to which program goals and outcomes were addressed as intended.

A final two implementation processes 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 domains and constructs adapted from the CFIR, our framework also incorporated specific key features of the SB-82/833 Triage Grant program, including the overarching SB-82/833 triage program goals and a set of **target program activities**

programs might have used to meet those goals. **Proximal program outcomes** are the measurable outputs of these target program activities.

Target Program Activities and Proximal Program Outcomes

The overarching SB-82/833 Triage Grant Program Goals outlined earlier are hypothesized to be the basis for specific **target program activities**. These are the specific actions a program took to align program goals with its actual implementation: in other words, the things a program actually did to meet its goals. These activities then result in **proximal program outcomes**, or the 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.

Table 1. Target program activities and proximal outcomes

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	- 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 considered seven implementation outcomes relevant to SB-82/833 programs (Proctor et al., 2009; 2011).

1. **Acceptability**: the extent to which individuals involved in implementation perceived the service or program to be satisfactory. For the evaluation of SB-82/833 programs, this included 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 was to meeting client and community needs or filling county service gaps (outer setting) as well as how compatible it was with features of the implementing organization or service setting (inner setting).

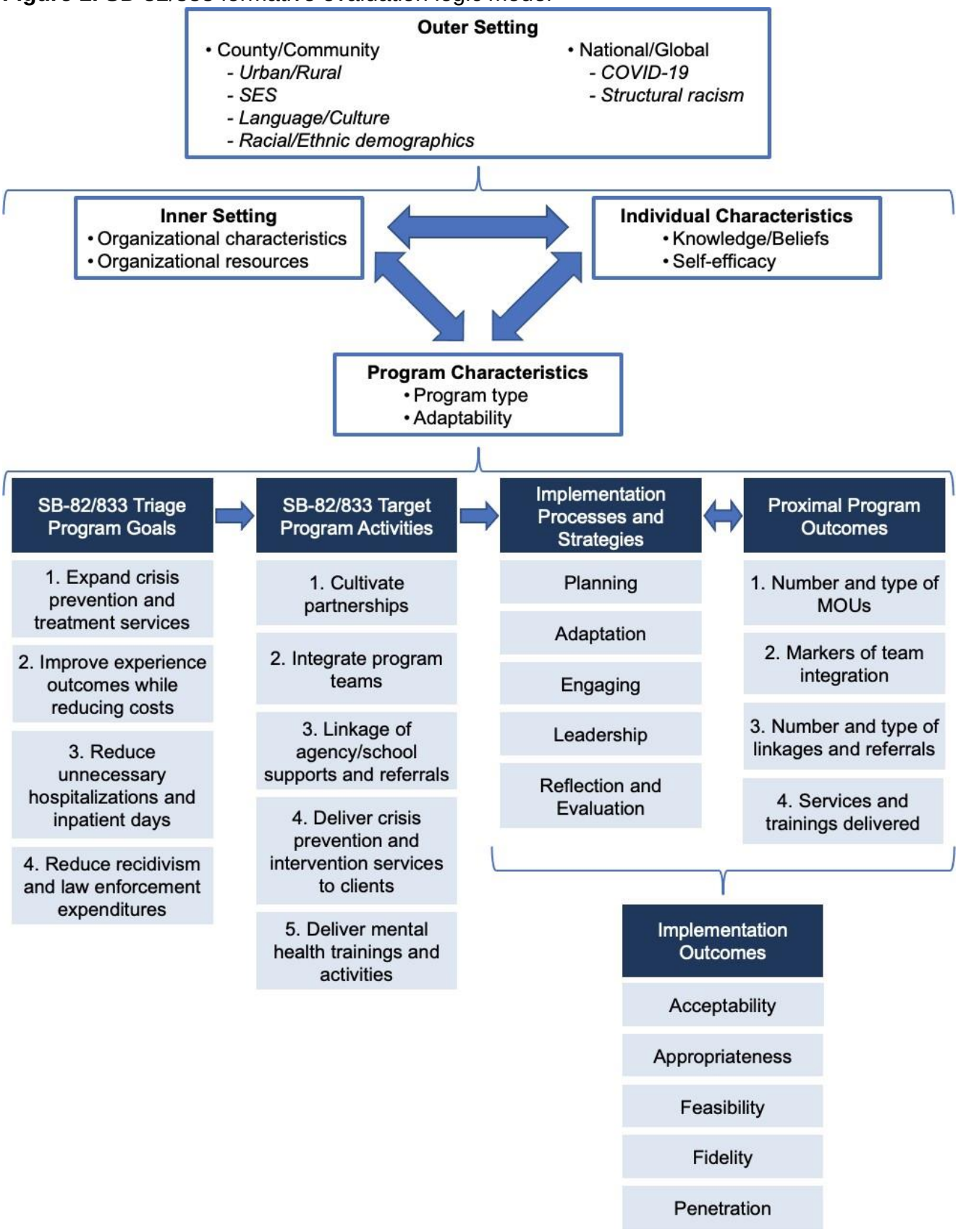
3. **Feasibility**: the extent to which services and programs could be executed successfully by the particular implementing organization or within a given service setting. For SB-82/833 programs, this included the extent to which a program was capable of carrying out its target activities and program 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 was implemented in accordance with plan or the intents of its designers. This could include how closely SB-82/833 program implementation matched 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 have been integrated into its organizational context (inner setting). For SB-82/833 programs, this might include how well integrated program activities were into the regular operation of the agency or school or how extensively program services were used by clients, students, and teachers eligible for them.
6. **Sustainability**: the extent to which the program was (or could be) maintained over time. We emphasized 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 ended.

2.3.2 Logic Model

The framework for the formative evaluation is summarized in the Logic Model in **Figure 1**. We used 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 took 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).

This framework and logic model provided a basic structure which guided our data collection and analysis while retaining a high degree flexibility.

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



3. Methods

3.1 Mixed Methods Approach

Integrating the goals of the grant program, scientific literature, and input from community partners, we chose a mixed methods approach to the formative evaluation centered 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 allowed us to create a statewide story of SB-82/833 programs which identifies commonalities in programs' efforts toward implementation while ensuring programs were understood in their distinctive local contexts.** This approach balanced shared goals and county/program characteristics, with flexibility to allow for the description of the unique strengths and challenges that stimulated innovation.

3.2 Study Design

We adopted a repeated cross-sectional observational study design to guide data collection and analysis. This design accommodated variation in program start time, followed the full course of program maturation, and captured program responsiveness and innovation in care delivery following the onset of the COVID-19 pandemic. A detailed table showing the components of this design, as executed from late 2018 through 2023, can be found in **Appendix C.**

3.2.1 Study Phases

Programs that received Child/Youth and School-County Collaborative grant funds were separated into two phases, Phase 1 and Phase 2, based on program start date. Phase 1 programs included all Child/Youth and School-County Collaborative programs that started delivering services using SB-82/833 funded personnel before the end of 2019. Phase 2 programs included all programs that, due to delays, did not begin service delivery until 2020.

> **Phase 1 Child/Youth programs** were Calaveras, Humboldt (Child/Youth), Placer (Child/Youth), Riverside, Sacramento, San Luis Obispo, Santa Barbara, Stanislaus, and Yolo counties as well as the City of Berkeley in Alameda County.
>
> **Phase 1 School-County Collaborative programs** were CAHELP (San Bernardino County), Humboldt (School-County), Placer (School-County), and Tulare.
>
> **Phase 2 Child/Youth programs** included 8 sites corresponding to the Service Planning Areas (SPAs) used in Los Angeles County.

Each SPA in Los Angeles County was conceptualized as a “county” for the purposes of data collection and analysis given the variation in implementing agencies and 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 were 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). Supplemental data collection also occurred 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

The study design incorporated some comparison groups for programs based on our aims, which included understanding variation in implementation and facilitators and barriers to implementation across program characteristics and contexts. The main comparison groups used were:

- SB-82/833 **grant type** (Child/Youth or School-County Collaborative)
- **school-based or non-school-based** (i.e., if the program provided most services in a school or non-school setting)
- **new or augmenting** existing crisis services (i.e., if the program constituted a new unit or augmented an existing unit in the service system)
- **directly operated or contracted** (i.e., if the program was directly operated by the grantee county or contracted to a public agency or private provider)
- **region** in the state of California the program served
- predominantly **urban or rural** county

These comparison groups were used to structure analyses using both qualitative and quantitative data. **Table 2** presents the specific comparison group classifications used to produce the findings in this report.

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	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, both quantitative and qualitative data on program implementation were collected for the formative evaluation:

> The main source of ***quantitative data*** was a two-part program survey (Data Coordinator Survey and Program Lead Survey), which provided insight on program operations and the perspectives of individuals involved in implementation.
>
> The main source of ***qualitative data*** was semi-structured interviews to capture the perspectives of the individuals involved with program implementation. These interviews were supplemented by notes on other meetings and other supplementary data provided by programs.

A table identifying the data sources for each major data element used in the analysis and findings in this report, organized by logic model domain, can be found in **Appendix D.**

3.3.1 Program Survey

The program survey was used to collect aggregate data on selected program target activities and proximal program outcomes as well as to supplement and corroborate themes from the qualitative data (as detailed in Appendix C). We worked closely with

our program partners to develop an approach to survey data collection that reduced burden since programs were required to participate in the evaluation as a term of the grant but did not receive direct support for that participation. The survey instrument itself was divided into two components—a Data Coordinator Survey and a Program Lead Survey—to ensure that each data element was obtained from the appropriate parties within programs as well as to reduce the total burden on any one individual. For some programs, however, the same individual functioned as the data coordinator and administrative lead for the program and therefore handled both surveys.

> The ***Data Coordinator Survey*** collected 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 and customization of the survey itself to the characteristics of each program.
>
> The ***Program Lead Survey*** was focused on administrative program leads' attitudes toward implementation and activities related to funding, revenue, and sustainability and was 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, was also offered to day-to-day program leads with direct knowledge of program operations.

Both surveys were deployed on the Qualtrics web 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.

3.3.2 Interviews

Our primary source of qualitative data was twice-yearly semi-structured interviews with selected personnel involved with implementation. These interviews provided rich data on inside perspectives of implementation settings, activities, processes, and proximal outcomes that were used to identify barriers to and facilitators of implementation. Cycles of interviews were conducted with individuals in each of four main personnel roles: Program Leads, Site or Agency Staff, SB-82/833 Clinical Supervisors, and Parent or Peer Partners.

Sampling Strategy

We used a two-stage purposeful sampling strategy to generate detailed information efficiently with minimal burden to informants (Landsverk et al., 2012). We purposefully identified and enrolled individuals that were especially knowledgeable about program implementation and sampled from the four sampling groups to capture multiple perspectives that offer a range of views and assessments of implementation. These strategies offered a depth of understanding within and across all intervention sites while capturing data systematically to allow for comparison.

We first used a Criterion-i sampling strategy to select program leads from each Child/Youth and School-County Collaborative Program (Marshall et al., 2008; Palinkas et al., 2015). The selection criteria for the recruitment of program lead participants were: 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 was invited to participate in the interview via email and asked to identify appropriate personnel meeting these selection criteria.

Next, we used a snowball sampling strategy to identify and interview participants representing the other three main participant 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 were asked to provide contact details for 1–3 participants from each group, using the selection criteria described above. Especially in smaller programs, a single staff member sometimes met the criteria for more than one participant group. Participants were contacted via email or phone and provided information on the interview format and areas of interest. Those who expressed willingness to participate were scheduled for an interview within the designated interview window. 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 sent each participant the interview guide before the scheduled interview for their review.

Interview Procedure

Interviews with personnel at each program were conducted every six months following the sampling group schedule in **Table 3**. Leads from each program were interviewed at least once per year, and one representative per program from each of the other participant groups was interviewed at least once within the length of the grant cycle (approximately 24 months). Interviews included one or more participants from a given program and lasted approximately one hour. Due to delays in Phase 2 programs, the interview schedule for these programs was 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 did not have a second round of interviews with the program leads for the 6-month interviews, but rather skipped to the sequence of interviews described in **Table 3** for the 12-month interviews and then continued in that order until their final round of interviews in June 2023. A full timeline of interview cycles by grant type and sampling group can be found in **Appendix E.**

Interviews took place over the phone or using a video conferencing platform and were audio-recorded with the verbal consent of the participant(s). Participants had the option to stop recording at any time or request that statements be considered "off the record." Following the interview, the recording was transcribed by evaluation staff, and all individual identifiers were removed from the transcript. If consent for recording was not obtained (or later retracted), the evaluation staff present for the interview compared and combined 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.

Table 3. 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 followed a modified schedule
[2]School-County Collaborative programs only

Interview Guide and Data Elements

Our interview protocol addressed the first five domains of our logic model: **program characteristics, outer setting, inner setting, individual characteristics, and implementation processes**. Each semi-structured interview protocol included questions related to particular domain(s) and their component constructs. Each round of interviews focused on 1–2 logic model domains (as shown in Table 3) and each interview built 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 allowed for exploration of important themes while also allowing the interviewee to guide the discussion (Seidman, 2013).

A table listing the dates of all interviews conducted is included in **Appendix F.**

3.3.3 Other Data Sources

Where available and feasible, we also used 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 were 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 facilitated and engaged in multiple groups comprised of key advisors: an Advisory Board, Data Coordinator's Workgroup, School-County Workgroup, and Child Workgroup.

The primary function of the Advisory Board and workgroups was engagement: they were oriented towards and structured around building relationships and partnerships, both among the programs themselves and between programs and the evaluation team. Nevertheless, where information was shared that enhanced the evaluation, the research team used this information as data. Although data collection strategies and input were often a topic of discussion, the agendas for these meetings were not designed to solicit 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 Appendix D.) Moreover, to encourage candid participation and genuine collaboration, the meetings were never recorded. Rather, evaluation staff took notes on the meetings which were later used to inform the evaluation and incorporated into the qualitative thematic analysis as a supplement to our interviews.

Multiple evaluation staff members took notes during each of our workgroups, producing more than one set of notes. We then compiled the notes into one complete set by consensus to ensure consistency and accuracy. A table of completed workgroup meetings to date can be found in **Appendix G.**

Program Records

Supplemental sources of quantitative and qualitative data for the formative evaluation were obtained from records kept by the intervention programs. Program records consisted 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, were provided to the evaluation team at program initiative and discretion. A complete list of the program records received can be found in **Appendix H.**

Publicly Available Datasets

Data on features of the outer setting of program counties were also abstracted from publicly available datasets, including the Household Pulse Survey (HPS; Fields et al., forthcoming); 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 elements from these data sets were linked to interview transcripts to allow the team to collate and analyze qualitative data by demographic and other community considerations.

Throughout the evaluation, we also monitored potential threats to external validity using publicly available data, which variously included COVID-19 pandemic indicators, wildfires, and other external factors that may have influenced program implementation. Data on COVID-19 included records of mandated statewide orders, school district statuses, quantity of new cases per month by county, and quantity of vaccinations administered by county. These data were collected to corroborate and supplement information from interviews on critical community-specific implementation contexts.

3.4 Mixed Methods Thematic Analysis

A thematic analysis of interview transcripts was the central method used to achieve our evaluation aims. This analysis addresses every domain in our logic model, with particular emphasis on the perspectives of individuals involved in implementation on the **contexts, activities, processes, and outcomes** relevant to program implementation. **From these themes, it was possible to generate "stories" of program impacts from the perspective of the individuals involved in implementation** (Bromley et al., 2018).

Interview transcripts and workgroup notes 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 allowed 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 Appendix D were included in the initial codebook. In addition to codes developed deductively, codes were also generated inductively during early rounds of coding, with such codes added to the codebook through coder consensus.

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. 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 reviewed 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 emerging themes. Selected data elements, including the comparison group classifications described earlier and community characteristics extracted from publicly available datasets, were linked to individual transcripts to allow comparisons across and between selected variables.

To support the thematic analysis, data collected with the Program Survey were cleaned, formatted, and analyzed to produce descriptive tables to expand on themes identified in qualitative analysis. Responses to the Program Survey, along with publicly available data, were also used to make the classifications of each program by comparison group.

3.5 Case Studies

The four School-County Collaborative Programs were also analyzed in greater depth as case studies to provide richer descriptions of the community and program contexts and processes that impacted implementation outcomes for such partnerships. The case study approach provided an opportunity to generate detailed narratives of program implementation, including exploring barriers and facilitators with greater specificity and understanding how programs grow and change in context.

The case studies were constructed using the entire body of data described above. Once preliminary thematic findings emerged, these provided the basis for additional reviews of program data from each School-County Collaborative Programs to identify how (and if) these themes manifested in each program and what additional themes, specific to such programs, might also be identified. The themes representing the most substantial barriers and facilitators of each program were then re-reviewed to identify commonalities and differences across the experiences of the four School-County Collaborative Programs. School-County Workgroup notes provided further evidence on the extent of common barriers and adaptation among school programs. These data were used to construct narratives of program implementation over time for each program, as well as to identify points of comparison that can be used to generate recommendations on the design and implementation of future School-County Collaborative Programs.

