Mathematica®
Progress Together

March 2025

CYBHI Evaluation Interim Report

Authors *(in alphabetical order)*: Eileen Kazura, Amanda Lechner, Marlena Smith-Millman
Contributors *(in alphabetical order):* Christina Altmayer, Joshua Baker, Christopher Bory, Michael Butler, Kate D'Anello, Ayesha De Mond, Maria Dobinick, Helen DuPlessis, Daniel Friend, Ning Fu, Anna Gu, Elisa Gonzalez, Jessica Laird, Jasmine Little, Paola Lopez, Marlena Luhr, Moira McCullough, Rick McManus, Catherine Mogil, Bailey Orshan, Shu Phua, Nichole Sturmfels, Annu Van Bodegom, Deliya Wesley, Joe Zickafoose

CalHHS
California Health & Human Services Agency

Table of Contents

Exhibits

Executive Summary

California's Children and Youth Behavioral Health Initiative (CYBHI) is an historic multi-year $4+ billion systems change initiative focused on improving the behavioral health and well-being of children, youth, and families. To actualize the initiative's values and goals, the CYBHI is implementing 20 distinct workstreams, each designed to contribute to transforming the behavioral health ecosystem and achieving three overarching outcomes: improve children and youth behavioral health and well-being, increase access to and experience with services, and advance system-level support and collaboration.

This initial evaluation report focuses on the design and early implementation progress of the CYBHI from its launch in July 2021 to July 2024. Using data gathered and analyzed in 2023 and early 2024, this report offers insight into the key strategies being leveraged by the CYBHI, the investments made, the progress achieved to date, the potential for future impact, and lessons learned for implementation of large, complex initiatives.

To build a behavioral health ecosystem that serves all children and youth, the CYBHI aims to implement several cross-cutting strategies at the initiative and workstream levels, including: (1) **centering children, youth, and families and grounding in equity;** (2) **investing in promotion, prevention, and public awareness;** (3) **developing workforce capacity to support behavioral health; and** (4) **investing in infrastructure to better deliver services**.

- The CYBHI has undertaken activities to **center children, youth, and families** and **advance equity** in workstream and initiative planning and implementation. In 2022, the California Health and Human Services Agency (CalHHS) conducted listening sessions with families and community members to share their experiences navigating the behavioral health system. The Youth at the Center report, prepared by The Social Changery, captures the findings from these sessions and highlights 12 calls to action that serve as guiding principles for the CYBHI's work to advance California toward a more equitable and youth-centered system. CYBHI implementation to date is strongly aligned with several of these Calls to Action, most notably through the initiative's efforts to increase availability, accessibility, and variety of behavioral health supports and develop a larger and more representative behavioral health workforce.
- More than $3.5 billion of CYBHI funds support implementation efforts focused on behavioral health prevention and promotion. Nearly all the CYBHI's workstreams aim to center the ethos of **prevention, promotion, and public awareness**. The diverse activities that comprise this strategy are aligned with expert consensus that multipronged behavioral health promotion strategies addressing individual, familial, community, and social influences are best positioned for impact. These workstreams have designed and are implementing activities to surround youth with behavioral health promotion supports delivered through various channels, delivering prevention messaging via universal media and public awareness campaigns, providing resources to parents and caregivers, strengthening the capacity of schools to support behavioral health wellness, and making promotion and prevention supports available to youth through digital tools and supports.
- The CYBHI is beginning to strengthen and diversify **workforce capacity to support behavioral health** through investments focused on training, expanding, and increasing the representativeness of California's behavioral health workforce. By investing in the workforce in these ways, the CYBHI is making efforts to improve access to care for

children and youth that is clinically effective, culturally relevant, and resonant with their lived experiences. The CYBHI workforce investments leverage diverse approaches including pipeline programs, scholarship and loan repayment programs, and graduate level training programs. Existing evidence supports the approach California is taking with these investments, and future work should focus on continued coordination and integration of these programs into a cohesive workforce strategy. Notably, the CYBHI established and is supporting adoption of a new behavioral health profession, Certified Wellness Coaches, as a pathway for building a more inclusive, representative, and youth-centered workforce. As of September 2024, California has certified 356 new Wellness Coaches, awarded over $125 million in grant funding to support Wellness Coach employment through Employer Support Grants, and established 18 Wellness Coach education programs at California community colleges and state universities. The geographic distribution of Wellness Coach Employer Support Grants is moderately statistically correlated with measures of student behavioral health need, signaling the possibility that the new role is gaining traction in high-need communities.

- Implementation of the CYBHI's **infrastructure investments** is largely underway, building physical and administrative structures to support expansion of behavioral health services for California's children and youth. In support of its efforts to activate schools as a key access point to behavioral health care for children and youth, the CYBHI has invested in Local Education Agency (LEA) and County Office of Education (COE) physical and administrative infrastructure through multiple distinct grant programs, including Student Behavioral Health Incentive Program (SBHIP) and School-Linked Partnership and Capacity Grants. The 2024 launch of the School-Linked Partnership and Capacity Grants provides an opportunity for counties and LEAs to leverage CYBHI funds to address emerging infrastructure needs, including those identified earlier in CYBHI implementation. The remainder of the CYBHI's physical infrastructure investment is allocated through the Behavioral Health Continuum Infrastructure Program (BHCIP) Round 4: Children and Youth grant funding, which awarded 52 projects that create 509 new residential/inpatient treatment beds and anticipate 76,977 individuals to be served annually in an outpatient setting.

Within the CYBHI, these strategies are notable for the scale of the investment and the cross-cutting nature of the effort, with implementation and anticipated impact occurring across multiple environmental settings in which youth receive behavioral health supports—**health care settings, educational settings, homes and communities, and digital spaces**. In addition to these direct investments, the CYBHI, in coordination with other large-scale policy efforts, aims to strengthen the behavioral health ecosystem as a whole. Noteworthy investments within each environment include:

- In **health care settings**, the CYBHI's Dyadic Services Benefit aims to reduce the barriers families face when accessing early intervention services, including mental health and behavioral health services. The Dyadic Services Benefit embraces the Youth at the Center report's call to action to "take care of adults so they can take care of young people" and increases access for current and future generations of children and their caregivers to critical, early intervention services. While establishment of the Benefit presents significant potential to expand the availability of Dyadic Services, upcoming milestones for CYBHI to fully realize its intended impact include approval of a pending State Plan Amendment governing reimbursement for Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), and Tribal entities and efforts to monitor and increase utilization of the benefit.
- The CYBHI's investments in **educational settings** leverage schools as a consistent and familiar environment in which youth spend much of their time. These workstreams build on several key strengths; schools are already a key point of access to behavioral health care for youth in California, are well-positioned to mitigate key barriers to access including transportation limitations, and have higher rates of service utilization following referral as compared with referral to community-based services. A hallmark investment of the CYBHI is the statewide multi-payer school-linked fee schedule (CYBHI Fee Schedule), intended to increase access to both preventive and clinical behavioral health care in and near schools and provide a consistent and predictable funding mechanism for service

delivery. To develop and inform early adoption of the CYBHI Fee Schedule, DHCS has engaged education partners, health plans, county behavioral health organizations, professional associations, and community-based organizations. To date, 138 LEAs have enrolled in Cohorts 1 and 2 of the CYBHI Fee Schedule. The initial cohort is preparing to submit the first CYBHI Fee Schedule claims in fall 2024, and the coming year will provide opportunities to adapt and refine Fee Schedule guidance and operations to address emerging implementation challenges and bolster intended impact.

- Recognizing the importance of positive, nurturing **home and community environments** to children and youth development, the CYBHI invested in several public awareness campaigns (Never a Bother, Public Education and Change Campaigns, and Live Beyond), to increase the behavioral health knowledge and skills of youth, their peers, and the adults who surround them. Complementing these population and community-level interventions, the more than $250 million in funding[1] distributed through Scaling Evidence-Based and Community-Defined Evidence Practices (EBPs and CDEPs) workstream is being used to strengthen capacity for high-quality, evidence-based care for children, youth, and families across a variety of settings including schools and community-based organizations. Scaling EBPs and CDEPs grants are in early implementation, supporting programs and practices focused on parent and caregiver support, trauma-informed care, early childhood wraparound services, youth drop-in centers and other youth-driven programs, and expansion of programs that support early intervention for behavioral health needs.
- The CYBHI investments in innovative **digital spaces** offer an opportunity to increase access to prevention resources and coaching via two digital platforms provided free to all California children, youth, and caregivers. These first in the nation investments remain in early stages of implementation but show potential for extending resources and services, particularly to remote or underserved areas.

More than halfway through the five-year initiative, the CYBHI has made strides in implementing a wide array of workstreams and programs aligned with these overarching strategies and within these four environments. The results of this report illustrate substantial early progress in designing and launching the CYBHI strategies and workstreams. Efforts to strengthen the behavioral health ecosystem through cross-cutting investments in prevention, promotion, and public awareness; workforce; and infrastructure show early indications of promise, though it is too early to see the impact of several large-scale, innovative efforts. Reflecting on the early implementation of the CYBHI offers insights both for the initiative (midway through its lifecycle) as well as a roadmap for California and other states pursuing similar investments in the future. The CYBHI's breadth poses challenges related to complexity and coordination across its 20 workstreams. Early findings suggest that clear communication and mechanisms to support shared governance and collaboration are critical to the success of work that involves many workstreams, state agencies, local agencies, and implementing partners.

[1] This total represents grants made under Rounds 1, 2, 4, and 5 of the Scaling EBPs and CDEPs workstream; award amounts for Round 3 grants were not available at the time of drafting.

1 | Introduction

In response to the worsening children's behavioral health crisis and heightened health inequities during the COVID-19 pandemic, California established the Children and Youth Behavioral Health Initiative (CYBHI). Launched in July 2021, the CYBHI is an ambitious multi-year $4+ billion systems change initiative focused on improving the behavioral health and well-being of children and youth (ages 0 to 25) as well as their families. Led by the California Health and Human Services Agency (CalHHS), the initiative is driven by five key CalHHS departments and offices: the Department of Health Care Services (DHCS), the Department of Managed Health Care (DMHC), the Department of Health Care Access and Information (HCAI), the Department of Public Health (CDPH), and the Office of the California Surgeon General (OSG). In general, implementation of the CYBHI will continue through June 2026, though certain aspects of the initiative will conclude earlier while others will continue beyond 2026.

Mathematica is evaluating the CYBHI on behalf of CalHHS in partnership with Health Management Associates, James Bell Associates, and the University of California, Los Angeles (UCLA) Prevention Center of Excellence. The evaluation started in November 2022 and will continue through June 2026. As part of the evaluation, this report gives an overview of the multiple CYBHI workstreams launched during the early implementation of the CYBHI.

California's call to action: Addressing the behavioral health crisis and system complexity

There is an escalating behavioral health crisis affecting California's children and youth. From 2018 to 2021, the percentage of children and youth ages 0 to 25 enrolled in Medi-Cal with a diagnosis of depression, anxiety, or trauma/stressor increased by 54 percent, 58 percent, and 43 percent, respectively. Accompanying this increase in behavioral health-related diagnoses were increases in severe outcomes: emergency department visits for self-harm increased from 3.7 visits per 1,000 children and youth ages 0 to 25 in 2017 to 4.6 in 2021.[2] Although the demand for behavioral health care has increased, Californians face several barriers to accessing timely and appropriate behavioral health care services. Key barriers include the difficulty of navigating the complex and uncoordinated systems of care and the state's chronic behavioral health workforce shortages.[3]

In California, as elsewhere, multiple systems serve children, youth, and families—including managed care plans, county behavioral health agencies, health care providers and systems, schools, child welfare agencies, and other human services providers. These systems are often siloed and struggle to identify and link children and youth to appropriate behavioral health services.[4] For example, children, youth, and families enrolled in Medi-Cal must navigate multiple independent systems for mild to moderate mental health needs, more intensive mental health needs, and substance use disorder (SUD) services.[5] Those with commercial coverage face challenges finding in-network providers and

[2] Niedzwiecki, M.J., R. Miller, E. Bouchery, J. Earlywine, N. Fu, and A. Gu. "Children and Youth Behavioral Health Initiative Evaluation: Baseline Analysis Chartbook, 2017 to 2021." Submitted to California Health and Human Services Agency. Washington, DC: Mathematica. September 2023.

[3] California Health Care Foundation. "Regional Market Almanac: Cross-Site Analysis—Medi-Cal Behavioral Health Services: Demand Exceeds Supply Despite Expansions." September 2021. https://www.chcf.org/wp-content/uploads/2021/09/RegionalMarketAlmanac2020CrossSiteAnalysisBH.pdf.

[4] Breaking Barriers. "Working Paper: California's Children & Youth Behavioral Health System," https://cybhi.chhs.ca.gov/wp-content/uploads/2023/04/Ecosystem-Working-Paper-_-ADA.pdf.

[5] While beyond the scope of this evaluation, there are other activities at CalHHS and DHCS occurring under CalAIM (such as No Wrong Door, SMHS medical necessity criteria, and Youth Screening Tools) seeking to streamline and increase coordination within the behavioral health ecosystem.

obtaining timely appointments. Delayed access contributes to unmet needs, missed opportunities for early intervention, and higher use of crisis and emergency services.[6]

The need for behavioral health supports is particularly notable among historically marginalized populations, underscoring the importance of specifically and directly augmenting resources for these groups. Youth who identified as transgender and youth who identified as gay or bisexual both had higher rates of suicidal ideation compared to their peers.[7] Among race and ethnicity groups, American Indian/Alaska Native (AI/AN) youth were most likely to have a behavioral health diagnosis or symptom, Black youth had the highest rates of death by suicide and the highest rates of use of acute care services for behavioral health needs, and Hispanic and Native Hawaiian/Pacific Islander (NH/PI) youth with behavioral health needs were least likely to use any behavioral health services.[8] Disparities in behavioral health challenges and service use also contribute to higher rates of chronic school absenteeism among these marginalized populations.[9]

Behavioral health outcomes also vary significantly by region within California. For example, between 2018 and 2022, youth in the Northern and Sierra region had the highest rates of death by suicide, emergency department visits for behavioral health diagnoses, and chronic absenteeism. Youth in the Northern and Sierra region also had the highest rates of utilization of behavioral health services among Medi-Cal enrollees 0–25 years old.

