WestEd
WestEd.org

The Mental Health Student Services Act (MHSSA) Statewide Evaluation Framework and Research Questions

Prepared by WestEd
Submitted May 24, 2024

© 2024 WestEd. All rights reserved.
WestEd is a nonpartisan, nonprofit agency that conducts and applies research, develops evidence-based solutions, and provides services and resources in the realms of education, human development, and related fields, with the end goal of improving outcomes and ensuring equity for individuals from infancy through adulthood. For more information, visit WestEd.org.

Table of Contents

History and Context of the MHSSA Evaluation 1
Purpose of the MHSSA Evaluation Framework 8
Centering Equity in the MHSSA Statewide Evaluation 8
Theoretical and Methodological Foundations 9
Developing a Framework Informed by Community Engagement 13
Considerations for Designing the MHSSA Evaluation Plan 17
Developing Research Questions 17
Theory of Change 18
Conceptual Models and Research Questions 20
Logic Model 40
Next Steps 41
References 43
Appendix A 48
Appendix B 50

The Mental Health Student Services Act Statewide Evaluation Framework and Research Questions

This technical report includes the proposed theory of change, logic model, and research questions that inform the ongoing development of the statewide Mental Health Student Services Act (MHSSA) Evaluation Plan.

History and Context of the MHSSA Evaluation

Now more than ever, there is a nationwide focus on the urgency of addressing the mental health needs of young people. This complex challenge requires a collective approach to reimagining how to support the mental health and well-being of young people, their families, and the communities in which they learn and live (United States Department of Health & Human Services, 2021; Office of the Surgeon General, 2021). As a state, California has been a national leader responding to the call for transformational systems change, including school-based mental health service delivery.

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

Communities across California have also leveraged other statewide mental health initiatives to support young people and their families. For example, the Student Behavioral Health Incentive Program supports the goals of California's Advancing and

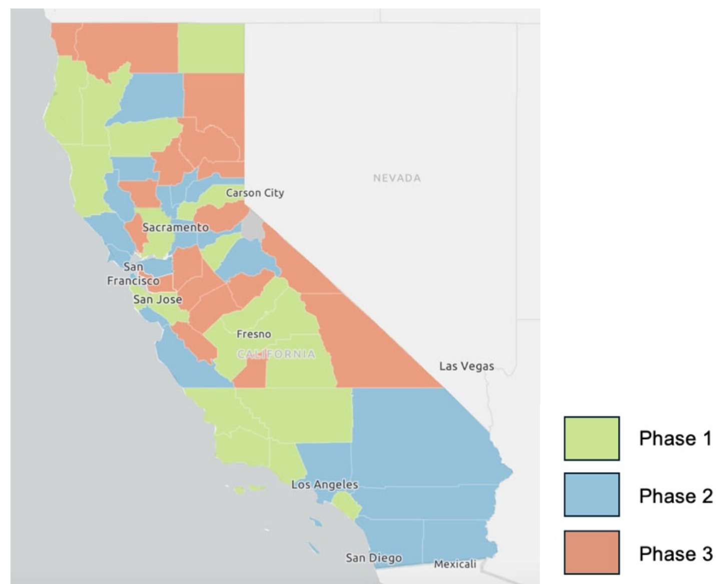
Innovating Medi-Cal (CalAIM) initiative and provides new investments in behavioral services, infrastructure, information technology and data exchange, and workforce capacity for school-based and school-affiliated behavioral health providers. In 2021, California invested $3 billion in the California Community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

Led by the Mental Health Services Oversight and Accountability Commission (MHSOAC), the MHSSA is one of California's historic investments to deliver timely, equitable, and quality mental health services within school communities. The MHSSA was enacted in 2019 to provide financial support to counties to address student mental health needs related to COVID-19. Since its launch, the MHSSA vision has expanded to address specific mental health goals for students and youth by establishing schools as centers of well-being to address unmet needs and improve access to services by centering schools as a core component of the community behavioral health system. To accomplish this, the MHSSA provided funding to incentivize change through local partnerships between county behavioral health departments and local education agencies. In addition, the legislation offered flexibility in how funds are used to meet the diverse and immediate needs of counties across the state.

Phases 1–3 of Funding

In 2019, Senate Bill 75 established the MHSSA and provided $40 million in one-time and $10 million in ongoing funding to establish partnerships between county behavioral health departments and local education agencies (LEAs) focused on student mental health needs. To date, the Commission has provided MHSSA funds to support school mental health partnerships to 57 grantees for a total investment of $255,000,000 (see Figure 1).

Figure 1. Grantees by Phase



For Phase 1, launched in 2020, a total of 18 grantees were awarded funding. The funding for these four-year grants totaled $74,849,047. Grantees in this first phase included Calaveras, Fresno, Humboldt, Kern, Madera, Mendocino, Orange, Placer, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Solano, Tehama, Trinity-Modoc, Tulare, Ventura, and Yolo. Ten grantees were awarded funding in Category 1 (existing partnerships) and eight grantees were awarded funding in Category 2 (new or emerging partnerships). Of these Phase 1 grantees, six identified as small, six as medium, and six as large.

In response to a great deal of interest in the program, the Budget Act of 2021 allocated additional funding for applicants who applied but did not receive a grant during the first phase. This second phase of funding resulted in 19 new grantees being funded in 2021 with a total of $77,553,078. Grantees that received Phase 2 funding included Amador, Contra Costa, Glenn, Imperial, Lake, Los Angeles, Marin, Monterey, Nevada, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, Santa Cruz, Shasta, Sonoma, Sutter-Yuba, and Tuolumne. Nine grantees were awarded funding in Category 1 (existing partnerships) and 10 grantees were awarded funding in Category 2 (new or emerging partnerships). Of these Phase 2 grantees, eight identified as small, four as medium, and the remaining seven as large.

In addition, the federal American Rescue Plan Act provided additional funds through the State Fiscal Recovery Fund. In 2022, Phase 3 funded 20 grantees with a total of $54,910,420. These grantees included: Alameda, Berkeley City, Butte, Colusa, Del Norte, El Dorado, Inyo, Kings, Lassen, Mariposa, Merced, Mono, Napa, Plumas, San Benito, San Joaquin, Sierra, Siskiyou, Stanislaus, and Tri-City. For Phase 3, grantees were not asked to report if they had existing (Category 1) or new or emerging partnerships (Category 2). Of these Phase 3 grantees, 13 identified as small, five as medium, and two as large.

In order to extend the work being done across the state, additional funding was made available to existing grantees. This resulted in $47,687,455 going to 41 grantees. Due to this additional funding and extensions, all but 15 grantees' programs will end in 2026, with the majority ending on December 31, 2026.[1] WestEd is collaborating with the Commission to develop a data collection plan that considers program end dates.

Table 1 reflects the program implementation timeline for each phase of grantees and the timeline for the evaluation: planning, implementation, and dissemination.

Table 1. Grant Phases and Proposed Evaluation Timeline

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

Activities and Services

Each MHSSA grantee is implementing a unique project plan based on local needs, priorities, and constraints. Grantee-specific project plans described in grant applications, Program Development Phase Plans, and MHSSA Grant Summaries contain the proposed activities and services provided through each MHSSA-funded partnership. County annual fiscal reports and hiring reports contain additional details on the roles and classification of hired MHSSA personnel; these details offer a more granular view into how the MHSSA funds were distributed across staff responsible for coordinating and/or implementing activities and services at the county, district, or school level.

To inform the MHSSA Evaluation Plan, WestEd staff conducted a thematic analysis (Braun & Clarke, 2012) of the 57 MHSSA Grant Summaries submitted to the Commission in May 2023, resulting in The Mental Health Student Services Act (MHSSA) Grant Summaries Review document. This review provided a snapshot of a continuum (i.e., Tier I, Tier II, and Tier III) of statewide MHSSA activities and services, as well as information about how grantees proposed to support MHSSA implementation. WestEd staff also coded contextual information to help frame the settings and describe identified target populations and proposed MHSSA staff.

---

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

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

Implementation support. In regard to implementation support, an MTSS framework was the most common implementation framework explicitly identified by grantees. Aligned with the MHSSA's focus on incentivizing change through partnerships, 79.0 percent of grantees included language about their partnerships and/or collaboration, and about half explicitly identified a specific team facilitating the implementation of MHSSA activities and services. Staff training and professional development were noted in nearly half of the grant summaries followed by numerous other examples of implementation supports for systems capacity building and sustainability (e.g., communication capacity, systems coaching/consultation, leveraging of various funding streams, procedure and protocol development). The most common types of data use included mental health screening (both universal and targeted; 45.6%), individual assessment (31.6%), and progress monitoring (17.5%).

Tier I, Tier II, and Tier III. Proposed activities and services were focused across all three tiers. Specifically, 80.7 percent of grantees proposed Tier I activities and services, 68.4 percent Tier II activities and services, and 98.3 percent Tier III activities and services. At Tier I, mental health awareness and literacy promotion and training activities (63.2%) were the most common, followed by mental health and wellness training/skill-building programs that were not further specified (31.6%) and suicide prevention (26.3%). At Tier II, the most common activities and services were unspecified groups (35.1%) and peer-to-peer support/mentoring (19.3%). At Tier III, the most reported activities and services were individual counseling, therapy, and/or supports (86.0%) and comprehensive case management, including systems navigation, referral, and outreach/engagement (57.9%). Finally, 45.6 percent of grantees proposed crisis intervention services.

Table 2. Services, Activities, and Supports by Phase

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

Phase 3 (*n* = 21)	76.2% (16)	66.7% (14)	100% (21)	100% (21)

Table 2 provides a summary of identified MHSSA Tier I, Tier, II, and Tier III Services and Activities as well as Implementation Supports across the three phases of grantees. Grantees in Phases 2 and 3 followed a similar pattern of being most likely to report Tier III supports, followed by Tier I and then Tier II. Phase 1 grantees were equally likely to mention Tier I and Tier II supports. Every Phase 3 grantee discussed how they planned to support MHSSA implementation, as did the majority of Phase 1 and Phase 2 grantees.

The Grant Summary Review was conducted in alignment with this statewide MHSSA Evaluation Framework and the results will inform the development of the MHSSA Evaluation metrics, data collection, and evaluation as a whole.

MHSSA Funded Schools

The MHSSA has a broad reach, funding over 2,000 schools throughout the state, including 842 elementary schools, 304 middle schools, 425 high schools, and 564 combined schools.

Table 3. Funded Schools by Phase

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

Findings summarized in Table 3 were generated from a Commission file containing a list of schools funded by the MHSSA grant. The original file contained information about county name, district name, school name, and CDS code. To create a more complete understanding of the school profile, the file was matched with raw data from the California Department of Education's California school directory (cde.ca.gov/school directory). The school data was matched using the CDS code, which is the unique ID for each school. The combined files ultimately utilized the following information: CDS code, county name, district name, school name, school type, EIL name, and grades offered.

Using this information, WestEd categorized each school into the following categories: elementary school, middle school, high school, and combined schools. The categories served as a proxy for student ages. "Elementary school" included schools that served the ranges of PK–5, "middle school" included schools that served grades 6–8, and "high

school" included schools that served grades 9–12. For schools that served a greater range of grades (e.g., K–8, 6–12), the schools were categorized as "combined schools."

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

The Opportunity to Learn From the MHSSA

The MHSSA, together with the rest of California's historic investments in student mental health, promises transformational change to the state's school mental health system. What is unknown is the extent to which each statewide initiative drives systems change, builds upon other initiatives, and contributes to positive outcomes for students, families, and school communities. The MHSSA statewide evaluation presents an opportunity for innovation and learning about the most promising approaches to interagency collaboration and transformational system change within California's larger school mental health context. Within several individual counties, evaluation efforts are also underway to understand the impact of the MHSSA at the local level.

Local external evaluators are partnering with WestEd and the Commission to support the MHSSA Evaluation Plan in a consultative role. Local evaluators have shared documents that provide insight into how each county built upon the statewide evaluation goals to create outcomes based on their local context. Some counties conducted program implementation and impact analyses, while others included systems change evaluation models. The documentation from each local evaluation provided examples of meaningful and useful quantitative and qualitative data describing the implementation process and early impact of different MHSSA-funded activities and services.

Counties and schools across California are layering, blending, and braiding funds to meet the unique mental health needs of young people within their communities. Each MHSSA grantee has taken a unique approach to address student mental health needs and improve student well-being. While the MHSSA has provided critically important flexibility for grantee partners to innovate, this flexibility introduces methodological challenges in evaluating the statewide implementation of a heterogeneous set of MHSSA activities and services. Thus, each grantee can be conceptualized as a unique study with unique independent and dependent variables, all focused on the same topic. An additional challenge to the design of the evaluation relates to the timeline of MHSSA implementation versus the MHSSA Evaluation. As previously noted, the statewide MHSSA Evaluation is currently being planned, whereas implementation has been underway since the first phase of funding in 2020. Therefore, the MHSSA Evaluation will need to account for varying start and end dates across the three phases of funding (see Appendix A).

Despite these methodological challenges, the MHSSA Evaluation serves as an opportunity to build the state's capacity to collect, analyze, and engage in participatory data-based decision-making on how to most effectively foster transformational school mental health systems change.

Purpose of the MHSSA Evaluation Framework

Welfare and Institutions Code Section (WIC) 5886(k) specifies that the MHSOAC is required to develop metrics and a system to measure and publicly report to the legislature on the performance outcomes of services provided using MHSSA grants. WestEd is contracted by the MHSOAC (WestEd-MHSOAC, 2023) to satisfy this requirement through designing an evaluation that measures

- the impact of MHSSA on cross-system partnerships, comprehensive mental health services in schools and local communities, and student outcomes;
- the MHSSA implementation and successes, challenges, and lessons learned; and
- the different needs and experiences of student subgroups (e.g., socially and economically disadvantaged, BIPOC, and LGBTQ) and the provision of mental health services to close the equity gap.