4. Main Findings

Main findings were drawn from the thematic analysis of interview data, supplemented by relevant data elements from the program survey, to provide an understanding of the major themes underlying program implementation and point to corresponding barriers to and facilitators of that implementation.

Each section is oriented around a main narrative theme with supporting findings:

> ***Theme One:*** *SB-82/833 programs represented a variety of approaches to crisis triage, with structures and components that were tailored to fill specific gaps in local service systems and address specific community needs.*
>
> ***Theme Two:*** *SB-82-82/833 programs sought to address, but also faced, existing challenges affecting delivery of community mental health crisis services.*
>
> ***Theme Three:*** *Adaptability, partnerships, and leadership engagement were major facilitators of successful programs by helping them work through significant challenges.*
>
> ***Theme Four:*** *Successful programs also depended on experienced and dedicated personnel to overcome significant workforce challenges and limited resources.*
>
> ***Theme Five:*** *SB-82/833 pilot programs faced significant barriers related to sustainability, including challenges in identifying appropriate sources of funding and revenue and in data collection and reporting.*

Quotes from interview participants are provided to support and illustrate themes where possible. The quotes included are not intended to be exhaustive and the absence of a quote does not indicate absence of evidence for that theme. When used, quotes are labeled with the individual's role, a program identifier (prefixed with "P"), and an individual identifier (prefixed with "I"). Where individuals had more than one role in a given program or were involved in the implementation of multiple programs, the role that was most relevant to their quoted statement was provided.

4.1 Theme One

SB-82/833 programs used a variety of approaches to crisis triage, with complex structures and components that were tailored to fill gaps in local service systems and address specific community needs.

4.1.1 Variation across Programs

SB-82/833 programs varied on a number of important characteristics, including:

- program setting(s)
- the types of care they provided
- the extent of program maturation
- amount of SB-82/833 Triage Grant personnel funding they received.

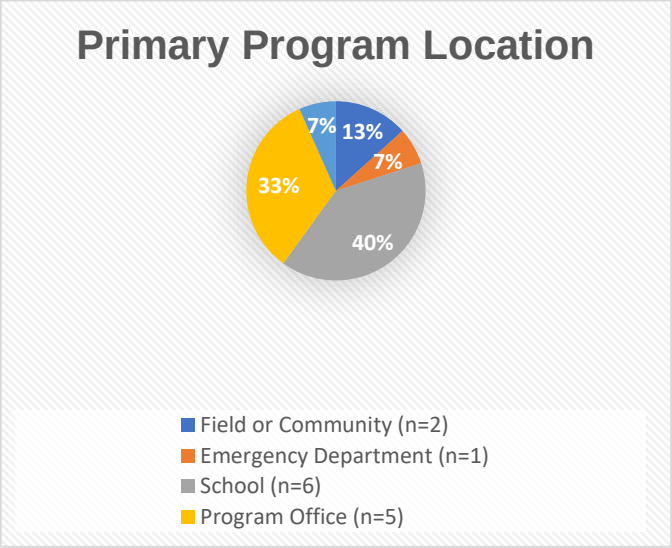
While sharing many of the same goals and target outcomes, Child/Youth and School-County Collaborative Triage programs varied significantly in their characteristics because they proposed and carried out interventions that were ***highly tailored*** to the existing mental health and other social service systems in their respective counties.

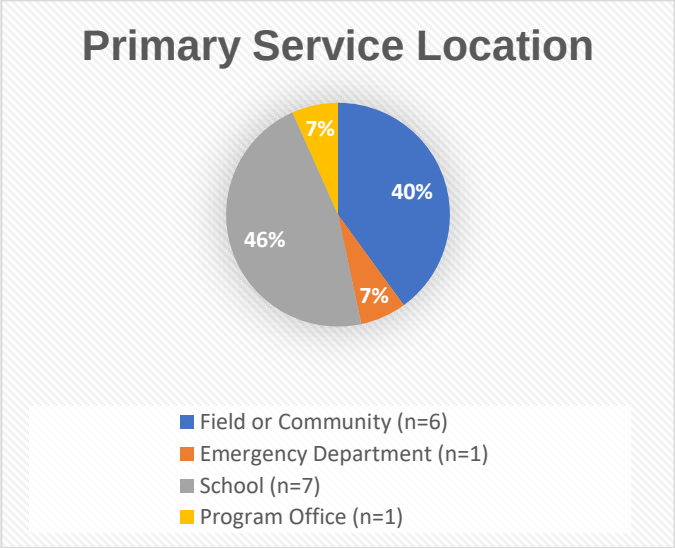
Variation in Program Setting

SB-82/833 programs were variously based in and delivered services in several different settings:

- the field or community at large (including mobile response teams)
- schools and other educational settings
- mental/behavioral health program offices
- an emergency department
- a police department

Programs varied in the **primary location of their program** (where their crisis triage personnel were typically based) as well as in their **primary service location** (where their crisis triage services were typically delivered):





In most programs, crisis triage personnel were based at the same location in which they typically delivered services. However, programs delivering services in the field or community varied in whether their personnel were purely mobile or had a fixed base, generally a program office in a behavioral health agency and one program based in a police station. The two programs that reported their program location as “in the field” were both mobile teams covering large counties with particularly widely dispersed populations.

What is particularly notable is that **personnel in two-thirds of programs were based in a non-mental health setting (10 of 15 programs) and all, but one program also primarily delivered services in non-mental health settings**. These were not surprising findings given the goal of SB-82/833 to increase the number of crisis triage personnel in community settings. On a practical level, though, it means that SB-82/833 personnel were generally operating in settings that are not typically optimized for the delivery of health services.

Schools and educational agencies were an especially notable setting for SB-82/833 programs, both for the four programs funded by a School-County Collaborative grant as well as several programs that received a Child/Youth grant. In all, **over half of SB-82/833 programs were either based in or provided services in schools and related educational settings** (8 of 15), though their role in and relationships to those educational settings varied.

By design, all four School-County Collaborative programs involved formal partnership(s) with local education agencies (such as county offices of education, SELPAs, and school districts), with each structuring these partnerships differently:

- One School-County Collaborative program was administered by the county children’s mental health agency and staffed by both the county and individual school districts.

- One School-County Collaborative program was run by a consortium of local education agencies that provides support and services to their member agencies.
- One School-County Collaborative program was administered by the county office of education and formed partnerships with individual school districts.
- One School-County Collaborative program was co-administered by the county children's system of care and the county office of education and formed partnerships with individual school districts.

Two Child/Youth grant programs were also both based in and delivered services in schools:

- One Child/Youth program was contracted to the county office of education by the county department of mental health.
- One Child/Youth program was administered by a municipal mental health agency in partnership with a local high school.

Additionally, two more Child/Youth programs were school-focused but not school-based, in that they were not based in or delivering services in schools but were specifically designed to fill a known gap in school-based crisis services (or lack of capacity in existing ones). While they developed direct relationships with schools to obtain referrals, their programs did not require formal partnerships with local education agencies or schools to be able to carry out their regular operations. Therefore, the extent and quality of the relationships with educational agencies was less directly impactful on program implementation than for programs that were actually housed in, required formal partnerships with, and/or provided services directly to schools.

Variation in Care Processes and Services

SB-82/833 programs provided a wide array of mental health care processes and services, consistent with their mandate to provide crisis triage services in communities. Since crisis services are for utilization by "anyone, anywhere and anytime" (Substance Abuse and Mental Health Services Administration [SAMHSA], 2020, p. 8) and crisis triage itself can involve a variety of care processes across the full continuum from prevention to treatment, **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**. Following this inherent diversity in crisis triage, SB-82/833 programs:

- differed substantially in the types of care processes and services they delivered
- targeted multiple care processes and services

The evaluation identified seven types of care processes targeted by SB-82/833 programs, meaning they were considered a main component of their program:

- Prevention (6 of 15, 40%)
- Early Intervention (6 of 15, 40%)
- Acute Crisis Services (15 of 15, 100%)

- Treatment (7 of 15, 46.7%)
- Referral (12 of 15, 80%)
- Care Coordination (10 of 15, 66.7%)
- Community Outreach (6 of 15, 40%)

Acute crisis services, referrals, and care coordination were the three most common care processes, each targeted by the majority of programs. Nearly half of programs also targeted prevention, early intervention, treatment, and/or community outreach. **While similar proportions of school-based and non-school based programs targeted acute crisis services, care coordination, and referral care processes, the majority of programs targeting crisis prevention, early intervention, and community outreach, were school-based.** Five of six school-based programs (83%) targeted crisis prevention, early intervention, and community outreach compared with only one of nine non-school-based programs (11.1%). This reflected a trend of school-based programs taking a broader view of crisis triage in their planning and operations, with most attempting to provide services and activities across the entire crisis care spectrum, while non-school-based programs generally focused on a narrower set of care processes related to acute crisis de-escalation and referral to longer-term care.

Interviews with program leads revealed that ***several non-school-based programs initially incorporated prevention, early intervention, and community outreach in their design but when faced with funding reductions, budget cuts, or external pressures (such as the COVID-19 pandemic) reduced (or eliminated) these components first to preserve their more acute services***. Indeed, leads from more than one large non-school-based program expressed considerable concern over the relative volume of community outreach services provided by their personnel, encouraging a reduction in such services to protect staff time and prioritize delivery of services that could be billed to external sources such as Medi-Cal. Within school-based programs, there was also some variation between programs with a greater focus on providing individualized, clinical mental health crisis services to children and families or providing crisis programming such as activities and trainings for school staff and teachers, parents and caregivers, children and families, or the community at large.

Variation in Program Maturation and Start Date

Of the fifteen SB-82/833 programs, seven added personnel to augment programs already in operation (46.7%) and eight constituted new programs within their respective systems (53.3%). At one end of the spectrum, some augmenting programs entered the grant period with existing workflows that could be readily adapted to new personnel, 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 was program start date. Phase 1 program start dates, defined as the date that program personnel started delivering crisis triage services, ranged 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.

Programs that were new versus those augmenting an existing program had different experiences implementing their programs, but it did not account for the variation in program start date. Reasons for the variation in start date included:

1. differences in the initial timelines for implementation proposed by each program (i.e., by design)
2. 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 funder)
3. delays related to developing partnerships, executing contracts, securing program sites, and hiring qualified staff, which were more closely related to *program setting* than whether the program was new or augmenting an existing program.

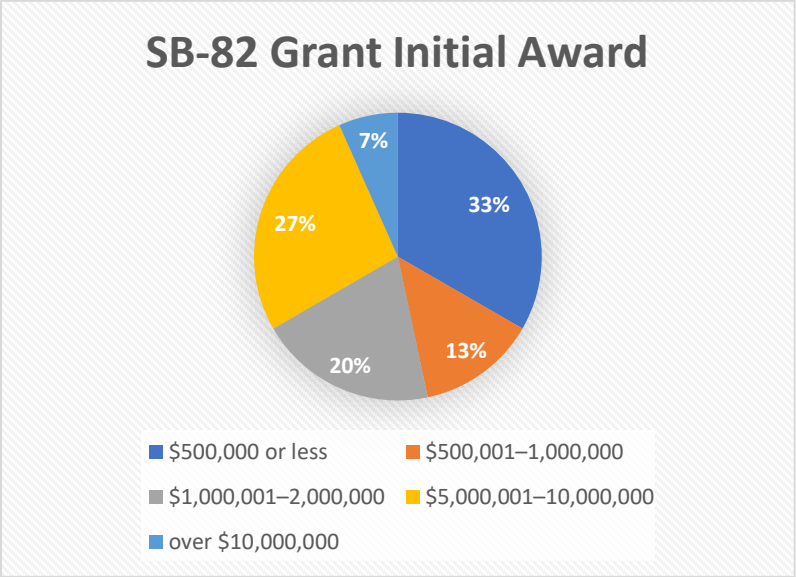
While existing programs had some significant advantages in ramping up, some still faced challenges in hiring staff and expanding their reach to new community sites and/or school districts that could not be expedited by existing workflows or team dynamics. The distinction between new and augmenting programs is still important, however, 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.

Variation in Grant Funding

SB-82/833 Child/Youth and School-County Collaborative Triage programs were awarded a wide range of funding for personnel and associated administrative costs over the 2018-2022 grant period, from support for less than one full-time staff position to entire crisis triage teams.

- Child/Youth programs were initially awarded **between $300,000 and $20,000,000** in funding for expanding crisis triage personnel, depending on program scope and county demographic factors.
- School-County Collaborative programs were each initially awarded **$7,500,000.**

Nine of the fifteen programs, including the four School-County Collaborative programs, were initially awarded $1,000,000 or more over the grant period. **This relative difference in funding between programs was 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 were notified of a 30% reduction to their grant award in late 2018, after initial awards had been accepted but, in some cases, after the programs had already started early implementation processes (e.g., obtaining county approvals, developing RFAs for contracted providers, and hiring staff). The impacts of these cuts, which were the result of broader state budget cuts, were summarized in statements of changes prepared by the SB-82/833 programs and elaborated on in interviews. Program leads described the cuts as "painful" and significantly impactful on their program capacity and early operations. The extent of the pain varied, however, with some programs leads viewed it as a manageable (or even expected) re-scaling of their program ambitions and other program leads viewed it as a substantial shift in program reach and service targets. Leads noted 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."

SB-82/833 programs variously reported that these cuts resulted in:

1. **delays to the start of implementation**, in some cases preventing school-based programs from aligning with the school year and creating challenges with hiring and building effective relationships with school sites
2. **reductions in the volume and types of care processes that were offered** (e.g., clinical, prevention, outreach), which disproportionately reduced prevention, early intervention, and community outreach components of programs)
3. **reductions in the number of sites that program teams could serve** (e.g., schools, hospitals) and therefore the overall reach of the program within the community)
4. **changes to the composition of staff roles on program teams** (i.e., clinical, case management, parent partners), which disproportionately reduced the number of peer and parent partners supports in several programs and completely eliminated the clinical roles in another program

5. **expansion of the geographic areas (and/or caseloads) that each regional team would serve**, either by reducing the number of geographic regions or assigning teams to multiple regions

Additionally, leads in at least three Child/Youth grant funded programs reported that these ***budget cuts were part of the motivation for county and system of care leaders to reassess their prioritization of the funded program within their system of care***. As with other state-funded initiatives, a major condition for qualifying for an SB-82/833 grant was that the county did not use grant funds to replace existing county funding commitments. As a result, these state budget cuts left some programs with holes that their county was not willing or financially prepared to fill. Over the course of the grant cycle, all three of these programs ended early: one was able to reallocate some grant funds to support another MHSOAC administered grant program and two ceased operations and returned a large proportion of their awarded funds to the state. Budget cuts were not the only factors that led those programs to end early, but the cuts created an additional hurdle for some programs to overcome with their county and agency leadership in order to sustain their operations even through the grant cycle.

Looking at the overall impression of program leads to the amount of funding the grant provided, the results were also mixed. Most administrative leads agreed in some capacity that their SB-82/833 program was "possible to implement with the funding provided by the SB-82/833 grant," but at least three leads disagreed and one neither agreed nor disagreed. Interviews and open-ended responses provide details on the aspects of program implementation for which funding was perceived by program leads as more or less satisfactory.

While program leads were grateful for the grant funding and the work that it enabled for their counties and communities, a major concern was the extent to which ***program implementation depended on significant in-kind contributions from both implementing agencies/organizations and their partners***. A particular concern was the ***limited support for non-direct service staff*** needed by the programs, including supervisors (clinical and administrative), contract monitors, and data analysts. As one county analyst who was 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 known 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 that this particularly affected partnered programs such as School-County Collaboratives, since their success (and sustainability) especially depended on additional support from external partners who received no grant funds and were therefore stretching their own limited resources:

> *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 major county contributions required to implement programs concerns the allocation of **funding for less than full-time position**. While programs, especially those in rural and remote regions, appreciated access to funding of any amount to increase their service capacity, rural and smaller counties noted that they still require a baseline in funding to achieve even minimum program capacity (e.g., staffing and infrastructure), regardless of their population size. As several programs noted, state and/or county rules on how grant funds can be used (e.g., that they cannot fund existing county commitments), make it challenging to design a staff role that combines SB-82/833 grant funding with funding from other sources. **This incentivized some programs to braid their SB-82/833 funds with other grants and prioritize services that could be reimbursed by Medi-Cal instead of securing long-term, stable local funding that is more restricted and thus challenging to braid.**

4.1.2 Complexity and Related Challenges

For programs with a wide scope of services, common in crisis triage, complexity was expected and even necessary for meeting program goals. That is, providing the range of crisis services covered under the umbrella of crisis triage means that **these programs were generally more complicated, and thus difficult to operate, than behavioral health programs with narrower targets and goals**. Even the programs targeting a more modest number of care processes evinced some degree of complexity in the duration of their interventions, the scope and depth of care they aimed to provide children and families, and the intricacy of the service systems they navigated to provide individualized care. Interviews with program leadership and staff routinely reflected their understanding of the inherent difficulty of both structuring and delivering crisis triage services.