Compounding these challenges is California's persistent shortage of behavioral health providers, which is expected to worsen over time. Projections from 2018 indicate that, by 2028, California will have 41 percent fewer psychiatrists and 11 percent fewer psychologists and other licensed behavioral health providers than needed. Moreover, the 80,000+ licensed behavioral health professionals are poorly distributed across the state, and there is an overall shortage of racially concordant providers for children and youth who identify as Black, Latino, AI/AN, and Asian American or Pacific Islander (AA/PI).[10]

California's response: Overview of the CYBHI

To address the multifaceted challenges in addressing behavioral health for California's children and youth, the CYBHI adopts an integrated systems change approach that is population based with an upstream focus. The initiative, comprised of 20 distinct workstreams, strives to promote social and emotional well-being, support early identification, prevent behavioral health needs from escalating, and improve access to high-quality services and supports. Guided by the vision summarized in the Youth at the Center Report and the ecosystem paper commissioned by CalHHS (Working Paper: California's Children & Youth Behavioral Health Ecosystem), the CYBHI seeks to create a behavioral health system that centers on children, youth, and families, advances equity, and integrates efforts across child and youth-serving systems. These values guide the objectives of the CYBHI, aiming to align its strategy with the overarching goal of building a responsive, accessible, inclusive, and sustainable behavioral health ecosystem for California's children, youth, and families.

---

[6] Nesper, A.C., B.A. Morris, L.M. Scher, and J.F. Holmes. "Effect of decreasing county mental health services on the emergency department." *Annals of emergency medicine*, vol. 67, no. 4, 2015, pp. 525-530. https://www.sciencedirect.com/science/article/abs/pii/S0196064415012706.

[7] Niedzwiecki, M.J., R. Miller, E. Bouchery, J. Earlywine, N. Fu, and A. Gu. "Children and Youth Behavioral Health Initiative Evaluation: Baseline Analysis Chartbook, 2017 to 2021." Submitted to California Health and Human Services Agency. Washington, DC: Mathematica. September 2023.

[8] Ibid.

[9] Ibid.

[10] Coffman, J., T. Bates, I. Geyn, and J. Spetz. "California's Current and Future Behavioral Health Workforce." The Healthforce Center at UCSF, February 2018. California's Current and Future Behavioral Health Workforce.pdf.

To actualize the initiatives' values and goals, the CYBHI has implemented 20 distinct workstreams, each designed to contribute to transforming the behavioral health ecosystem. These workstreams are described briefly in Appendix 1. To date, the workstreams are at various stages of implementation.

The CYBHI evaluation framework: Overview of the CYBHI's strategies, environmental settings, intended systems changes, and outcomes

The CYBHI engaged with an external evaluation firm, Mathematica, to design an evaluation strategy that will allow CalHHS, its partners, and children, youth and families across California to assess the impact of California's broad investment in the children and youth behavioral health ecosystem. Evaluating complex initiatives that are comprised of multiple programs and strategies presents unique challenges. To support comprehensive assessment, the CYBHI has grounded its evaluation of the initiative in the overall strategies that are being employed, the environmental settings in which the activities are occurring, and the outcomes that California hopes to achieve.

CYBHI strategies

To achieve its vision and goals, the CYBHI includes several core cross-cutting strategies that serve as critical components of and guiding principles for a well-functioning behavioral health ecosystem.

Across the initiative, the CYBHI employs the following strategies:

1. **Centering children, youth and families and grounding in equity.** Many workstreams have intentionally engaged youth in planning, design, and implementation activities. Several of the CYBHI workstreams were designed to address disparities in behavioral health experiences and outcomes, and many workstreams seek to **ground grant-making and implementation processes in equity**.
2. **Investing in promotion, prevention, and public awareness.** The CYBHI focuses on enhancing broad-based capacity (among parents and caregivers, educators, community members, and youth themselves) to support behavioral health, with significant investments in **promotion, prevention, and public awareness campaigns.**
3. **Developing workforce capacity to support behavioral health.** The CYBHI focuses on **building a larger, more representative behavioral health workforce** to meet increasing demand for behavioral health services.
4. **Investing in infrastructure to support service delivery.** The CYBHI invests in strengthening equitable access to behavioral health services by adding new facilities and administrative and digital infrastructure to expand service delivery.

The CYBHI workstreams in four environmental settings

Children, youth, and families experience behavioral health needs and access support and care across diverse environments. To create a transformed behavioral health ecosystem that supports children and youth in these environments, the CYBHI workstreams are designed to make direct impacts in **four key environments: health care settings**, **educational settings**, **homes and communities,** and **digital spaces.** By seeking to strengthen supports for behavioral health in these diverse environments, the CYBHI seeks to ensure that support systems are accessible and tailored to the needs of each child, youth, and family, increasing the likelihood that supports and services will be available when, where, and how they are needed most.

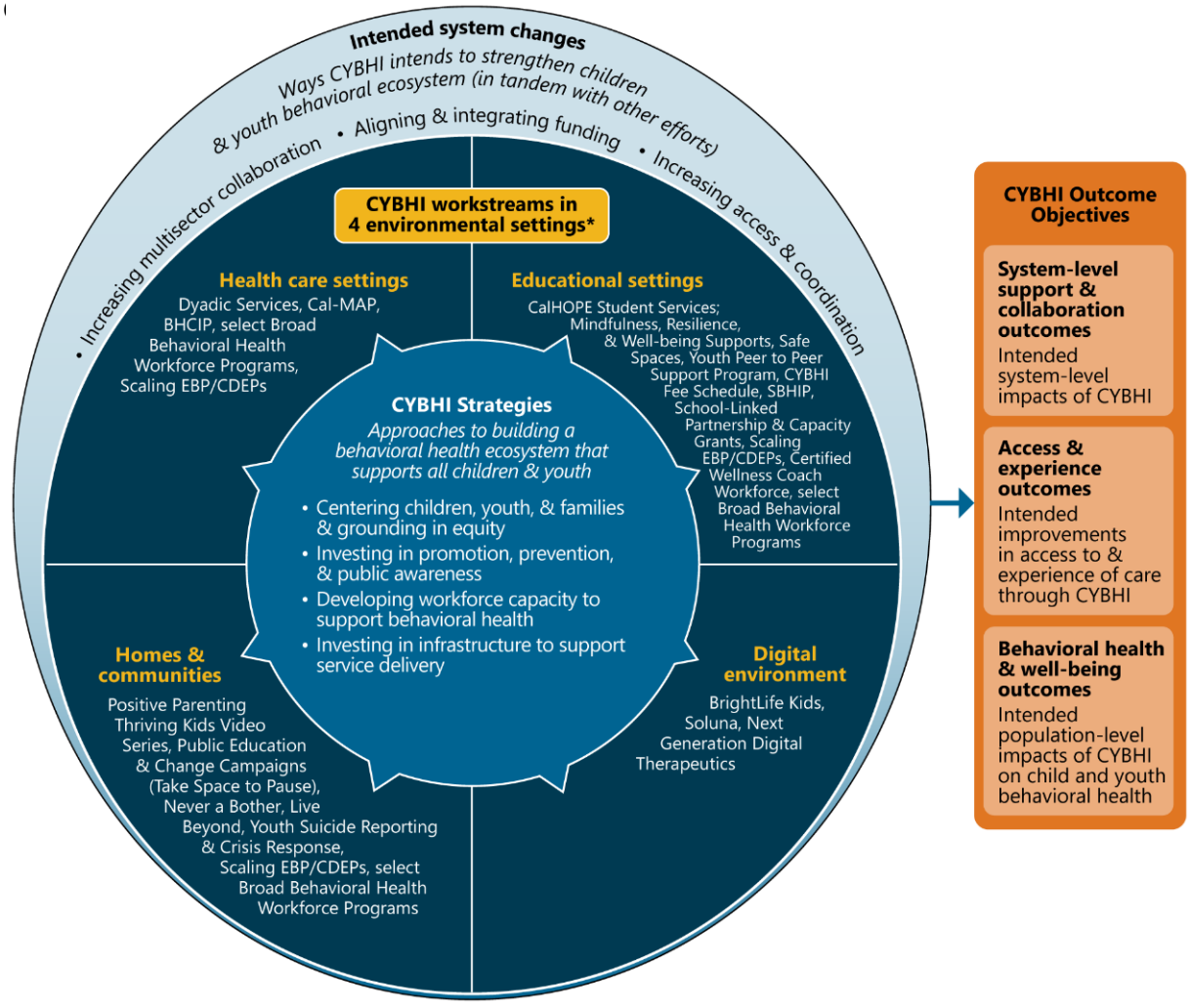
Intended system changes

In addition to these direct investments, the CYBHI aims to strengthen the behavioral health ecosystem as a whole by coordinating with other large-scale policy efforts. These parallel efforts include the Behavioral Health Services Act, California Advancing and Innovating Medi-Cal (CalAIM), the Mental Health Student Services Act, the California Community Schools Partnership Program (CCSPP), workforce investments, and additional reforms in key sectors

serving children and families. The concurrent implementation of these varied initiatives by state and local partners introduces complexities but also creates opportunities to increase **multisector collaboration**, **alignment and integration of CYBHI funding** with other behavioral health funding sources, and **access to and coordination of care**.

Exhibit 1 illustrates how the CYBHI strategies shape workstream implementation across the four environmental settings as experienced by children, youth, and families. Taken together, these cross-cutting strategies and workstream efforts intend to transform the behavioral health ecosystem and improve system-level support and collaboration, access to and experience of care, and behavioral health and well-being (operationalized as the 15 CYBHI outcome objectives described next). For the purposes of this graphic and report, we have reflected workstreams within the environmental setting in which children, youth, and families are most likely to experience the effects of CYBHI implementation; this assignment is not intended to imply that workstreams may not impact multiple environmental settings.[11]

Exhibit 1. The CYBHI evaluation framework



*For the purposes of this graphic, workstreams are reflected within the environmental setting in which children, youth, and families are most likely to experience the effects of CYBHI implementation. This assignment is not intended to imply that workstream implementation may not impact multiple environmental settings.

BHCIP = Behavioral Health Continuum Infrastructure Program; **Cal-MAP** = California Child and Adolescent Mental Health Access Portal; **CDEP** = community-defined evidence practice; **CYBHI** = Children and Youth Behavioral Health Initiative; **EBP** = evidence-based practice; **SBHIP** = Student Behavioral Health Incentive Program.

[11] Given the breadth and diversity of implementation activities within the five rounds of the Scaling EBPs/CDEPs grant program, we have chosen to reflect this workstream in multiple settings.

The CYBHI outcome objectives

Through a collaborative and thorough engagement process, CalHHS and department teams engaged multi-sector partners, youth and families, and subject matter experts in early 2022 to define initiative-wide outcomes, known as outcome objectives, to assess the progress and impact of the CYBHI implementation. CalHHS selected and defined 15 key outcome objectives across three dimensions: (1) behavioral health and well-being, (2) access to and experience with services, and (3) system-level supports and collaboration (Exhibit 2). These broad outcome objectives provide a holistic measure of how the CYBHI strategies and workstream efforts are advancing its vision and goals. These outcome objectives are interconnected, interdependent, and reflective of the CYBHI's multi-pronged approach to addressing complex and varied challenges across the behavioral health ecosystem. CYBHI workstreams seek to influence these outcomes through various pathways. For example, public awareness campaigns seek to indirectly improve behavioral health and well-being by reducing stigmatizing attitudes toward behavioral health. Other workstreams seek to improve child and youth behavioral health and well-being outcomes through their influence on the other dimensions, such as access to and experience with services and system-level support and collaboration.

Exhibit 2. CYBHI outcome objectives

Behavioral health and well-being	Access to and experience with services
1. Increase in (a) overall social, emotional, and mental well-being and (b) improvement in children and youth's strengths and skills to address behavioral health challenges	7. Improvement in the experience of (a) accessing and (b) receiving behavioral health services and supports
2. Decrease in behavioral health challenges	8. Increase in (a) knowledge of available behavioral health supports and services and (b) increase in confidence that children, youth, and families can get supports and services when they self-identify need
3. Decrease in rates of suicidal ideation among children and youth	9. Increase in children and youth who receive behavioral health services and supports
4. Decrease in emergency department visits and hospitalizations for behavioral health-related conditions	10. Increase representativeness in demographic characteristics and diversity in type of behavioral health professionals, especially in underserved communities
5. Increase in school engagement, as measured through reducing absenteeism	11. Increase in preventive services and family supports for children and youth of all ages
6. Decrease in stigmatizing attitudes toward behavioral health	12. Increase in substance use prevention strategies, specifically for younger children and adolescents
System-level support and collaboration	
13. Decrease in system-level barriers to behavioral health care for children and youth, especially in underserved communities	
14. Increase in cross-sector collaboration within the behavioral health ecosystem	
15. Increase in utilization of the school-linked statewide Fee Schedule	

CYBHI = Children and Youth Behavioral Health Initiative.

Overview of this report and the evaluation's methods

This initial evaluation report focuses on the design and early implementation progress of the CYBHI from its launch in July 2021 to July 2024; the report offers insight into the CYBHI strategies, the investments made through workstreams, the progress achieved to date, the potential for future impact, and suggestions to strengthen implementation. The purpose of this evaluation is to assess the implementation of the CYBHI and whether the investments made through the initiative are likely to impact the 15 outcome objectives. CalHHS and its evaluation partner have designed the early phases of the evaluation to assess whether the investments made are designed and being implemented in ways that

reasonably would lead to future impact on the 15 outcome objectives. Future evaluation reports will articulate additional progress toward CYBHI's expected impact across the outcome objectives.

We used data from four key activities conducted from November 2022 to July 2024:

1. Workstream coordination activities with implementing departments
2. Workstream document review, including analysis of workstream funding
3. Interviews with key state personnel in December 2023 and January 2024
4. A pulse survey conducted in March and April 2024 on behavioral health experiences and awareness of services from 1,046 caregivers, 234 youth, and 444 young adults

To inform data collection approaches and protocols, the evaluation periodically convenes and receives input from the CYBHI Evaluation Advisory Group (CEAG), which is comprised of California youth, families, frontline workers, local systems leaders, and researchers. Appendix 2 provides more information about the CYBHI evaluation.