WestEd must also develop performance metrics that cut across systems to create a shared understanding of student success and well-being and build the capacity of MHSSA grantees for data-driven approaches informing continuous improvement toward effective and sustainable school mental health systems, including engaging in the MHSSA Evaluation requirements.

The foundation of the statewide MHSSA Evaluation is the MHSSA Evaluation Framework, which includes

- the MHSSA Theory of Change (ToC), which illustrates the mechanisms of change underlying the intent and goals of the MHSSA legislation and grants and represents the relationships between elements represented in the ToC;
- conceptual models, which operationalize each element within the ToC and outline the theoretical underpinnings of the constructs represented in each conceptual model, situating these constructs within their respective literature bases;
- research questions aligned with each conceptual model; and
- the MHSSA Logic Model, which depicts the relationships between resources and inputs, activities, outputs, and outcomes for MHSSA.

Each of these components weaves together literature bases, the unique California landscape and current findings from ongoing community engagement informing the MHSSA Evaluation Plan. Together, the components of the statewide MHSSA Evaluation Framework will inform the metrics, measures, methods, and methodological and analytic approaches included in the statewide MHSSA Evaluation Plan.

Centering Equity in the MHSSA Statewide Evaluation

Schools are a natural setting for comprehensive mental health services, including prevention and early intervention services for *all* students (United States Department of

Education, 2021). The MHSSA provides an opportunity for transforming systems through critical partnerships for creating culturally responsive and sustainable conditions that support the mental health and well-being of California's diverse school communities.

Behavioral health equity is multifaceted and, as such, requires a comprehensive approach that leverages the strengths and resources of school communities while reimaging the systems that have maintained disparate mental health outcomes for California’s young people.

> *Behavioral health equity is the right of all individuals, regardless of race, age, ethnicity, gender, disability, socioeconomic status, sexual orientation, or geographical location, to access high-quality and affordable healthcare services and support. Advancing behavioral health equity means working to ensure that every individual has the opportunity to be as healthy as possible. In conjunction with access to quality services, this involves addressing social determinants of health—such as employment and housing stability, insurance status, proximity to services, and culturally responsive care—all of which have an impact on behavioral health outcomes (Substance Abuse and Mental Health Services Administration, 2023, para. 1).*

In the work to center equity, the MHSSA Evaluation Framework is guided by anti-racist evaluation principles. WestEd’s approach to anti-racist evaluation centers anti-racist self-reflection and learning; collaborative and equitable partnerships; and attention to cultural, historical, and political contexts throughout all stages of the evaluation (WestEd, 2021). This approach centers close collaboration with those who are most proximal to the program, initiative, or organization that is being evaluated. Participants are ideally engaged in all stages of the evaluation, including evaluation design, data collection, analysis, dissemination, and decision-making (Cousins & Whitmore, 1998). In the case of this MHSSA Evaluation, we collaborate with young people, families, partners, and systems change leaders throughout the evaluation, from defining outcomes to disseminating learnings (see Appendix B). Through this process, the partners cocreate meaningful and practical findings to continuously improve, demonstrate impact, scale lasting change, and build internal capacity to sustain systems change efforts over time (Romer et al., 2023; Valdez et al., 2023).

Theoretical and Methodological Foundations

The MHSSA Evaluation Framework is informed by a multidisciplinary body of research literature that contextualizes the learning from WestEd’s community engagement efforts and review of program documents and activities. The MHSSA Evaluation Framework is grounded in several bodies of research, including anti-racist participatory research, developmental systems change evaluation, implementation science, ecological models of development, and school mental health systems change.

Developmental Systems Change Evaluation

The MHSSA, a systems change initiative, must be evaluated within the larger landscape of school mental health with California. As such, the WestEd team has integrated principles from developmental evaluation to offer insight into the dynamic environment in which the MHSSA is implemented. Developmental evaluation offers a framework to measure the impact of systems change initiatives implemented in complex environments in which linear evaluation approaches that proceed logically from inputs through processes to outcomes may not sufficiently account for context.

Systems thinking is at the core of developmental evaluation. Thus, a developmental evaluation centers on understanding interrelationships, engaging with multiple perspectives, and reflecting deeply on the practical and ethical consequences of boundary choices (Patton, 2015b). The focus is on relationships instead of discrete components. The core components of developmental evaluation include

- developmental purpose,
- evaluation rigor,
- utilization focus,
- innovation niche,
- complexity perspective,
- systems thinking,
- cocreation, and
- timely feedback (Patton, 2015a).

This dynamic framework informs how the evaluation is designed and, critically, keeps the focus on systems change and the relationships across all parts of the MHSSA and its implementation across the state.

Implementation Science

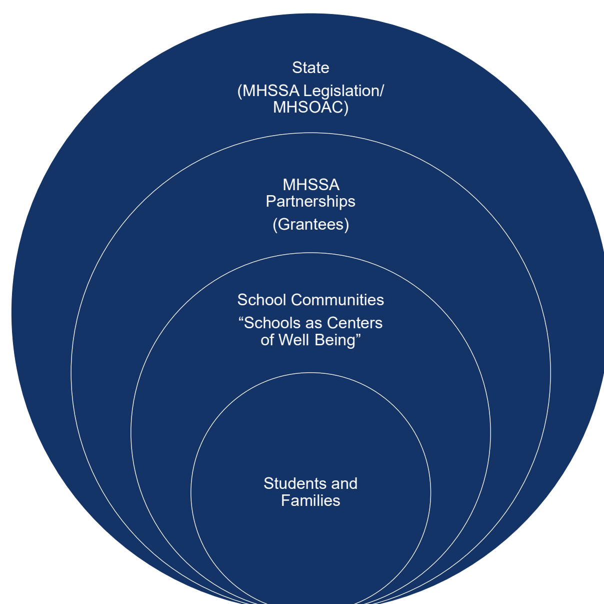
In response to requirements stated under WIC Section 5886(k), the MHSSA Evaluation must build the capacity of MHSSA grantees for data-driven approaches informing continuous improvement toward effective and sustainable school mental health systems. Implementation Science is a complex, continuous improvement process in which implementation variables influence intervention outcomes (Durlak & DuPre, 2008; Fixsen et al., 2005; Sanetti & Kratochwill, 2009) and is critically important to scaling practices to have a socially meaningful impact (Horner et al., 2017; Kania et al., 2018). Beyond changing the practices that have long maintained the status quo of how young people experience mental health supports and services, transformational change will also require what Blasé et al. (2015) describe as “changing hearts, minds, and behavior” among leaders, practitioners, and educators.

The statewide MHSSA Evaluation provides a unique opportunity to consider how partnerships and organizational systems support large-scale implementation of the MHSSA. The MHSSA Evaluation will take a systematic approach to gathering multiple and complementary sources of data. This allows for better understanding of behavioral health and education systems conditions as they relate to partnership capacity to effectively facilitate implementation of MHSSA activities (i.e., who is doing what and how) and continuous improvement toward sustainable school mental health service delivery.

Ecological Models of Development

The vision of the MHSSA is to establish schools as centers of well-being that address unmet needs and improve access to services. To understand and measure the mechanisms of change underlying the intent and goals of the MHSSA, an ecological model accounts for the interactions between individuals and their environment (see Figure 2). Bronfenbrenner's (1979) ecological model of human development offers a framework in which to consider the influencing factors that play a role in shaping young people's mental health outcomes. While the focus of this evaluation is on the statewide implementation and impacts of the MHSSA, this will require investigating all levels of the system (i.e., state, MHSAA partnership, school community, and students and families) and how they impact each other. For the purpose of the statewide MHSSA Evaluation, the focus is on the cumulative impacts of the collective activities and services across the state (i.e., the outermost layer).

Figure 2. MHSSA Ecological Systems Model



Meta-Analytic Framework

The original intent of the MHSSA was to provide financial support to counties to address student mental health needs related to COVID-19. To do so, the legislation offered flexibility in how funds were used, recognizing the diverse and immediate needs of counties across the state. As previously noted, the heterogeneous set of MHSSA activities and services can be conceptualized as a unique study with unique independent and dependent variables, all focused on the same topic. Moreover, to address the methodological challenges that the heterogeneity of MHSSA activities and services presents, WestEd is conceptualizing the quantitative analysis portion of the MHSSA Evaluation using a meta-analytic framework.

A meta-analysis is a quantitative approach to aggregate quantitative data from quantitative research studies, often identified using systematic review procedures (Borenstein et al., 2021). Meta-analysts use quantitative data from different research studies examining similar research questions to aggregate or combine the data to estimate the average relationship among variables or the average effect of an intervention, program, or practice. Gene Glass, the originator of the term *meta-analysis*, put it best when he said, “Our problem is to find the knowledge in the information” (1976, p. 4). By this, he meant that meta-analysis allows researchers to bring together all the available quantitative research on a given topic and evaluate the overall relationship or effect. Meta-analysis is a method that can be used to measure the overall impact of heterogeneous activities and services, such as those implemented in grantee sites. This approach is different from traditional meta-analysis, which typically is the aggregation of published research studies. However, the methodology has been used to aggregate data in a similar way to the proposed approach for this evaluation (e.g., Gage et al., 2021; Katsiyannis et al., 2020).

School Mental Health Systems Change

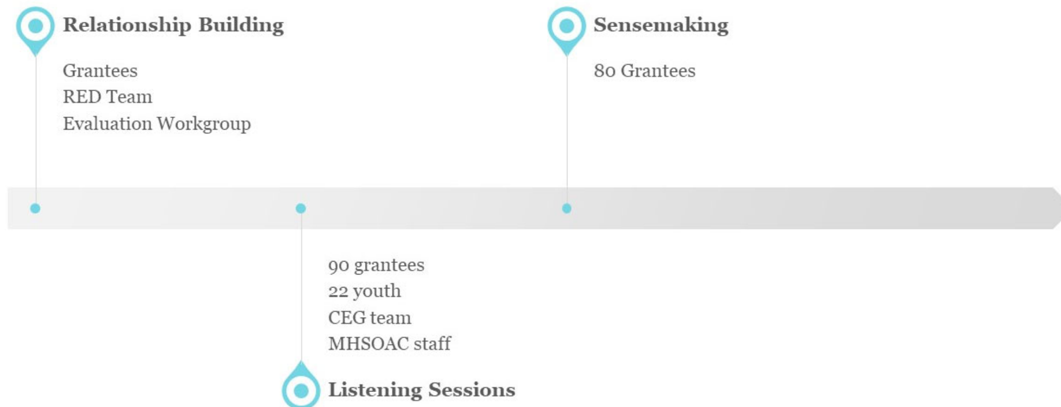
Schools are a natural setting for collaboration across youth-serving systems to promote and support student mental health and well-being. School-based mental health systems are increasingly being characterized as a cross-agency, muti-tiered system of supports designed by and uniquely for a school community (Stephan et al., 2015; United States Department of Education, 2021; Weist et al., 2018). This multi-tiered implementation framework has evolved from a public health approach that targets upstream determinants of mental health (Dopp & Lantz, 2020; Forman, 2015). A public health approach emphasizes different types of prevention: primary prevention to address risk factors and promote protective factors (Tier I), and secondary (Tier II) and tertiary (Tier III) prevention to reduce the duration of mental health challenges (Forman, 2015; National Research Council and Institute of Medicine, 2009). Aligned with the MHSSA focus on partnerships, comprehensive school mental health systems build capacity for partners to support a full continuum (i.e., Tiers) of culturally responsive and sustainable interventions that promote mental health and well-being while reducing the prevalence and severity of emotional and behavioral problems (Lazarus et al., 2021).

Developing a Framework Informed by Community Engagement

The research questions, the theory of change, and the accompanying conceptual models in the Evaluation Framework integrate what WestEd staff heard during their conversations with county behavioral health staff, county and LEA staff, youth, and MHSOAC staff. WestEd's community engagement informing the statewide MHSSA Evaluation thus far has been categorized as three primary activities (Figure 3):

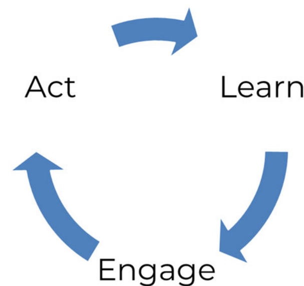
- **Relationship Building.** Community engagement activities began with relationship building with the Commission Research and Evaluation Division (RED) team, the Community Engagement and Grants (CEG) team, the MHSSA Research and Evaluation Workgroup, MHSOAC staff, MHSSA grantees, and youth to foster the relational trust, shared goals, and vision for the MHSSA Evaluation. Beginning in spring 2023, WestEd focused on listening to these partners' hopes and fears about the MHSSA Evaluation planning process and building a shared understanding of what can be expected throughout Phase 1 of the MHSSA Evaluation.
- **Listening Sessions.** The WestEd community engagement team met virtually with partners to learn about grantees' MHSSA project plans, the shared and unique goals of each local effort, how grantee partnerships operate, grantee implementation strategies, and what outcomes are meaningful and useful to different interest holders. WestEd held a conversation with members of the Community Engagement and Grants team in which they described the roles of providing technical assistance, grant management, and oversight. Through the conversations with Commission staff and leaders at a kickoff meeting in Sacramento, WestEd learned more about the overall vision for the MHSSA and the leadership provided by the Commission and state leaders. In the fall of 2023, WestEd provided multiple opportunities for MHSSA grantees to share more details about their MHSSA partnerships and MHSSA-funded activities and services.
- **Sensemaking.** WestEd collected written feedback and met virtually with partners to hear feedback about the emerging Evaluation Framework and understanding of MHSSA's impact on behavioral health and educational systems conditions.