Three particular types of complexity were identified among SB-82/833 programs:

1. **Organizational complexity** occurred in programs that relied on organizational partnerships with **multiple departments or agencies**, especially where these partners were spread across different sectors (e.g., education, hospitals, law enforcement) and entailed multiple bureaucracies for programs to navigate. More organizationally complex programs had more potential challenges in proportion to the number of partners/relationships required to operate their programs. However, organizationally complex programs with a relatively small number of partners also experienced distinct challenges since each partnership was therefore more critical to and impactful on the success of the program.
2. **Structural complexity** occurred in programs whose operations were 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 could also be organizationally complex to the extent that their multiple sites or teams were housed in different organizational settings, such as multiple local schools, or hospitals.

3. **Regulatory complexity** was often a function of organizational and structural complexity and occurred when programs had to interface with **multiple regulatory systems** to carry out their services and activities. The extent of regulatory complexity, however, did not depend entirely on the number of organizations or structural units involved in implementation, but rather depended a lot on what *types* of partners the program had and how different their regulatory environments were from those of the implementing organization.

Challenges Related to Complexity

Each form of complexity was linked to distinct challenges for implementation frequently faced by programs and described by program leadership and staff in interviews. Since this complexity was at least partially inherent to crisis triage, however, successful implementation of such programs required **efforts to mitigate and account for the impact of program complexity**, which was also necessary when evaluating programs' progress towards meeting SB-82/833 Triage Program goals and summative outcomes. This was especially important for new (as opposed to augmenting) SB-82/833 programs: all but one of the programs categorized as new were also high in all three types of complexity plus had less pre-existing experience to navigate this complexity.

The analysis suggested **particular needs of programs by the type of complexity they entailed**; 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 operated in or depended on non-mental health primary service setting(s) such as schools, hospitals, or law enforcement, needed 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 was also necessary to meet both of these needs.
- Programs with a greater degree of **structural complexity**, independent of their organizational complexity, needed special strategies for ensuring that staff turnover in their sites and/or teams did not disproportionately impact their programs, since such programs were less flexible and unable to rapidly reallocate regionally dispersed personnel. These programs may also need a higher and more coordinated level of administrative and supervisory resources to maintain overall program integration across their teams or regions.
- Programs with a greater degree of **regulatory complexity** needed significant time and resources to first identify the regulatory systems that were relevant to

implementation (such as in hiring, service coordination and delivery, data collection and maintenance) as well as to develop procedures for personnel to navigate those systems. To minimize disruption to services and activities, this was best achieved in advance of the start of service operations, but several programs were delayed when they were unable to resolve issues related to regulatory compliance until months into the grant cycle. Programs partnered with law enforcement and schools reported the greatest impacts of regulatory considerations on implementation, pointing to special needs involved in delivering crisis services in these sectors and settings.

Across all SB-82/833 programs, school-based programs had the greatest challenges related to complexity since many had to deal with all three types: they operated 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, of 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 Incorporating Needs of Patients and Communities

Needs of Patients and Communities in Program Design

While programs conducted needs assessments as a component of their SB-82/833 Triage Grant program applications, data from interviews provided additional detail on which needs program leads considered to be of particular relevance, both based on the input they received from their own needs assessment processes 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 4** summarizes the types of community needs mentioned in interviews with program leads.

Table 4. 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
School	- 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

These community needs therefore represent major identified (and prioritized) gaps in the service systems to which crisis triage services were applied.

Needs of Patients and Communities in Program Implementation

SB-82/833 programs were also tailored to the specific needs of patients and families in the communities in which the programs operated. **Two areas of broad concern on the part of SB-82/833 program staff were the 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 hiring staff that represented 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 mentioned by six programs in interviews and addressed in workgroups as a major area of interest for program leadership. Concerns related to structural racism included the extent to which minoritized racial and ethnic groups were 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 5 summarizes these population-specific needs and provides examples of the ways that their programs were tailored to address them. Each of the populations and needs summarized in Table 5 were mentioned in interviews with at least five of fifteen programs.

Table 5. Examples of SB-82/833 tailoring to population and 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 they faced in meeting these types of community needs:

- For serving communities and families in rural areas, challenges included a lack of resources for mental health and difficulties recruiting and retaining clinicians in rural and more isolated regions.
- For serving Native American and other Indigenous communities and families, challenges included substantial language barriers with monolingual Indigenous groups and difficulties recruiting and retaining clinicians.
- For serving immigrant communities and families, a major challenge related to the legal precarity of children and families without documentation 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 aimed at mitigating these concerns.
- A challenge for meeting the needs of Spanish-speaking communities and families was the need for more bilingual staff, which was particularly challenging for programs with a small number of program staff.

4.2 Theme Two

SB-82/833 programs faced challenges in delivering community mental health crisis services, including some of the same structural challenges that their program was intended to mitigate.

Interviews provided insight on the external challenges that leads and staff experienced in operating their crisis triage programs. In many cases, the local gaps in services that motivated counties to apply for crisis triage personnel support were also linked to other inadequate resources (such as existing mental health infrastructure or community providers). ***Limited resources in the broader community mental health system can be a barrier to implementing crisis triage since triage is a short-term intervention that requires facilities and providers to which clients can be referred for longer-term care.*** The COVID-19 pandemic and related public health orders, which started in March 2020 while most SB-82/833 grantees were still early in program implementation, became the most impactful of these external challenges: both exacerbating existing barriers to implementation and creating novel ones.

4.2.1 State and Community Resources for Mental Health

Several programs attributed the limits of available resources for their programs to broader, systemic deficiencies in funding and resources for mental health services and community mental health resources in their counties and the state of California as a whole. Discussions of resources with program leads in counties large and small were therefore often centered on work to overcome a perceived 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 (nor qualified) for the grant in the first place. Further, many leads noted that local/county resources for mental health were allocated through processes to which they themselves had limited direct input. Others were more involved (and even successful) in securing local funding commitments for program functions, but noted that such funds were still unpredictable to the extent that they are tied to tax revenue bases that can vary year to year.

Local Community Resources

Since the ability to link to resources for mental health services in local communities is critical to crisis triage, SB-82/833 **programs tended to be mutually dependent on external agencies with varying access to resources**. Since they also often operated across the full range of the mental health care continuum, there were therefore many points at which access to community resources could either facilitate programs or constitute a significant barrier to delivering effective crisis triage.

Moreover, certain target outcomes for programs—such as reducing unnecessary hospitalization—were directly linked to the accessibility of these resources/assets. Beyond crisis triage personnel themselves, effective crisis triage required the ability for programs to coordinate with mental health treatment facilities and community mental health services, including:

- psychiatric hospitals
- 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
- outpatient clinics and providers

While triage programs were designed to provide alternatives to, and diversion from, more invasive forms of psychiatric care (including inpatient hospitalization), the nature of crisis triage also necessarily put triage personnel in contact with some youth and families for whom hospitalization was indicated or even legally mandated. For many SB-82/833 programs, especially those that were focused on crisis response care processes and those in smaller and more rural counties, **deficiencies in mental health infrastructure and posed a significant barrier to accessing timely, appropriate psychiatric hospitalization**, 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 haps 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 critical services to which youth and families were referred, 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 wide variation in community assets for mental health across counties with SB-82/833 programs was also 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 were already 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 have appeared less able to accomplish certain concrete program targets such as linking to services. However, **that same lack of resources may have also allowed programs in less-resourced counties to have a greater relative impact on mental health services in their communities** since they gaps and deficiencies they were filling were larger. That is, in absolute terms their impact on targeted outcome metrics may be less than what was 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 existing mental health service infrastructure.

Beyond the organizations that directly implement (and administer) SB-82/833 programs, the **organization(s) that housed many SB-82/833 programs, including partnered schools/school districts, hospitals, and law enforcement agencies, were also**

important sources of program resources. While these organizations were 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: 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.

Program leads in several programs also described new initiatives to expand crisis infrastructure and capacity in their counties, including through SB-82/833 CHFFA grants for Mobile Crisis, Crisis Stabilization and Crisis Residential infrastructure and MHSOAC grants funded by the Mental Health Student Services Act. **Since implementation of these grants occurred alongside SB-82/833 crisis triage pilot programs, the synergistic benefits across these initiatives were not yet realized during the grant cycle**. While the long-term intent of these separate initiatives, also alongside implementation of nationwide 9-8-8 services and major state mental health reforms (e.g., CalAIM), is to create more robust, integrated health systems, **the timing of SB-82/833 crisis triage pilot programs meant that crisis triage personnel were added to some county systems of care before pending infrastructure improvements that would support crisis triage services**. This may have been due to the slower progress of infrastructure improvement programs, which involved greater capital outlay and planning than programming with personnel only.

Grant Funding

While programs reported challenges in accessing infrastructure and providers in their communities, an arguably greater area of concern for programs was ensuring their program itself was adequately staffed. **Table 6** summarizes responses to program survey questions on the adequacy of the staffing for their SB-82/833 programs. Leads from eight of the fourteen Phase 1 SB-82/833 programs agreed that their programs had adequate staff for its activities, services, and program administration, but leads from **only six programs agreed that their program had adequate staff for data coordination and reporting.**

Table 6. 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 provided details on these perceived challenges with staffing, which increased over time for many programs. Besides funding considerations, workforce challenges related to hiring and retention were a major factor, especially once the COVID-19 pandemic started.

> *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]

> *…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 (and traumas) 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 was time and labor intensive, and more so when it also involved the contract monitoring and evaluation commitments associated with a short-term 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 especially acute. Clinical staffing and productivity were often difficult for such programs to maintain and balance given both their "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]

4.2.2 COVID-19 Pandemic

The COVID-19 pandemic was another external context that profoundly impacted many 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 program demand
- **extensive and innovative adaptations** made to meet those needs and continue service delivery during an unprecedented global crisis.

Changes in Community Needs

With little exception, staff expressed that the pandemic had resulted in an overall **increase in mental health needs for children and families**. At the start of the pandemic, program staff described active concerns about 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 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, 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.

Increases in Severity and Acuity

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. Potential **client and family level 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
- worsening of existing symptoms due to loss of existing routines
- 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. Additional **service system level explanations for changes in 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.

Changes in Youth and Family Needs

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.

Early 2020: Significant Drops in Demand

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 have also been linked to school closures.

Late 2020: Variable Barriers to Demand

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 was increasingly difficult to get students to engage in "another virtual thing" since "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.

2021 and Beyond: Back to Busy

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 found that their demand was back to "normal," "busy," or that they were handing "tremendous" volume of referrals, typically connected to the return of students to schools. For programs in areas still awaiting school reopenings in early 2021, a common concern was 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."

For programs that remained in operation throughout 2021 and 2022, pandemic impacts significantly reduced over time as local communities stabilized and program leads and staff accepted a "new normal."

Program 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 required (e.g., social distancing requirements, school closures, and stay-at-home orders), but many 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.

Some programs continued (and even prioritized) in-person services throughout the pandemic. However, many programs—especially those based in or providing services at non-mental health community sites such as schools, police departments, and hospitals—had little input on whether or not their program could coordinate or deliver services in person. Across all programs, the pandemic was a continual exercise in "trying to ride and tame the [pandemic] 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. Many programs, especially school-based, found that telehealth was better suited to certain care processes such as outreach activities, prevention trainings, and client 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. 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.

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, programs often utilized both telephone and teleconferencing platforms depending on the reason for connecting or preferences of the client and family. Services related to an acute crisis, for example, would sometimes start in-person and then shift to telehealth for consults, follow-ups, and parent/caregiver outreach. 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]

> *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. **Telehealth was more challenging, though arguably more important, in regions where access to internet or technology is limited, particularly rural or low-income areas**. This constituted a significant obstacle to program service delivery during the pandemic, especially when programs didn't have the ability to fix it:

> *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 loaner 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]

Attitudes toward Telehealth

While adoption of telehealth was widespread, **program personnel perspectives on the appropriateness and efficacy of telehealth were somewhat mixed.** Some clinicians were 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]

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 …it wasn't effective for them.* [Child/Youth Clinician: P12 I076]

Many programs also noted that **client engagement through telehealth became more challenging over time**, particularly after a few months of attending school through video teleconferencing. "Zoom fatigue" was a regular point of discussion in School-County Workgroup meetings. Some clinicians also felt **interpersonal connection being lost on a virtual platform**. By summer of 2020, many clinicians and staff voiced the need for a return to in-person service delivery since body language nuances and other critical elements of interpersonal care were hampered through remote platforms:

> *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]

A related challenge involved the **willingness of parents to engage with or provide consent for telehealth services**. 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**. While some families, especially those facing

challenges in basic needs, may have been harder to engage, programs also noted that some parents were actually more engaged on issues of mental health that were brought to light during (and by) the pandemic. Similarly, some program staff 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 additional burden on their staff.**

Challenge, Innovation, and Opportunity during the Pandemic

While the pandemic was a major challenge that required adaptation to overcome, **its particular impacts were often complex: variously resulting in durable challenges, stimulating innovations, and even creating new opportunities**. Notably, 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 really step up. The situation has allowed [the SB-82/833 team] to really show what they are capable of.* [P10 I042]

Table 7 provides a list of examples of the innovative solutions described by program leads and staff in response to the specific challenges posed by the pandemic.

Table 7. 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 potential referees - increased staff time for coordination with referral sources - increased coordination withs 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)
Barrier's 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 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

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 encourage schools to either restart or reprioritize the services provided by their programs, but detecting youth and family needs remained a durable particular

challenge for school-based programs since they generally depend on direct in-person observation by teachers, counselors, and program staff to identify student needs.

> *[Before the pandemic] 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 during the pandemic, personnel in one program specifically described knowing that youth in their school were struggling but were unable to convince their partnered school district to coordinate with them on processes for identifying these needs.

As the pandemic unfolded, increases in needs and (at least temporarily) reduced school capacity for detection led to an overall **disruption of pre-pandemic referral sources**. Since schools were a major source of referrals for many crisis triage programs, regardless of whether they were school-based or school-focused, challenges identifying student needs within schools had a broader impact on programs to which youth and families would ordinarily be referred, including mobile crisis programs. While these programs often had other referral bases besides schools, they expressed concern that they were also receiving fewer referrals or referrals for cases further along in the progression of a crisis due to this reduced detection and interventions from schools.
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:

> *…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 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 helped to keep the communication and relationships as strong as they can be.* [Child/Youth Program Lead: P16 I084]

> *…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… 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 *already* 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 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 **challenges related to the pandemic that were much harder to adapt to**, 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 or closely linked to decisions or resources outside of the authority of the program or its leadership.

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. 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) in addition to 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 distancing their personnel on site.

Another critical aspect of implementation that was difficult for some programs to sustain during the pandemic was 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 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 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 described earlier.**

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.

4.3 Theme Three

Adaptability, partnerships, and leadership engagement were critical facilitators of program implementation by helping successful programs work through their challenges.

4.3.1 Adaptability

The adaptability of a program is the extent to which it can be tailored or refined to meet local needs or adjusted in response to changing conditions. Adaptability was evident in successful programs' efforts to adapt to cuts in their grant funding as well as continuous adjustments to customize their supports, including to the challenges of the pandemic. **Overall, SB-82/833 programs were more successful at implementation when they were more adaptable: that is, focused more on meeting bigger picture goals** (increasing access, meeting community and patient needs) **rather than narrowly focused on arbitrary targets**. While not all challenges could be adapted to effectively, especially when linked to resources and authority beyond the control of the program, **programs varied widely in their willingness to adapt their programs over the course of the grant cycle**. Since SB-82/833 programs were intended as pilot programs, adaptability was considered an important *feature* of some 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]

On the other hand, **some program leads expressed considerable resistance to modifications to the operations of their programs**, despite provider feedback and internal monitoring efforts.