In the chapters that follow, we discuss the four CYBHI strategies for improving the behavioral health ecosystem (Chapter 2) and workstream implementation from July 2021 through July 2024 within the context of four environments in which the workstreams are reaching children, youth, and families (Chapter 3). We then discuss the design and early implementation of the CYBHI as a systems change initiative, summarizing early findings regarding the successes and challenges encountered by state agencies, offering recommendations for immediate actions to enhance the CYBHI implementation, and sharing lessons learned that can guide future large-scale systems change efforts (Chapter 4). The conclusion reflects on overall progress to date and identifies strategic next steps as the initiative continues (Chapter 5).

As of October 2024, the CYBHI workstreams are at various stages of implementation, and Mathematica is in the process of obtaining: 1) programmatic data to further detail implementation activities and workstream progress and 2) Medi-Cal claims data that will allow for further analysis of certain outcomes. Implementation timelines for select workstreams preclude analysis of some proximal and distal outcomes within this report; for example, youth suicide data have a six-month release cycle, which limits the evaluation's ability to assess changes over time until future data are released. Because several CYBHI activities are in their infancy, it will take time to acquire the data necessary to fully evaluate outcomes. As another example, health care claims are typically not available to researchers until 6-12 months after the time of service, for a variety of reasons including timely claims submission rules and data processing timelines by state data warehouses.

Future evaluation activities will consider additional intended systems changes at the local level, analyze data as it becomes available, and assess change in the CYBHI outcome objectives. Forthcoming reports will describe how select counties within California are implementing the CYBHI; how the initiative is interacting with the ecosystem serving children, youth, and families; and how it is contributing to the goals of improving multisector collaboration and driving systems change.

2 | CYBHI Strategies: Approaches to Building a Behavioral Health Ecosystem That Supports All Children and Youth

To build a behavioral health ecosystem that serves all children and youth, the CYBHI is implementing several cross-cutting strategies at both initiative and workstream levels. In the sections that follow, we explore the CYBHI's efforts related to the four CYBHI strategies: centering children, youth, & families and grounding in equity; investing in promotion, prevention, and public awareness; developing workforce capacity to support behavioral health; and investing in infrastructure to support service delivery. Within the CYBHI, these strategies are notable for the significance of the investment and the cross-cutting nature of the effort, with implementation and impact anticipated across the various environmental settings in which youth receive behavioral health supports.

2.1. Centering children, youth, & families and grounding in equity

Since inception, the CYBHI has engaged over 2,100 organizations across the behavioral health ecosystem through webinars, virtual and in-person meetings, site visits, working groups, expert convenings, conference presentations, and other mechanisms. The CYBHI's youth-centered and equity-focused strategies are intended to drive the CYBHI's efforts to realize a more robust and equitable behavioral health ecosystem and place the experiences, needs, and voices of children, youth, and families at the center of the CYBHI's efforts. Through intentional engagement, the CYBHI aims to include children and youth in shaping ecosystem changes and to advance equity by ensuring that the needs of specific groups of youth—particularly those who are from marginalized groups or experiencing disparities in outcomes—are well understood and integrated in design and implementation efforts.

During early implementation, the central component of CYBHI's youth-centered strategy was the Youth at the Center Report, prepared by The Social Changery[12]. The Youth at the Center Report captures the findings from 50 listening sessions that the Social Changery conducted with 29 organizations in 2022. The goal of these sessions was to gather information from youth that could be used to ensure that the CYBHI's work is guided by the experiences of those it intends to serve. Approximately 600 youth, families, and community members shared their experiences navigating the behavioral health system. The Youth at the Center report highlights 12 calls to action that surfaced, shown in Exhibit 3. These calls to action outline ways to shift thinking, reimagine services, and transform systems based on the insights gathered.

To support the CYBHI's workstreams in operationalizing equity in their design, planning, and program administration, CalHHS convened an equity working group to advise CalHHS and its departments, develop an equity framework for the initiative, and make recommendations for applying the framework across the initiative. The resulting document, the CYBHI Equity Framework and Toolkit,[13] defines equity for the CYBHI, distills key components of an equity-centered approach, provides a framework for application, and outlines reflection questions for implementing departments.

The CYBHI workstreams are infusing equity into their work in context-specific ways based on the interventions they are undertaking. Given the need for a participatory approach across the initiative, the workstreams have used the CYBHI

[12] The Social Changery is an organization that works closely with communities in California to advance educational, health, and economic justice. They are partnering with CalHHS and Mathematica to produce a community facing report which speaks specifically to how the CYBHI responds to their 12 calls to action.

[13] California Health and Human Services Agency. (2023). CYBHI Equity framework, toolkit, and resources. Adopted by the CYBHI Equity Working Group, March 29, 2023; revised May 26, 2023.

Equity Framework and Toolkit as well as individualized strategies to address disparities in access, experience, and outcomes among marginalized populations. Further, several workstreams specify particular populations of focus that guide dissemination of funding and inform creation of appropriately tailored resources.

What is the potential for impact?

Involving youth and families as partners in the decisions that affect them increases the likelihood that the decisions will be accepted, adopted, and become part of their daily lives.[14] Early evidence suggests that community-based interventions, including those that emphasize community members as integral to the intervention, are effective for improving mental health.[15] Participatory approaches have been demonstrated to result in more effective and sustainable solutions.[16]

Exhibit 3 maps the CYBHI's activities to the calls to action identified in this report and provides insight into the CYBHI's alignment with the vision children, youth, and communities crafted for the initiative. There is substantial alignment between the calls to action and CYBHI activities, further reinforcing the potential for CYBHI activities to impact areas that youth in California articulate as critical areas for action.

Exhibit 3. CYBHI alignment with the Youth at the Center Calls to Action

Youth at the Center Call to Action	Alignment with the CYBHI
Shift thinking	
Addressing stigma is foundational first step	Public awareness campaigns including the Live Beyond Campaign; Public Education and Change Campaigns; Never a Bother Campaign; and Positive Parenting, Thriving Kids Video Series are well-positioned to reduce stigma.
Culture is healing	Workstreams centering cultural relevance and co-creation processes include Public Education and Change Campaigns (partnering with youth and Community Based Organizations (CBOs) to craft both state-wide and local-level campaigns), Live Beyond (partnering with Native youth and artists), and Scaling EBPs/CDEPs Round 4 (youth-driven programs). Additionally, many workstreams embed efforts to promote cultural and linguistic responsiveness. For example, the Virtual Services Platform offers coaching in multiple languages, Wellness Coach Certification includes cultural competency training, and the Scaling EBP/CDEPs workstream considers potential awardees' ability to provide culturally relevant and responsive services when making awards.
Youth and communities want self-determination – not 'empowerment'	As a whole, the initiative seeks to strengthen the availability, accessibility, and quality of services available to children, youth, and families across environmental settings, with the intention of facilitating greater self-determination around how, when, and where to seek needed support. Many of the CYBHI workstreams provided opportunities for youth and families to play a role in identifying solutions and designing strategies to address behavioral health challenges. Key examples include the CYBHI Youth Fellows (initiative-level) and youth advisory groups convened to inform the development of public awareness campaigns, including Never a Bother, Live Beyond, and Public Education and Change Campaigns.

[14] Youth Gov. "Involving Youth in Positive Youth Development." n.d. https://youth.gov/youth-topics/involving-youth-positive-youth-development. Accessed on August 27, 2024.

[15] Castillo, E.G., R. Ijadi-Maghsoodi, S. Shadravan, E. Moore, M. Mensah, M. Docherty, M.G.A. Nunez et al. " Community Interventions to Promote Mental Health and Social Equity" *Current Psychiatry Reports*, vol. 21, no. 5, March 2019, pp. 1-14. https://doi.org/10.1007/s11920-019-1017-0.

[16] Leask, C.F., Sandlund, M., Skelton, D.A. *et al.* Framework, principles and recommendations for utilising participatory methodologies in the co-creation and evaluation of public health interventions. *Research Involvement and Engagement*, vol. 5, no. 2, 2019. https://doi.org/10.1186/s40900-018-0136-9.

Youth at the Center Call to Action	Alignment with the CYBHI
Rethink treatment: what it looks like and who provides it	Several CYBHI workstreams are expanding the traditional behavioral health 'workforce,' for instance by seeking to increase peer or near-peer services (through the Certified Wellness Coach Workforce Program, Youth Peer-to-Peer Support Program, and Peer Personnel Training and Placement Program), and by providing behavioral health training to non-behavioral health professionals who work with children and youth daily (as in the Open Doors Training (SUD/JSIY), Safe Spaces, CalHOPE Student Support & Schools Initiative, and Mindfulness, Resilience and Wellbeing Support Grants). The CYBHI also seeks to invest in innovative, alternative sites of care, including schools, primary care, and digital services.
Reimagine services	
Help must be available before it's a crisis	Most of the CYBHI workstreams focus upstream of crisis. For example, the CYBHI public awareness campaigns, school-linked workstreams, virtual service platforms, and workforce investments are intended to support promotion, prevention, and various outpatient clinical services.
Make places for youth to belong, create, and connect to the outdoors	While the CYBHI workstreams do not explicitly address this call to action, funding awarded under BHCIP and SBHIP may be used to support outdoor wellness centers, community spaces, and similar investments.
Take care of adults so they can take care of young people	Enhanced Medi-Cal Benefits - Dyadic Services expands options for caregivers to receive timely behavioral health care services alongside their child. Several workstreams provide resources for parents and caregivers, including the Positive Parenting, Thriving Kids video series; BrightLife Kids; and Scaling EBPs/CDEPs Round 1. Several school-linked workstreams including Mindfulness, Resilience, and Wellbeing Grants; CalHOPE Student Support & Schools Initiative; and Safe Spaces may provide opportunities to strengthen educator resilience and skills.
Create a mental health system everyone can navigate, even when struggling	Several CYBHI workstreams intend to expand access points into the behavioral health system, including at schools (Fee Schedule, SBHIP, School-Linked Partnership & Capacity Grants), primary care (Cal-MAP, Dyadic Services), virtual services (Soluna and BrightLife Kids), the community, and at home.
Transform systems	
Build a representative workforce	HCAI has implemented a broad array of workforce investments aimed at expanding and diversifying the behavioral health care provider workforce. These programs support training and pipeline programs and scholarship/loan repayment to individuals, prioritizing applicants who are underrepresented in the behavioral health workforce.
Decriminalize mental health – including substance use	The authorizing legislation that established the CYBHI did not create a workstream explicitly dedicated to decriminalization of behavioral health challenges. However, some CYBHI workstreams seek to support or address the particular behavioral health needs of justice-involved populations. For instance, the Open Doors Training (SUD/JSIY) seeks to increase behavioral health competency for non-behavioral professionals.
Unacknowledged harm gets in the way of hope and trust	The CYBHI workstreams prioritized listening to children, youth, and families in workstream planning; this represents a first step for rebuilding trust, but addressing unacknowledged harm requires continual, intentional engagement across sites and sectors.
Take action to address systemic inequalities and oppression	To equip the CYBHI's implementers with the needed supports to integrate equity in the overall initiative, the CYBHI Equity Working Group was convened to develop the CYBHI Equity Framework and Toolkit. This toolkit has been used to inform program and evaluation planning. Additionally, many workstreams prioritize focus on historically underserved populations. While the CYBHI workstreams aim to center equity in their design and funding decisions, addressing systemic inequalities and oppression requires continual, intentional engagement across sites and sectors.

The Social Changery continues to be a key partner in operationalizing and assessing the CYBHI's child, youth, and family engagement approach. The CYBHI's youth-centered strategy will be explored in greater detail in a report authored by The Social Changery, expected later in 2025.

To support the CYBHI's workstreams operationalizing equity in their design, planning, and program administration, CalHHS convened an equity working group to advise CalHHS and its departments, develop an equity framework for the initiative, and make recommendations for applying the framework across the initiative. The resulting document, the CYBHI Equity Framework and Toolkit,[17] defines equity for the CYBHI, distills key components of an equity-centered approach, provides a framework for application, and outlines reflection questions for implementing departments.

To improve equity in behavioral health outcomes, the CYBHI blends universal and tailored approaches such as strengthening points of near-universal access and influence (K-12 schools, primary care settings) while supporting population- and community-specific strategies (for instance, through local-level Public Education and Change Campaigns). These efforts are informed by targeted universalism concepts, as described within the CYBHI Equity Framework and Toolkit. Nearly all CYBHI workstreams target the broad population of all children, youth, and families who need behavioral health services, but to ensure that "services are available, safe, high quality, and accessible, in a timely manner, regardless of means, location, resources, or affiliation for all, including using specific approaches for specific groups as needed to achieve the universal goal," some workstreams, to differing degrees, also employ population-specific approaches to augment their universal efforts.[18] For instance, Cal-MAP aims to connect primary care providers with behavioral health consultation, augmenting their ability to diagnose and treat behavioral health needs among the families, children, and youth they serve.

Further, the CYBHI makes substantial investments in school-based behavioral health services, aligned with evidence that school-based provision of health care services can advance equity by reducing barriers to access and improving both educational and health related outcomes for low-income and racial or ethnic minority students.[19,20] Workstreams such as CalHOPE Student Services, SBHIP, and School-Linked Partnership and Capacity Grants seek to build capacity for behavioral health in educational settings, strengthening the ability of schools and educators to support well-being, identify behavioral health needs, and increase access to school-linked care for all students.

As of September 2024, CYBHI workstreams collectively distributed over $2.1 billion dollars in awards to local entities across California. These awards include funds that were allocated to all counties as well as competitive grants to which counties could apply. This mix of strategies ensured a baseline level of funds going to each county, with a minimum of $59 per child and youth across all counties. In addition to universally distributed funding, counties with greater need and larger populations were able to apply for additional funding in alignment with local need, interest, and readiness to undertake further transformation.