Figure 3. Community Engagement Activities at a Glance



Learnings from community engagement efforts are integrated into the development of this evaluation ramework alongside our comprehensive MHSOAC document and literature review through an iterative learn/engage/act cycle: learn about existing experiences, knowledge, and assets; engage in collective sensemaking and prototyping of ideas; and act on moving ideas forward (Figure 4).

Figure 4. Learn/Engage/Act Cycle to Community Engagement



Learn. In addition to the listening sessions described above, during the learning phase, WestEd conducted a literature scan and a comprehensive document review. The document review included the following MHSSA program and related documents provided by the RED Team: 2022 Legislative Status Report and 2024 Legislative Status Report outline, feedback from the Legislature on the 2024 Legislative Status Report outline, biannual data collection and reporting tools, MHSSA Collaboration Meeting documents (agendas, materials, minutes, and surveys), MHSSA Workgroup materials (agendas, materials, and minutes), Commission meeting presentations, annual fiscal reports and budget modifications, quarterly hiring reports, program summaries and at-a-glance tables, Program Development Plans, grant proposals, external evaluation reports and materials, and monthly check-in reports.

Engage and Act. In the engage and act phases, components of the MHSSA ToC were developed and shared with partners through the sensemaking processes outlined above to communicate the information that had been gathered and synthesized; generate ideas; and prototype components of the ToC, conceptual models, and logic model. The WestEd team collaboratively informs the development of topics and protocols for listening sessions and following listening sessions, processes and integrates the learnings into the ongoing development of the MHSSA Evaluation Plan. Through the learn/engage/act feedback loops, the ToC has begun to solidify along with a corresponding set of conceptual models, research questions, and an aligned logic model presented later in this report. This cyclical community engagement process continuously refines the emerging MHSSA Evaluation Plan and elicits new questions to engage in continuous learning. As WestEd meets with a broader group of partners, new perspectives will continue to shape the team's thinking moving forward.

The emerging MHSSA ToC, logic model, and research questions reflect the perspectives of partners, including youth, county office of education system administrators, county mental and behavioral health system administrators, and other evaluators who have worked with individual grantees to evaluate their MHSSA activities and services at the county level. The perspectives of parents and caregivers, school-based educators and staff, school district administrators, school-based behavioral health service providers, and state agency administrators have not yet been incorporated. However, these partners will be engaged in the next stage of our process, and their perspectives will be incorporated into future iterations of the MHSSA Evaluation Framework prior to finalizing the MHSSA Evaluation Plan.

In the coming months, as WestEd continues to develop the MHSSA Evaluation Plan, the WestEd team will leverage their relationship with the MHSOAC to connect with different partner groups. In 2023, WestEd's community engagement focused on relationship building with MHSSA grantees and learning more about the context and outcomes of MHSSA. Similar to the process of developing relationships with the MHSSA grantees and MHSOAC staff, the WestEd team plans to leverage these relationship to identify school, behavioral health, and family partners. In February 2024, the community engagement team kicked off a youth advisory group that will codesign portions of the evaluation and dissemination plan over the next several months. As the team continues to engage existing and new partners, the research questions and outcomes in the Framework will be iteratively revised to better reflect the perspectives collected throughout our community engagement efforts.

Strengths-Based Approach to Community Engagement

Presenting a strengths-based lens for evaluating the community engagement component of the MHSSA involves embracing principles from social work and positive psychology, departing from the traditional medical model's deficit-centered approach to health and well-being (Xie, 2013). A strengths-based lens recognizes that individuals possess unique strengths to address challenges, and key principles include prioritizing strengths, building on existing assets, and fostering collaborative problem-solving with

interest holders (Hammond, 2010; Warren, 2021). Best practices for utilizing a strengths-based approach in evaluation entail identifying and uplifting community strengths, cocreating solutions, and using asset-based language to highlight capabilities.

Community engagement efforts to date have highlighted the need to reconceptualize evaluation outcomes. This involves shifting from deficit-based language to asset-based language, reframing metrics to focus on strengths and capacities rather than deficits and limitations (Hammond, 2010; HERE to HERE, 2020). This process not only enhances the effectiveness of the evaluation but also fosters a more collaborative and empowering approach to addressing mental health needs in schools and local communities.

The MHSSA Evaluation aims to gauge the impact of MHSSA activities and services focusing on diverse student needs. In the process of revising outcome language through a strengths-based approach, it is crucial to recognize the impact of the words used to discuss young people and their communities (Hammond, 2010; HERE to HERE, 2020). These words shape not only how they are perceived but also how they perceive themselves and their opportunities. Language can either deepen understanding and foster meaningful connections or perpetuate negative stereotypes and alienate individuals. Therefore, embracing asset-based language that prioritizes the person over characteristics and is specific in its description becomes paramount. This involves identifying and eliminating problematic language that may perpetuate harmful stereotypes or misinformation and assigning responsibilities to systems that create and perpetuate inequities rather than placing blame on individuals. By adopting a strengths-based approach, the revised outcome language not only reflects strengths and potentials but also promotes clarity, accuracy, and inclusivity in communication.

In our ongoing efforts to revise outcome language through a strengths-based lens within the MHSSA Evaluation, WestEd is actively applying asset-based language to showcase strengths and potential for positive change. The current outcome language, such as “preventing mental health challenges from becoming severe and disabling,” “reducing school failure or dropout,” and “reducing removal of children from their homes,” is being reimagined to reflect asset-based language, characteristic of a strengths-based approach. WestEd is exploring different language to maintain the essence of legislative language while utilizing asset-based language through input from youth as a first step. While in the early phases of this rewording process, initial and evolving examples include the following:

- “preventing mental health challenges from becoming severe and disabling” into “enhancing early intervention and support for mental health challenges” places emphasis on proactive measures and the capacity for growth and resilience
- “reducing school failure or dropout” into “supporting academic success and retention rates” highlights educational empowerment and achievement as strengths
- “reducing removal of children from their homes” into “promoting family stability through comprehensive support services aimed at keeping families together and

thriving" recognizes the strengths within families and the importance of holistic support systems

By embracing this strengths-based approach, we ensure that the MHSSA Evaluation not only captures the nuanced impact of mental health services but also fosters empowerment and collaboration within communities.

Community engagement efforts are underway to inform the future iterations of a narrower set of outcomes and as this feedback is collected, WestEd will make adjustments accordingly. At this stage in the evaluation planning process, WestEd has provided a summary of what community partners have shared, representing perspectives of those individuals and groups who have participated in MHSSA community engagement opportunities thus far.

Community engagement will continue to inform the evolution of the final MHSSA Evaluation Plan as WestEd engages in a community feedback loop to refine the elements of the plan to reflect diverse community perspectives (WestEd-MHSOAC, 2023).

Considerations for Designing the MHSSA Evaluation Plan

One critical feature of any evaluation plan, including the development of metrics, measurement tools, and methodological and analytic approaches, is clear alignment and linkage to the ToC, conceptual models, research questions, and logic model (Ravitch & Riggan, 2016). The constructs and variables represented in this report reflect legislative requirements purposefully as a starting point for ongoing conversations with a range of partners. In addition, as the evaluation planning process continues, there are practical considerations that will factor into the identification and selection of outcomes that are measurable and feasible given the available data. WestEd recognizes that there will be times when community input may not be feasible to incorporate into the plan due to these potential limitations. If and when community partner feedback cannot be incorporated due to limitations imposed by data, WestEd will document the partner feedback and process used to explore integration into the final MHSSA Evaluation Plan.

Developing Research Questions

Research questions for the statewide MHSSA Evaluation were developed by applying the ToC and community engagement findings to the FINERMAPS framework developed by Ratan and colleagues (2019).

The MHSSA Evaluation research questions are designed to be

- **feasible**—within the ability of MHSOAC, WestEd, and grantees to carry out;

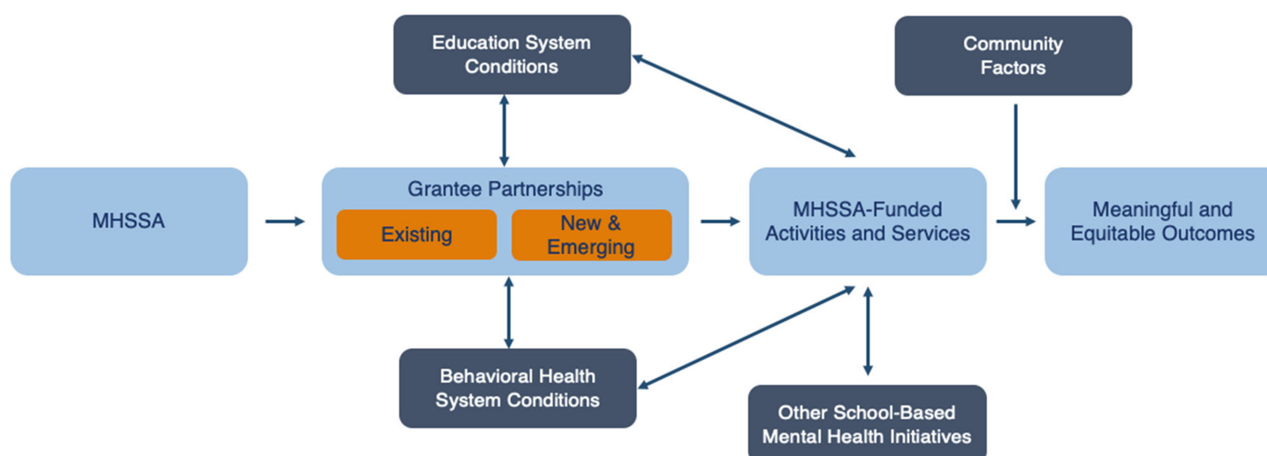
- **interesting**—of interest to leaders, educators, community organizations, and youth across the state;
- **novel**—reflective of the innovation within MHSSA and the imagination of grantees and evaluators;
- **ethical**—minimizing the risk of harm, maximizing benefit, and meaningfully incorporating community voice throughout the process;
- **relevant and useful**—arising from current strengths, needs, and opportunities and having utility to grantees and partners working across the state in school based mental health;
- **manageable**—able to be managed by the evaluators and grantee partners;
- **appropriate**—logical and meaningful to all parties: the Commission, grantees, community partners, and all others working in school-based mental health;
- **valuable**—able to make a significant impact within California and beyond; and
- **systematic**—containing steps to be taken in a specified sequence in order to ensure the highest quality.

As the MHSSA metrics are being developed, the research questions are being refined based on feedback from the Commission, external evaluators, and our ongoing community engagement efforts. As community engagement continues, WestEd will iterate (i.e., fine-tune) this Evaluation Framework until the final Evaluation Plan is presented.

Theory of Change

The MHSSA Evaluation ToC (Figure 5) illustrates the mechanisms of change underlying the intent and goals of the MHSSA legislation and grants and represents the relationship between elements in the ToC. The ToC depicts the directional influence of the MHSSA on supporting existing, or establishing new, partnerships between county behavioral health and county offices of education or local education agencies. These partnerships lead to specific activities and services enacted in schools and communities and, as a result of these activities and services, youth, families, communities, and schools experience meaningful and equitable outcomes. This ToC is an a priori, hypothesized mechanism of a change model and is specific to the MHSSA and its implementation across California. Although additional elements and complexities may exist, the ToC presents the most direct and measurable framework for evaluating statewide MHSSA implementation and impact.

Figure 5. The MHSSA Theory of Change



In addition to depicting pathways from one element to another, the ToC depicts potential feedback loops that reflect the nonlinear nature of the MHSSA mechanisms of change (Mayne, 2023). The logic reflected in this model assumes that transformational change is facilitated by effective grantee partnerships. Through the work of grantee partnerships, both education and behavioral health systems conditions become more conducive to both reinforce effective partnerships and support the implementation of MHSSA-funded activities and services.

The arrows between each system (educational and behavioral health) and the MHSSA-funded activities and services depict the bidirectional relationship between systems and the activities and services themselves. This portion of the ToC focuses on those system-level conditions, partnerships, and types of collaboration that would be needed to support implementation of the MHSSA-funded activities and services. When MHSSA-funded activities and services are implemented, then individuals, families, schools, communities, and the systems themselves will be positively impacted in meaningful and equitable ways.

The context in which an initiative operates is an important factor in the potential relationship between the initiative and the outcomes of interest (Vanderkruik & McPherson, 2017). These factors may be observed or unobserved, and they influence the extent to which the initiative achieves its intended outcome. As one contextual element of a broader investment in California’s student behavioral health system, the evaluation must consider the relationship between the MHSSA and other school mental health (SMH) activities and services. These SMH activities and services are a critical contextual factor in this model and likely have both direct and indirect effects on implementation of MHSSA-funded activities and services in each county.

A second contextual consideration within this model is the community context in which the MHSSA activities and services operate. All communities experience facilitators and barriers that influence the outcomes of SMH activities and services—in this case, those outcomes associated with the MHSSA. There are myriad community contexts to consider, including urbanicity, financial resources, safety, and racial composition, to name just a few. We acknowledge that community factors likely influence every element in the ToC, from partnerships to the activities and services conducted in schools and communities. However, we are focusing on the moderating effects of community factors on the relation between what is implemented and the meaningful and equitable outcomes because we can directly measure and statistically model these influences. As noted above, the ToC does not capture all possible complexity but instead focuses on the elements and contexts that can be measured and evaluated.