Barriers to Adaptability

Even when programs were willing to make extensive adaptations to their programs to address increases in the acuity of patient needs, such efforts were generally insufficient 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 also inadequate or absent. This was 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 existed for programs addressing changes in the demand for their program's services during the pandemic, which were impacted by state and local policies over which they did not have authority. Where 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 concerned the extent to which grant terms provided the 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 (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 the 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]

Perhaps most critically, ***there was not agreement among SB-82/833 programs about what types of adaptations they perceived as acceptable to the funder***. While program leads in some counties felt empowered to make substantial but necessary changes to their operations over the course of the grant cycle, both informally and through contract renegotiation, others program leads reported that their interpretation of contractual terms prevented adaptation. In one program, that ultimately ended before the end of their grant cycle and returned a significant portion of grant funds to the state, personnel delivering services reported that they were told by the implementing county agency that contract terms prohibited the program from altering their referral sources or program components. Despite disagreement among programs on what types of adaptations were considered acceptable to the funder, areas where program leads or staff expressed a desire for greater flexibility included how SB-82/833 funding can be allocated or blended, how staff roles were allocated and defined, what activities or services were considered "crisis services" (a special concern for school-based programs that emphasize crisis prevention or provide universal supports), and the duration and intensity of services delivered.

Facilitators of Adaptability

Programs with stronger pre-existing networks and partnerships—both inside and outside of their agencies—were generally better able to adapt since they had more options for adaptation. 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. These include systemic deficiencies in resources as well as government policies and bureaucratic regulations that programs lack the authority to alter. Such challenges were evident in programs prior to the pandemic as well, but the pandemic further strained the adaptive capacity of most programs.

4.3.2 Organizational and Community Partnerships

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 board
- 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

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]

A key finding about these partnerships was that SB-82/833 programs were generally **not merely highly connected but necessarily (and often inherently) so, in that their operation was critically dependent on partnerships with other organizations and agencies in their counties and communities**. An important corollary was that SB-82/833 programs were not just complex in their connections within the implementing organization, but their **critical organizational partnerships often span sectors**, meaning they involve both mental health and non-mental health agencies. Common intentions were for these 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.

Advantages of Community Partnerships

All SB-82/833 programs used 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 reduced 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 described 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]

The advantages of partnerships about which program leads and staff expressed the most enthusiasm, however, were using new partnerships to center mental health in conventionally non-mental health settings, making existing relationships between agencies and sectors more "solid", and using partnerships to fill and bridge gaps in existing resources. These aligned 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 required significant time and resources under any circumstances, but this was 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 also required 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 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 happens when this leaves 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 actually 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 a 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]

4.3.3 Internal Partnerships and Teaming

Paralleling their relationships with multiple external organizations**,** SB-82/833 programs were also closely integrated with or embedded in the other service teams in their own agency or organization. While **some programs operated relatively autonomously within their implementing organization, many worked hand-in-hand with existing team(s)**, especially (but not limited to) the programs defined as augmenting. Some programs performed 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 were intertwined with those teams. **Some SB-82/833 staff were not part of a wholly separate program, but rather performed a dedicated triage role in a larger team that received funding from multiple sources** (such as county/municipal funds, other grants). Some programs were at least partially integrated with other teams because their funding did not support enough staff hours to meet demand, relying on support from another team to stopgap during the hours or days when their program was not operating (including in some cases, other county SB-82/833 triage programs).

Active collaboration by SB-82/833 programs with internal units in their implementing organization(s) and immediately proximate partners, included:

- 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

Similar to the relationships programs had with larger organizations, ***these relationships with other teams often significantly enhanced program implementation but also***

created the possibility of role ambiguity, especially for smaller programs and those in smaller and more rural counties with less resources for mental health services.

4.3.4 Organizational Culture and Leadership Engagement

Compatibility with Organizational Culture

Just as SB-82/833 programs were tailored to the needs of their communities, they were **also tailored to 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

Program leads also provided details on how well their programs were aligned with existing organizational missions, norms, and values. While programs were generally tailored to (and fit with) the workflows of their implementing organization(s), **there was some variation in compatibility around norms, values, and existing workflows, especially for programs based or delivering services in non-mental health settings** (e.g., law enforcement, education, hospitals). In many cases, programs reported strong compatibility in 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]

But other programs described needing to overcome 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 newer ones, experienced **challenges in setting up workflows that aligned with the existing systems in non-mental health settings**, some of which were also disrupted by loss of regular access to these settings during the pandemic. Additional work was 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 were set in *multiple* non-mental health sites (e.g., multiple schools, school districts, or hospitals), compatibility was 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 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 or the needs of the particular community site**. Such programs had a critical role in introducing and enhancing attention to mental health needs in their non-mental health settings, but required more resources and effort to achieve alignment in values and work within the existing workflows of the setting. Other programs, however, either deliberately selected sites for 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 require consideration.**

Prioritization of Programs

Related to their compatibility with their implementing organizations, **SB-82/833 program leads and staff also described the extent to which their program was 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 prioritization was among programs set in non-mental health settings**. While most felt that their contributions were recognized and appreciated, variations in compatibility with the values and norms of the setting sometimes translated into variation in how much priority was placed on their ongoing operations in these settings. In some cases, there were stark differences between how personnel felt their program was prioritized by the different agencies involved in implementation. In some cases, personnel attested to a very high level of prioritization of the program by the agencies delivering services but felt equally strongly that the county agency implementing the grant did not intend for the program to succeed or continue at the end of the grant cycle. **For some programs, personnel felt that their lack of prioritization (and efforts to overcome it) were a demonstration of the importance of the program within that particular setting or service system: simultaneously a barrier and an illustration of how uniquely such programs**

contributed 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]

Leadership Engagement

Interviews with SB-82/833 program leadership indicated that program leads were well-informed about and generally very passionate about their SB-82/833 programs and teams**. In addition to prioritizing programs, program leads were generally described in positive terms by program staff, with some singled out for exceptional praise by their team. Most programs had multiple leads with 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 had a correspondingly higher number of leads, requiring more coordination to ensure smooth program implementation**. Especially for programs that were operated by a different organization than the one that received and administered the grant—as with some partnered programs or programs that contracted all or some of their services—there was often** wide variation in the type and level of engagement each lead had with day-to-day operations**.**

Interviews provided insight into the types of ways that program leads, both administrative and day-to-day, engaged with and facilitated their SB- 82/833 programs. Program leads, both administrative and day-to-day, variously engaged with staff, implementing organization(s), and program contexts (including community resources). Engagement practices aimed at facilitating SB-82/833 programs are summarized in **Table 8.**

Table 8. Leadership engagement practices to facilitate implementation

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 occurred through regular meetings, clinical supervisions, and informal support channels. Some leads described efforts to ensure that they **maintained 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 entailed **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 came alongside **efforts to ensure that program staff felt 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 respected their expertise and considered their program adaptations 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 I05]

> *…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 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 facilitated program implementation were ***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. 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 [in] 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 whole 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 I22]

Leadership Engagement with Inner Setting

Program lead engagement related to the implementing organization(s) is frequently aimed at **building and sustaining strong networks within their organization(s) that facilitate program implementation**. Much of this took the form of regular communication and coordination with leadership in other units to ensure that programs were adequately understood and supported by the implementing organization(s), as well as that program activities were 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 came from these coordination processes was **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 a 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 Theme Five.

Leadership Engagement with Outer Setting

Leadership engagement with external partners was 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 partnered nature of SB-82/833 crisis triage programs, such relationships were rarely completely top-down, so leadership often acted more as facilitators or, rather than the sole drivers of, partnership-building. As SB-82/833 program staff were often instrumental in both establishing and sustaining relationships with external partners, leadership engagement sometimes took the form of providing support for those staff efforts. This included providing resources and contact that made such relationships possible or making sure that all appropriate parties were 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 facilitated 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.

4.4 Theme Four

Successful programs depended on experienced and dedicated personnel to overcome significant workforce and other challenges.

4.4.1 Workforce Challenges

Almost **all SB-82/833 programs reported significant workforce challenges, 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 9** 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 9. 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 described taking on additional work to fill gaps or even being assigned additional responsibilities outside of their normal job responsibilities. For smaller programs, which had fewer staff to share the additional workload, this resulted 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 depended on the maintenance of complex, long-term relationships between multiple agencies, the loss of the institutional knowledge and social capital of a single individual could 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 were 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 was 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 were 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 was likely to be unique to smaller and more rural counties, however, concerned the **difficulty of retaining staff in particularly remote areas**, especially for structurally complex programs in which program staff were 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 was likely that they are not *sufficient.* Indeed, for each of these three recommendations, there were 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 were 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 was short- term it could have been difficult for programs and agencies to recruit qualified candidates to whom they could not promise long-term employment or to justify hiring replacement staff to county leadership when a role was 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 expected 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 inhibited, 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 have 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 had limited control over many aspects of recruitment and hiring, some showed resilience by modifying how existing staff are allocated. However, the same degree of flexibility was not possible in all programs: programs that were structurally complex, especially those with multiple regional teams or teams with staff who had different specializations and credentials, may have been less able to reallocate staff. Organizationally complex teams in which all staff were not employed by the same organization have similar challenges in flexibly reallocating staff to fill gaps.

4.4.2 Staff Experience and Engagement

By all accounts, child and youth crisis triage programs involved challenging work for both the program leads and staff. **Staff often had heavy and challenging workloads** for a variety of reasons including program complexity, unpredictable (and often intense) demand for services, workforce challenges, 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 their position within weeks of this interview, laid out the central 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 [in] 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 **worked under particularly challenging conditions due to the nature of crisis work**, which was often acutely time sensitive and intensive, involved high stakes, and entailed exposure to "vicarious trauma" which, especially for staff with lived experience, may have also mirrored their own lived traumas.

Despite these challenges, **interviews with program leads and staff attested 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 expressed enthusiasm for investment in the programs they led, with many also integrally involved in program design and ongoing execution. Although their direct involvement in and engagement with the programs varied, 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 evinced 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]

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 provided some indication that insufficient passion, fit, or self-efficacy was 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 brought to their roles***, crediting much of the successes of their programs to the individuals who carried 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 engaged and championed their programs**. Several program leads (and staff) described 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 were often 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: P09 I156]

> *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 described themselves as team efforts and many had multiple dedicated leaders who were critical to program implementation, **some relied 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 were staff in implementing organizations, often leadership and analysts, that were not formally assigned to (or funded by) the SB-82/833 program but provided very significant and often critical support to programs.

Despite the outsized role that champions played in many SB-82/833 programs, these individuals were 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 Theme Five

SB-82/833 pilot programs faced significant barriers related to sustainability, including challenges in identifying sources of funding and revenue and in data collection and reporting.

4.5.1 Funding and Revenue

For SB-82/833 programs, **significant efforts were aimed at achieving financial stability**, which was linked to the availability of sufficient funding sources to support program operations. Since SB-82/833 grant 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 were generally unstable with respect to funding**. Further, since grant funding was not, for all programs, sufficient to sustain their initial proposal 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, **SB-82/833 program implementation generally required efforts toward achieving funding stability.**

Programs attempted to achieve this stability by:

1. securing additional funding or generating revenue, as needed, to support ongoing operations
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 SB-82/833 programs reported that their operations were fully funded using the SB-82/833 Triage Grant alone, the rest relied on additional sources of funding or revenue to sustain their programs. **Table 10** summarizes how many additional sources of funding and revenue Phase 1 programs reported using: while six programs relied on only one additional source of funding or revenue, another six programs relied on between two and five additional sources. **Table 11** reports the sources of revenue and funding used by programs to sustain their ongoing operations by the number of Phase 1 programs that reported using it: billing Medi-Cal was 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 10. 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

Table 11. 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 provided additional context for understanding *how* programs used these additional sources of funding and revenue, including the challenges they posed to program implementation. While some programs structured 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 were often fruitless, especially as circumstances changed. For many programs, this 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:

> *…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 to programs whereby decisions made around a certain set of funding options constrained their future options**. With a landscape of future options that were 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 grant cycle.

Ultimately, **twelve programs were sustained through their entire grant cycles. All of these programs have also remained in operation through the end of 2023**. Three programs ended prior to the end of their grant cycles for reasons that included challenges with revenue and funding. Two of the programs that ended before the end of the grant cycle received grants of less than $1,000,000 and one received a grant over $5,000,000.

In 2021, program leads from all twelve of the fifteen programs that survived the grant cycle agreed that their implementing organization or agency was actively supporting the SB-82/833 program in identifying ways to replace program funding after the end of the grant period. Of the nine program leads also reporting on a specific sustainability plan in place in 2021, 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 six programs, four program leads were not confident in their program's sustainment and two neither agreed nor disagreed (see **Table 12** for Phase 1

program results). Three of the four programs with leads that were not confident in their sustainment ended before the end of the grant cycle.

Table 12. 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

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 13**. 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 14.**

Table 13. 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 14. 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 Theme Two, 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 15 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 15. 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 were 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.

4.5.2 Data Collection and Reporting

There was 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 16**). 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 workflow.

Program 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 16). 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 16. 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 17**).

Table 17. 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]

> *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]

> *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]

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 provided insight on how program implementation was oriented toward SB-82/833 Triage Grant program goals and the target activities that were intended to meet those goals.

4.6.1 Triage Grant Program Goals

Overall, programs engaged in a wide range of activities that fit with and addressed the stated goals of the SB-82/833 Triage Grant Program. Moreover, while Child/Youth programs and School-County Collaborative programs had some distinct SB-82/833 Triage Grant program goals, **many Child/Youth programs showed 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 demonstrated significant flexibility in aligning the SB-82/833 Triage Grant Program goals with their community and system needs, leading to **a statewide set of programs that varied in their specific operations yet coherently fit with broader-level aims and goals of the grant program**.

Goal 1: Expanding Crisis Prevention and Treatment Services

The overall intention of both Child/Youth and School-County Collaborative programs was 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. **SB-82/833 programs reported targeting care processes across the full crisis care continuum to address these goals**, though the specific areas of focus for each program varied. Previously described findings also indicate that program activities were oriented toward the *expansion* of options for crisis prevention and treatment. Survey responses from program leads provided 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.** All SB-82/833 programs expanded prevention and treatment services within or across care sectors in some way whether they were new or augmenting. While the details varied, **every SB-82/833 program did one or more of the following:**

Introduced 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 in appropriately responding.* [Child/Youth Program Lead: P11 I069]

Expanded 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]
Expanded the settings or sites at which mental health crisis services were 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. [Child/Youth Program Lead: P05 I056]
Provided services to youth and families with significant barriers, or who 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]

Increased 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]
Increased 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 were suitable for addressing needs that were not adequately met by other mental health programs in their 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. Program leads for the programs in operation for 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.** Program leads for all but one of the 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 one program lead, in a program that contracted its services to an external agency, responded "Don't Know."

Goal 2: Increasing Client Wellness

Programs addressed the goal of increasing client wellness by providing crisis services that were targeted to the specific mental health needs of their communities. Client wellness was also an identified priority and regular area of discussion in program workgroups, with program leads sharing details on how their program activities and services were designed to improve the wellness of youth and families, not just deliver services as such. Both workgroups and interviews attested 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 l079]

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 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 were both suitable for and effective at increasing client wellness, with only one responding, "Don't Know."

Goal 3: Decreasing Unnecessary Hospitalizations

Decreasing unnecessary hospitalizations and associated costs was a SB-82/833 Triage Grant program goal for Child/Youth Crisis programs. Unnecessary hospitalizations occur where hospitalization is used to address a crisis that could have been better managed by a lower (i.e., less invasive) service. The overwhelming majority of program leads at least somewhat agreed that the activities and services of their SB-82/833 program were suitable for and effective at reducing unnecessary psychiatric hospitalizations and associated costs. Exceptions were one School-County Collaborative program lead that responded that this goal was not applicable to their program, as it did not directly deliver acute crisis intervention or response, and the lead for one program that ended early in the grant period.

While not all SB-82/833 programs directly provided acute crisis intervention or response, **both Child/Youth and School-County Collaborative programs provided 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 and early intervention services aimed at identifying needs or crises before they escalate to the point where hospitalization is indicated.**

> *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]

2. **By providing plentiful, age-appropriate crisis services to improve the quality and depth of child and family crisis de-escalation.**

> *…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]

3. **By addressing the inappropriate (yet often necessary) 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 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…* [Child/Youth Crisis Program Lead: P14 l097]

As discussed in Theme Two, **in the absence of appropriate crisis facilities (e.g., crisis residential services, crisis stabilization units, mental health emergency or urgent care centers) and accessible outpatient clinics, emergency departments are likely to continue to be overutilized for youth mental health crises in counties throughout the state**. SB-82/833 programs 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 l076]

> *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 [in a hospital]… 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 l063]

Programs also provided their insights on the other contexts that led to unnecessary emergency department usage for mental health crises, including county policies, law enforcement practices, and broader dynamics of inappropriate emergency department utilization. In one county, a Child/Youth program clinician reported that the only way to initiate a youth psychiatric hospitalization of any kind is through an emergency department. A Child/Youth clinician in another county also explained that law enforcement often used emergency departments for mental health crises when they were unwilling to wait long periods for psychiatric mobile 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.