Exhibit 4 shows the distribution of total CYBHI awards as well as awards per capita of individuals under the age of 25 by county. This analysis shows that more CYBHI total funding has been allocated to counties that are predominantly urban counties, but more per capita funding has been awarded in rural counties (Exhibit 4). Funding distribution is also related to the specific, relative needs within counties. For example, funding for suicide prevention-focused work was distributed to counties experiencing higher levels of acute need (discussed further in section 3.3). This alignment of

[17] California Health and Human Services Agency. (2023). CYBHI Equity framework, toolkit, and resources. Adopted by the CYBHI Equity Working Group, March 29, 2023; revised May 26, 2023.

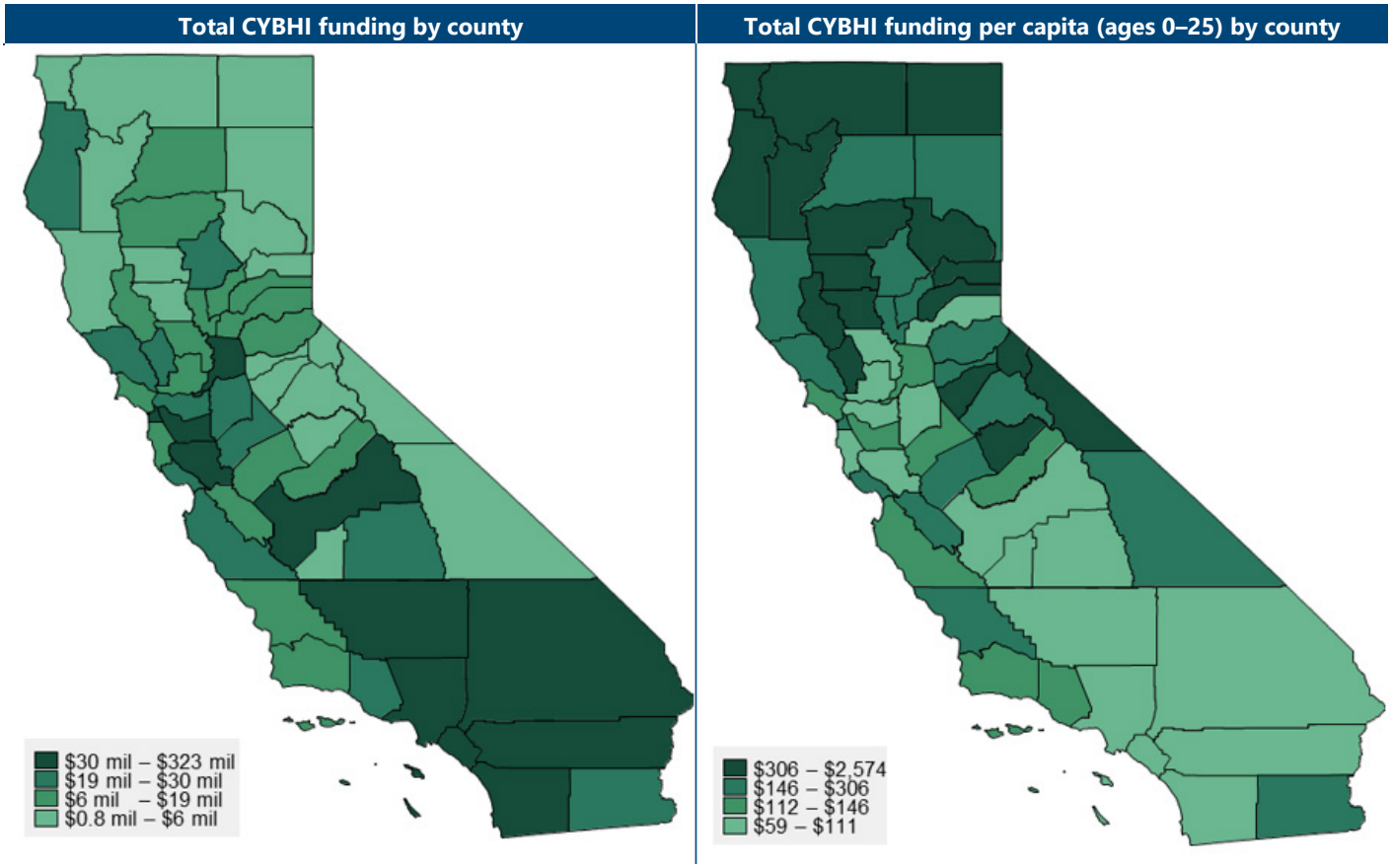
[18] Examples of the workstream targeted populations include underrepresented or underserved populations, people of color, immigrants and refugees, American Indian/Alaska Native, system-impacted, economically disadvantaged, LGBTQIA+, and people with disabilities.

[19] Knopf, J.A., R.K.C. Finnie, Y. Peng, R.A. Hahn, B.I. Truman, M. Vernon-Smiley, V.C. Johnson, et al. "School-Based Health Centers to Advance Health Equity: A Community Guide Systematic Review" *American Journal of Preventive Medicine*, vol. 51, no. 1, July 2016, pp. 114-126. https://www.sciencedirect.com/science/article/abs/pii/S0749379716000350.

[20] Itriyeva, K. "Improving Health Equity and Outcomes for Children and Adolescents: The Role of School-Based Health Centers (SBHCs)" *Current Problems in Pediatric and Adolescent Health Care*, vol. 54, no. 4, April 2024. https://doi.org/10.1016/j.cppeds.2024.101582.

higher per-capita funding in areas with traditionally lower health care investments (such as rural areas) as well as alignment to higher documented need will contribute to likelihood of success in these areas.

Exhibit 4. Geographic distribution of CYBHI funding



Source: Mathematica analysis of the CYBHI documentation.
Notes: Does not include the Broad Behavioral Health Workforce Capacity components of: Community Based Organization Behavioral Health Workforce Grant Program, Health Careers Exploration Program Awards, Health Professional Pathways Program, California Social Work Education Center, and Peer Personnel Training and Placement Program, or Scaling EBPs/CDEPs Round 3. For the Behavioral Health Continuum Infrastructure Program, we allocated regional based funding to counties based on the portion of awardees in each county.

2.2. Investing in promotion, prevention, and public awareness

To build an equitable, youth-centered behavioral health ecosystem, it is essential to strengthen capacity for support across the environments in which children and youth spend the majority of their time. Embracing former CalHHS Secretary Mark Ghaly's vision of a "coordinated, youth-centered, equitable, and prevention-oriented ecosystem," the CYBHI provides direct funding for upstream resources focusing on prevention, promotion, and public awareness. Evidence indicates that many mental, emotional, and behavioral disorders can be prevented before they begin.[21] Early research, community engagement, and a needs assessment conducted by the CYBHI identified the rationale and desire for increased investment in prevention and promotion. The 2023 Youth at the Center report (discussed further in Section 2.1) emphasizes the need for investment in upstream services through the following Calls to Action:

[21] National Research Council and Institute of Medicine. *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*. 2009. https://doi.org/10.17226/12480.

- Addressing stigma as a foundational first step,
- Rethinking treatment in terms of what it looks like and who provides it,
- Making help available before it becomes a crisis, and
- Supporting adults so they can take care of young people.

Findings from the pulse survey, conducted by Mathematica in spring 2024 on behavioral health experiences and awareness of services youth (ages 12-18), young adults (ages 18-25), and their caregivers, additionally support the need for investment in promotion and prevention in the following areas:

- **Reducing stigma.** One in three young adults expressed discomfort with others knowing about their behavioral health problems, a rate nearly twice as high as for caregivers and youth. The results underscore the value of tailoring strategies such as directing public messaging about stigma to teens and young adults, which is a strategy currently planned by the CYBHI Public Education and Change Campaigns.

Spring 2024 Pulse Survey: Overview of Methods

In spring 2024, Mathematica conducted a statewide survey of caregivers, youth, and young adults to measure indicators of behavioral health and wellbeing, including:

- Behavioral health stigma,
- Knowledge of behavioral health and help-seeking,
- Experiences with accessing behavioral health services, and
- Skills to address behavioral health challenges.

The survey had three groups of respondents:

- 1,046 caregivers (ages 26 and over) of youth ages 12–18
- 234 youth ages 12–18
- 444 young adults ages 18–25

Mathematica performed descriptive quantitative analysis for both overall findings and differences across demographic groups where available.

- **Increasing behavioral health knowledge and help-seeking.** Although more than 70 percent of caregivers, youth, and young adults in California reported general awareness of behavioral health issues, treatment options, and when and where seek help, many lacked confidence in their knowledge. Notably, less than half strongly agreed with statements about understanding mental health causes and knowing where to turn. For example, only about 40 percent of each group felt confident in knowing where to seek help if needed. Particularly, fewer youth (20 percent) strongly agreed that they understood mental health causes than caregivers (33 percent) and young adults (42 percent). Confidence in knowing when to seek help had similar results, with 28 percent for youth, 43 percent for caregivers, and 39 percent for young adults. These gaps indicate significant opportunities for the CYBHI interventions to enhance mental health literacy.
- **Strengthening behavioral health management skills.** Most caregivers in California reported being aware of their strengths and actively managing behavioral health challenges in their families. They reported similar levels of confidence in their personal behavioral health skills, including emotional awareness, articulating thoughts and feelings, and managing stress. Although most youth and young adults also reported confidence in their personal behavioral health skills, young adults generally felt less confident than youth.

As evidence of the commitment of CYBHI workstreams to the ethos of awareness, prevention, and health promotion, more than $3.5 billion of total CYBHI funds support implementation efforts focused on behavioral health prevention and promotion.[22] The CYBHI's prevention, promotion, and public awareness activities aim to surround youth with

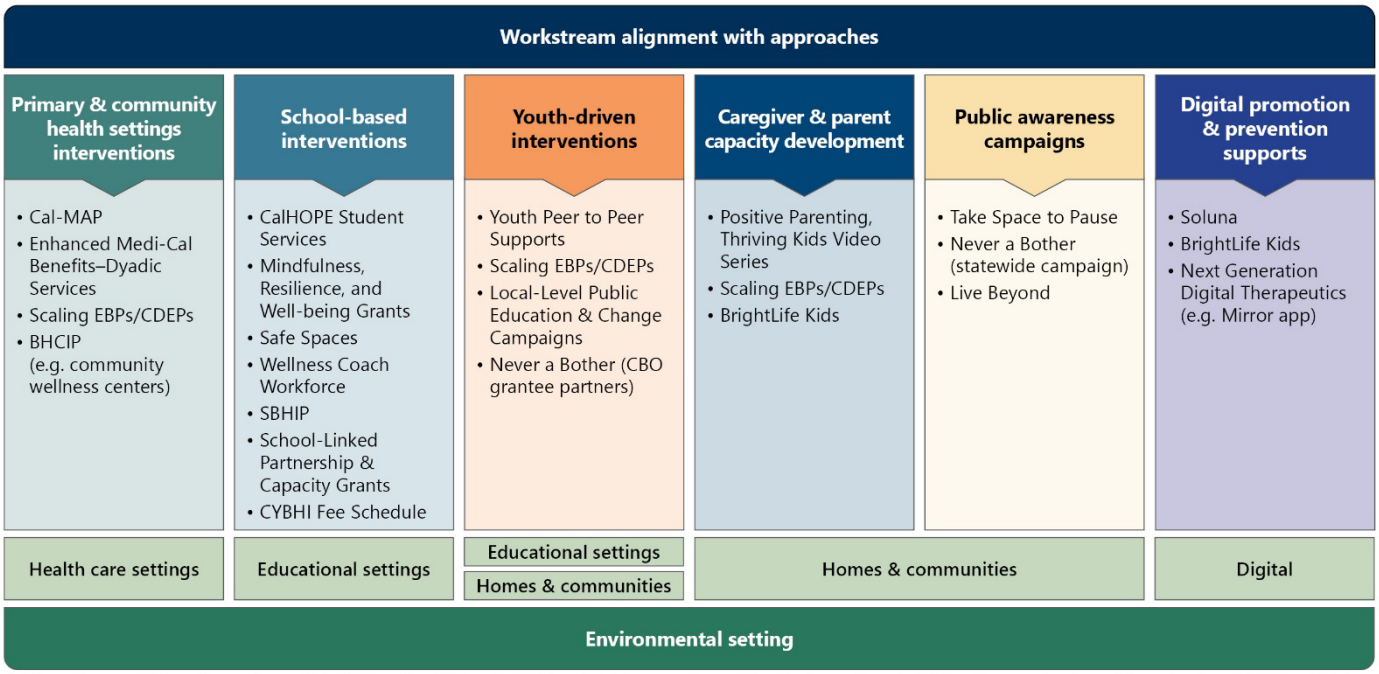
[22] For the purposes of this figure, we have focused on workstreams with an explicit, near-term impact on the availability of behavioral health promotion and prevention resources, supports, and services, encompassing the broad array of activities described above. Excluded from this figure are CYBHI investments in acute care facilities (through BHCIP), clinical support tools (developed through Next Generation Digital Therapeutics), investments in crisis response systems (Youth Suicide Reporting & Crisis Response

behavioral health promotion supports delivered through various channels, delivering prevention messaging via universal media and public awareness campaigns, providing resources to parents and caregivers, strengthening the capacity of schools to support behavioral health wellness, equipping primary care providers (PCPs) to better identify and address behavioral health needs, investing in peer-driven supports, and making promotion and prevention supports available to youth through digital tools and supports.

What is the potential for impact?

Through a number of workstreams, the CYBHI intends to surround youth with people and places that foster improved well-being and prevent behavioral health issues. Exhibit 5 illustrates the alignment of the CYBHI's workstreams with behavioral health promotion and prevention strategies, and maps each to a specific environmental setting within the ecosystem.