Conceptual Models and Research Questions

The conceptual models (Figures 6–14) operationalize each element of the MHSSA ToC and outline the theoretical underpinnings of the constructs represented in each conceptual model, situating these constructs within their respective literature bases. Insights from community engagement are also included alongside each of the conceptual models. Each conceptual model section ends with the specific research questions that align with their respective models that, together, will shape the MHSSA Evaluation Plan. All of the research questions, organized by conceptual model, are presented together below (Table 4).

As described above, the research questions represented in this report reflect legislative requirements purposefully as a starting point for ongoing conversations with a range of partners.

As previously noted, research questions and outcomes are being revised in the development of the MHSSA Evaluation Plan to better reflect the perspectives collected through ongoing community engagement, strengths-based language, and constraints/opportunities identified in the metrics mapping process.

Table 4. Statewide MHSSA Evaluation Research Questions

The MHSSA	
1.	How did the MHSOAC support the implementation of effective MHSSA partnerships?
2.	What were the facilitators related to the MHSOAC's • provision of funding to counties, • technical assistance, • evaluation, • oversight and accountability, and • leadership?

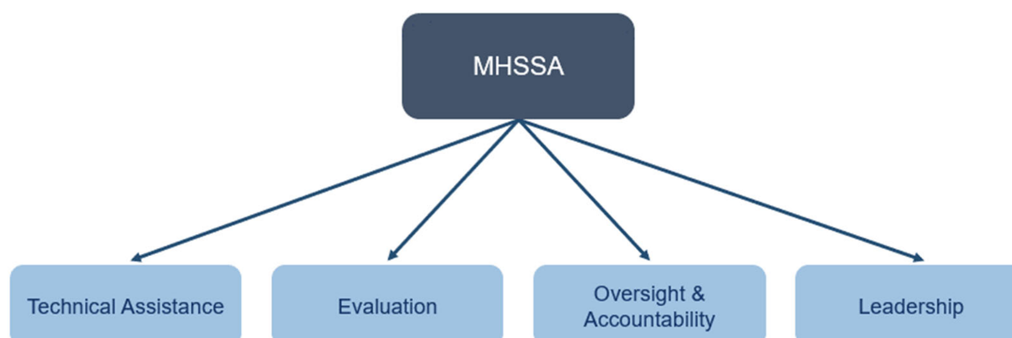
<table>
<tr><th colspan="2">The MHSSA</th></tr>
<tr><td>3.</td><td>What were the barriers related to the MHSOAC's
provision of funding to counties,
technical assistance,
evaluation,
oversight and accountability, and
leadership?</td></tr>
<tr><th colspan="2">Grantee Partnerships</th></tr>
<tr><td>4.</td><td>Who was involved in the MHSSA-funded partnerships at each level of the system (county, district, school) and what was their role?</td></tr>
<tr><td>5.</td><td>What were the facilitators related to fostering agreement among partners on
the goals of their MHSSA's partnership,
staffing decisions,
roles and responsibilities of the individuals and entities within the partnership,
fiscal management of their MHSSA initiative,
collaborative decision-making, and
oversight of their MHSSA initiative?</td></tr>
<tr><td>6.</td><td>What were the barriers related to fostering agreement among partners on
the goals of their MHSSA's partnership,
staffing decisions,
roles and responsibilities of the individuals and entities within the partnership,
fiscal management of their MHSSA initiative,
collaborative decision-making, and
oversight of their MHSSA initiative?</td></tr>
<tr><td>7.</td><td>How were the MHSSA's grantee partnerships strengthening and strengthened by local education and behavioral health systems conditions?</td></tr>
<tr><th colspan="2">Education Systems Conditions</th></tr>
<tr><td>8.</td><td>To what extent were new sets of incentives created within the education system because of the MHSSA partnership?</td></tr>
<tr><td>9.</td><td>To what extent were new sets of constraints created within the education system because of the MHSSA partnership?</td></tr>
<tr><td>10.</td><td>To what extent were new sets of opportunities created within the education system because of the MHSSA partnership?</td></tr>
<tr><th colspan="2">Behavioral Health System Conditions</th></tr>
<tr><td>11.</td><td>To what extent were new sets of incentives created within the behavioral health system because of the MHSSA partnership?</td></tr>
<tr><td>12.</td><td>To what extent were new sets of constraints created within the behavioral health system because of the MHSSA partnership?</td></tr>
<tr><td>13.</td><td>To what extent were new sets of opportunities created within the behavioral health system because of the MHSSA partnership?</td></tr>
<tr><th colspan="2">MHSSA-Funded Activities and Services</th></tr>
<tr><td>14.</td><td>What activities and services were implemented using MHSSA funding?</td></tr>
<tr><td>15.</td><td>How were activities and services selected, designed, and implemented to close the equity gap?</td></tr>
<tr><td>16.</td><td>Who implemented the activities and services, and how frequently were the services implemented?</td></tr>
</table>

The MHSSA	
17.	What were the facilitators of the implementation process?
18.	What were the barriers of the implementation process?
19.	To what extent did grantees collect fidelity of implementation measures, how did they collect them, and what were the results?
20.	What additional school mental health initiatives were in place in the district or county?
21.	How did educators and behavioral health professionals perceive those other school mental health initiatives influencing decision-making around the MHSAA-funded activities and services?
Meaningful and Equitable Outcomes	
22.	What was the relationship between implementation of MHSSA-funded activities and services and each of the short-term outcomes? And for whom?
23.	What was the relationship between implementation of MHSSA-funded activities and services and each of the intermediate outcomes? And for whom?
24.	Did short-term outcomes mediate the relationship between implementation of MHSSA-funded activities and each of the long-term outcomes? And for whom?
Community Factors	
25.	To what extent did community factors moderate the relationship between the MHSSA-funded initiative and the short-term and intermediate outcomes?

The MHSSA

In 2022, the California Legislature and governor appropriated funding for encumbrance or expenditure by the MHSOAC to support the MHSSA, including funding for grants, evaluation, and technical assistance. The MHSOAC was created by the Mental Health Services Act, in WIC Section 5845, to provide oversight, accountability, and leadership to guide the transformation of California's mental health system (Mental Health Services Oversight and Accountability Committee, 2022). Two inputs make up the MHSSA, the WIC Section 5886 and the appropriated funding. The MHSSA is responsible for four outputs: technical assistance, evaluation, oversight and accountability, and leadership (Figure 6).

Figure 6. Conceptual Model of the MHSSA



Comprehensive school mental health systems change requires alignment of leadership teams at all levels of the system, including the state, to ensure that policies, funding, communications, and resources align to support school communities (Council of Chief State School Officers [CCSSO] and National Center for School Mental Health [NCSMH], 2023; Walrond & Romer, 2021). The constructs represented in Figure 5 are defined in legislation and support downstream systems change.

Leadership for the MHSSA is provided largely by the Executive Director and two key teams: the Research & Evaluation Division (RED) Team and the Community Engagement & Grants (CEG) Team. The RED team "guides the Commission's assessment activities to realize transformational changes across service systems to advance the overarching goal of ensuring that everyone receives timely and effective mental health services when needed" (MHSOAC, n.d.). In short, the RED Team provides evaluation, oversight and accountability. The CEG Team, monitors, provides technical assistance, and supports grantee recipients as they implement on the ground (CEG meeting, 2024). Similar to the RED Team, the CEG Team provides oversight and accountability, as well as technical assistance to the grantees.

Partner Insights

The conceptual model of the MHSSA is informed by conversations with the Commission. Through conversation with Commission staff and leaders at a kickoff meeting in Sacramento, WestEd learned more about the overall vision for the MHSSA and the leadership provided by the Commission and other state leaders. In addition to conducting a comprehensive document review, WestEd spoke with more than two dozen MHSOAC staff involved in the administration and implementation of the MHSSA, including staff across the CEG team and RED team, to understand more about the key elements of MHSSA administration.

Through conversations with the RED team, WestEd understands the MHSSA supports and activities they provide include preparing MHSSA Legislative Reports, collecting data through the Biannual Data Collection and Reporting Tools, facilitating meetings

with grantees and external workgroups, organizing and facilitating engagement with a broad set of community partners, and coordinating evaluation contracts with external contractors.

Through conversations with the CEG team, WestEd understands the MHSSA supports and activities they provide include collecting and reviewing required grantee documents, facilitating the formation of partnerships, organizing and facilitating grantee collaboration meetings, and providing technical assistance. These activities are represented in the categories of providing technical assistance, grant management, and oversight. Anecdotally, the CEG described various activities supporting the implementation of effective partnerships and being responsive to grantee challenges, which are important to capture in an evaluation to truly understand the role of the MHSSA.

MHSSA Research Questions

1. How did the MHSSA Commission support the implementation of effective MHSSA partnerships?
2. What were the supports related to the MHSOAC's
    a. provision of funding to counties,
    b. technical assistance,
    c. evaluation,
    d. oversight and accountability, and
    e. leadership?
3. What were the barriers related to the MHSOAC's
    a. provision of funding to counties,
    b. technical assistance,
    c. evaluation,
    d. oversight and accountability, and
    e. leadership?

Grantee Partnerships

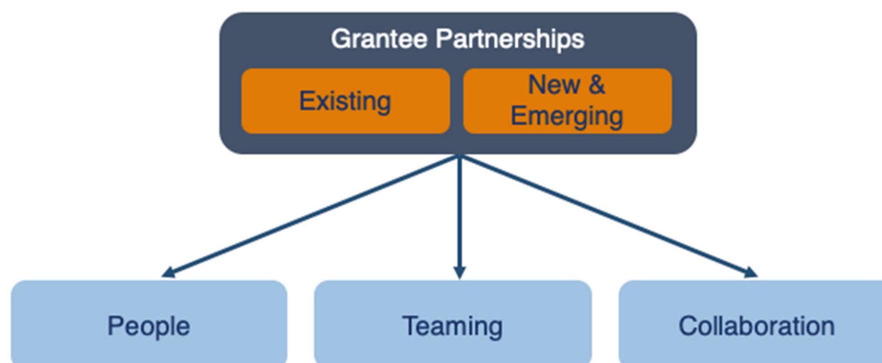
The MHSSA vision was to establish schools as centers of well-being to address students' unmet needs and improve their access to services. To this end, the MHSSA is intended to foster stronger school–community mental health partnerships that can leverage resources to help students succeed by authorizing counties and local education agencies to enter into partnerships that support a more comprehensive and integrated model of school mental health services and supports.

School mental health systems integrate partners so that supports and services are aligned and coordinated (Barrett et al., 2017; CCSSO and NCSMH, 2021) and, thereby, increase access for young people and their families to services. While MHSSA partnerships range from existing to new and emerging, these partnerships are the proximal result of the MHSSA and integral to all subsequent activities and services enacted in schools and communities. Thus, the partnerships are the key component of the grantee activities.

The roles and responsibilities of school and behavioral health partners will differ from one community and team to the next; however, collaboration and teaming practices are critical at all levels of the service delivery system (i.e., state, county, district, school) to support ongoing implementation of a culturally responsive and sustainable school mental health system (Bohnenkamp et al., 2023; Eber et al., 2019; Malone et al., 2022). The majority of MHSSA grantees have identified collaboration and partnering in their plans for implementation.

Figure 7 depicts the MHSSA partnerships to include both existing partnerships and the development of new and emerging partnerships. The core components of each of these partnerships include people, teaming practices, and collaboration. The people component includes leadership team composition, roles, and participation—essentially, the “who.” The teaming practices and procedures of cross-agency leadership teams (e.g., operating procedures; data-based decision-making informed by school, community, and student data; referral pathway protocols; data sharing; meeting agendas and action plans) are essential for facilitating the implementation of an integrated system of supports and services (NCSMH, 2020; Splett et al., 2017). Finally, the collaboration component involves sharing knowledge and resources to accomplish more than either agency could accomplish on its own (Mellin & Weist, 2011). It has been characterized by newly defined relationships and roles, interdependence, collective ownership and accountability, shifting beliefs, building a shared understanding, and addressing power inequalities (Bronstein, 2003; Mellin & Weist, 2011; Splett et al, 2017).

Figure 7. Conceptual Model of Grantee Partnerships



Partner Insights

From conversations with MHSOAC staff and MHSSA grantees, WestEd has an initial understanding of the important components of grantee partnerships that are essential to the success of the MHSSA's implementation. During listening sessions, grantees shared information about local implementation of the MHSSA project plans that reflected each county's history of collaboration between departments of behavioral health and local education agencies. Grantees across each funding phase had unique challenges and experiences in establishing or improving partnerships.

Grantees described a range of facilitators and barriers to fostering agreement. In particular, agencies that underwent staffing changes had more challenges in building and maintaining their partnerships. Based on this information, the conceptual model of grantee partnerships focuses on the importance of people as a distinct element that has a significant role in the implementation and success of partnerships.

Grantees also shared that interagency leadership requires county behavioral health departments and county offices of education to address their processes of teaming and collaboration, including relationship building and transparency, development of formal agreements, shared decision-making and follow-through on action plans, creation of referral pathways to link students to services, development of communication systems, and braided funding. Finally, grantees spoke extensively about the importance of shared vision and goals and of agreement on a unified approach, and they described fiscal management and oversight of grant funds. Based on these conversations, WestEd's proposed research questions include measuring the facilitators and barriers to fostering agreement among partners.

Grantee Partnerships Research Questions

1. Who was involved in the MHSSA-funded partnerships at each level of the system

(county, district, school) and what was their role?