Goal 4: Reducing Unnecessary Law Enforcement Involvement

Reducing unnecessary law enforcement involvement and law enforcement cost was a SB-82/833 Triage Grant program goal for Child/Youth Crisis programs. Since programs varied in their operations and services, they also varied in the extent to which their services were likely to intersect 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 were 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 was 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, provided services that were more likely to result in *indirect* impacts on law enforcement involvement, while others worked directly with law enforcement or provided services that were intentionally targeted at reducing the burden on law enforcement for mental health response. One Child/Youth program was housed at a municipal police department, another Child/Youth program had one team co-located at a local sheriff's department, one School-County Collaborative program delivered programming to parents in partnership with a sheriff's department, and at least two programs were part of agencies that deliver mental health trainings to law enforcement. Many other programs, both school-based and not school-based, interacted with law enforcement more informally or on an as needed basis. These programs also described efforts to develop relationships with law enforcement but did so in less structured or formalized ways.

SB-82/833 programs provided services and activities that were aimed, either directly or indirectly, toward reducing unnecessary law enforcement involvement—or improving the quality of their involvement when it occurred and/or was legally mandated—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 occurred**.

> *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 l091]

> *…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 l222]

…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**.

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 drew attention to situations where law enforcement involvement was either necessary or where it was legally mandated but not necessarily indicated (that is, where unnecessary law enforcement involvement could be reduced through policy changes). A major area of law enforcement involvement in many counties concerned "5585" involuntary holds which often involve law enforcement either because:

1. the crisis itself involved a threat to safety to which law enforcement have been called to respond
2. law enforcement officers are empowered to write such holds by county policy
3. law enforcement officers are *not* permitted to write holds and must therefore coordinate with county behavioral health whenever 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 responses to 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 a hold in hands, which is scary for us, legally.* [Child/Youth Program Clinician: P12 I060]

Goal 5: Increasing 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 was a SB-82/833 Triage Grant program goal for School-County Collaborative programs. Despite significant variation between the School-County Collaborative programs, each was 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 were 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 described specific enhancements to school mental health services that were tied to these partnerships; that is, program leads and staff did not merely describe the introduction of new mental health supports in schools as such, but also new ways of integrating mental health supports and community resources into the broader 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 program leads and staff in 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 usually used in school settings**. Since school-based programs generally targeted a wide range of care processes using an impressively diverse array of agency, school, and community resources, 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 l033]

3. **By doing the above using a partnered approach—integrating and 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 l063, 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 l048]

…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 l053]

> *…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 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]

Goal 6: Developing Crisis Response Systems on School Campuses

Developing coordinated and effective crisis response systems on school campuses when mental health crises arise was 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 was 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 fourteen 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 involved 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 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… the schools greatly appreciate having staff that are in their regions that are available that they can call when there is a student in crisis. 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 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]

Goal 7: Engaging Parents and Caregivers

Engaging parents and caregivers in supporting their child's social-emotional development and building family resilience was 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 was 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" was in a program that contracted 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 was a frequently described component of all School-County Collaborative programs and most other school-based and school-focused Child/Youth programs. This was partially by design, as including parent (or peer) partners was a condition of the grant. In most programs, parent partners were called on to directly engage parents and caregivers to support their needs and clinicians and case managers engaged with parents through collaborative care and safety planning, generally via family-team meetings. **Programs providing a wider variety of services also described 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 many programs increased their involvement in developing new modes of engaging parents and caregivers. 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 [personnel] 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 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 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; they're not just making a single referral to one agency per se. 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]

Goal 8: Reducing 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 was a SB-82/833 Triage Grant program goal for School-County Collaborative programs. **Of the 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 or impossible 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 overall 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 was, at least on principle, 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 did not deliver direct services in schools. One Child/Youth program also reported that their program activities were 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 designed to meet this goal or believed they had been able to address it under the conditions of the pandemic, interviews with some programs' leads and staff revealed 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 coming 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 the 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 Outcomes

This section describes how program implementation addressed the target activities hypothesized in our evaluation framework. Since assessing program outcomes is beyond the scope of a formative evaluation, these findings instead provide considerations for the measurement and interpretation of these activities and their proximal outcomes. In particular, it summarizes **the ways that programs engaged with target activities that were customized to their particular system structure and community needs.**

Target 1: Cultivating Partnerships

Cultivating partnerships, both in and outside of implementing organizations and program settings, was a major way that programs addressed their own program goals and 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, evidence strongly points to the ongoing importance of these partnerships to program implementation**.

The corresponding proximal program outcomes hypothesized in the evaluation plan for cultivating partnerships were 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. Interviews, however, revealed that focusing on the use of MOUs to form new partnerships inadvertently prioritized formal partnerships over the informal partnerships and relationships that program leads and staff *also* emphasized in describing their work. While formal partnerships were often necessary to early program implementation, once programs were in operation, more highly complex and extensively networked programs did not necessarily have the time and resources to formalize agreements with every agency or organization with whom they had important ongoing collaborative relationships. Moreover, the disruptions of the COVID-19 pandemic likely inhibited the development of new MOUs even where they might otherwise have been pursued.

This was 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 does not capture important relational elements of partnership, that is, the complex interlinkages that programs often describe as the real assets to their programs.

Target 2: Integrating Program Teams

Programs reported engaging in activities to integrate their program teams, in support of both SB-82/833 Triage Grant Program goals and their own program goals, but encountered barriers to doing so. The corresponding proximal program outcomes hypothesized in the evaluation plan for integrating program teams included three markers of team integration:

1. development of new communication channels within the implementing organization
2. changes in hiring or staff allocation
3. task shifting over time

Program personnel described the development of new communication channels within their organizations and how these lines of communication were both challenged by and, in some cases, enhanced during the pandemic. While some programs made regular adjustments to their staff allocation and reorganized tasks to better integrate their teams, **the same programs that were generally less willing to adapt their program**

operations were also rigid in their communication channels and staff allocation patterns, with negative effects on program sustainment. All three markers of team integration were also directly impacted by workforce challenges, which suggests that **improvements in team integration that program make may merely offset staff turnover, gaps, and challenges hiring qualified staff.**

Target 3: Linkage of Agency/School Supports and Referrals

Virtually all SB-82/833 programs were engaged in activities to link clients to supports and referrals appropriate to their service settings and twelve of fifteen programs identified referral as one of their program's main target areas. 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 referred youth and families.

The corresponding proximal program outcomes hypothesized in the evaluation plan for the linkage of agency/school supports were the *number* and *type* of links or referrals made. A major finding is that **youth crisis triage programs generally struggled to comprehensively track or report their referrals and linkages** for at least one of several reasons:

1. the agency or program's internal data tracking used paper records or entries in databases that were not designed for abstraction or export
2. their records on referrals were limited, such as only referrals to county services or certain types of services only (generally those that were billable)
3. their records on referrals did not differentiate between referrals that were incomplete versus those that were completed, meaning that the youth or family utilized the resource to which they were referred

Some programs were unable to provide any complete data on referrals made during the evaluation period, some others could provide data on the number of referrals but were not able to report on the specific types. Further, interviews with program data analysts and clinical staff and reviews of the aggregated data provided by programs support a discrepancy between the amount and types of referrals programs made and their reporting of those activities. Perhaps most critically given the goals of the grant program, most programs lacked capacity to comprehensively report the number of referrals to psychiatric hospitalizations that their programs made, generally because they only stored this data in an abstractable record when the hospitalization occurred at a county facility.

This lack of data capacity affected the ability for program outcomes to be evaluated as well as the ability of programs to internally track their own referral patterns and address potential problems in program implementation. Indeed, at least one program reported figures on referrals to psychiatric hospitalization that were highly variable and may point to significant differences in the rate of psychiatric hospitalization in particular communities were delivered.

As a result, programs were more likely to have data on referrals to clinical and billable services but not their efforts toward non-clinical and non-mental health referrals, even if those amounted to a large percentage of the program's operations. Many reasons were identified by programs to explain the lack of available data, including:

- lack of data infrastructure, including the use of legacy systems by county agencies
- incompatibility of data systems between agencies
- insufficient staff capacity to systematically record relevant data elements
- insufficient staff capacity to consistently engage in a "warm" hand-off or follow-up
- need to protect staff time for core program components
- lack of funding or resources for data management

Target 4: Delivering Crisis Prevention and Intervention Services to Clients

SB-82/833 programs were 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 provided some direct services to students in schools. Only one program did not provide direct services as part of its SB-82/833 program, but provided support and other system enhancements to the units in its organization that deliver prevention and intervention services.

The corresponding proximal program outcomes hypothesized in the evaluation plan for delivering crisis prevention and intervention services to clients are the number and type of services delivered. Interviews and direct feedback from programs on survey development provided the evaluation team with a rich understanding of the overall types of services provided by programs and confirm that **data collected on program services did not comprehensively capture the services they delivered**. Many of the same challenges in reporting referrals made by programs also applied to the services that they delivered directly. The data collected by programs for internal monitoring or compliance purposes often systematically underreported services that were: not already documented in existing workflows, not billable, provided in non-mental health settings (such as classrooms), and/or non-clinical (such as case management and follow-up). For programs in schools, data reporting was further complicated by challenges quantifying services delivered during schoolwide initiatives. Many programs also found it more challenging to report their services once the COVID-19 pandemic disrupted their routine workflows.

Target 5: Delivering Mental Health Trainings and Activities

Many, but not all, SB-82/833 programs delivered mental health trainings and activities within their program and other sites. As expected, **these activities were especially**

relevant to School-County Collaborative programs, though all school-based programs and some other Child/Youth programs also provided 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 they needed to preserve their strained resources during the pandemic for delivering their core crisis response and intervention services.** As described in Theme 2, 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. Even more than referrals or services delivered, however, interviews and data provided show that **trainings and non-personalized, non-clinical activities were not recorded systematically by most programs**. While program leads and staff in most programs were able to extensively describe the role of trainings and activities in their programs, only a third of programs were able to provide detailed accountings of their trainings and activities across most quarters. More programs had records on their internal staff trainings and community outreach activities than on the activities they delivered with other staff or teachers, parents and caregivers, and child or family activities, even if such activities were reported to be a major component of their program.

5. Case Studies for School-County Collaborative Programs

Examining each of the four School-County Collaborative program grantees as an individual “case” made it possible to explore, in-depth, the features of each program that impacted its implementation while accounting for the specific contexts in which the program operates. Case studies therefore facilitated the identification of unique features of programs and the communities that would not otherwise be evident in an analysis spanning programs. In constructing narrative accounts of programs in their unique contexts, case studies also critically engaged with the *processes* and *progression* of program implementation over time, showing how separate themes are intertwined in practice. Looking across these single cases therefore allowed for stronger comparisons between programs to identify potentially generalizable findings across school-county partnerships.

This section describes three major themes across the School-County Collaborative programs before presenting narratives of each program that put those themes into context and motion.

5.1 Major Themes for School-County Collaborative Programs

Major themes for the School-County Collaborative program case studies were identified in the thematic analysis and refined through the case study analysis process and through partnership with program personnel, our Advisory Board, and the MHSOAC. Through this process, three broad themes emerged as particularly important for understanding the development and implementation of each of these programs and shared factors *across* programs. These were:

1. findings on the characteristics of and variation in School-County Collaborative programs
2. findings on the complexity of School-County Collaborative program implementation
3. findings around the sustainability of School-County Collaborative programs

5.1.1 Variation in Program Characteristics

Building on findings in Theme One on variation between programs in their settings, care processes, maturation, and funding, the case analysis suggests an especially high degree of variation across the four School-County Collaborative programs. Not only did these programs operate in significantly different outer settings with respect to

community characteristics and needs, but they varied considerably in the **care processes they delivered**, the **intended targets and reach of their programs**, the **settings in which they operated**, and the **partnership models adopted** to facilitate their collaboration.

Community Characteristics and Needs

While the thematic analysis addressed the wide range of community characteristics and needs that programs variously considered when designing and implementing their programs, the case narratives allowed a deeper examination of the *particular* characteristics of each community, including whether it served a predominantly **urban or rural region**, the specific **underserved groups** present in the community, unique **community needs** identified by program staff, and other distinctive **characteristics of the community that may affect service uptake and delivery**, such as the existing service system, community resources, and prevailing norms.

Care Processes

All four School-County Collaborative programs targeted prevention, early intervention, acute crisis, and referral services in their operations. Three of the four programs provided treatment outside of the context of immediate crisis response and community outreach activities. Half offered some form of care coordination or case management. One program did not directly deliver services, but provided direct administrative support to expand crisis services in schools.

Program Targets and Reach

School-County Collaborative programs varied in both the specific student populations they targeted as well as in the overall reach of their programs within the county. Programs variously aimed to provide universal interventions to all students, interventions for students identified as “at risk” of mental health challenges, and/or intensive individualized interventions for students with specific identified needs.

Programs also targeted students at different levels of education, with some targeting primary or secondary schools or particular grade levels. Relatedly, programs also varied in their reach across their county with some aiming to provide interventions throughout their entire county, only in particular school districts, or only in particular schools.

Partnership Models

While all four School-County Collaborative programs constituted formal partnerships with local education agencies, the specific partnership models adopted by programs varied significantly. Programs involved **partnerships with education agencies at different levels**, ranging from county offices of education at the broadest level to particular school districts and/or SELPAs and even individual schools. The

administrative and organizational structures of these partnerships also varied:

- one School-County Collaborative program was administered by the county children's mental health agency and staffed by both the county and individual school districts
- one was run by a consortium of local education agencies (LEAs) that provides support and services to their member districts
- one was administered by the county office of education and has partnerships with school districts
- one was co-administered by the county children's system of care and the county office of education and has partnerships with school districts.

Program leads were also able to provide insight on the factors and decision points leading to the particular partnership model chosen by their county, which included existing services (and gaps) in the local mental health and/or educational systems, previously established partnerships, their intended targets and reach, and their evaluations of which partners were best optimized to achieve the specific goals of the county.

5.1.2 Program Complexity

As discussed in Theme One, School-County Collaborative programs were generally complex in their organizational, structural, and regulatory features. While complexity was sometimes necessary for programs involving multiple collaborators, serving large populations, addressing particularly challenging issues and needs, or working across sectors, **the level of intricacy involved in program implementation impacted the ease with which it could be executed.** Since the School-County Collaborative programs generally targeted a larger number of care processes than non-school-based programs, required a greater degree of cross-sector partnership, and operated at more sites with separate specialized teams, this meant they also tended to feature greater organizational and structural complexity. This larger matrix of cross-sector organizational partners, program teams and units, and service settings also meant that School-County Collaborative programs needed to achieve compliance within multiple regulatory systems in carrying out their services and activities, most notably those within the mental health and educational sectors.

5.1.3 Sustainability

Funding and Revenue

Although the most common additional funding support across all Child/School and School-County Collaborative programs was Medi-Cal reimbursement, among School-County Collaborative programs the most commonly cited sources of support were other MHSA funds and school and school district funds. **Leads and personnel from all four**

School-County Collaborative programs described significant challenges and limits in the use of Medi-Cal for school-based services, as described in Theme Five.

Future Sustainment

All four School-County Collaborative programs operated throughout the entire grant cycle and reported substantial contributions made by their grant funded program to broader county initiatives for school mental health supports. **Programs continued to rely on some of the same additional sources of support, including other MHSA grants and county and school funds**.

5.2 Case Study Narratives

The case study narratives include:

1. An **overview of the program's basic goals, design, and components**
2. A **narrative timeline of the program over the grant period**, highlighting relevant changes in the program over time as well as changes in the facilitators and barriers identified by individuals involved in implementation
3. Sections detailing how the three main themes described in section 5.1—**community context, complexity, and sustainability**—played out in the program during the grant period

5.2.1 Case One

Program Overview

School-County Collaborative program 1 placed social workers and peer partners in schools through multi-year contracts with individual county schools. Each school under contract was provided grant-funded personnel for one year under the condition that they commit to funding a second year of personnel support. The program was administered and overseen by the county Office of Education, with support from county Department of Mental Health. Program personnel were generally on-site one day a week at each of the four schools and had one day a week for case coordination, documentation, and preparing programming and trainings. In addition to providing direct services and support in schools, program personnel could also refer students to county mental health for ongoing treatment.

School-County Collaborative program 1 emerged from a previous project by the county Office of Education in partnership with county Department of Mental Health to provide a social worker to a small school district in the county. The initial design of the program was to provide access to a social worker and a peer partner in two-year cycles to a total of 64 school sites within the county: 32 schools in the first two-year cycle, and another

32 schools in the second two-year cycle. Following budget cuts, the number of partnered schools was reduced to 24 for each cycle.