Exhibit 5. CYBHI workstream alignment with behavioral health promotion and prevention strategies to support mental, emotional, and behavioral development for children and youth



ACE = adverse childhood experience; **Cal-MAP** = The California Child and Adolescent Mental Health Access Portal; **CBO** = Community-Based Organization; **CYBHI** = Children and Youth Behavioral Health Initiative; **EBPs/CDEPs** = Evidence-Based Practices/Community-Defined Evidence Practices

The CYBHI's diverse array of prevention, promotion, and public awareness activities aligns strongly with the National Academies' 2019 national agenda report on *Fostering Healthy Mental, Emotional, and Behavioral Development in Children and Youth*. This report underscores the need for a comprehensive, multi-level approach to mental, emotional, and behavioral (MEB) development that addresses individual, family, community, and societal influences.[23] A public health strategy that mobilizes community and state sectors to implement promotion and prevention efforts is key to improving population-level outcomes and mitigating adverse environments that threaten healthy MEB development. The CYBHI's multi-pronged strategy, which seeks to bolster primary health care and educational settings, youth-driven programs, caregiver capacity-building efforts, public awareness campaigns, and digital supports, reflects this

Pilots), and the (not prevention-specific) behavioral health workforce investments represented by the Broad Behavioral Health Workforce Capacity programs and Youth Mental Health Academy workstream.

[23] National Academies of Sciences, Engineering, and Medicine. 2019. *Fostering Healthy Mental, Emotional, and Behavioral Development in Children and Youth: A National Agenda*. Washington, DC: The National Academies Press. https://doi.org/10.17226/25201.

recommended approach. The National Academies report highlights various evidence-based strategies to promote well-being and build resilience while preventing harm, organized around different access points—parenting and caregiver programs, educational settings, health care, and policy-driven strategies. CYBHI not only aligns with these strategies but expands them by incorporating youth-driven and digital interventions, indicating a robust approach to supporting MEB development at multiple levels. As with any complex intervention comprised of distinct activities, collective impact depends on the implementation of its component parts. We have included discussion of specific workstreams with a promotion, prevention, or public awareness focus within the relevant environmental setting in section 3 of this report.

2.3. Developing workforce capacity to support behavioral health

The CYBHI investments in building a larger, more representative behavioral health workforce focus on training and expanding the workforce to encompass varied types of providers who reflect the cultural and linguistic diversity of California's children, youth, and families. Through these investments, the CYBHI seeks to ensure that children and youth receive care that is both clinically effective and culturally relevant and sensitive to their lived experiences.

As of 2016, there were more than 80,000 licensed behavioral health providers in California, which is insufficient to meet the needs of the state's residents.[24] As of the end of 2023, about 8 million Californians lived in a federally designated Mental Health Professional Shortage Area (MHPSA).[25] In addition, reports from the California Future Health Workforce Commission and University of California San Francisco (UCSF) forecast a decline in the supply of psychiatrists, psychologists, and licensed clinical social workers in the state. Current behavioral health providers are not culturally, linguistically, or racially/ethnically representative of the youth needing access to their services, with Latino and Black providers particularly underrepresented.[26] Furthermore, many providers are aging out of regular practice, with 45 percent of psychiatrists and 37 percent of psychologists older than age 60.[27]

HCAI, formerly the Office of Statewide Health Planning and Development, has long been responsible for helping develop California's health workforce education and training with a focus on building a diverse and effective health workforce that meets the health and related needs of all Californians. As part of the CYBHI, HCAI has been working to transform how California meets the behavioral health needs of children, youth, and families by broadening the scope, the continuum of preparation for, and the types of behavioral health workforce roles. The CYBHI's workforce investments are concentrated in HCAI's three workstreams: **Certified Wellness Coach** (CWC), **Youth Mental Health Academy,** and the **Broad Behavioral Health Workforce Capacity** workstream (which notably comprises 18 distinct programs). Select DHCS workstreams are also aligned with the overarching aim of increasing behavioral health workforce capacity. The workstreams and programs that comprise the CYBHI's workforce strategy are organized into the seven key approaches described below.

[24] Coffman, J., T. Bates, I. Geyn, and J. Spetz. "California's Current and Future Behavioral Health Workforce." The Healthforce Center at UCSF, February 2018. California's Current and Future Behavioral Health Workforce.pdf.
[25] National Center for Health Workforce Analysis. "Behavioral Health Workforce, 2023." December 2023. https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/Behavioral-Health-Workforce-Brief-2023.pdf.
[26] Coffman, J., T. Bates, I. Geyn, and J. Spetz. "California's Current and Future Behavioral Health Workforce." The Healthforce Center at UCSF, February 2018. California's Current and Future Behavioral Health Workforce.pdf.
[27] California Future Health Workforce Commission. "Meeting the Demand of Health: Final Report of the California Future Health Workforce Commission." February 2019. https://futurehealthworkforce.org/.

Approach 1: Promoting early interest in behavioral health careers through pipeline and exploration programs. The CYBHI funds multiple pipeline and exploration programs focused on exposing high school and undergraduate students to behavioral health careers. These programs are intended to increase the number of individuals joining the workforce and increase the representation from historically and systematically excluded communities and cultural backgrounds. The CYBHI investments in programs to recruit, prepare, and mentor students interested in health careers are discussed in section 3.3.

Approach 2: Expanding and developing new workforce roles through diverse investments intended to develop new behavioral health provider roles and support existing ones. Notably, the CYBHI established and is supporting adoption of a new behavioral health profession, CWCs, discussed further in the spotlight box and in section 3.2. The CYBHI investments in school-based peer-to-peer supports are discussed in section 3.2, while investments in SUD and peer certification are discussed in section 3.3. Additionally, the CYBHI's virtual services platforms, BrightLife Kids and Soluna (discussed further in section 3.4), incorporate behavioral health coaching services; to provide these services, the CYBHI virtual services platform implementation partners are providing training and supporting certification of these coaches as either Peer Support Specialists or Certified Wellness Coaches.

Spotlight on development of the Certified Wellness Coach Profession

Certified Wellness Coaches (CWC) are intended to increase California's overall behavioral health workforce capacity through wellness promotion, prevention, and early intervention services, screening, and crisis referral.

To support this new profession, this workstream includes (1) development of two certification pathways (the education and workforce pathways), (2) a scholarship program that supports students pursuing an associate's or bachelor's degree that will qualify them for Wellness Coach Certification in exchange for a 12-month service obligation at a qualified site, and (3) an employer support grant effort that supports educational institutions and school-linked behavioral health agencies seeking to employ CWC before the position is eligible for Medi-Cal reimbursement.

HCAI began certifying Wellness Coaches in February 2024, announced employer support grant awards in July 2024, and awarded nearly 200 scholarships in September and October 2024. Though adoption of the role is in early stages, over 400 wellness coaches have already been certified to date.

This program has proceeded along appropriate administrative pathways but has important implementation efforts remaining. The 2024-25 California budget authorized DHCS to seek the approval of the Centers for Medicare and Medicaid (CMS) to establish the Certified Wellness Coach as a new state plan benefit in Medi-Cal with a go-live date of January 1, 2025, contingent upon CMS approval. As HCAI and DHCS collaborate to finalize this approval and establish CWCs as providers under the CYBHI Fee Schedule (which requires commercial health plans and Medi-Cal, as applicable, to reimburse services provided as part of the Fee Schedule at or above published rates), the CYBHI should continue to monitor these programs for administrative progress and identify opportunities to access existing program data for implementation and impact evaluation.

Approach 3: Providing scholarships to support students in pursuing behavioral health careers across behavioral health provider types. Within the CYBHI, these scholarships are often accompanied by a post-graduate service obligation in a particular region or type of organization; these investments are discussed in section 3.1.

Approach 4: Expanding the capacity of education programs to train new providers through funding to expand the size of existing behavioral health training programs or establishing new training programs. Funds can also be used to recruit culturally and linguistically diverse students and modify curriculum or augment efforts to prepare providers to work with unserved and underserved. Within the CYBHI, these investments focus primarily on expanding or establishing new social work, psychiatric residency, and psychiatric mental health nurse practitioner training programs and are discussed in section 3.1.

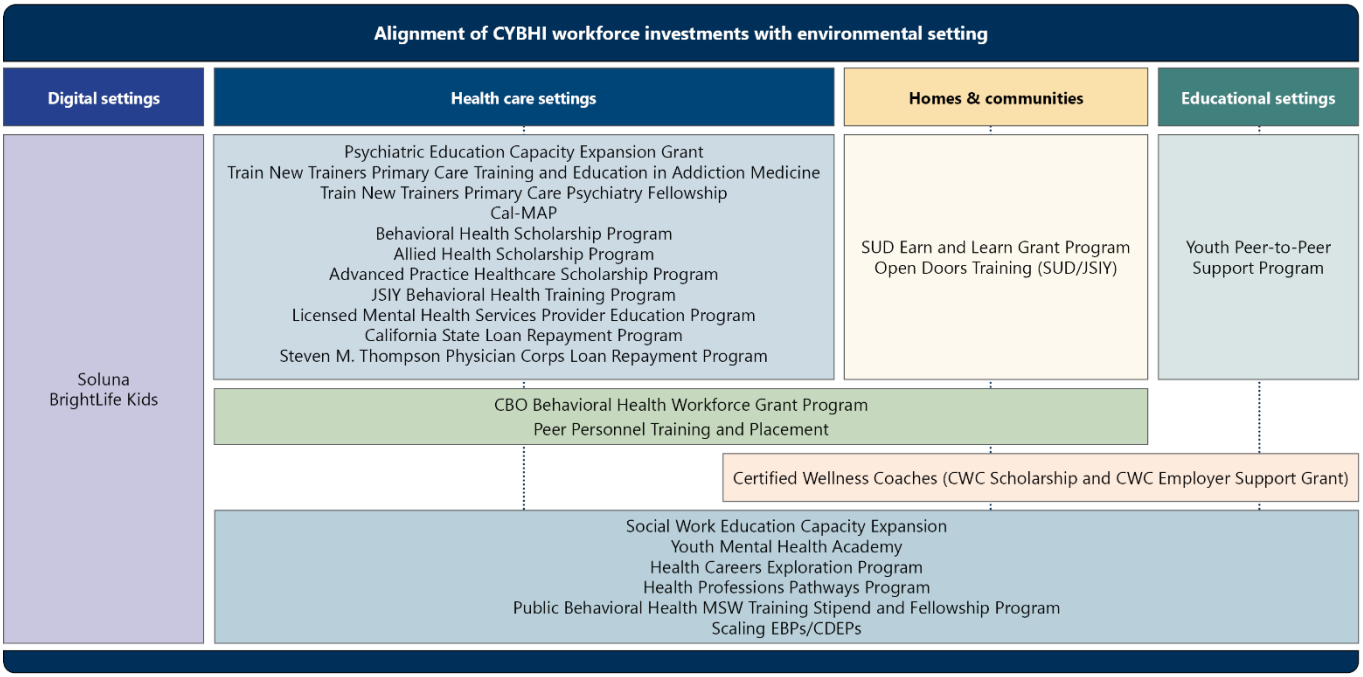
Approach 5: Providing incentives to work in underserved areas through loan repayment scholarship programs to offset educational debt and increase providers in predefined geographic areas or settings such as underserved areas (HPSA) or qualified facilities, or at selected Community Based Organizations (CBOs). The CYBHI-supported loan repayment and scholarship are offered to a wide range of students seeking to become, as well as those already working as, behavioral health professionals, including licensed master's and doctoral level clinicians, social workers, SUD counselors, and others; these investments are discussed in section 3.1.

Approach 6: Developing behavioral health capacity among non-behavioral health practitioners by providing behavioral health training to primary care and emergency department clinicians and to non-medical, non-behavioral health staff working closely with youth. These programs represent some of the more innovative approaches to expanding the behavioral health workforce and are discussed in sections 3.1 and 3.3.

Approach 7: Improving organizational and workforce capacity to provide evidence-based services to increase the quality and effectiveness of services. Investments in scaling evidence-based care are embedded throughout health care settings, educational settings, and homes and communities; as such, they are discussed in sections 3.1- 3.3.

The CYBHI is intentionally building professional capacity to achieve a larger, more representative behavioral health workforce and training other individuals serving children in homes, communities, and educational settings. Funding for the CYBHI-supported workforce investments have progressed through initial program design and administrative and disbursement processes. These workstreams and programs are designed to operate across environments, building capacity in the health care workforce and fostering impact in health care settings, educational settings, and local communities (Exhibit 6). Discussion of specific programs supporting workforce development is integrated within the relevant environmental setting in section 3 of this report.

Exhibit 6. CYBHI investments to improve the behavioral health workforce across environmental settings



Cal-MAP = The California Child and Adolescent Mental Health Access Portal; **JSIY** = Justice System-Involved Youth; **SUD** = Substance Use Disorder; **BH** = Behavioral Health; **CBO** = Community-Based Organization; **CWC** = Certified Wellness Coach; **EBPs/CDEPs** = Evidence-Based Practices/Community-Defined Evidence Practices

Through planned analyses of HCAI application data, Mathematica will be able to draw deeper insights about the individuals and organizations supported through these investments. Although these data will not facilitate the assessment of grantee performance or impact, they will increase understanding of workforce investments' intended or potential contributions to workforce expansion and increased provider representativeness. The volume of programs, paired with the significant methodological investment and infrastructure required to longitudinally track employment, presents challenges for assessing the impact of workforce programs.

What is the potential for impact?

Although some interventions have the potential for near-term impact, it is important to recognize that quick-fix interventions alone will not resolve California's behavioral health workforce crisis. Instead, short-term solutions are needed in conjunction with longer-term investments to meet the needs of California today, tomorrow, and in the future. As such, some of the CYBHI's workforce investments may have more immediate effects on building workforce capacity, especially those focused on retaining providers focused on high-need populations or geographic areas (for example, the **Community Based Organization (CBO) Behavioral Health Workforce Grant** and similar loan repayment programs). Other investments, such as education capacity expansion programs, will affect workforce capacity over a longer time horizon. Exhibit 7 maps the programs and workstreams to the seven workforce approaches discussed above, along with the time horizon on which impact can be anticipated.