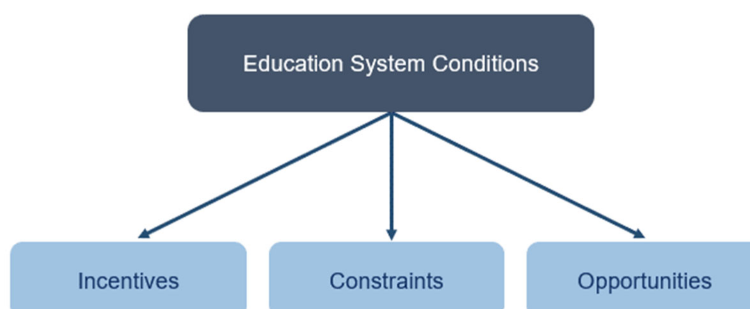
2. What were the facilitators related to fostering agreement among partners on
    a. the goals of their MHSSA's partnership,
    b. staffing decisions,
    c. roles and responsibilities of the individuals and entities within the partnership,
    d. fiscal management of their MHSSA initiative,
    e. collaborative decision-making, and
    f. oversight of their MHSSA initiative?
3. What were the barriers related to fostering agreement among partners on
    a. the goals of their MHSSA's partnership,
    b. staffing decisions,
    c. roles and responsibilities of the individuals and entities within the partnership,
    d. fiscal management of their MHSSA initiative,
    e. collaborative decision-making, and
    f. oversight of their MHSSA initiative?
4. How were the MHSSA's grantee partnerships strengthening and strengthened by local education and behavioral health systems conditions?

Education System Conditions

Within interagency systems change initiatives such as the MHSSA, change must occur both within and across agencies. Figure 8 and Figure 9 depict the conditions within agencies that make change possible—we refer to these as system conditions.

System conditions are comprised of structures within an agency, such as policies, laws, funding, knowledge, culture, norms, and standard practices (Latham, 2014). They incentivize, constrain, and create opportunities for change within that system. Incentives are defined as potential benefits for taking a particular action, constraints as rules or limits that prevent a particular action or make an action difficult, and opportunities as conditions that enable or help facilitate a particular action (Latham, 2014). Adverse incentives, undesirable constraints, and limited opportunities create structural barriers. Structural supports are created with altered incentives, relaxed constraints, and new opportunities. Systems change occurs when structural barriers are reduced and structural supports are developed.

Figure 8. Conceptual Model of Education System Conditions



Several grantees described the mental health professional workforce shortage as a significant structural barrier in the education system. While lower student–staff ratios are necessary, there is a constraint related to the availability of trained and certified professionals. Grantees identified opportunities like internships, workforce development programs, and professional development to help address this barrier.

Partner Insights

The theory of change includes education systems conditions to reflect the experiences shared by grantees during listening sessions. Grantees were asked how education systems conditions impact their MHSSA partnership. Grantees described the ways in which education system conditions have affected their planning and decision-making and, ultimately, the implementation of MHSSA-funded activities and services. For example: financial incentives to strengthen mental health and well-being supports in schools; constraints related to resources, space, and staffing; and the promise of training to address gaps in the knowledge of staff across the county, district, and school systems. WestEd heard from grantees about the creative ways that their MHSSA partnerships have led to new incentives and opportunities to implement and improve school mental health initiatives. Due to these insights, the evaluation will measure the extent to which education system conditions impact and are impacted by MHSSA partnerships.

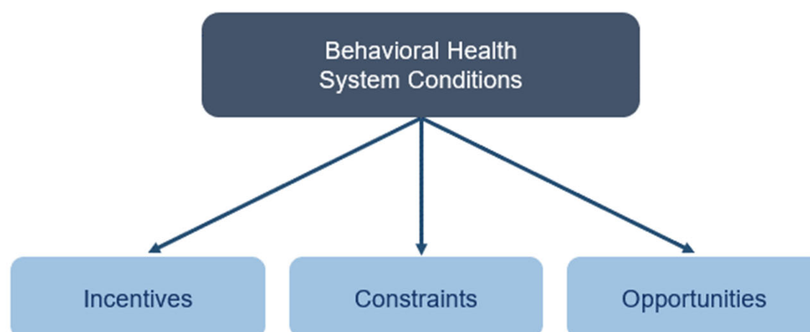
Education System Research Questions

1. To what extent were new sets of incentives created within the education system because of the MHSSA partnership?
2. To what extent were new sets of constraints created within the education system because of the MHSSA partnership?
3. To what extent were new sets of opportunities created within the education system because of the MHSSA partnership?

Behavioral Health System Conditions

As previously noted, system conditions may comprise policies, laws, funding, knowledge, culture, norms, and standard practices (see Figure 9; Latham, 2014). They incentivize, constrain, and create opportunities for change within that system. Systems change occurs when structural barriers are reduced, and structural supports are developed.

Figure 9. Conceptual Model of Behavioral Health System Conditions



An example of a structural barrier in a behavioral health system is limited access to outpatient mental health care, especially for those in economically disadvantaged communities. Grantees proposed addressing this barrier by leveraging MHSSA funds to provide in-school group and individual therapy, supports, and case management through telehealth and other creative means.

Partner Insights

The theory of change includes behavioral health systems conditions to reflect the experiences shared by grantees during listening sessions. Grantees were asked how behavioral health systems conditions impact their MHSSA partnership. Grantees described behavioral health systems conditions that impacted their infrastructure for tracking referrals, billing insurance, and maintaining staff to meet the needs of their communities. Grantees shared examples of facilitators introduced through their MHSSA partnerships, such as revising protocols to improve coordination of behavioral health care for students. Due to these insights, the evaluation will measure the extent to which behavioral health system conditions impact and are impacted by MHSSA partnerships.

Behavioral Health System Research Questions

1. To what extent were new sets of incentives created within the behavioral health

system because of the MHSSA partnership?

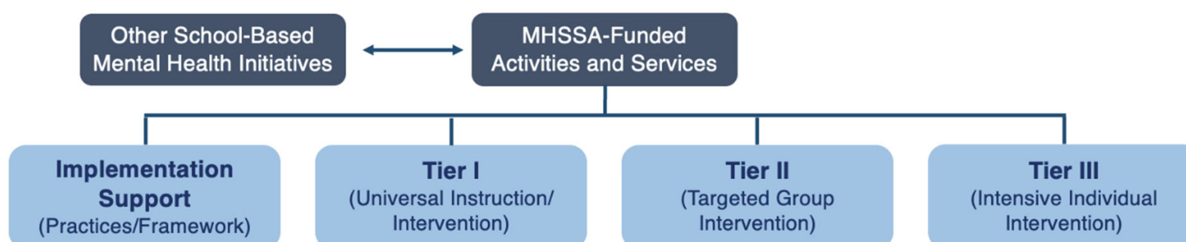
2. To what extent were new sets of constraints created within the behavioral health system because of the MHSSA partnership?

3. To what extent were new sets of opportunities created within the behavioral health system because of the MHSSA partnership?

MHSSA-Funded Activities and Services

The MHSSA activities and services groupings (Figure 10) are based on a comprehensive review of all available documents from grantees and the Commission to date, the Grant Summaries Review, and feedback collected during community engagement activities. Further refinement may be required after additional feedback is collected from a broader range of community partners about the critical features of their MHSSA-funded activities and services. Because of the evolving nature of the MHSSA Evaluation, an important goal of Phase 2 of this evaluation will be to systematically inventory all activities and services grantees have implemented during the complete funding period.

Figure 10. Conceptual Model of MHSSA-Funded Activities and Services



As previously noted, MHSSA-funded activities and services are occurring within a larger school mental health landscape. As such, other school-based mental health initiatives may have impacted decisions to (a) pursue MHSSA funding, (b) select activities and services to develop using the MHSSA funds, and, ultimately, (c) implement MHSSA-funded activities and services. In their grant applications, counties were asked to name the additional sources of funds supporting the MHSSA partnership. Additional funding sources vary and reflect the range of available funds associated with federal, state, and local funding sources that may have influenced why a particular activity or service was chosen. The relationship between MHSSA-funded activities and services and other school-based mental health initiatives is bidirectional, as MHSSA-funded activities and services may also have influenced how schools, districts, or counties implemented other

mental health initiatives.

Partner Insights

WestEd hosted a series of listening sessions with grantees to learn more about the activities and services that are supported by MHSSA funds. Each grantee is implementing activities and services that address a specific gap in their county, and thus the activities and services range widely, though all activities described fit within a tiered model and/or can be characterized as implementation support. The variation in MHSSA-funded activities and services described by grantees reflects the importance of measuring the activities and services implemented using MHSSA funds and understanding the relationship between the community context and local need.

Grantees also shared their desire to learn about best practices and lessons learned from MHSSA implementation through the evaluation. Grantees are interested in how other counties use their funds, including strategies to effectively braid funds to sustain the work initiated through the MHSSA. Grantees also expressed interest in data sharing and use and capacity building efforts within schools and districts to recruit, train, and sustain school mental health personnel. They also expressed interest in learning from one another about strategies to navigate administrative barriers that exist due to high staff turnover and loss of institutional knowledge. These questions can be answered by aligning the MHSSA Evaluation Plan with the implementation evaluation questions below.

MHSSA-Funded Activities and Services Research Questions

1. What activities and services were implemented using MHSSA funding?
2. How were activities and services selected, designed, and implemented to close the equity gap?
3. Who implemented the activities and services, and how frequently were the services implemented?
4. What were the facilitators of the implementation process?
5. What were the barriers of the implementation process?
6. To what extent did grantees collect fidelity of implementation measures, how did they collect them, and what were the results?
7. What additional school mental health initiatives were in place in the district or county?
8. How did educators and behavioral health professionals perceive those other school mental health initiatives influencing decision-making around the MHSAA-

funded activities and services?

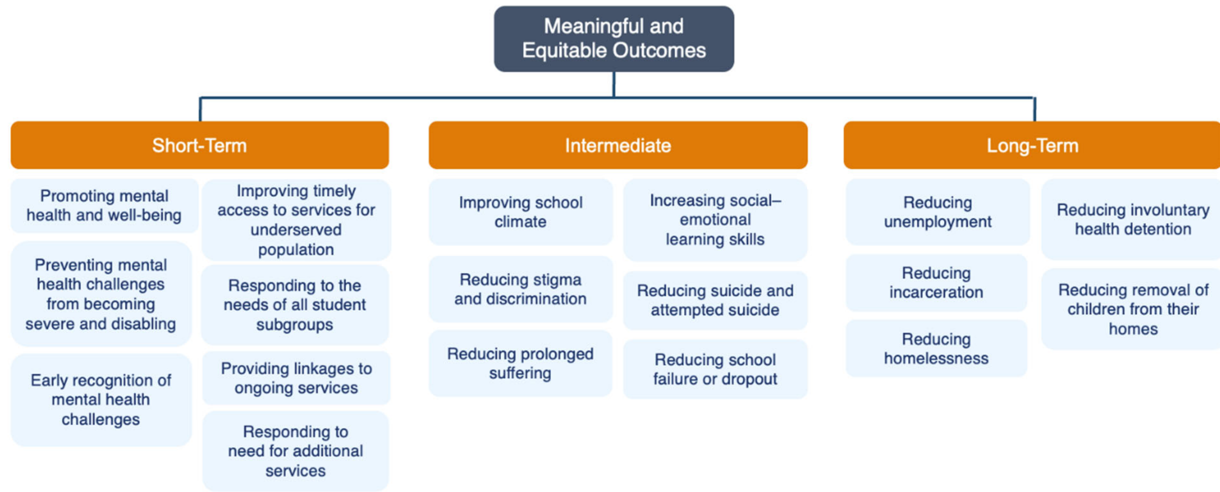
Meaningful and Equitable Outcomes

The statewide MHSSA Evaluation Framework builds the foundation for a systematic exploration of how the underlying theoretical constructs and mechanisms of this large initiative ultimately impact student outcomes in the short-term and over time. The evaluation will uncover how the MHSSA was implemented within the larger school mental health landscape, what impact it had, and for whom. As such, the focus is on outcomes that are meaningful (i.e., facilitate learning and continuous improvement) to various interest holders and center equity (i.e., close the equity gap). The outcomes listed in Figure 11 were identified in the legislation, our ongoing community engagement efforts, and a comprehensive review of all available documents from grantees.

The constructs and variables represented in this report purposefully reflect the language in legislation as a starting point for ongoing conversations about strengths-based language, meaningful and equitable outcomes, and outcomes that are feasible to measure. Community engagement efforts are underway to inform the future iterations of a narrower set of outcomes. At this stage in the evaluation planning process, WestEd has provided a summary of what community partners have shared for those individuals and groups who have been engaged thus far. Those comments are summarized below.

A final consideration in narrowing down the list of outcomes is identifying the conceptual linkage of each outcome to the mechanisms of change outlined in this report. One important step in the metrics mapping process is to ensure that all data collected through this evaluation are conceptually linked to the grantee partnerships and MHSSA-funded activities and services.

Figure 11. Conceptual Model of Meaningful and Equitable Outcomes of the MHSSA



Partner Insights

The conceptual model for meaningful and equitable outcomes reflects many of the short-, intermediate-, and long-term goals that grantees and youth discussed during listening sessions. While the MHSSA Evaluation focuses on the collective impact of MHSSA activities and services, grantees have identified how grant funds would be used within their own local contexts to achieve the outcomes listed in the legislation, which are a subset of those listed in Figure 11. Examples of grantee activities linked to each outcome set forth in WIC Section 5886(c) are summarized below (Table 5). Table 5 highlights example mechanisms of change as articulated by grantees and demonstrates linkages between activities and outcomes. As outcomes become more distal, grantees describe the indirect effects of their MHSSA-funded activities and services on each outcome, often referring back to the importance of short- or intermediate-term outcomes in promoting long-term student mental health and well-being. An important caveat for the table below is that grantees were required to identify activities that were conceptually related to every legislative outcome within their grant proposals. The CEG team and grantees themselves have shared that some of the proposed activities did not occur, particularly those linked to long-term outcomes.