Program Timeline

Although budget cuts lead to the downsizing of the program to available funds, existing relationships with county agencies and other community partners facilitated early implementation at schools across the county. The timing of the COVID-19 pandemic, however, complicated the planned transition between the two-year cycles of school site support. The second two-year cycle began in the 2020-2021 school year, at which point county schools were still navigating COVID pandemic public health orders from the state. While the transition took place as planned, the timing of the transition alongside the unique and fast-moving circumstances of the pandemic created workforce challenges for the program, including challenges with retention and managing staff workload and strain.

Community Context

Program personnel highlighted the small, rural nature of many communities in the county alongside significant cultural and linguistic diversity. Program personnel reported limited existing community resources for mental health services and few to no pre-existing mental health resources in public schools. Thus, the program was observed to fill significant gaps in county services for youth mental health. Other pre-existing barriers to service delivery described by program personnel included cultural stigmas around mental health and limited community access to resources, such as high-speed internet, that can facilitate youth and family engagement in mental health services.

Complexity

The program was organizationally and structurally complex since it required coordination with multiple school sites. However, its leadership and administration were relatively centralized and streamlined, which reduced the burden of this complexity. Coordinating with multiple different school sites led to more time-intensive engagement efforts with schools, as well as some transitional difficulties between the two-year school site cycles as social workers worked to establish new relationships with schools and youth during the height of the pandemic school closure.

Sustainability

The primary sustainment plan for this program involved continuing to partner with individual schools to co-fund program operations, using a combination of external funding sources to substitute for SB-82/833 funds. The program leads reported use of another state grant program under the Mental Health School Services Act (MHSSA) to expand the program. Due to county policy, the program could not bill Medi-Cal for any program services but reported working toward contracts with two managed care

providers to make some reimbursement possible. The program described considerable success in securing matching funds from schools, but noted that the funding model essentially disqualified the smallest and most under-resourced schools from being able to participate in the program, limiting dissemination and cross-county sustainability despite the program improving services access for participating areas.

5.2.2 Case Two

Program Overview

School-County Collaborative program 2 delivered direct mental and behavioral health services at wellness centers in select county elementary, middle, and high schools. This program was a collaboration between the county office of education, the county's integrated children's system of care, and two school districts. The children's system of care acted as the administrative lead on the grant, with the county Office of Education managing program operations and staffing under the oversight of the children's system of care. In addition to two coordinators, the grant funded a mental health specialist (social worker, MFT, or LPCC) and a peer and parent partner for each school wellness center. These staff variously provided drop-in services for students, engaged families and connected them with mental and behavioral health resources, delivered universal interventions in schools and classrooms, and provided support and workforce development to school staff.

School-County Collaborative program 2 was designed to support more intensive and collaborative implementation of an existing multi-tier system of support (MTSS) model required in all county schools. Understanding that resources for implementation were limited at many schools, the intention of the grant was to provide on-site staff to support the universal, small-group, and individualized interventions within the MTSS model. While budget cuts reduced the number of schools in which wellness centers could be staffed with grant funding, the wellness centers introduced new services such as specialists and peer/parent partners that had not previously been available at county elementary and middle schools and new collaborative activities between the educational and behavioral health sectors. A strong emphasis for the program was to "braid" school supports with other community organizations and agencies.

Program Timeline

Though funding cuts led to a re-scaling of the program and delayed program start, the county successfully executed the School-County collaborative program alongside the simultaneous implementation of an SB-82/833 Child/Youth grant. While the timing of the COVID-19 pandemic school closures required personnel to navigate rapid pivots between in-person and virtual work, the program benefitted from the county's strong existing integrated system of care and administrative leads having extensive experience within that system of care. Despite reported workforce challenges, particularly in recruiting personnel with requisite credentials, the program remained in operation for

the duration of the grant period. However, the program faced significant challenges aligning the grant with the school year calendar, including the standard hiring seasons of the educational sector—an important issue for planning future service extension programs.

Community Context

Program personnel described the county as distinct for its integrated children's system of care and the multi-decade collaborative relationship between that system of care and the county Office of Education, which facilitated program development and operation. While the county is distinct for the relative affluence of some of its communities, personnel reported that this affluence belies the extent of mental health need in schools and noted that existing community resources for youth mental health were inadequate to meet this need. Personnel also reported changes in communities in the county, including increasing cultural diversity, that emphasized the need for resources to address emerging needs for culturally sensitive mental health services.

Complexity

This program was organizationally and structurally complex compared to most SB-82/833 Child/Youth programs, involving placement of personnel at multiple school wellness centers. However, it was structured in a relatively streamlined manner compared to other School-County Collaborative programs due to the organizational model of the county system of care. Since the program was intended as proof of concept for a model that could be scaled up to include more districts or schools, however, it is possible that additional barriers to implementation, similar to those of more structurally complex programs, could emerge.

Sustainability

Despite the relative affluence of local communities, program leads reported major challenges in securing adequate local funding for school mental health. The primary sustainment plan for this program involved continuing to braid funding sources including local MHSA funds, an MHSSA grant, and revenue from service reimbursements where possible. Personnel noted that some revenue sources, such as Medi-Cal reimbursement, were inadequate for sustaining programs that aim to provide services to all students regardless of insurance status. Leads also reported challenges in pursuing reimbursement from private insurance for services delivered in school settings.

5.2.3 Case Three

Program Overview

School-County Collaborative program 3 was a school-based mental health crisis

response program focused on the entire county. In simplest terms, this program was a collaboration between two entities: county Department of Mental Health and the county Office of Education. County Department of Mental Health was the primary administrator of the program and provided the program with six clinicians, each hired to serve one of six units: five representing a specific region of the county as well as a unit that served the age 0-5 population for the entire county. On the school side of the partnership, the county Office of Education partnered with five school districts, one in each of the five county regions plus the countywide 0-5 conglomerate, each of which independently hired and supervised program staff acting in the capacity of a case manager. The program aimed to have a clinician and case manager based at a school in each unit available to co-respond to crisis referrals from all schools in that region and provide support and linkage, regardless of the students' ability to pay, or their insurance status.

School-County Collaborative program 3 was described by leads involved in its design as the result of aligned goals between school and county mental health systems. Acknowledging the county's lack of infrastructure to support student mental health needs in schools, the county Department of Mental Health and Office of Education officials started meeting regularly to discuss common goals and better serve students. Though funding cuts led to a re-scaling of the program and delayed program start, the county successfully executed the School-County Collaborative program alongside the simultaneous implementation of an SB-82/833 Child/Youth grant. While the timing of the COVID-19 pandemic school closures required personnel to navigate rapid pivots between in-person and virtual work, the program benefitted from the county's strong existing integrated system of care and administrative leads having extensive experience within that system of care. Despite reported workforce challenges, particularly in recruiting personnel with requisite credentials, the program remained in operation for the duration of the grant period. However, the program faced significant challenges aligning the grant with the school year calendar, including the standard hiring seasons of the educational sector—an important issue for planning future service extension programs. These conversations continued for about five years when the SB-82/822 Crisis Triage grant(s) arose, allowing this existing communication and collaboration to be formalized through implementation of the School-County Collaborative grant. The county also received an SB-82/833 Child/Youth crisis triage grant, allowing further cross-sector collaboration as the two grant programs coordinated their service delivery.

Program Timeline

Though funding cuts also led to a re-scaling of School-County Collaborative program 3, the county successfully executed their program alongside the simultaneous implementation of the SB-82/833 Child/Youth grant. The two grant programs reported substantial collaboration in the form of an emerging division of labor for youth crisis response, with the School-County Collaborative program increasingly taking the lead on mental health crises in schools and co-response by the two programs where complex community needs arose, such as in the aftermath of natural disasters or acute community social crises. The program also benefitted from continued efforts to expand community partnerships, which helped mitigate challenges including high community

need following reopening of schools and significant workforce challenges in hiring and retention that accelerated over the course of the COVID pandemic. Like program 2, however, the program also reported challenges aligning the grant with the school year calendar, including the standard hiring seasons of the educational sector.

Community Context

Program personnel emphasized the expansive and mostly rural character of the county, with many isolated communities lacking basic infrastructure for mental health services. Personnel described the need for extensive collaboration with community organizations to address distinctive community needs, which included the needs of local tribal Nations and other local indigenous communities, local challenges with generational poverty and substance use, and distinctive local cultural norms which entail distrust of the service system or government more broadly. Many of the same factors that posed barriers to service delivery also made it challenging to recruit and retain program staff, especially in the most isolated regions of the county.

Complexity

School-County Collaborative program 3 was high in all three types of complexity, with significant challenges related to organizational and structural complexity (as well as suggesting the need for support around regulatory complexity). Since the program was organized both in multiple units across the county as well as administratively divided across two major county agencies, this considerably increased the administrative lift of the program. This was most evident in challenges with workforce management, which was already a challenge in isolated, rural communities.

Sustainability

Similarly to other counties, program leads reported major challenges in accessing adequate local funding for school mental health. In addition, they noted the inadequacy of available revenue streams, particularly Medi-Cal, in sustaining programs that aim to provide services to all students regardless of insurance status. Like program 2, School-County Collaborative program 3 planned for program sustainment by braiding a combination of local and state MHSA funds (including an MHSSA grant) with Medi-Cal and private insurance reimbursement where possible.

5.2.4 Case Four

Program Overview

School-County Collaborative program 4 is a supplemental support team for an existing county-wide multi-tiered system of support (MTSS) carried out in the county's 19 local education agencies (LEAs), which include both public school districts and charter

schools in the county. The administering organization of this grant is a 14-year-old public education consortium with joint power authority and composed of three collaborative units: the public education Special Education Local Plan Area (SELPA), the charter school SELPA, and a student services agency that operates direct mental and behavioral health service programs for students in both SELPAs as well as in other community settings. The SB-82/833 program provides staff that support the consortium's MTSS programs but does not provide direct services to students; namely administrators to coordinate MTSS efforts across the consortium, intervention specialists to provide support to district staff around direct service delivery, and community services assistants to support the peer and parent partners in a set of districts. While not providing direct services, grant-funded staff variously deliver community outreach activities, provide parent and caregiver trainings and resources, offer referral assistance for families in need of basic and mental health supports, facilitate universal screenings and interventions in particular districts and schools, and deliver partnered programming with other agencies.

Program Timeline

Despite ongoing staffing issues described by the implementing agencies, the program's operations were not significantly delayed by the start of COVID-19 pandemic since they supported an existing system of support that was already in place prior to the pandemic. The program did, however, describe variations in readiness and leadership buy-in for MTSS across districts and schools that impacted progress toward greater fidelity in the use of these supports.

Community Context

Program personnel described the county as urban but decentralized, with expansive rural areas dotted by isolated communities and entrenched challenges with basic needs in the community, especially housing and access to high-speed internet. Additionally, personnel reported limited community resources for mental health services, underscoring the need for mental health supports for youth in schools.

Complexity

While the MTSS supported by SB-82/833 personnel was quite complex in its organization and administration, the grant funded aspects of the program were relatively centralized and low in regulatory burden compared to the other three School-County Collaborative programs since SB-82/833 funded staff do not provide direct services to students.

Sustainability

Similarly to other counties, program leads reported major challenges in accessing adequate local funding for school mental health and noted the inadequacy of available

revenue streams, particularly Medi-Cal, in sustaining universal interventions. Unlike the other School-County Collaborative programs, since the crisis triage personnel in this program do not provide direct services, Medi-Cal and private insurance cannot be used to sustain operations after the grant ends.

School-County Collaborative program 4 planned for program sustainment by braiding a combination of local and state MHSA funds (including an MHSSA grant) with Medi-Cal and private insurance reimbursement where possible. Other sustainment options program leads reported pursuing include contracts with LEAs and identifying ADA funding to support students and families with IEPs.

6. Lessons Learned and Recommendations

The findings from the formative evaluation were distilled into key lessons learned that form the basis of recommendations on future youth crisis triage program design and implementation, as well as future data collection and evaluation efforts.

Key Lesson One

The twelve SB-82/833 pilot programs that operated for the duration of their grant cycle made **substantial and promising contributions to youth mental health services in their counties and communities**.

- They were designed and implemented to **increase access to youth mental health services** 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 non-mental health settings, especially education, that are critical to youth mental health
- They took concrete actions throughout the grant period 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 could focus on their own responsibilities and areas of specialization
- These programs also **expanded mental health and crisis services in schools** by:
  - providing services and activities across the crisis 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

Recommendations:

1. **At the system-level:**
    a. State and county planners should prioritize the expansion of these promising pilot programs and other locally-designed crisis triage services in California communities.
    b. State and county agencies should promote initiatives to improve and standardize infrastructure and capacity in behavioral health agencies to better quantify the effects of these programs on client and population outcomes, such as hospitalization and law enforcement involvement in mental health crisis response.
2. **At the program-level**:
    a. Crisis triage programs should develop workflows to ensure that the data elements needed to analyze program outcomes and impacts are collected systematically and internally monitored in real-time for service improvement. These data are necessary to support quality improvement as well as to demonstrate program impacts to local planners and potential funders.

Key Lesson Two

The wide range of care processes involved in crisis triage combined with the extensive tailoring of programs to the specific needs of their communities and service systems led to high variation between SB-82/833 programs and complexity in their design and operations.

Recommendations

1. **At the system-level:**
    a. State planners should ensure that grant-funded crisis triage programs for youth are afforded enough flexibility to meet the local needs of their communities.
    b. State and county agencies should expect crisis triage programs to require significant time for advance planning *before the start of services* to resolve issues related to program complexity.
    c. State funders and county planners should anticipate, and plan for, a significant need for administrative resources, direct support or consultation, and collective learning opportunities (such as workgroups or conferences) to mitigate common problems among crisis triage programs due to their role filling gaps in service systems as well as their organizational, structural, and regulatory complexity.
    d. State and county agencies should promote initiatives to improve and standardize infrastructure and capacity in behavioral health agencies to better quantify the effects of these programs on client and population outcomes, such as hospitalization and law enforcement involvement in mental health crisis response.

2. **At the program-level:**
    a. Crisis triage programs benefit from a period of advance planning before services start to mitigate some of the challenges related to complexity (multiple sites or teams, multiple implementing agencies, multiple regulatory systems).
    b. Since school-based programs and other programs in non-mental health settings are especially likely to encounter complexity related challenges—such as navigating multiple bureaucracies, complex hiring and licensure restrictions, and multiple prevailing privacy laws (e.g., HIPAA and FERPA)—leads should take efforts to reduce the complexity of their programs wherever it isn't necessary to achieve core program goals. More streamlined administration, partnership models, and workflows are especially essential for programs with a lot of moving parts.

Key Lesson Three

Even successful SB-82/833 programs reported challenges ensuring that the resources needed for successful crisis triage—including community mental health infrastructure, providers, and program personnel—were sufficient to deliver their services with fidelity, especially with the COVID-19 pandemic exacerbating existing challenges in crisis triage service delivery.

Recommendations

1. **At the system-level:**
    a. State and county agencies should commit stable, long-term resources to expanding youth community mental health infrastructure so that programs providing crisis triage have access to facilities needed to provide appropriate stabilization and treatment for youth and families experiencing crisis.
    b. Where possible, state and county planners should ensure that the staffing volume of crisis triage programs is adequate to the intended reach of their programs. Increasing staff improves workloads, reduces proximity to secondary trauma, makes it easier for programs to hire a workforce that represents the diversity in California communities (including bilingual and bicultural personnel), and ensures that programs have adequate capacity for tracking and reflection.
    c. State and county funders should ensure that publicly-funded crisis triage programs have access to the resources needed for program delivery *besides* personnel, including administrative support, data analysts, funds for travel to ensure continuity of care and basic need supports for clients.
    d. Future personnel-only crisis triage grant programs would benefit from a more explicit process outlining the resources needed to successfully execute a given crisis triage program, the resources the grantee and

partners are expected to furnish, and concrete commitments on the part of grantee to supply those resources.

e. State and county planners should design programs that are appropriately scaled to available program and community resources so that programs are not incentivized to throttle their service delivery (by, for example, excluding known referral sources due to lack of capacity) or offer crisis triage services without access to the appropriate referral options to meet youth and family needs.
f. State and county agencies should commit resources to improving and crisis-proofing their integrated crisis response systems, since crisis triage programs can play a critical role in community response to public health or social crises.
g. Future evaluations, including evaluations of program outcomes, must take into account the broader availability of child mental health care resources and workforce capacity in the community the program serves.

2. **At the program-level:**
    a. Programs benefit from advance effort toward community resource mapping, either as part of a broader needs assessments or as an early program implementation process.
    b. Programs benefit from using partnerships to develop creative solutions to inadequate youth mental health community resources and share the burden of limited resources.
    c. Programs benefit from regular opportunities to exchange information and collaborate with other crisis triage programs about external resources that may mitigate against shared areas of challenge, strategies for securing funding and effectively using available revenue streams.