Exhibit 7. CYBHI programs by workforce development approach and timeline for anticipated impact on workforce capacity

	Near-Term These programs are anticipated to immediately increase workforce capacity and/or capability	**Mid-Term** These programs are anticipated to increase workforce capacity and/or capability within the next 1–4 years	**Long-Term** These programs are anticipated to increase workforce capacity and/or capability
Promoting early interest (including high school and undergraduate) in behavioral health careers through pipeline and exploration programs	--	--	• YMHA* • HCEP • HPPP
Expanding and developing new workforce roles	• Peer Personnel Training and Placement • Wellness Coach Employer Support Grant* • Soluna • BrightLife Kids	• Certified Wellness Coaches* • Peer Personnel Training and Placement • SUD Earn and Learn Grant Program* • Youth Peer-to-Peer Support Program	--
Providing scholarships to support students in pursuing behavioral health careers	• Public Behavioral Health MSW Training Stipend and Fellowship Program	• BHSP • AHSP • APHSP • Public Behavioral Health MSW Training Stipend and Fellowship Program • Wellness Coach Scholarship Program*	• BHSP • AHSP • APHSP • JSIY BH Pipeline
Expanding the capacity of education programs to train new providers	--	• PECE (program expansion)* • SWECE (program expansion)*	• PECE (new programs)* • SWECE (new programs)*
Providing incentives to work in underserved areas through loan repayment/stipend programs to offset educational debt	• CBO BH Workforce Grant* • SLRP • Steven M. Thompson Physician Corps Loan Repayment Program • LMHSPEP	--	--
Developing behavioral health capacity among non-behavioral health practitioners	• Open Doors Training (SUD/JSIY) • TNT PCP • TNT PC-TEAM • Cal-MAP*	--	--
Improving organizational and workforce capacity to provide evidence-based services.	• Scaling EBPs*		--

*Significant program, funded at over 20m

YMHA = Youth Mental Health Academy; **HCEP** = Health Careers Exploration Program; **HPPP**= Health Professions Pathways Program; **SUD** = Substance Use Disorder; **MSW** = Master of Social Work; **BHSP** = Behavioral Health Scholarship Program; **AHSP** = Allied Health Scholarship Program; **APHSP** = Advanced Practice Healthcare Scholarship Program; **JSIY BH Pipeline** = Justice- and System-Involved Youth Behavioral Health Training Program; **PECE** = Psychiatric Education Capacity Expansion Grant; **SWECE** = Social Work Education Capacity Expansion Grant; **CBO** = Community-Based Organization; **BH** = Behavioral Health; **SLRP** = California State Loan Repayment Program; **LMHSPEP** = Licensed MH Services Provider Education Program; **TNT PC-TEAM** = Train New Trainers Primary Care Training and Education in Addiction Medicine; **TNT PCP** = Train New Trainers Primary Care Psychiatry Fellowship; **Cal-MAP** = The California Child and Adolescent Mental Health Access Portal; **EBPs/CDEPs** = Evidence-Based Practices/Community-Defined Evidence Practices.

A review of state efforts to develop the behavioral health workforce shows that states are addressing workforce shortages through various strategies, including pipeline programs, loan repayment initiatives, and expanded training opportunities. Evidence suggests that different categories of health workforce policy interventions, such as pipeline programs, scholarship programs, loan repayment programs, graduate-level health profession training programs, and residency programs, can work together to address the behavioral health professional workforce shortages in California.[28] Each approach uniquely contributes to improving behavioral health access, such as increasing the number of workers in underserved areas or increasing the racial and ethnic diversity of the workforce. The programs are synergistic and more effective together than any one strategy alone. The interventions will be most effective when they are coordinated and integrated into a cohesive workforce strategy in which programs and incentives complement and connect with one another. For instance, HCAI could consider incentivizing pipeline program participation by offering automatic eligibility for or enrollment in later training or scholarship programs.

Of particular note within the suite of CYBHI workforce investments, HCAI has established the Certified Wellness Coach role. This newly established behavioral health role has been designed to support near- and mid-term expansion of the behavioral health workforce and increase workforce diversity by lowering barriers to workforce entry by creating both education and experience (workforce) pathways to certification, accessible to those with associate and bachelor's degrees. Pending CMS approval for inclusion of CWC services under the CYBHI Fee Schedule, Wellness Coaches are well-positioned to supplement the existing school-linked behavioral health workforce, thereby expanding capacity to offer prevention-focused supports and services to students. The addition of the CWC role to the California behavioral health workforce landscape fills a gap between roles that require master's level education and roles requiring less formal training, such as Community Health Workers and Peer Support Specialists, and creates a potential workforce pipeline that can facilitate career progression for those who want to advance their training and scope of practice.[29]

2.4. Investing in infrastructure to support service delivery

In order to provide needed services to children and youth, the behavioral health ecosystem must have sufficient, appropriate, and geographically accessible physical sites for providing behavioral health services as well as the administrative and operational infrastructure and capacity required to support service delivery and billing. Significant infrastructure gaps that hinder access to treatment exacerbate the high prevalence of behavioral health concerns for those who need care most. To meet the demand for services, the children and youth behavioral health ecosystem requires infrastructure investments in physical facility projects (such as the creation of crisis stabilization units, residential treatment facilities, acute care psychiatric hospitals, and wellness centers) and efforts to strengthen behavioral health data and reporting systems.

[28] Rittenhouse, D., A. Ament, J. Genevro, and K. Contreary. "Health Workforce Strategies for California: A Review of the Evidence." April 2021. https://www.chcf.org/wp-content/uploads/2021/04/HealthWorkforceStrategiesReviewEvidence.pdf.

[29] HCAI (2024). *Certified Wellness Coach (CWC) Model.* [PowerPoint slides]. https://hcai.ca.gov/document/wellness-coach-model-june-2023/.

Physical projects. The availability of sufficient and appropriate physical facilities in which to provide behavioral health services is a critical factor influencing access to and experience of these services. There are gaps in the physical infrastructure necessary to support the increasing need for behavioral health services across the continuum of care, including in traditional health care settings[30] and in schools.[31]

Administrative and digital infrastructure. Providing behavioral health care also requires investment in data and reporting systems. As the children and youth behavioral health ecosystem increasingly invests in expanding school-linked services to address mild to moderate behavioral health needs, accompanying investments in capacity to track, manage, secure, and safely transmit student health information and claims are necessary to aid this transformation.

The CYBHI's infrastructure strategy spans three workstreams and includes physical infrastructure investments in traditional behavioral health settings and makes funding available to support physical, administrative, and digital infrastructure development in school settings, reflecting their increasing importance as key sites for behavioral health access.

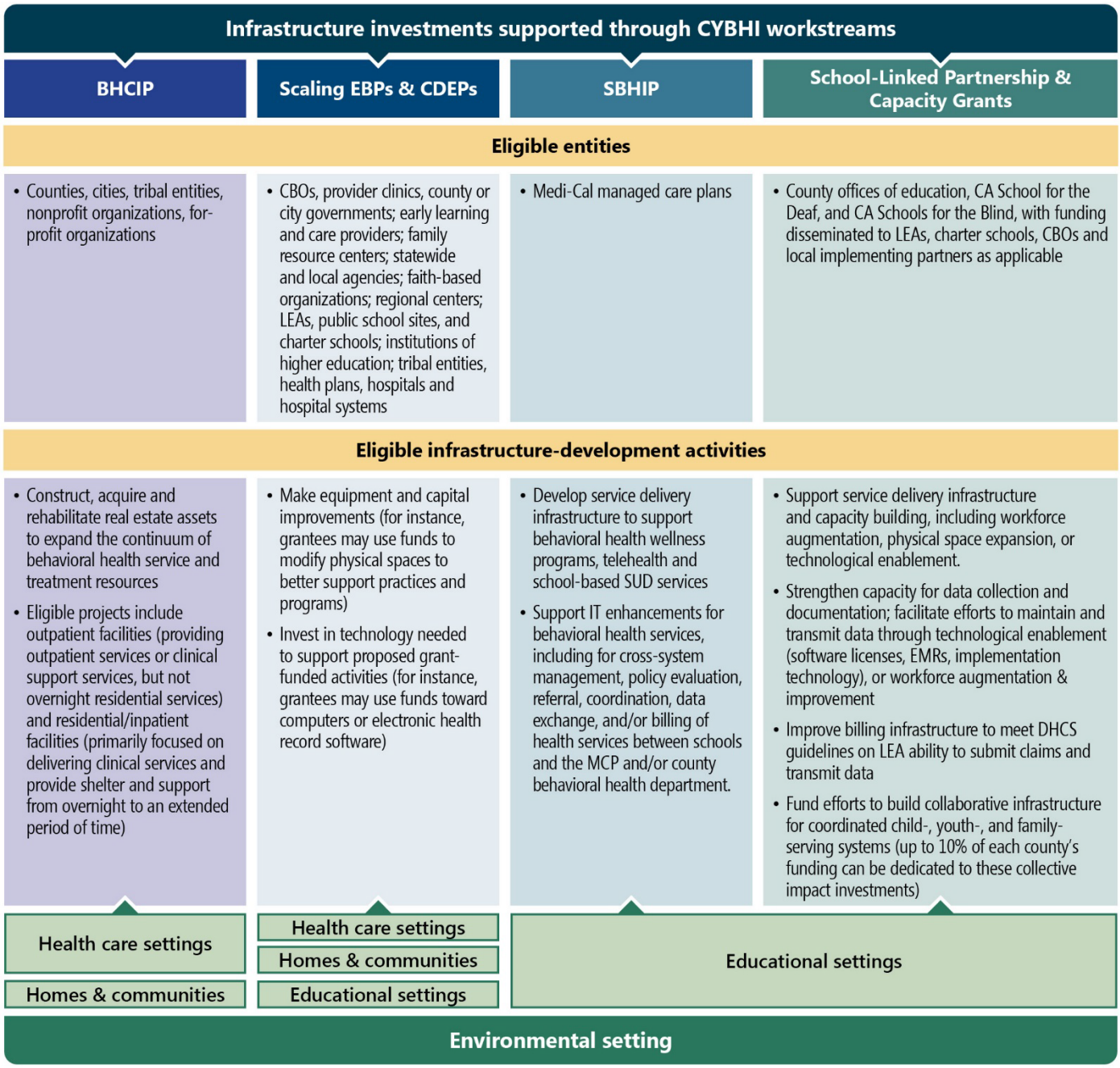
What is the potential for impact?

With intentional, dedicated funding intended to address gaps in infrastructure, the CYBHI workstreams targeting infrastructure investments are aligned with identified needs. Exhibit 8 details eligible infrastructure-development activities across these three workstreams and how they are intended to strengthen each environment.

[30] Manatt Health and Anton Nigusse Bland. *Assessing the Continuum of Care for Behavioral Health Services in California: Data, Stakeholder Perspectives, and Implications.* Report prepared for California Department of Health Care Services. January 2022. https://www.dhcs.ca.gov/Documents/Assessing-the-Continuum-of-Care-for-BH-Services-in-California.pdf.

[31] The CYBHI's investments in educational settings are discussed in further detail in section 3.2.

Exhibit 8. The CYBHI's infrastructure investments aligned with environmental settings



BHCIP = Behavioral Health Continuum Infrastructure Program; **CBO** = community-based organization; **DHCS** = Department of Health Care Services; **EBPs/CDEPs** = Evidence-Based Practices/Community-Defined Evidence Practices; **EMR** = electronic medical record; **LEA** = local education agency; **MCP** = Medi-Cal managed care plans; **SBHIP** = Student Behavioral Health Incentive Program; **SUD** = substance use disorder.

The CYBHI has operationalized the majority of its physical infrastructure investments through the **Behavioral Health Continuum Infrastructure Program (BHCIP),** with projects intended to expand physical infrastructure for behavioral health treatment in communities that lack inpatient, residential, or outpatient facilities. A DHCS Behavioral Health needs assessment report published in 2022 characterized the infrastructure gaps in traditional health care settings, with the gaps in residential treatment options for youth with SUD being particularly significant.[32] CYBHI's physical infrastructure investments align with identified needs, particularly for facilities providing youth substance use treatment, short-term residential treatment, and children's crisis residential programs (discussed further in Section 3.1.2).

A cornerstone of the CYBHI is its investment in schools as a critical setting in which children and youth may access behavioral health supports and services. The **CYBHI Fee Schedule** represents a significant opportunity for COEs and LEAs to expand and sustain provision of behavioral health services in schools; however, successful adoption of the Fee Schedule requires sufficient physical, administrative, and digital capacity to enable service delivery and claims processing. LEAs can use funding made available through the **Student Behavioral Health Incentive Program (SBHIP)** and **School-Linked Partnership and Capacity Grants** to bolster this capacity (discussed further in 3.2.2). Local education agency (LEA) infrastructure and capacity to support service delivery, data and documentation, and billing may vary widely; while many schools might have already significantly invested in developing these systems either independently or by leveraging other funding sources before the CYBHI (for instance, by obtaining electronic medical records), there are still more schools that require significant funding and support to develop the operational capacity required to ensure successful **CYBHI Fee Schedule** implementation and thus expansion of access to behavioral health services. DHCS has defined operational readiness standards required to begin submitting claims through the CYBHI Fee Schedule program, including sufficient service delivery infrastructure, sufficient workforce resources, ability to collect and handle student health information in compliance with state and federal regulations, ability to collect and report provider information,[33] and appropriate infrastructure to support billing and claims submission.[34, 35 36] Taken together, these workstreams provide COEs and LEAs with multiple opportunities to augment or expand on their existing infrastructure, particularly given their staggered implementation timelines. Beyond the CYBHI investments with an explicit focus on augmenting infrastructure for school-linked behavioral health supports and services, school districts have proposed leveraging **Scaling EBPs/CDEPs** grant funding to modify existing physical spaces to facilitate implementation of the funded EBP/CDEP.

---

[32] Manatt Health and Anton Nigusse Bland. *Assessing the Continuum of Care for Behavioral Health Services in California: Data, Stakeholder Perspectives, and Implications.* Report prepared for California Department of Health Care Services. January 2022. https://www.dhcs.ca.gov/Documents/Assessing-the-Continuum-of-Care-for-BH-Services-in-California.pdf.

[33] LEA enrollment differs from other Medi-Cal provider enrollment processes; it is not conducted through PAVE and LEAs are not currently subject to all Medi-Cal provider requirements.