Table 5. Example Grantee Activities by Outcome

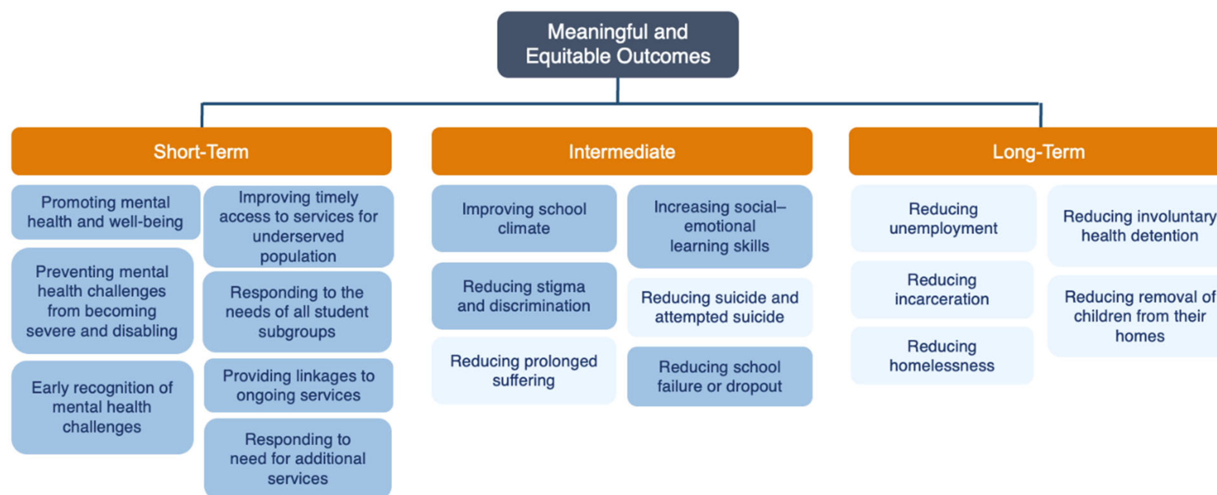
Short-Term	
Improving timely access to services for underserved populations	• Develop clear universal screening and referral pathways. • Develop a health & wellness center on-site at the high school to increase capacity to provide direct services through partnership with community-based organizations.

Preventing mental health challenges from becoming severe and disabling	• Tighten protocols for a screen-triage-connect process. • Increase student counseling services on site and improve the pathways for that service.
Providing outreach to families, employers, primary care healthcare providers, and others to recognize the early signs of potentially severe and disabling mental illnesses	• Provide training to parents, community agencies, student groups, and educational staff members. • Host informational meetings and provide information to the community.
Intermediate	
Reducing stigma and discrimination around mental health challenges	• Normalize service delivery through trusted on-site clinician. • Promote positive school/district climate.
Reducing prolonged suffering	• Improve timely access to services for underserved populations. • Create rapid access to care pipelines and youth and family-friendly linkages to available resources.
Reducing suicide and attempted suicide	• Provide screening. • Make training available for project staff and members of the community to recognize signs of mental illness and substance use disorders and work to reduce access to lethal means.
Reducing school failure or dropout	• Identify barriers to school success and determine appropriate methods to address them in treatment. • Attend local school attendance review team meetings to help diagnose and resolve persistent student attendance or behavior problems.
Long-Term	
Reducing unemployment	• Provide person-centered planning and other transition support to encourage youth goal achievement in areas that include employment. • Assist our adolescents on how to apply their therapeutic skills and manage their mental illness in the workplace so that retaining employment is not an issue.
Reducing incarceration	• Provide training to law enforcement of the early identification of youth with mental health issues and how to engage them in care to deter from and decrease incarceration.

	• Develop a guide for service providers and the general public to help determine which responders to contact and when.
Reducing homelessness	• Work with our schools' homeless liaisons on a monthly basis. • Work with students who are experiencing homelessness and their families to connect them to resources and services.
Reducing involuntary health detention	• Ensure students have services after discharge from hospitalization. • Give school staff the tools necessary to de-escalate student behavior and reduce or prevent the need for referrals for involuntary mental detentions.
Reducing removal of children from their homes	• Coordinate training for Child Protective Services staff so they are aware of the services available at schools and can communicate with schools so services continue and/or be provided when children are removed from the home. • Assist with helping parents raise children that may have destructive adolescent behavior or provide guidance for parents with difficult younger children.

Figures 12 through 14 summarize what WestEd has heard from grantees, youth, and Commission leaders about outcomes broadly throughout community engagement thus far. Many of the long-term outcomes do not appear to be particularly meaningful to grantees and youth. Grantees stated that their immediate focus and set of priorities is on short-term outcomes and a few of the intermediate outcomes listed in legislation.

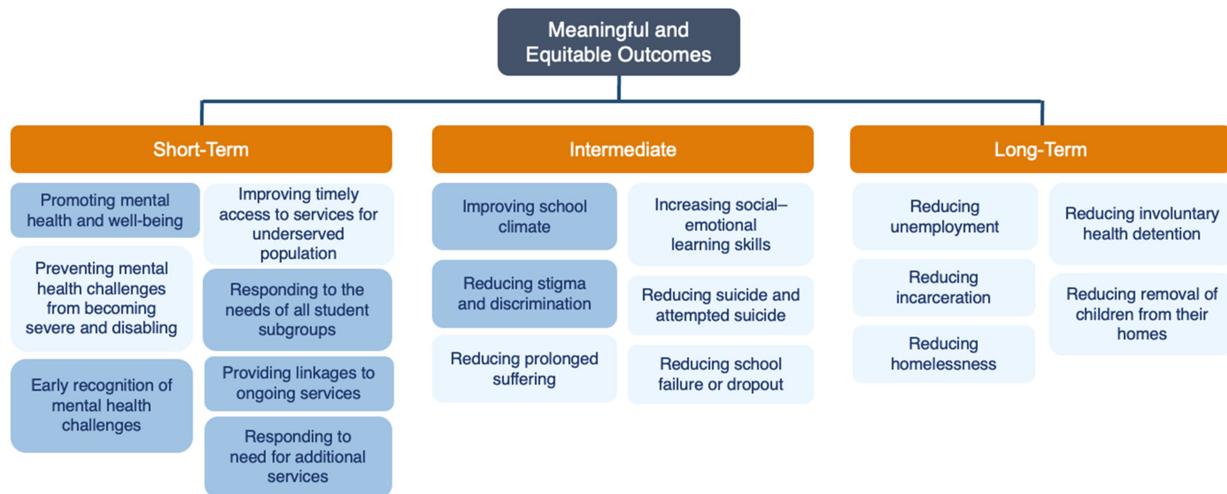
Figure 12. Outcomes Reflected in Grantee Engagement



During fall listening sessions with grantees, grantees identified outcomes such as strengthening school mental health systems and addressing inequities in access to responsive and effective mental health supports and services. Grantees discussed student-level outcomes that would result from effective MHSSA implementation, such as addressing service gaps for specific populations of students (e.g., those who are MediCal eligible); ensuring more students receive appropriate referrals; linking students to services; and accessing culturally responsive, trusted mental health resources. Many grantees spoke of the benefits of MHSSA funding to improve Tier I and II supports to prevent students from needing Tier III, intensive, and/or urgent supports.

Grantees identified outcomes that would occur in the intermediate term following implementation of MHSSA-funded activities and services. Some identified priorities included promoting positive school climate, raising awareness about mental health to reduce stigma, reducing incidence of de-escalations, and improving school-level academic and behavioral outcomes (i.e., chronic absenteeism, suspensions) to ultimately prevent school failure and dropout. Grantees did not speak extensively about long-term outcomes although they emphasized the overall outcome of MHSSA to improve cross-system collaboration.

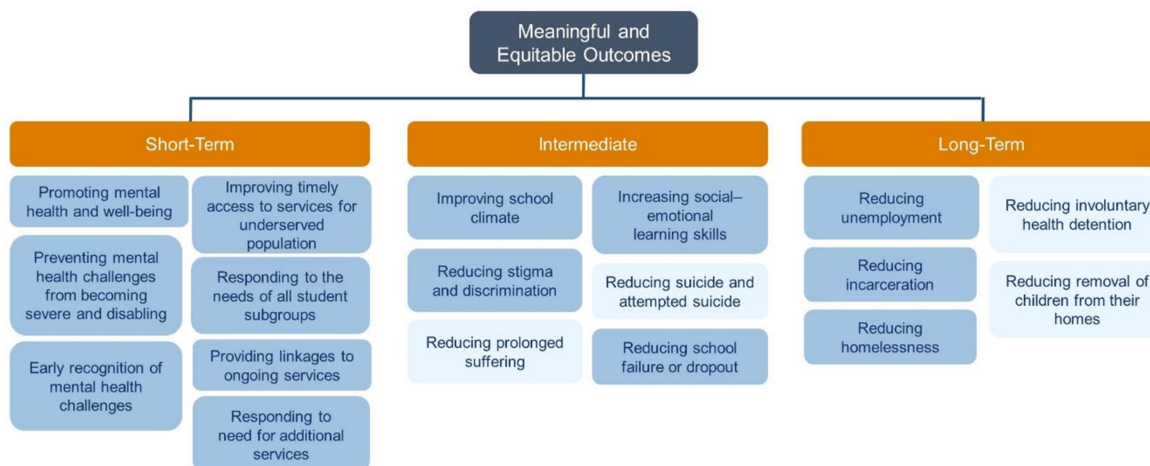
Figure 13. Outcomes Reflected in Youth Engagement



The community engagement team also spoke with youth to understand what outcomes are most meaningful to them. During listening sessions and youth advisory group sessions, youth primarily spoke to the short-term outcomes related to responding to students needs with timely access and/or linkage to services. Youth emphasized the importance of adults in school being able to understand student needs; addressing gaps in school mental health systems; and ensuring access to trusted resources such as student toolkits, safe spaces, and information about mental health services. They indicated that should these outcomes occur, youth would know where to get help and have the ability to access those services.

In our conversations with youth, they also stressed the importance of intermediate-term outcomes such as improving school climate and reducing stigma and discrimination. Many youth emphasized the importance of a school environment that is not stressful and where there is no bullying and students get along. Youth described the importance of having trusted adults who take time to ask them how they are rather than focusing on discipline. In regard to reducing stigma and discrimination, youth spoke to the importance of mental health being a topic discussed regularly in school and having resources available in an open format such as wellness centers, bulletin boards, and so forth. They indicated that should these outcomes occur, students would be more willing to seek support and follow through with accessing behavioral and mental health services.

Figure 14. Outcomes Reflected by MHSOAC Partners



WestEd also spoke with interest holders in the MHSOAC Research and Evaluation Workgroup, the CEG Team, and other MHSOAC leaders to inform the MHSSA Evaluation outcomes. The CEG team expects that there will be several “universal” outcomes of the MHSSA, such as responding to needs of all student subgroups, responding to student need for additional services, and ensuring timely access and/or linkage to services to prevent mental health challenges from becoming severe and disabling. They indicated that the heterogeneity of MHSSA activities and services would necessitate flexibility in which outcomes would be associated with different grantees.

The Research and Evaluation Workgroup emphasized the importance of the evaluation capturing how short-term outcomes impact long-term outcomes. In addition to the existing short-term outcomes, workgroup members suggested including outcomes related to the organizational culture and leadership of schools. This would include, for example, promoting effective student mental health leadership and promoting competency for educators to refer appropriately. The Research and Evaluation Workgroup was interested in outcomes related to the sustainability of MHSSA-funded activities and services. Some examples of sustainability outcomes included an increase in capacity for billing for services. Workgroup members had suggestions for a number of long-term outcomes, including focusing less on justice system involvement and ensuring a long-term continuum of care.

MHSOAC Leadership described the importance of developing sustainable and comprehensive services for all students tailored to the diversity of the community. Leaders also spoke to the intermediate-term outcomes of students feeling supported and a reduction of mental health stigma. They indicated that should these outcomes occur, students are more likely to be engaged in school. Lastly, they also highlighted that in the long term, an important outcome is information and resource sharing

between schools, the medical field, and community organizations.

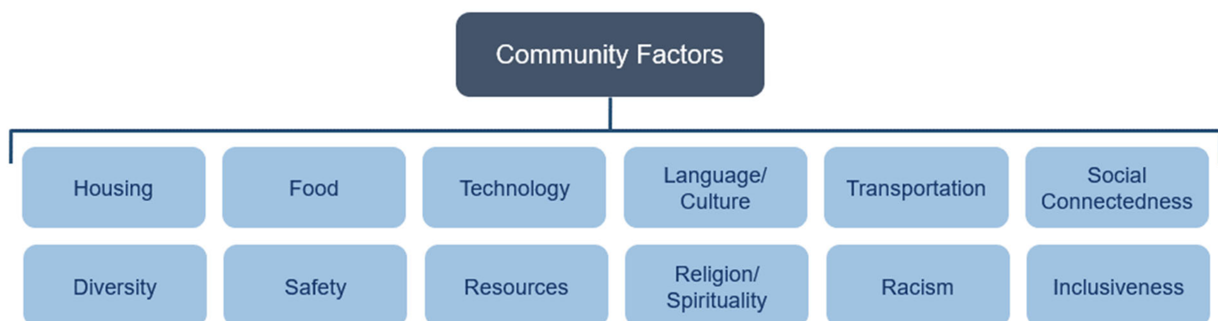
Meaningful and Equitable Outcomes Research Questions

1. What was the relationship between implementation of MHSSA-funded activities and services and each of the short-term outcomes? And for whom?
2. What was the relationship between implementation of MHSSA-funded activities and services and each of the intermediate outcomes? And for whom?
3. Did short-term outcomes mediate the relationship between implementation of MHSSA-funded activities and each of the long-term outcomes? And for whom?