Key Lesson Four

The programs that were *least* successful in implementing their programs (including those that ended before the end of their grant cycle) were less adaptable, less willing to use new partnerships to support program implementation, and had lower leadership engagement and/or greater conflicting priorities among leadership at the county level.

Recommendations

1. **At the system-level:**
    a. Crisis triage grant programs benefit from explicit terms and procedures for adapting core program components that are communicated to and understood by grant awardees. This avoids any confusion in grant terms resulting in programs taking insufficient steps to adapt and improve their program operations.
    b. Crisis triage grant programs also benefit from regular channels for communication between the funder and grantee that encourage regular reporting of challenges necessitating program adaptation.

   c. State and county officials would benefit from promoting initiatives to establish best practices for developing partnerships across sectors, such as behavioral health, education, and law enforcement, so that programs better understand the options and strategies available.

2. **At the program-level:**
   a. Program leadership for youth crisis triage programs should plan to regularly re-evaluate program operations, services, and outcomes so that adaptations can be made in real-time for quality improvement.
   b. Programs benefit from dedicated time for building necessary partnerships, including leadership support for these initiatives. Programs that put less time into their regular communication with partners or were in a county that disincentivized or discouraged the development of new partnerships by programs had greater challenges adapting and mitigating limited community resources.
   c. Programs strongly benefit from partnerships that involve leadership at all levels, bringing all the relevant actors to the table on a regular basis rather than relying on hierarchical or segmented communication channels. Such partnerships also promote greater leadership engagement and sense of ownership among partners.
   d. Programs benefit from taking advance steps to define relevant roles and responsibilities among their partners to avoid problems with role ambiguity or conflicting expectations. This also eases tensions in programs set in non-mental health settings (such as schools, emergency departments, and police department), wherein existing leads or staff may be at varying degrees of understanding and readiness to support mental health services in their setting.
   e. Programs may have to engage in extensive engagement with their own local leadership to achieve buy-in for their programs, especially for programs operating across sectors in which each of the implementing agencies may have significant different prerogatives with respect to the importance and function of crisis triage.
   f. For crisis triage programs that are partnered or work closely with services at a higher level of acuity and urgency, such as psychiatric mobile response teams, emergency departments, or police departments, concerted efforts are necessary to ensure that triage functions are not deprioritized.

Key Lesson Five

All programs, whether more or less successful in implementation, grappled with workforce challenges in hiring and retention that they relied on dedicated staff “champions” to manage.

Recommendations

1. **At the system-level:**
    a. State planners should support initiatives to holistically develop the youth behavioral health workforce to support placement of crisis triage personnel in community settings, especially in smaller and more rural counties. This includes support for education and career development to increase the number of qualified crisis triage personnel in the workforce.
    b. State, county, and local agencies would benefit from considering reforms to licensure requirements to expand the number of individuals able to provide crisis triage services by reducing conflicts in standards across sectors.
    c. County planners should ensure that they offer providers a competitive salary scale to attract qualified candidates for vacant positions and to avoid high turnover.
2. **At the program-level:**
    a. Crisis triage personnel benefit from regular supervisions to detect signs of burnout.
    b. Programs benefit from investing in workforce development initiatives to support their program personnel.
    c. Programs should regularly re-evaluate staffing patterns and roles to reduce the burden of secondary and vicarious trauma on individual program personnel, where possible. Rotating roles in close proximity to trauma may reduce strain on the personnel providing crisis care.
    d. Since some turnover is inevitable and programs often depend heavily on experienced champions, programs would benefit from concerted efforts to build program and institutional knowledge so that critical program capacity isn't lost with the resignation or retirement of an individual.

Key Lesson Six

Even successful programs faced significant challenges identifying and securing appropriate stable, long-term funding and revenue options for their youth crisis triage programs.

Recommendations

1. **At the system-level:**
    a. Funders should work to ensure that programs receiving grant funds do not have their awards significantly impacted by budget cuts, even if this means planning around the possibility of cuts. Contingency planning should be incorporated into the grant proposal process to ensure that programs are less impacted when cuts occur and have plans for securing supplementary funds.
    b. State and county planners should incorporate mechanisms throughout the grant and program development process to plan for long-term

sustainment, including working to ensure that state and local planning processes incorporate *stable* support for youth crisis triage so programs do not have to rely on a complicated patchwork of funding that reduces their flexibility and complicates their goal alignment.

c. State initiatives to reform Medi-Cal, such as CalAIM, should continue to prioritize the expansion of community supports, including short-term recovery and housing supports for youth and families experiencing mental health crisis, as these are among the most difficult for crisis triage programs to sustain using existing billing models.
d. State initiatives to expand mental health crisis services in non-mental health settings, such as schools, should also include efforts to create new revenue and funding channels for the services and activities that are hardest to bill to Medi-Cal, including universal supports, prevention and early intervention services, parent and community engagement.
e. Since initiatives to promote crisis triage require data to track their implementation and effectiveness at meeting target outcomes, state and county planners should work to improve and standardize data elements for tracking crisis triage service delivery and associated client and population outcomes. This includes statewide standardization of data infrastructure, as supported by CalAIM.

2. **At the program-level:**
    a. Sustainability planning was smoother for programs with a higher and more consistent level of engagement with leaders across the sectors their programs operated in, allowing them to demonstrate the value of their programs to planners in multiple agencies.
    b. Programs benefit from administrative and data support from the beginning of implementation to identify appropriate data elements for tracking key program activities and goals.

Key Lesson Seven

School-County Collaborative programs and school-based Child/Youth programs demonstrate the importance of schools for the delivery of youth crisis services and highlight the distinctive challenges of working across the educational and behavioral health sectors.

Recommendations

1. **At the system-level:**
    a. Initiatives to expand school-county and other educational-behavioral health partnerships must be directed at every level of partnership, including initiatives to increase buy-in from schools and school districts on mental health services.
    b. The COVID-19 pandemic demonstrated that programs serving youth and families rely heavily on schools, so system-level efforts to expand

educational-behavioral health partnerships should also promote the expansion of formal and informal partnering between non-school based mental health crisis triage programs and local educational agencies.

2. **At the program-level:**
    a. School-based programs 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.
    b. Since some programs were aimed at introducing mental health services to schools that were otherwise inexperienced, programs would benefit from additional support toward achieving school readiness, including built in time to get buy-in from school/school districts.
    c. 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.
    d. Alignment of grant funding with the school year would ease implementation of school-based programs. Programs benefit 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.

7. Limitations

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.

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.

8. Conclusion

This report summarized the formative evaluation of Child/Youth and School-County Collaborative Triage programs funded by the second round of the SB-82/833 Triage Grants. Findings from this evaluation shed light on the intricacies of implementing child and school-based crisis triage programs. While navigating mental health care systems may be complex, these programs addressed specific and tailored needs in their communities, highlighting the importance of crisis triage programs. The lessons learned and recommendations drawn from their experiences provide key areas of focus for future program implementation. Together with the formative evaluation of the SB-82/833 Adult/TAY programs, led by UC Davis, and the summative evaluation led by the MHSOAC, this evaluation will provide a statewide story of the mental health landscape in California and support future mental health program implementation.

References

Bayliss, E. A., Bonds, D. E., Boyd, C. M., Davis, M. M., Finke, B., Fox, M. H., & Stange, K. C. (2014). Understanding the context of health for persons with multiple chronic conditions: Moving from what is the matter to what matters. *The Annals of Family Medicine*, *12*(3), 260–269. https://doi.org/10.1370/afm.1643

Braithwaite, R., & Warren, R. (2020). The African American petri dish. *Journal of Health Care for the Poor and Underserved, 31*(2), 491–502. https://doi.org/10.1353/hpu.2020.0037

Bromley, E., Figueroa, C., Castillo, E. G., Kadkhoda, F., Chung, B., Miranda, J., Menon, K., Whittington, Y., Jones, F., Wells, K.B., & Kataoka, S. H. (2018). Community partnering for behavioral health equity: Public agency and community leaders' views of its promise and challenge. *Ethnicity & Disease*, *28*(Suppl 2), 397–406. https://doi.org/10.18865/ed.28.S2.397

Chambers, D. A., Glasgow, R. E., & Stange, K. C. (2013). The dynamic sustainability framework: Addressing the paradox of sustainment amid ongoing change. *Implementation Science, 8*(1), 117. https://doi.org/10.1186/1748-5908-8-117

Chambers, D. A., & Norton, W. E. (2016). The adaptome: Advancing the science of intervention adaptation. *American Journal of Preventive Medicine*, *51*(4), S124–S131. https://doi.org/10.1016/j.amepre.2016.05.011

Choi, K. R., Martinez-Hollingsworth, A., Mead, M., & Dappolonia, M. S. (2020). Adolescent psychiatric emergencies precipitated by the COVID-19 Pandemic. *Journal of Psychosocial Nursing and Mental Health Services.* https://doi.org/10.3928/02793695-20201203-05

Chowkwanyun, M., & Reed, A. L. (2020). Racial health disparities and Covid-19—Caution and context. *New England Journal of Medicine*, *383*(3), 201–203. https://doi.org/10.1056/NEJMp2012910

Couch, K. A., Fairlie, R. W., & Xu, H. (2020). Early evidence of the impacts of COVID-19 on minority unemployment. *Journal of Public Economics*, *192*, 104287. https://doi.org/10.1016/j.jpubeco.2020.104287

Czeisler, M. É., Lane, R. I., Petrosky, E., Wiley, J. F., Christensen, A., Njai, R., Weaver, M. D., Robbins, R., Facer-Childs, E. R., Barger, L. K., Czeisler, C. A., Howard, M. E., & Rajaratnam, S. M. (2020). Mental health, substance use, and suicidal ideation during the COVID-19 pandemic—United States, June 24–30, 2020. *Morbidity and Mortality Weekly Report, 69*(32), 1049–1057. https://doi.org/10.15585/mmwr.mm6932a1

Creamer, E.G. (2018). *An introduction to fully integrated mixed methods research.* Sage Publications.

Damschroder, L. J., Aron, D. C., Keith, R. E., Kirsh, S. R., Alexander, J. A., & Lowery, J. C. (2009). Fostering implementation of health services research findings into practice: A consolidated framework for advancing implementation science. *Implementation Science, 4*(1), 1–15. https://doi.org/10.1186/1748-5908-4-50

Dedoose, web application for managing, analyzing, and presenting qualitative and mixed method research data (Version 8.0.35). (2018). SocioCultural Research Consultants, LLC. www.dedoose.com

Feller S. C., Castillo, E. G., Greenberg, J. M., Abascal, P., Van Horn, R., Wells, K. B., and University of California, Los Angeles Community Translational Science Team. (2018). Emotional well- being and public health: Proposal for a model national initiative. *Public Health Reports*, *133*(2), 136–141. https://doi.org/10.1177/0033354918754540

Galea, S., Merchant, R. M., & Lurie, N. (2020). The mental health consequences of COVID-19 and physical distancing: The need for prevention and early intervention. *JAMA Internal Medicine*, *180*(6), 817–818. https://doi.org/10.1001/jamainternmed.2020.1562

Jones, L., & Wells, K. (2007). Strategies for academic and clinician engagement in community- participatory partnered research. *JAMA, 297*(4), 407–410. https://doi.org/10.1001/jama.297.4.407

Klassen, A. C., Creswell, J., Clark, V. L. P., Smith, K. C., & Meissner, H. I. (2012). Best practices in mixed methods for quality of life research. *Quality of Life Research, 21*(3), 377–380. https://doi.org/10.1007/s11136-012-0122-x

Kohli, S. & Blume, H. (2020, March 31). Coronavirus-caused LAUSD school shutdown worsens inequities as many students go AWOL. *Los Angeles Times*. https://www.latimes.com/california/story/2020-03-31/coronavirus-school-shutdown-students-awol

Landsverk, J., Brown, C. H., Chamberlain, P., Palinkas, L., Ogihara, M., Czaja, S., Goldhaber-Fiebert, J. D., Reutz, J. A. R., & Horwitz, S. M. (2012). Design and analysis in dissemination and implementation research. In R. C. Brownson, G. A. Colditz, & E. K. Proctor, (Eds.), *Dissemination and implementation research in health: Translating science to practice*. Oxford Scholarship Online. https://doi.org/10.1093/acprof:oso/9780199751877.001.000

Lee, J. (2020). Mental health effects of school closures during COVID-19. *The Lancet Child & Adolescent Health, 4*(6), 421. https://doi.org/10.1016/S2352-4642(20)30109-7

Marshall, T., Rapp, C. A., Becker, D. R., & Bond, G. R. (2008). Key factors for implementing supported employment. *Psychiatric Services, 59*(8), 886–892. https://doi.org/10.1176/appi.ps.59.8.886

Maxwell, J. A. (2005). *Qualitative research design: An interactive approach* (2nd ed., Vol. 41). Sage Publications.

McClure, E. S., Vasudevan, P., Bailey, Z., Patel, S., & Robinson, W. R. (2020). Racial capitalism within public health—How occupational settings drive COVID-19 disparities. *American Journal of Epidemiology*, *189*(11), 1244–1253. https://doi.org/10.1093/aje/kwaa126

Miles, M. B., Huberman, A. M., & Saldaña, J. (2014). *Qualitative data analysis: A methods sourcebook* (3rd ed.). Sage Publications.

Noelke, C., McArdle, N., Baek, M., Huntington, N., Huber, R., Hardy, E., & Acevedo-Garcia, D. (2020, January 21). Child Opportunity Index 2.0 Technical Documentation. https://www.diversitydatakids.org/research-library/research-brief/how-we-built-it

Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2015). Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Administration and Policy in Mental Health and Mental Health Services Research, 42*(5), 533–544. https://doi.org/10.1007/s10488-013-0528-y

Pfefferbaum, B., & North, C. S. (2020). Mental health and the Covid-19 pandemic. *New England Journal of Medicine*. https://doi.org/10.1056/NEJMp2008017

Proctor, E. K., Landsverk, J., Aarons, G., Chambers, D., Glisson, C., & Mittman, B. (2009). Implementation research in mental health services: An emerging science with conceptual, methodological, and training challenges. *Administration and Policy in Mental Health and Mental Health Services Research, 36*(1), 24–34. https://doi.org/10.1007/s10488-008-0197-4

Proctor, E., Silmere, H., Raghavan, R., Hovmand, P., Aarons, G., Bunger, A., Griffey, R., & Hensley, M. (2011). Outcomes for implementation research: Conceptual distinctions, measurement challenges, and research agenda. *Administration and Policy in Mental Health and Mental Health Services Research, 38*(2), 65–76. https://doi.org/10.1007/s10488-010-0319-7

Ryan, G. W., & Bernard, H. R. (2003). Techniques to identify themes. *Field Methods, 15*(1), 85–109. https://doi.org/10.1177/1525822X02239569/

Seidman, I. (2013). *Interviewing as qualitative research: A guide for researchers in education and the social sciences* (4th ed.). Teachers College Press.

Stetler, C. B., Legro, M. W., Wallace, C. M., Bowman, C., Guihan, M., Hagedorn, H., Kimmel, B. Sharp, N.D., & Smith, J. L. (2006). The role of formative evaluation in implementation research and the QUERI experience. *Journal of General Internal Medicine, 21*(2), S1–S8. https://doi.org/10.1111/j.1525-1497.2006.00355.x

Substance Abuse and Mental Health Services Administration. (2020). National guidelines for behavioral health crisis care: Best practice toolkit.