[34] DHCS. "Operational Readiness Standards for Cohort 2 of the CYBHI Fee Schedule Program." April 2024. https://www.dhcs.ca.gov/CYBHI/Documents/Cohort-2-Operational-Readiness-Standards.pdf.

[35] DHCS. "CYBHI Fee Schedule Program Operational Readiness Standards." October 2024. https://www.dhcs.ca.gov/CYBHI/Documents/Cohort-3-Readiness-Requirements.pdf.

[36] DHCS. "Cohort 4 CYBHI Fee Schedule Program Readiness Application." November 2024. https://pan.dhcs.ca.gov/CYBHI/Documents/Cohort-4-CYBHI-Fee-Schedule-program-readiness-application-Independent.pdf.

3 | CYBHI Implementation by Environment: Rationale, Investment, Progress to Date, and Potential for Impact

The CYBHI's four core strategies are implemented across four environments in which children, youth, and families live, learn, grow, play, and flourish: health care settings, educational settings, homes and communities, and digital environments. Strengthening behavioral health programming, resources, and services across these environments positions the CYBHI investments to improve the well-being of all children and youth and support those who need it most. By implementing the core strategies outlined in Section 2 across the four environments, the CYBHI seeks to surround children and youth with care and support them achieve well-being.

3.1. Health care settings

Health care settings, such as primary care clinics, hospitals, and specialized behavioral health facilities, are necessary for delivering preventive and treatment-focused care. These are the traditional environments in which children, youth, and families seek treatment for physical and behavioral health needs. By implementing the core strategies in health care settings, the CYBHI aims to improve access to needed services ranging from early intervention to high-acuity behavioral health care.

What is the relevant background and need?

Health care settings relevant to behavioral health care span the continuum of care and include community and outpatient offices and facilities, emergency facilities, inpatient hospitals and facilities, and residential programs. Prevention and wellness services for people with mild to moderate behavioral health needs are generally provided in community or outpatient settings, such as primary care offices. Outpatient settings serve children and youth whose behavioral health needs require regular therapy and medication management and those who may experience more significant behavioral health needs that cause some impairment but can be managed on an outpatient basis (such as through intensive outpatient programs or partial hospitalization programs). People whose conditions result in severe impairment or functional deterioration[37] often require services in more intensive facility-based settings, including hospital inpatient or residential programs. Children and youth might also require crisis intervention services provided in emergency settings, psychiatric, or other hospital settings[38]. In most instances, the providers who deliver higher-acuity services are licensed behavioral health providers such as psychiatrists, psychologists, psychiatric nurse practitioners, and clinical social workers, who may be supported in their activities by other non-licensed staff.

To effectively serve children, youth, and families across the behavioral health continuum of care, CYBHI workstreams are supporting several critical components in health care settings. First, CYBHI is investing in the **behavioral health workforce** that is needed across health care settings through several education and training workstreams (section 3.1.1). Second, CYBHI is investing in **physical infrastructure** for behavioral health services, which remains essential

[37] State of California Department of Health Care Services, All-Plan Letter 22-006, Medi-Cal Managed Care Plan Responsibilities for Non-specialty Mental Health Services.

[38] The continuum of behavioral health care relies on a variety of organizations and provider types, including many beyond traditional health care settings. For instance, telehealth and other virtual care services expand opportunities for some forms of behavioral health care. Prevention and wellness activities are often delivered community-based organizations, in school-linked settings, or in digital or virtual settings, and can be provided by people with and without formal behavioral health training, professional licensure or certification. CYBHI investments in home & community environments as well as digital environments are discussed later in this report (sections 3.3 and 3.4 respectively).

regardless of the growth of telehealth, especially for high-intensity care (section 3.1.2). Third, California's creation of an enhanced Medi-Cal benefit to support providing **Dyadic Services** is a notable effort to improve children and youth behavioral health through the CYBHI (section 3.1.3). Establishing this benefit advances the state's efforts to integrate primary care and preventive behavioral health supports as best practices in the field.

3.1.1. Strengthening the capacity of the health care workforce to support behavioral health

What is the relevant background and need?

Medicaid managed care and commercial health plans—in California and other states—face challenges maintaining adequate networks of behavioral health providers, with key underlying reasons including provider shortages, low reimbursement rates relative to private pay rates, and perceptions among providers that credentialing, billing, and reporting requirements of health plans are onerous.[39,40,41] Numerous workforce assessments forecast that, by 2028, California will have 41 percent fewer psychiatrists and 11 percent fewer psychologists, licensed clinical social workers, and licensed marriage and family therapists than are needed to meet the demand for behavioral health services in the general population.[42,43,44] Among that group, licensed marriage and family therapists are the only provider type expected to increase in volume. These figures do not account for the linguistic and cultural diversity needed across the workforce to meet the unique needs of diverse populations.

CYBHI workstreams discussed in this section:

- Psychiatric Education Capacity Expansion
- Social Work Education Capacity Expansion
- Behavioral Health Scholarship Program
- Allied Health Scholarship Program
- Advanced Practice Healthcare Scholarship Program
- Justice- and System-Involved Youth Behavioral Health Training Program
- Public Behavioral Health MSW Training Stipend and Fellowship Program
- State Loan Repayment Program
- Steven M. Thompson Physician Corps Loan Repayment Program
- Licensed Mental Health Services Provider Education Program
- Train New Trainers Primary Care (TNT-PC)
- Primary Care – Training and Education in Addiction Medicine (PC-Team)
- Cal-MAP
- Scaling Evidence-Based and Community-Defined Evidence Practices (EBP & CDEP)

[39] Horner, L., J. Kim, M. Dormond, K. Hardy, J. Libersky, Debra J. Lipson, M. Hossain, and A. Lechner. "Behavioral Health Provider Network Adequacy Toolkit." Report submitted to the Division of Managed Care Policy, Center for Medicaid and CHIP Services, Centers for Medicare and Medicaid Services. Ann Arbor, MI: Mathematica, November 12, 2020. https://www.medicaid.gov/medicaid/downloads/behavior-health-provider-network-adequacy-toolkit.pdf.

[40] Bradley, K., A. Wishon, A.C. Donnelly, and A. Lechner. "Network Adequacy for Behavioral Health: Existing Standards and Considerations for Designing Standards." Final report submitted to the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. Washington, DC: Mathematica, August 20, 2020. Network Adequacy for Behavioral Health: Existing Standards and Considerations for Designing Standards (hhs.gov).

[41] Bishop, T.F., M.J. Press, S. Keyhani, and H.A. Pincus. "Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care." *JAMA Psychiatry*, vol. 71, no. 2, February 2014, pp. 176-181. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3967759/.

[42] Meeting the Demand of Health: Final Report of the California Future Health Workforce Commission, California Future Health Workforce Commission, February 2019. Meeting Demand For Health Final Report (CFHWC).pdf.

[43] Coffman, J., T. Bates, I. Geyn, and J. Spetz. "California's Current and Future Behavioral Health Workforce." The Healthforce Center at UCSF, February 2018. California's Current and Future Behavioral Health Workforce.pdf.

[44] Coffman, J. and M. Fix. "Building the Future Behavioral Health Workforce: Needs Assessment." A report for the County Behavioral Health Directors Associations. February 2023. https://static1.squarespace.com/static/5b1065c375f9ee699734d898/t/63e695d3ce73ca3e44824cf8/1676056025905/CBHDA_Needs_Assessment_FINAL_Report_2-23.pdf.

While a critical factor, increasing overall behavioral health workforce volume is insufficient to fully address the gap between workforce supply and demand for services. The gap between need for behavioral health services and service capacity is particularly acute in remote or rural regions. In addition, ensuring linguistic and cultural concordance with clients' needs and preferences remains a challenge for the workforce. Furthermore, the payer-mix within the existing behavioral health workforce poses challenges to equitable access, as a substantial percentage of the licensed behavioral health workforce operate as private pay, limiting service availability to those who are able to pay directly rather than relying on insurance coverage.

How is implementation progressing? What is the potential for impact?

CYBHI is expanding the licensed behavioral health workforce by expanding education programs and providing direct-to-recipient scholarships, stipends, and loan repayment supports (accompanied by service obligations). Under the CYBHI, several workstreams contribute to this aim.

Expanding capacity of education programs to train new providers

CYBHI has supported two grant programs to expand the capacity of education programs to train new providers.

- The **Psychiatric Education Capacity Expansion Grants** provide funding to educational institutions, medical sites, or other organizations to expand or create new psychiatry residency programs or psychiatric mental health nurse practitioner training programs. In addition to expanding training slots, grantees can use these funds to recruit culturally and linguistically diverse students and modify curriculum or augment efforts to prepare providers to work with unserved and underserved children and youth. HCAI announced 15 awardees in October 2022 and 8 awardees in June 2024.
- The **Social Work Education Capacity Expansion Grants** provide educational institutions with funding to create or expand social work (MSW or bachelor) programs. In addition to expanding training slots, grantees can use these funds to recruit culturally and linguistically diverse students and modify curriculum or augment efforts to prepare providers to work with unserved and underserved children and youth, in alignment with the grant's guiding principles. HCAI announced 23 awardees in January 2023 and 8 in June 2024.

Providing scholarships to support students in pursuing behavioral health careers

Several workstreams provide scholarships to support students pursuing behavioral health careers. These grants or payments, made to support a student's behavioral health training, can be offered in exchange for postgraduate service in a particular specialty or geography.

- The **Behavioral Health Scholarship Program** provides scholarships to students seeking to advance their training as behavioral health practitioners through a certificate, associate, bachelor, master, and doctoral degree program. Scholarship recipients commit to a year of providing direct patient care in an underserved community. The program awarded scholarships in August 2023 and July 2024
- The **Allied Healthcare Scholarship Program** provides scholarships to students pursuing careers in allied health (e.g., Certified Nurse Assistant, Community Health Worker, Home Health Aide, Paramedic, etc.) in exchange for a 12-month service obligation providing direct patient care in an underserved community. The program announced scholarship recipients in December 2023 with an anticipated next cycle in November 2024.

- The **Advanced Practice Healthcare Scholarship Program** provides scholarships to students pursuing eligible graduate and postgraduate health professional degrees (e.g., Certified Nurse Practitioner, Clinical Nurse Specialist, Physician Assistant, Rehabilitation Counselor, etc.) in exchange for a 12-month service obligation practicing and providing direct patient care in an underserved community. The program announced scholarship recipients in December 2023 with an anticipated next cycle in November 2024.
- The **Justice- and System-Involved Youth Behavioral Health Training Program** distributes grants to organizations to support system-involved and economically, environmentally, or educationally disadvantaged youth in pursuing behavioral health careers by providing a comprehensive range of supports. Grant funding can be used to provide income and rent support, academic enrichment, career development, mentorship, and advising to students with current or recent system involvement. The program announced awardees to five organizations in January 2024.
- The **Public Behavioral Health MSW Training Stipend and Fellowship Program** supports behavioral health training, MSW stipends, and postgraduate fellowships for people seeking clinical licensure in exchange for a 12-month service obligation (per year of program participation) in publicly funded behavioral health settings in California. The program is intended to support MSW students at up to 22 universities in California. In fall 2023, the center awarded 192 stipends to students pursuing careers in social work in exchange for a 12-month service commitment. As of July 2024, the center's programs are now hosted through University of California (UC) Davis and UCLA.

Providing incentives to work in underserved areas through loan repayment/stipend programs

In addition to scholarships for education or training, several workstreams provide incentives to current providers to work in underserved areas through loan repayment or stipend programs to offset educational debt. This financial support repays all or part of a student's loans in exchange for postgraduate service in a predefined type of geographic area or setting, typically in an underserved area (HPSA) or qualified facility, or at selected CBO (through the CBO Behavioral Health Workforce Grant).

- The **State Loan Repayment Program** provides loan repayment support to licensed care providers for a two-year service obligation in federally designated California HPSAs. Primary care physicians, dentists, dental hygienists, physician assistants, nurse practitioners, certified nurse midwives, pharmacists, and behavioral health providers are eligible. Recipients are required to submit regular employer verification forms to monitor their progress. Awards were announced for FY 23-24 cycle; additional awards are expected in FY 24-25.
- The **Steven M. Thompson Physician Corps Loan Repayment Program** provides eligible physicians with loan repayment support in exchange for a 36-month service obligation in a medically underserved area or qualified facility, with the aim of increasing the number of licensed physicians and surgeons providing direct patient care in a qualified facility. Another award cycle opened in July 2024 with announcements expected in October 2024.
- The **Licensed Mental Health Services Provider Education Program** offers loan repayment support to eligible health care providers in exchange for a two-year service obligation to provide direct client care in a medically underserved area or qualified facility. Eligible providers include psychiatric nurses, psychiatric mental health nurse practitioners, behavioral disorder counselors, mental health counselors, rehabilitation counselors, and SUD counselors. This program announced awardees in May 2022 and plans to announce another round of in October 2024.

Supporting primary care providers to deliver behavioral health care

Supporting continuous learning for PCPs and other non-specialist providers as they deliver behavioral health care is a critical mechanism for expanding access to behavioral health services for children and youth. In addition to licensed

behavioral health providers, PCPs also provide assessment and diagnostic services. Increasingly, PCPs provide behavioral health screening and treatment for people with behavioral health conditions, operating as a key entry point into behavioral health services.[45,46] From a structural perspective, PCPs are well-positioned to play this role; primary care (provided in a variety of settings, including offices, safety-net clinics, Federally Qualified Health Centers, or other community health centers) is a common point of contact for children, youth, and families. In addition, PCPs typically conduct regular screening for developmental and behavioral health conditions. When screening identifies a treatment need within their scope of practice, or when access to treatment is delayed or difficult, PCPs can also deliver behavioral health services, including counseling, prescribing, and managing psychiatric medications, depending on their level of comfort. Programs to support PCPs and other providers in delivery of behavioral health care services include:

- The **California Child and Adolescent Mental Health Access Portal (Cal-MAP)**, provides remote and real-time consultation support for pediatricians and PCPs to connect with behavioral health clinical experts. The statewide platform is intended to improve the capacity of pediatric, primary care, and other health care providers by offering them access to learning opportunities via resources, tools, training, and additional support. There is evidence that behavioral health consultation programs are effective in expanding the capacity of pediatric primary care settings to provide behavioral health care. For example, research has shown consultation programs have improved perceptions among pediatric primary care providers of their ability to care for psychiatric needs.[47] State-wide consultation programs for children's behavioral health are common throughout the United States.[48] The longest standing program is in Massachusetts; since 2004, the Massachusetts Child Psychiatry Access Program (MCPAP) has provided pediatric primary care providers with access to psychiatric consultation and supported referrals for ongoing behavioral health care.[49, 50] Many other states have modeled similar programs after MCPAP.[51] While more research is needed to assess impacts on patient outcomes,[52,53] consultation programs are associated with high rates of parent satisfaction with the PCP's handling of children's mental health needs[54] and increased utilization of

[45] Gray, G. V., D. S. Brody, and D. Johnson. "The evolution of behavioral primary care." *Professional Psychology: Research and Practice*, vol. 36, no. 2, 2005, pp. 123-129. https://psycnet.apa.org/record/2005-03020-001.