Community Factors

Community factors play an integral role in child and youth development, impacting achievement, health, and well-being (Bronfenbrenner, 1979; Center for Health and Health Care in Schools [CHHCS] et al., 2020). A common method of conceptualizing community factors is viewing them as social influencers. Social influencers of health and education refer to the characteristics of children's and youth's local environment that affect a broad range of health, well-being, and learning outcomes (Braveman & Gottlieb, 2014; CHHCS et al., 2020, 2021). This includes, for example, access to safe and stable housing, food security, neighborhood social connectedness, access to important resources, and language barriers. Each of the identified community factors can be a source of strength (e.g., strong public transportation options making access to services possible) or a barrier (e.g., lack of public transportation preventing access to services). As depicted in Figure 14, the MHSSA Evaluation will account for these important influencers.

Figure 15. Conceptual Model of Community Factors



Partner Insights

Across all our conversations with grantees, it was evident that each county has tailored

its approach to MHSSA's implementation based on the community's unique history and needs. Multiple grantees emphasized the importance of culturally responsive and relevant services for students in their counties and mentioned the importance of considering factors such as the primary languages of students and families. We heard examples of how factors such as local transportation and infrastructure, for example, guide grantees' decision-making regarding MHSSA implementation. To complete a thorough evaluation that highlights the implementation of MHSSA across California, our research questions include a focus on community factors and how they moderate the relationship between MHSSA-funded activities and services and outcomes.

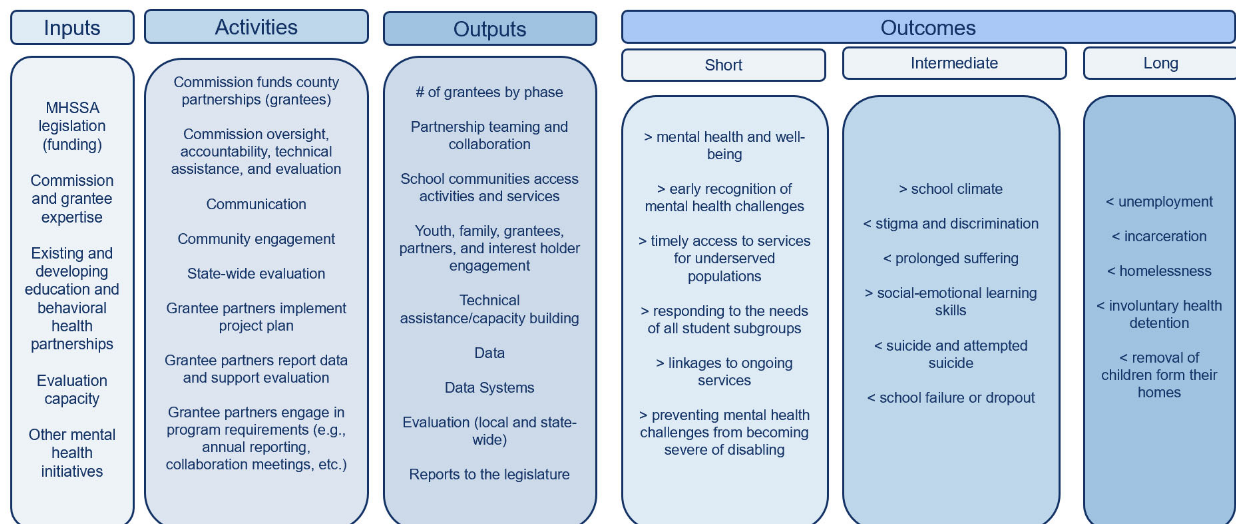
Community Factors Research Question

1. To what extent did community factors moderate the relationship between the MHSSA-funded initiative and the short-term and immediate outcomes?

Logic Model

The MHSSA Logic Model (Figure 15) for the statewide MHSSA Evaluation depicts the relationships between inputs, activities, outputs, and short- and long-term outcomes for MHSSA.

Figure 16. MHSSA Logic Model



The MHSSA Logic Model depicts the relationships between resources and inputs, activities, outputs, and outcomes for the MHSSA and is aligned with the previously described ToC.

Among the inputs are the MHSSA legislation and funding, as well as MHSOAC and grantee expertise, and other mental health initiatives (i.e., state and local resources). Additional inputs include existing and developing educational and behavioral health partnerships, and evaluation capacity. The activities that follow these inputs include funding partnerships and ongoing oversight, accountability, technical assistance, and evaluation support from the MHSOAC, communication related to the MHSSA to different audiences, as well as community engagement and the statewide evaluation that is currently being developed. Grantee activities include implementing the project plan, data reporting, and engaging in evaluation and other program requirements. The outputs of these activities include the formation or strengthening of grantee partnerships that range from established (Category 1) to new and developing (Category 2). MHSSA partners leverage leadership teams to collaboratively carry out MHSSA activities and services, which in turn are accessed by school communities. Other outputs include engagement by youth, families, grantees, partners, and interest holders; technical assistance (e.g., peer-to-peer) and capacity building; data systems and the resulting data that is collected; local and statewide evaluations; and periodic reports to the legislature.

The outcomes depicted in the Logic Model mirror those listed in the ToC. Short-term outcomes include promoting mental health and well-being, recognizing mental health challenges early on, improving timely access to services for underserved populations, responding to the needs of all student subgroups, providing linkages to ongoing services, preventing mental health challenges from becoming severe and disabling, and responding to the need for additional services.

Intermediate outcomes include improving school climate, reducing stigma and discrimination around mental health challenges, reducing prolonged suffering, increasing social-emotional learning skills, reducing suicide and attempted suicide, and reducing school failure or dropout.

Finally, the long-term outcomes include reducing unemployment, reducing incarceration, reducing homelessness, reducing involuntary health detention, and reducing removal of children from their homes.

Next Steps

Statewide School Mental Health Metrics, Measures, Data Collection Plan, and Methodological and Analytic Approaches

WestEd will develop statewide school mental health metrics, measures, a data collection plan, and methodological and analytic approaches to be used in the MHSSA Evaluation Plan. To do so, WestEd (WestEd-MHSOAC, 2023) will do the following:

- Identify which outcomes are a priority for MHSSA partners.
- Develop an understanding of the community or grantee context and examine existing sources of data and their associated metrics.

- Develop a data inventory of indicators used across multiple state entities and systems (education and behavioral health) including
    - existing data sources at state and local levels and
    - gaps and needs related to data collection and the development of metrics.
- Map existing metrics onto the MHSSA Logic Model to determine the breadth and alignment of existing data to the stated MHSSA's practices, outcomes, and anticipated impact.
- Recommend metrics to meet legislative reporting requirements, considering alignment with state and policy entities, meeting grantee needs, and aligning with universal metrics used for statewide evaluation.
- Develop a series of data collection instrument(s), storage, and reporting mechanisms.
- Develop a data collection plan with a narrative description of all proposed metrics, the component of the MHSSA Evaluation Framework each metric supports, the MHSSA activities and services that the metrics are relevant to, the data and data sources for the metric, the approach and frequency with which data will be collected, and barriers and concerns that may arise with the metric. Additionally, the data collection plan will provide a profile of the MHSSA grants and participants that can be updated annually or biannually
- Develop the methodological and analytic approaches to be used, which shall include the qualitative and quantitative approach to analyzing the data.

References

Barrett, S., Eber, L., & Weist, M. D. (Eds.). (2017). *Advancing education effectiveness: Interconnecting school mental health and school-wide positive behavior support*. Center on Positive Behavioral Intervention and Supports. https://www.pbis.org/resource/advancing-education-effectiveness-interconnecting-school-mental-health-and-school-wide-positive-behavior-support

Blasé, K. A., Fixsen, D. L., Sims, B. J., & Ward, C. S. (2015). *Implementation science: Changing hearts, minds, behavior, and systems to improve educational outcomes*. National Implementation Research Network, Frank Porter Graham Child Development Institute, University of North Carolina at Chapel Hill. https://fpg.unc.edu/sites/fpg.unc.edu/files/resources/reports-and-policy-briefs/2014%20Wing%20Summit%20KB.pdf

Bohnenkamp, J. H., Patel, C., Connors, E., Orenstein, S., Ereshefsky, S., Lever, N., & Hoover, S. (2023). Evaluating strategies to promote effective, multidisciplinary team collaboration in school mental health. *Journal of Applied School Psychology*, *39*(2), 130–150. https://doi.org/10.1080/15377903.2022.2077875

Borenstein, M., Hedges, L. V., Higgins, J. P., & Rothstein, H. R. (2021). *Introduction to meta-analysis* (2nd ed.). John Wiley & Sons.

Braun, V., & Clarke, V. (2012). Thematic analysis. In H. Cooper, P. M. Camic, D. L. Long, A. T. Panter, D. Rindskopf, & K. J. Sher (Eds.), *APA handbook of research methods in psychology: Vol. 2. Research designs: Quantitative, qualitative, neuropsychological, and biological* (pp. 57–71). American Psychological Association. https://doi.org/10.1037/13620-004

Braveman, P., & Gottlieb, L. (2014). The social determinants of health: It's time to consider the causes of the causes. *Public Health Reports*, *129*(1, Suppl. 2), 19–31. https://doi.org/10.1177/00333549141291S206

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Harvard University Press. https://doi.org/10.2307/j.ctv26071r6

Bronstein, L. R. (2003). A model for interdisciplinary collaboration. *Social Work, 43*(3), 297–306. https://www.jstor.org/stable/23721052

California for All. (2023). *California's mental health movement.* Office of Governor Gavin Newsom. https://www.gov.ca.gov/wp-content/uploads/2023/10/Mental-Health-Glossy-Plan_10.11.23-530-PM.pdf

Center for Health and Health Care in Schools, School-Based Health Alliance, National Center for School Mental Health. (2020). *Understanding social influences of health education: A role for school-based health centers and comprehensive school mental health systems*. School Health Services National Quality Initiative. https://www.schoolmentalhealth.org/media/som/microsites/ncsmh/documents/flie

rs-resources-misc-docs/resources/Understanding-Social-Influencers-of-Health-and-Education.pdf

Center for Health and Health Care in Schools, School-Based Health Alliance, National Center for School Mental Health. (2021). *Addressing social influencers of health and education using a multi-tiered system of supports framework*. School Health Services National Quality Initiative. https://www.schoolmentalhealth.org/media/som/microsites/ncsmh/documents/fliers-resources-misc-docs/resources/Addressing-SIHE-Using-MTSS_FINAL-.pdf

Council of Chief State School Officers and National Center for School Mental Health. (2021). *Advancing comprehensive school mental health systems: A guide for state education agencies*. https://learning.ccsso.org/advancing-comprehensive-mental-health-systems

Cousins, J. B., & Whitmore, E. (1998). Framing participatory evaluation. *New Directions for Evaluation, 1998*(80), 5-23. https://doi.org/10.1002/ev.1114

Dopp, A. R., & Lantz, P. M. (2020). Moving upstream to improve children's mental health through community and policy change. *Administration and Policy in Mental Health and Mental Health Services Research*, *47*, 779–787. https://doi.org/10.1007/s10488-019-01001-5

Durlak, J. A., & DuPre, E. P. (2008). Implementation matters: A review of research on the influence of implementation on program outcomes and the factors affecting implementation. *American Journal of Community Psychology*, *41*(3–4), 327–350. https://doi.org/10.1007/s10464-008-9165-0

Eber, L., Barrett, S., Perales, K., Jeffrey-Pearsall, J., Pohlman, K., Putnam, R., Splett, J., & Weist, M. D. (2019). *Advancing education effectiveness: Interconnecting school mental health and school-wide PBIS, Volume 2: An implementation guide*. Center for Positive Behavior Interventions and Supports. University of Oregon Press.

Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M., & Wallace, F. (2005). *Implementation research: A synthesis of the literature*. University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network (FMHI Publication No. 231). https://nirn.fpg.unc.edu/resources/implementation-research-synthesis-literature

Forman, S.G. (2015). *Implementation of mental health programs in schools: A change agent's guide.* American Psychological Association. https://doi.org/10.1037/14597-000

Gage, N. A., Katsiyannis, A., Rose, C., & Adams, S. E. (2021). Disproportionate bullying victimization and perpetration by disability status, race, and gender: A national analysis. *Advances in Neurodevelopmental Disorders*, *5*, 256–268. https://doi.org/10.1007/s41252-021-00200-2

Glass, G. V. (1976). Primary, secondary, and meta-analysis of research. *Educational Researcher*, *5*(10), 3–8. https://doi.org/10.3102/0013189X005010003

Hammond, W. (2010). Principles of strength-based practice. *Resiliency Initiatives*, *12*(2), 1–7.

HERE to HERE. (2020). *The HERE to HERE language guide: A resource for using asset-based language with young people*.