Tomoaia-Cotisel, A., Scammon, D. L., Waitzman, N. J., Cronholm, P. F., Halladay, J. R., Driscoll, D. L., Solberg, L.I., Hsu, C., Tai-Seale, M., Hiratsuka, V., Shih, S.C., Fetters, M.D., Wise, C.G.,Alexander, J.A., Hauser, D., McMullen, C.K., Schoelle, S.H., Tirodkar, M.A., Schmidt, L., . . . Stange, K. C. (2013). Context matters: the experience of 14 research teams in systematically reporting contextual factors important for practice change. *The Annals of Family Medicine, 11*(Suppl 1), S115–S123. https://doi.org/ 10.1370/afm.1549

Volkow, N. D. (2020). Collision of the COVID-19 and addiction epidemics. *Annals of Internal Medicine*. https://doi.org/10.7326/M20-1212

Wang, G., Zhang, Y., Zhao, J., Zhang, J., & Jiang, F. (2020). Mitigate the effects of home confinement on children during the COVID-19 outbreak. *The Lancet, 395*(10228), 945–947. https://doi.org/10.1016/S0140-6736(20)30547-X

Xie, X., Xue, Q., Zhou, Y., Zhu, K., Liu, Q., Zhang, J., & Song, R. (2020). Mental health status among children in home confinement during the coronavirus disease 2019 outbreak in Hubei Province, China. *JAMA Pediatrics*. https://doi.org/10.1001/jamapediatrics.2020.1619

Yancy, C. W. (2020). COVID-19 and African Americans. *JAMA, 323*(19), 1891–1892. https://doi.org/10.1001/jama.2020.6548

Yao, H., Chen, J. H., & Xu, Y. F. (2020). Patients with mental health disorders in the COVID-19 epidemic. *The Lancet Psychiatry, 7*(4), e21. https://doi.org/10.1016/S2215-0366(20)30090-0

Zima, B. T., Hurlburt, M. S., Knapp, P., Ladd, H., Tang, L., Duan, N., Wallace, P., Rosenblatt, A., Landsverk, J., & Wells, K. B. (2005). Quality of publicly-funded outpatient specialty mental health care for common childhood psychiatric disorders in California. *Journal of the American Academy of Child & Adolescent Psychiatry, 44*(2), 130-144. https://doi.org/10.1097/00004583-200502000-00005

Appendix A

Stakeholder Feedback and Responses

Date	Source	Feedback	Response
5/2/19	*Quarterly Triage Collaboration Meetings*	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 started 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 scheduled 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	*Advisory Board Meeting*	A few stakeholders prefer in-person meetings over Zoom meetings.	The team revisited interest and feasibility of an in-person Stakeholder Advisory Board, however stakeholders preferred to meet over Zoom.
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 how language should not blame children for being in these positions and to reframe this to 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 had 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 was 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 explored using Census Bureau pandemic questions and census tract data to understand if this was 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 continued 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 contact to inquire about another live 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 shared workgroup notes with the MHSOAC after program partners reviewed and approved notes.
1/14/21	*Data Coordinator's Workgroup*	Programs shared this meeting clarified lingering questions and helped them understand the current evaluation timeline.	We continued 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 continued creating a space where programs shared mutual strengths.
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 recognized this is a space for more than program specific topics and we continued 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 continued to be mindful of data asks as we refined 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 following meeting and the MHSOAC met our stakeholder group.
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 used 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 asked 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 shared this with our evaluation partners and recognized 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 explored 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, quantitative data was easier to collect but it did not capture the stories captured in qualitative data.	We recognized 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 was not feasible for this evaluation. Nevertheless, interviews with stakeholders were 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 looked for this in the analysis of telehealth codes and explored this in subsequent interviews.
5/13/21	*School-County Workgroup*	Program partners expressed great interest in testifying before the legislature to share their program narratives.	We relayed this valuable information to the MHSOAC.
5/13/21	*School-County Workgroup*	Staff are growingly concerned with data collection, especially the burden placed on staff not funded by the grant.	We included this data in our report.
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 recognized this was important to program partners and included 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 explored how to support programs in their own evaluations.
6/17/21	*School-County Workgroup*	Programs would like evaluation feedback.	We revisited 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 continued to hold workgroups throughout the duration of the evaluation. The workgroup provided a space for cross program learning and relationship building.
7/27/21	*Stakeholder Advisory Board Meeting*	Stakeholders shared they would like to keep the current agenda for future meetings.	We continued to ask stakeholders to share updates at the beginning of each call.

8/5/21	*School-County Workgroup*	Programs recommend grants related to schools should be aligned with the school calendar so that grants don't end in the middle of a school year.	This has been brought up in multiple interviews and we included this in our recommendations.
8/5/21	*School-County Workgroup*	Programs expressed interest in attending a conference organized by the MHSOAC after the completion of the grant period.	We shared this with the MHSOAC in a meeting about conference planning.
9/2/21	*School-County Workgroup*	Programs would like the upcoming conference to be in hybrid format to remove barriers to attendance.	We shared this with the MHSOAC in a meeting about conference planning.
10/7/21	*School-County Workgroup*	Programs recommend the MHSOAC have the evaluation plan finalized before program implementation begins.	We included these recommendations in the report.
10/26/21	*Stakeholder Advisory Board Meeting*	Stakeholders stressed the importance of making the results of the evaluation available online to the public.	The report and future reports will be posted on the MHSOAC webpage.
11/18/21	*School-County Workgroup*	Programs continued to share changing client needs and difficulty in retaining and hiring program staff.	We reviewed our interview guides and continued to explore these areas in interviews.
12/19/21	*School-County Workgroup*	Programs expressed gratitude for space to share common barriers and success.	We continued to hold workgroups until the end of the school-county grant period.
1/13/22	*School-County Workgroup*	Staff shared concerns about staff burnout, increased need for services, and a higher attrition rate.	We incorporated these areas in subsequent interview guides.
1/25/22	*Stakeholder Advisory Board Meeting*	Stakeholders shared concerns about staff burnout and turnover.	We incorporated this into subsequent interview guides.
2/3/22	*School-County Workgroup*	Stakeholders inquired about MHSOAC quarterly meetings and discussed that the MHSOAC does not need to attend future workgroup meetings.	We asked the MHSOAC about the quarterly meetings and shared the wishes of the stakeholders.
3/3/22	*School-County Workgroup*	Programs shared updates in navigating sustainability plans and creatively funding their programs in the future.	We added findings to the case studies section of the report.
4/26/22	*Stakeholder Advisory Board Meeting*	Programs shared concerns about leadership burnout in addition to the existing staff burnout.	We incorporated this probe into subsequent interview guides.
4/28/22	*School-County Workgroup*	Programs shared continued challenges to sustaining the grants after the grant period.	We continued to hold this workgroup call as it is both beneficial for the evaluation team and programs.
5/19/22	*School-County Workgroup*	Staff shared concerns regarding the next roadmap report due to the MHSOAC.	We shared these concerns with the MHSOAC staff.

6/9/2022	*School-County Workgroup*	Programs shared importance of sharing reports.	We continued to request all future reports be posted on the MHSOAC webpage.
7/7/2022	*School-County Workgroup*	Programs continued to explore how to fund their services after the end of the grant period.	We continued to meet with the programs to learn about their efforts.
8/4/2022	*School-County Workgroup*	Programs are preparing for the new school year and completion of the grant period.	We continued to document these changes and shared these findings in reports.
9/1/2022	*School-County Workgroup*	Programs clarified data collection period dates with evaluation team.	We updated and clarified expectations for the end of the grant period.
10/6/2022	*School-County Workgroup*	Programs shared recommendations for how to implement new programs, continued provider shortages, and efforts to increase the workforce.	Programs continued to engage in a reciprocal learning process and assist each other overcome common challenges.
10/25/22	*Stakeholder Advisory Board Meeting*	Stakeholders shared clients and staff are facing more stress from the increasing cost of living in California.	We will probe basic needs in future interviews with programs.
11/3/2022	*School-County Workgroup*	Programs shared how they are anticipating closing out their programs their programs.	We incorporated findings into our reports.
12/15/2022	*School-County Workgroup*	Programs thanked our evaluation team for starting the workgroup and shared the importance of disseminating findings.	We plan to share reports with the public.
1/31/2023	*Stakeholder Advisory Board Meeting*	Stakeholders shared state Medi-Cal payment reform will impact program service delivery; this change is anticipated for July 1, 2023.	We will share this with the MHSOAC to guide future developments.

Appendix B

Definitions of Framework and Logic Model Domains and Constructs

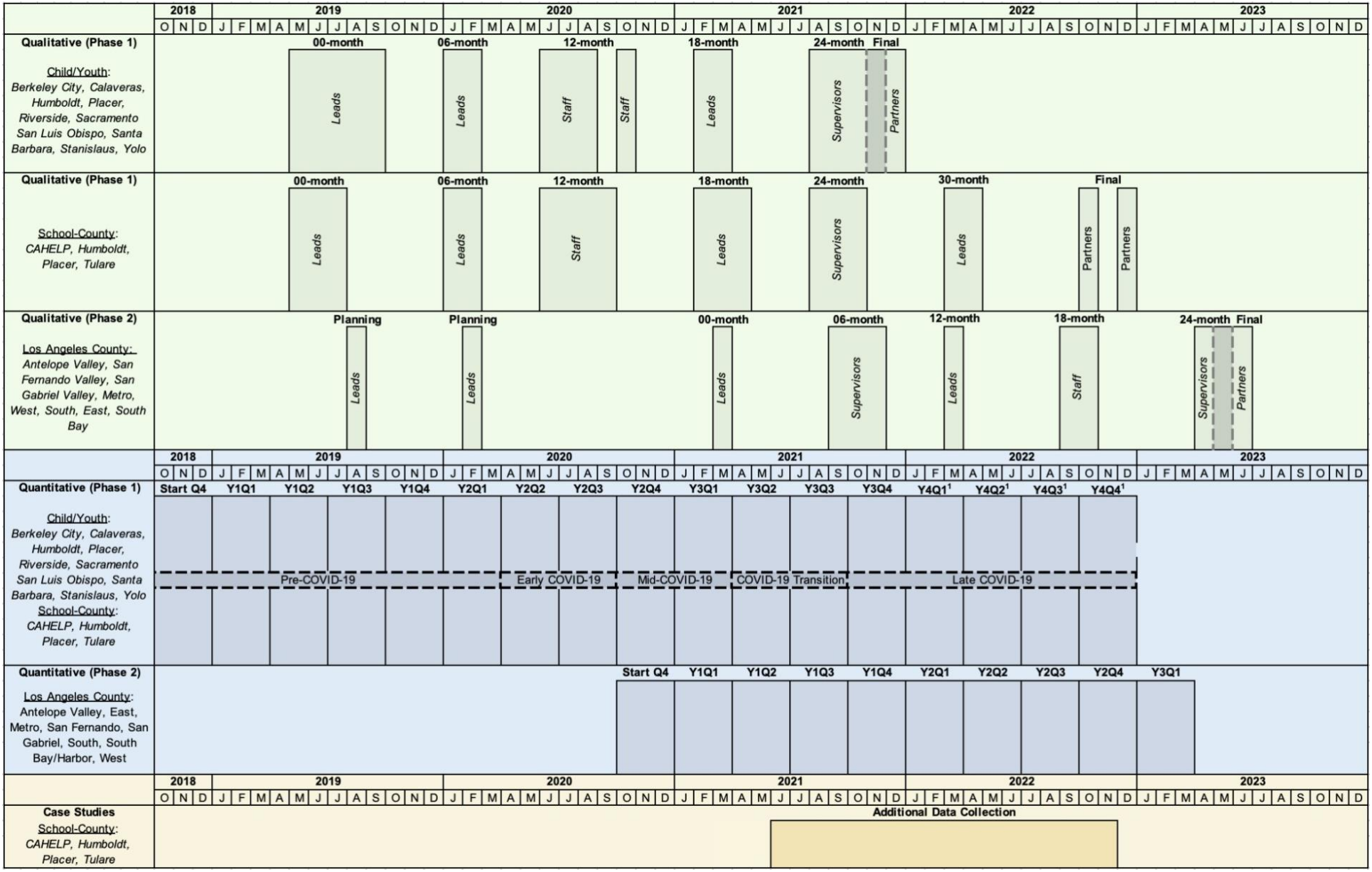
Domain I: SB-82/833 Program Characteristics Features of SB-82/833 programs that might influence implementation.	
Construct	**Definition(s)**
Descriptive Characteristics	The basic features of the program and its interventions that provide context for, and may also impact, the course of implementation
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

Detailed Study Design



[1]Indicates School-County only

Appendix D

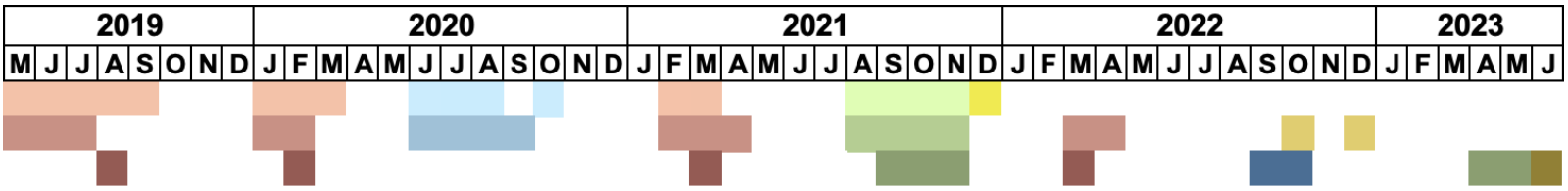
Data Elements and Sources by Logic Model Domain

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

Appendix E

Interview Timeline by Program Type and Sampling Group



Appendix F

Interviews Conducted by Program, Phase, and Cycle

Phase 1								
Program	**00-mo**	**06-mo**	**12-mo**	**18-mo**	**24-mo**	**Final[4]**	**30-mo**	**Final[5]**
Berkeley City	8/7/19[1]	2/13/20	7/7/20	3/22/21	9/22/21	11/18/21	--	--
CAHELP	6/7/19	1/29/20	7/20/20	3/3/21	9/7/21	--	3/9/22	10/26/22
Calaveras	6/6/19	2/28/20	7/21/20	3/11/21	9/29/21	11/30/21	--	--
Humboldt (Child)	5/28/19[1]	1/16/20	6/17/20	3/9/21	9/9/21	11/8/21	--	--
Humboldt (School)	5/28/19[1]	1/22/20	6/25/20	4/13/21	10/8/21	--	4/1/22	12/12/22
Placer (Child)	7/19/19[1]	2/27/20	7/14/20	2/22/21	9/1/21	11/2/21	--	--
Placer (School)	7/19/19[1]	2/14/20	8/14/20	2/24/21	8/30/21	--	3/29/22	12/14/22
Riverside	7/17/19	2/27/20	8/25/20	2/17/21	10/28/21	12/15/21	--	--
Sacramento	7/1/20[2]	1/14/20	6/23/20	2/16/21	9/8/21	11/10/21	--	--
San Luis Obispo	9/24/19	2/27/20	7/28/20	3/1/21	9/23/21	11/12/21	--	--
Santa Barbara	7/10/19	2/14/20	8/4/20	3/2/21	11/30/21	--	--	--
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	9/22/21	--	3/21/22	12/19/22
Yolo	6/13/19	1/17/20	8/18/20	2/1/21	8/27/21	--	--	--
Phase 2								
Program	**Planning**	**Planning**	**00-mo**	**06-mo**	**12-mo**	**18-mo**	**24-mo**	**Final**
Los Angeles SPA 1 Antelope Valley	--	--	3/29/21	9/9/21	3/8/22	9/20/22	5/8/23	--
Los Angeles SPA 2 San Fernando Valley	--	--	3/21/21	9/21/21	3/14/22	9/29/22[3]	4/17/23[3]	4/17/23[3]
Los Angeles SPA 3 San Gabriel Valley	--	--	3/19/21	10/1/21	3/31/22	9/29/22	4/28/23[3]	4/26/23[3]
Los Angeles SPA 4 Metro	--	--	3/8/21	9/16/21	3/16/22[3]	10/11/22[3]	5/2/23[3]	4/27/23[3]
Los Angeles SPA 5 West	--	--	3/22/21[3]	11/1/21[3]	3/30/22[3]	10/7/22[3]	6/9/23[3]	5/31/23[3]
Los Angeles SPA 6 South	--	--	3/22/21[3]	11/1/21[3]	3/30/22[3]	10/7/22[3]	6/9/23[3]	5/31/23[3]
Los Angeles SPA 7 East	--	--	3/12/21	9/21/21	3/10/22	9/29/22[3]	4/17/23[3]	4/17/23[3]
Los Angeles SPA 8 South Bay	--	--	3/11/21	9/14/21	3/16/22[3]	10/11/22[3]	5/2/23[3]	4/27/23[3]
LAC DMH	8/8/19	2/13/20	--	--	5/11/22	--	6/13/23	--

[1]Interview covered Child, School-County, and Adult/TAY programs
[2]Interview covered Child and Adult/TAY programs
[3]Interview covered multiple sites
[4]Final interview for Child programs
[5]Final interview for School-county programs

Appendix G

Workgroup Meeting Dates

Data Coordinators			School-County				Child
2019	**2020**	**2021**	**2019**	**2020**	**2021**	**2022**	**2021**
6/13/19	1/9/20	1/14/21	10/3/19	3/12/20	1/21/21	1/13/22	1/22/21
7/11/19	4/9/20	4/8/21	12/5/19	4/2/20	2/4/21	2/3/22	2/26/21
8/8/19	7/9/20	7/8/21		5/7/20	3/4/21	3/3/22	3/26/21
9/13/19	11/12/20	10/14/21		6/4/20	4/1/21	4/28/22	4/23/21
10/10/19				7/16/20	5/6/21	5/19/22	5/28/21
11/14/19				8/13/20	6/17/21	6/9/22	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
					11/18/21	11/3/22	
					12/9/21	12/15/22	

Appendix H

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