Horner, R. H., Sugai, G., & Fixsen, D. L. (2017). Implementing effective educational practices at scales of social importance. *Clinical Child and Family Psychology Review*, *20*(1), 25–35. https://doi.org/10.1007/s10567-017-0224-7

Kania, J., Kramer, M., & Senge, P. (2018). *The water of systems change*. FSG. https://www.fsg.org/wp-content/uploads/2021/08/The-Water-of-Systems-Change_rc.pdf

Katsiyannis, A., Gage, N. A., Rapa, L. J., & MacSuga-Gage, A. S. (2020). Exploring the disproportionate use of restraint and seclusion among students with disabilities, boys, and students of color. *Advances in Neurodevelopmental Disorders*, *4*, 271–278. https://doi.org/10.1007/s41252-020-00160-z

Latham, N. (2014). *A practical guide to evaluating systems change in a human services system context*. Center for Evaluation Innovation; Learning for Action. https://www.evaluationinnovation.org/wp-content/uploads/2014/07/Systems-Change-Evaluation-Toolkit_FINAL.pdf

Lazarus, P. J., Suldo, S. M., & Doll, B. (Eds.). (2021). *Fostering the emotional well-being of our youth: A school-based approach.* Oxford University Press. https://doi.org/10.1093/med-psych/9780190918873.001.0001

Malone, C. M., Wycoff, K., & Turner, E. A. (2022). Applying a MTSS framework to address racism and promote mental health for racial/ethnic minoritized youth. *Psychology in the Schools*, *59*(12), 2438–2452. https://doi.org/10.1002/pits.22606

Mayne, J. (2023). Assumptions in theories of change. *Evaluation and Program Planning*, *98*. https://doi.org/10.1016/j.evalprogplan.2023.102276

Mellin, E. A., & Weist, M. D. (2011). Exploring school mental health collaboration in an urban community: A social capital perspective. *School Mental Health*, *3*, 81–92. https://doi.org/10.1007/s12310-011-9049-6

National Center for School Mental Health. (2023). *School mental health quality guide: Teaming*. University of Maryland School of Medicine. https://www.schoolmentalhealth.org/media/som/microsites/ncsmh/documents/quality-guides/Teaming.pdf

National Research Council and Institute of Medicine. (2009). *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities* (M.E. O'Connell, T. Boat, K.E. Warner, Eds.). Committee on the

Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults: Research Advances and Promising Interventions. Board on Children, Youth, and Families, Division of Behavioral and Social Sciences and Education. The National Academies Press. https://www.ncbi.nlm.nih.gov/books/NBK32775/

Office of the Surgeon General. (2021). *Protecting youth mental health: The U.S. Surgeon General's advisory*. https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf

Patton, M. Q. (2015a). The developmental evaluation mindset: Eight guiding principles. In M.Q. Patton, K. McKegg, & N. Wehipeihana (Eds.), *Developmental evaluation exemplars principles in practice* (pp. 289–312). Guilford Publications.

Patton, M. Q. (2015b). State of the art and practice of developmental evaluation: Answers to common and recurring questions. In M.Q. Patton, K. McKegg, & N. Wehipeihana (Eds.), *Developmental evaluation exemplars principles in practice* (pp. 1–24). Guilford Publications.

Ratan, S. K., Anand, T., & Ratan, J. (2019). Formulation of research question: Stepwise approach. *Journal of Indian Association of Pediatric Surgeons*, *24*(1), 15–20. https://doi.org/10.4103/jiaps.JIAPS_76_18

Ravitch, S. M., & Riggan, M. (2016). *Reason & rigor: How conceptual frameworks guide research*. SAGE Publications. https://doi.org/10.1080/07380577.2017.1360538

Romer, N., Hollins-Sims, N., Owens-West, R., Perales, K., Walrond, N., Payno-Simmons, R., & McIntosh, K. (2023). *Centering equity in data-based decision-making: Considerations and recommendations for leadership teams.* Center to Improve Social and Emotional Learning and School Safety at WestEd and the Center on Positive Behavioral Interventions and Supports. https://www.wested.org/wp-content/uploads/2023/09/CISELSS-PBIS-Centering-Equity-in-DBDM_FINAL-ADA.pdf

Sanetti, L. M. H., & Kratochwill, T. R. (2009). Toward developing a science of treatment integrity: Introduction to the special series. *School Psychology Review*, *38*, 445–459.

Scerra, N. (2012). Strengths-based practices: An overview of the evidence. Developing Practice: *The Child, Youth and Family Work Journal*, 31), 43–52.

Splett, J. W., Perales, K., Halliday-Boykins, C. A., Gilchrest, C. E., Gibson, N., & Weist, M. D. (2017). Best practices for teaming and collaboration in the interconnected systems framework. *Journal of Applied School Psychology*, *33*(4), 347–368. https://doi.org/10.1080/15377903.2017.1328625

Stephan, S. H., Sugai, G., Lever, N., & Connors, E. (2015). Strategies for integrating mental health into schools via a multitiered system of support. *Child and*

Adolescent Psychiatric Clinics of North America, *24*(2), 211–231. https://doi.org/10.1016/j.chc.2014.12.002

Substance Abuse and Mental Health Services Administration. (2023). *Behavioral health equity*. https://www.samhsa.gov/behavioral-health-equity

United States Department of Education, Office of Special Education and Rehabilitative Services. (2021). *Supporting child and student social, emotional, behavioral, and mental health needs*. https://www2.ed.gov/documents/students/supporting-child-student-social-emotional-behavioral-mental-health.pdf

United States Department of Health & Human Services. (2021). Protecting youth mental health: The U.S. Surgeon General's Advisory. https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf

Valdez, A., Cerna, R., & Hashmi, S. (2023). *Participatory systems change for equity: An inquiry guide for child-, youth-, and family-serving agencies*. California Center for School Climate & Center to Improve Social and Emotional Learning and School Safety. WestEd. https://www.wested.org/wp-content/uploads/2023/03/V13_Participatory-Planning-for-Equity_FINAL_ADA-compliant.pdf

Vanderkruik, R., & McPherson, M. E. (2017). A contextual factors framework to inform implementation and evaluation of public health initiatives. *American Journal of Evaluation*, *38*(3), 348–359. https://doi.org/10.1177/1098214016670029

Walrond, N., & Romer, N. (2021). *Serving the whole person: An alignment and coherence guide for state education agencies*. WestEd. https://www.wested.org/resources/serving-the-whole-person-an-alignment-and-coherence-guide-for-state-education-agencies/

Warren, M. A., Donaldson, S. I., & Galport, N. (2022). Using the science of positive psychology in the formative evaluation of social justice interventions: A case example. *Evaluation and Program Planning*, *91*(102017).

Weist, M. D., Eber, L., Horner, R., Splett, J., Putnam, R., Barrett, S., Perales, K., Fairchild, A. J., & Hoover, S. (2018). Improving multitiered systems of support for students with "internalizing" emotional/behavioral problems. *Journal of Positive Behavior Interventions*, *20*(3), 172–184. https://doi.org/10.1177/1098300717753832

WestEd. (2021). *Anti-racist evaluation strategies: A guide for evaluation teams*. https://www.wested.org/resources/anti-racist-evaluation-strategies/

WestEd-MHSOAC. (2023). *WestEd-MHSOAC contract*.

Xie, H. (2013). Strengths-based approach for mental health recovery. *Iranian Journal of Psychiatry and Behavioral Sciences*, *7*(2), 5–10.

Appendix A.

Grantee	Phase	Size	Total funding	Contract end date	Elementary schools	Middle schools	High schools	Combined schools
Calaveras	1	Small	$ 3,174,751	12/31/26	7	0	0	3
Fresno	1	Large	$ 7,619,403	8/31/26	171	38	57	78
Humboldt	1	Small	$ 3,174,751	12/31/26	18	8	15	25
Kern	1	Large	$ 7,619,403	8/31/26	0	6	2	0
Madera	1	Small	$ 3,174,150	9/30/26	0	1	1	4
Mendocino	1	Small	$ 3,174,751	12/31/26	7	3	6	7
Orange	1	Large	$ 7,619,403	8/31/25	7	5	5	1
Placer	1	Medium	$ 5,079,602	12/31/26	4	0	0	0
San Luis Obispo	1	Medium	$ 3,856,907	8/31/25	1	5	1	2
San Mateo	1	Large	$ 5,999,999	9/30/24	13	6	10	3
Santa Barbara	1	Medium	$ 5,022,151	9/30/26	22	6	11	7
Santa Clara	1	Large	$ 7,619,403	10/31/25	0	3	3	0
Solano	1	Medium	$ 5,079,602	8/31/25	0	0	0	4
Tehama	1	Small	$ 3,174,751	9/30/26	10	6	4	11
Trinity-Modoc	1	Small	$ 2,945,830	9/30/25	3	1	10	14
Tulare	1	Medium	$ 5,079,602	8/31/25	0	5	6	17
Ventura	1	Large	$ 7,619,314	12/31/26	1	0	7	0
Yolo	1	Medium	$ 5,079,602	12/31/26	24	7	12	10
Amador	2	Small	$ 2,487,384	8/31/26	6	2	3	0
Contra Costa	2	Large	$ 7,613,588	12/31/26	0	2	0	0
Glenn	2	Small	$ 2,500,000	7/31/25	3	2	4	0
Imperial	2	Small	$ 3,174,751	7/31/26	0	0	10	2
Lake	2	Small	$ 2,499,450	9/30/25	7	3	11	16
Los Angeles	2	Large	$ 7,619,403	12/31/26	0	0	7	0
Marin	2	Medium	$ 5,079,602	7/31/25	0	3	4	0
Monterey	2	Medium	$ 3,999,979	8/31/25	14	3	5	1
Nevada	2	Small	$ 3,174,050	8/31/25	3	0	0	0
Riverside	2	Large	$ 7,272,483	8/31/26	0	0	5	1
Sacramento	2	Large	$ 7,619,403	8/31/25	12	5	9	4

WestEd WestEd.org

San Bernardino	2	Large	$ 5,998,000	1/31/26	19	5	7	4
San Diego	2	Large	$ 7,111,133	6/30/26	263	70	67	99
San Francisco	2	Large	$ 6,000,000	9/30/26	0	13	3	0
Santa Cruz	2	Medium	$ 5,079,602	8/31/25	3	4	6	0
Shasta	2	Small	$ 2,965,755	12/31/26	0	0	4	6
Sonoma	2	Medium	$ 5,079,602	7/31/25	7	7	11	3
Sutter-Yuba	2	Small	$ 2,618,184	1/31/26	1	1	3	17
Tuolumne	2	Small	$ 2,494,962	10/31/25	0	0	2	8
Alameda	3	Large	$ 7,619,403	12/31/26	3	12	5	3
Berkeley City	3	Small	$ 2,500,000	6/30/26	11	3	2	0
Butte	3	Medium	$ 5,079,602	9/30/26	12	7	5	9
Colusa	3	Small	$ 2,500,000	12/31/26	5	2	4	4
Del Norte	3	Small	$ 2,500,000	12/31/26	5	1	2	7
El Dorado	3	Small	$ 5,044,665	12/31/26	23	8	10	11
Inyo	3	Small	$ 2,499,444	6/30/26	4	1	2	2
Kings	3	Small	$ 3,174,751	12/31/26	3	2	1	1
Lassen	3	Small	$ 2,274,040	6/30/26	3	2	5	12
Mariposa	3	Small	$ 2,500,000	12/31/26	0	0	3	7
Merced	3	Medium	$ 4,810,949	12/31/26	13	4	9	4
Mono	3	Small	$ 2,500,000	6/30/26	2	1	3	3
Napa	3	Small	$ 2,954,476	12/31/26	17	6	7	7
Plumas	3	Small	$ 1,749,800	6/30/26	3	0	3	5
San Benito	3	Small	$ 2,500,000	12/31/26	1	4	2	15
San Joaquin	3	Large	$ 7,619,403	12/31/26	40	12	31	93
Sierra	3	Small	$ 1,566,204	6/30/26	2	0	1	2
Siskiyou	3	Small	$ 3,174,751	12/31/26	0	0	0	1
Stanislaus	3	Medium	$ 5,079,602	12/31/26	40	14	10	21
Tri-City	3	Medium	$ 4,852,204	12/31/26	29	5	9	10

WestEd WestEd.org

Appendix B.

The following are examples of anti-racist evaluation strategies that help inform the statewide MHSSA Evaluation planning process:[2]

- **Share power and center self-determination by…**
  - Providing opportunities for attendees to make additions, corrections, and feedback before finalization of community engagement summaries
  - Integrating suggestions for listening session topics and audiences into the community engagement roadmap
- **Elevate community strengths and attend to place by…**
  - Conducting listening sessions by groups of grantees, such as by funding phase or type of activities
  - Attending to less common experiences of individuals, such as those in rural counties
  - Reflecting on common strengths across counties and departments
  - Summarizing all learnings from community engagement sessions regardless of the level of agreement
- **Build individual and collective capacity and recognize interdependence by…**
  - Engaging grantees in group settings to share knowledge and prompt each other
  - Defining key terms when speaking with partners about technical components of the Evaluation Framework
  - Teaching youth about evaluation for them to meaningfully provide input during youth advisory group meetings

---

[2] Guiding principles are defined in detail in the MHSSA Phase 1 Evaluation Community Engagement Plan.

- Speaking with a variety of individuals who engage with MHSSA in different ways, including grant managers, MHSOAC leaders, county offices of education, and county behavioral health agencies

- **Promote culturally responsive and sustaining change by...**
  - Translating recruitment materials to the diverse languages of the intended audience to ensure comprehension
  - Continually inviting feedback from our partners to improve our teams' processes
- **Prioritize transparency and accessibility by…**
  - Maintaining a dedicated MHSSA Evaluation team inbox to facilitate bi-directional communication with community engagement participants
  - Sharing drafts of all community engagement summaries with the session's participants to build trust and transparency with participants
  - Sharing all community engagement summaries with the broad WestEd team and MHSOAC Research and Evaluation Division (RED) members to promote transparency with the Commission
  - Presenting updates at quarterly MHSSA grantee collaboration meetings to maintain transparency
- **Illuminate oppression and take liberatory action by…**

Centering this work around the ultimate goals of address systemic inequities and disparities impacting minoritized communities