[46] Petterson, S., B. F. Miller, J.C. Payne-Murphy and R.L. Phillips. "Mental health treatment in the primary care setting: Patterns and pathways." *Families, Systems & Health*, vol. 32, no. 2, 2024, pp. 157–166. https://doi.org/10.1037/fsh0000036.

[47] Straus, J. H. and B. Sarvet. "Behavioral Health Care For Children: The Massachusetts Child Psychiatry Access Project." *Health Affairs,* vol. 33, no. 12, December 2014, pp. 2153-2161. https://doi.org/10.1377/hlthaff.2014.0896.

[48] The Health Resources Services Administration provides grant funding through the Pediatric Mental Health Care Access Programs (PMHCA) to approximately 50 states, tribes, and territories. An evaluation of these grant programs in underway with a final report expected in September 2026. For more information, see: https://mchb.hrsa.gov/programs-impact/programs/pediatric-mental-health-care-access.

[49] Massachusetts Child Psychiatry Access Program. "Connecting Primary Care with Child Psychiatry." n.d. mcpap.com. Accessed on December 9, 2024.

[50] Dvir, Y., J. H. Straus, B. Sarvet, and N. Byatt. "Key attributes of child psychiatry access programs." *Frontiers in Child and Adolescent Psychiatry*, vol. 2, July 2023. https://doi.org/10.3389/frcha.2023.1244671.

[51] Straus, J. H. and B. Sarvet. "Behavioral Health Care For Children: The Massachusetts Child Psychiatry Access Project." *Health Affairs,* vol. 33, no. 12, December 2014, pp. 2123-2161. https://doi.org/10.1377/hlthaff.2014.0896.

[52] Pranav, A., S. Goldberg, A. Schaefer, and T. I. Mackie. "Child Psychiatry Access Programs: A Preliminary Scoping Review." Clinical Poster Project for the American Academy of Child and Adolescent Psychiatry. 2024. Aurora_P_2024_SOCSP_Poster.pdf.

[53] Sullivan, K., P. George, and K. Horowitz. "Addressing National Workforce Shortages by Funding Child Psychiatry Access Programs." *Pediatrics,* vol. 147, no. 1, January 2021. https://doi.org/10.1542/peds.2019-4012.

[54] Shireen, C., A. Knee, and B. Sarvet. "Impact of Child Psychiatry Access Programs on Mental Health Care in Pediatric Primary Care: Measuring the Parent Experience." *Psychiatric Services,* vol. 71, no. 1, January 2020. https://doi.org/10.1176/appi.ps.201800324.

evidenced-based treatment.[55] The design of Cal-MAP was informed by research and engagement efforts including a survey of 150 pediatric care providers, literature review, consultation with experts, and think tank workshops. Cal-MAP was launched statewide in spring 2024, and full functionality will be made available in September 2024. Cal-MAP builds on the foundation of UCSF's Child & Adolescent Psychiatry Portal (CAPP), which launched in 2019. With the expansion facilitated by the CYBHI, approximately 2,800 users have registered across 44 California counties (as of September 2024). Since 2019, Cal-MAP (and, previously, CAPP) has facilitated over 4,200 consultations for more than 3,300 youth.[56] Current functionality includes synchronous e-Consult and telephone warm line consultations for PCPs and other outpatient physicians, including clinical staff at school-based health centers; training resources (including continuing medical education credits); and topical and diagnosis-specific educational resources for providers and families.

- **Train New Trainers Primary Care (TNT-PCP)** is a year-long clinical certificate program for pediatricians and PCPs (including physicians, nurse practitioners, and physician assistants) using a curriculum with didactic, case-based, and small group learning modalities. Goals of the program include strengthening specific competencies in interview, diagnosis, and treatment for clients with commonly encountered behavioral health conditions and developing capacity (resources) and capability (knowledge and abilities) to teach other PCPs. The program is offered by the UC Irvine School of Medicine. TNT-PCP has supported multiple cohorts of students (more than 700 since 2021) and is currently recruiting for 2025.
- **Primary Care – Training and Education in Addiction Medicine (PC-TEAM)** is a year-long clinical certificate program, based on the TNT-PC model and is intended for primary care and emergency medicine-oriented providers interested in advanced SUD training and opioid management. The program is offered by the UC Irvine School of Medicine. In fall 2024, TNT PC-TEAM was seeking applicants for a 2025 cohort.

Improving organizational and workforce capacity to provide evidence-based services

Evidence-based, culturally relevant behavioral health services, particularly those focused on prevention, early intervention, and resiliency and recovery for children and youth, are a key component of efforts to improve outcomes and health equity for California's children and youth by improving the quality and cultural relevance of care delivered by the behavioral health workforce.

- The **Scaling Evidence-Based and Community-Defined Evidence Practices (EBP & CDEP) grant program**, administered by DHCS, distributes grants to organizations seeking to scale EBPs or CDEPs. While the Scaling EBPs and CDEPs workstream is introduced and discussed in its entirety within the Health Care Settings section of this report, it should be noted that awardees include many community- and school-based organizations, who are leveraging this funding to expand and strengthen provision of behavioral health services beyond traditional health care settings. As such, this workstream is also discussed in sections 3.2 (Educational settings) and 3.3 (Home and communities).

  EBPs are defined as having rigorous empirical evidence of effectiveness in improving children and youth behavioral health, while CDEPs are community-based behavioral health practices that have reached a strong level of support within specific communities. The grant program is distributing five rounds of grants to organizations seeking to scale EBPs and/or CDEPs that improve youth behavioral health based on robust evidence for effectiveness, impact on racial equity, and sustainability. Many of these grant awards focus on training additional behavioral health care

[55] Hurst, L. E., E. Tengelitsch, T. Bruni, J. Lee, S. Marcus, and J. Quigley. "Psychiatry Consultation in Primary Care: Examining Treatment Access for Adolescent Depression." *Journal of Adolescent Health,* January 2024. https://www.jahonline.org/article/S1054-139X(24)00409-9/fulltext.

[56] California's Child & Adolescent Mental Health Access Portal – Cal-MAP.

providers in EBPs. DHCS identified a set of practices well-documented in federal and state clearinghouses for evidence-based practices and implemented an extensive community engagement process (convening a work group and a series of meetings with a think tank comprised of youth and relevant community members with lived and professional experience or expertise, as well as leading experts from academia, government, and industry) to determine which EBPs and CDEPs to prioritize for scaling throughout the state. The selected EBPs and CDEPs were then grouped into specific categories or themes corresponding to each round of grant funding, guided by the equity goals in DHCS' Comprehensive Quality Strategy and Medi-Cal's Strategy to Support Health and Opportunity for Children and Families. The five grant rounds cover (1) parent and caregiver support programs and practices, (2) trauma-informed programs and practices, (3) early childhood wraparound services, (4) youth-driven programs, and (5) early intervention programs and practices.[57]

Selected evidence-based practices (EBPs) and community-defined evidence practices (CDEPs) by funding round

- **Round 1: Parent and Caregiver Support Programs and Practices:** HealthySteps, Incredible Years, Parent-Child Interaction Therapy, Positive Parenting Program, and other practices for specified populations of focus (e.g., Parents Anonymous, Effective Black Parenting Program, Strong African American Families, Positive Indian Parenting)
- **Round 2: Trauma-Informed Programs and Practices:** Attachment and Biobehavioral Catch-Up, Child Parent Psychotherapy, Cognitive Behavioral Interventions for Trauma in Schools, Dialectical Behavior Therapy, Family Centered Treatment, Functional Family Therapy, Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems, Trauma-Focused Cognitive Behavioral Therapy, Multisystemic Therapy, Crossover Youth Practice Model and other practices for specified populations of focus (e.g., Family Acceptance Project)
- **Round 3: Early Childhood Wraparound Services:** Healthy Families America, Nurse Family Partnership, Family Spirit, Parents as Teachers, select practice components (e.g., child-specific clinical consultation) of Infant and Early Childhood Mental Health Consultation, and additional practices and programs focused on early childhood wraparound services
- **Round 4: Youth-Driven Programs:** Allcove model youth drop-in centers and other youth-driven programs, which includes but are not limited to: Drop-in centers for homeless youth, Drop-in centers for LGBTQIA+ youth, Clubhouse model (Young adults with Serious Mental Illness), Fostering Healthy Futures-Preteen (FHF-P), Transition to Independence Process (TIP) Model, Peer Respite, and Across Ages
- **Round 5: Early Intervention Programs and Practices:** Coordinated Specialty Care (CSC) for First Episode of Psychosis, Blues Program, Culturally Informed and Flexible Family-Based Treatment for Adolescents (CIFFTA), Familias Unidas, Residential Student Assistance Program (RSAP), Resourceful Adolescent Program-Adolescent (RAP-A), and Youth Mobile Crisis Response

To date, the Scaling EBPs and CDEPs grant program has awarded nearly $250 million in CYBHI funding to 481 organizations across all 58 counties in California.[58] The grant awards are supporting the delivery of more than 50 different evidence-based and community-defined evidence practices across the state. These include parent and caregiver support programs (round 1, announced July 2023), trauma-informed programs and practices (round 2, announced December 2023), early childhood wraparound services (round 3, announced September 2024), youth-driven programs (round 4, announced December 2023), and early intervention programs (round 5, announced March 2024); the callout box below highlights the EBPs and CDEPs specified by DHCS by funding round.[59]

[57] DHCS partnered with the Mental Health Services Oversight & Accountability Commission (MHSOAC) to scale specified prevention and early intervention practices in Rounds 4 and 5.

[58] The total number of awards made under the Scaling EBPs and CDEPs workstream is inclusive of Rounds 1-5; however, the total monetary value of awards to date represents Rounds 1, 2, 4, and 5. Award amounts for Round 3 were unavailable at the time of this drafting.

[59] Additional information on the specific organizations and EBPs and CDEPs funded through this workstream can be found on the CYBHI Impact page (Impact – CYBHI) and the DHCS Scaling EBPs and CDEPs webpage (EBP-CDEP-Grants).

Evidence-based practices (EBPs) are associated with improved behavioral health outcomes, but research indicates adoption and scaling could take as long as 17 years.[60,61] Barriers to implementing EBPs include lack of access to funding, lack of knowledge and skill, lack of resources for training, and need for workflow and other change management activities.[62,63,64] DHCS appears to have created the application and approval infrastructure necessary to identify awardees and disburse grant funds to local organizations in an effort to alleviate many of these barriers. Early findings from key informant interviews indicate delays in announcement of awards and delays between notices of award and receipt of funding; as such, implementation of grant-funded projects is in early stages across most Scaling EBPs/CDEPs funding rounds. To support the scaling and development of EBPs/CDEPs, training and technical assistance is being provided to grantees by DHCS' third-party administrator, the California Institute for Behavioral Health Solutions, through monthly learning collaboratives and office hours as well as implementation plan and data collection support.

3.1.2. Developing and expanding physical infrastructure for behavioral health services

What is the relevant background and need?

CYBHI workstreams discussed in this section:

- Behavioral Health Infrastructure Program Round 4 (BHCIP)

California is confronting a shortage of general psychiatric beds across levels of care that is particularly acute for children and youth. As of January 2022, there were twenty-four counties with no inpatient facilities; of the 34 counties with inpatient facilities, 41% are in need of additional inpatient capacity. Facilities for children and youth with specific needs, such as first episode psychosis, crisis stabilization, eating disorders, or youth with complex medical conditions or who are justice-involved, are even more limited.[65] On the other end of spectrum, schools, and community-based organizations are repurposing existing space, where available, to support individual and group therapy sessions or serve as wellness spaces. PCPs taking on additional behavioral health service responsibilities may also face space challenges in clinic and practice spaces designed more for physical exams than for consultation and counseling.

---

[60] Connor, L., J. Dean, M. McNett, D.M. Tydings, A. Shrout, P.F. Gorsuch, A. Hole, et al. "Evidence-based practice improves patient outcomes and healthcare system return on investment: Findings from a scoping review." *Worldviews on Evidence-Based Nursing*, vol. 20, no. 1, February 2023, pp. 6-15. https://pubmed.ncbi.nlm.nih.gov/36751881/.

[61] Morris, Z. S., S. Wooding, and J. Grant. "The answer is 17 years, what is the question: understanding time lags in translational research." *Journal of the Royal Society of Medicine*, vol. 104, no. 12, December 2011, pp. 510-520. https://doi.org/10.1258/jrsm.2011.110180.

[62] Peters-Corbett, A., S. Parke, H. Bear, and T. Clarke. "Barriers and facilitators of implementation of evidence-based interventions in children and young people's mental health care - a systematic review." *Child and Adolescent Mental Health*, vol. 29, no. 3, September 2024, pp. 242-265. https://pubmed.ncbi.nlm.nih.gov/37608642/.

[63] Pagoto, S.L., B. Spring, E.J. Coups, S. Mulvaney, M. Coutu, and G. Ozakinci. "Barriers and facilitators of evidence-based practice perceived by behavioral science health professionals." *Journal of Clinical Psychology*, vol. 63, no. 7, July 2007, pp. 695-705. https://pubmed.ncbi.nlm.nih.gov/17551940/.

[64] Meyer, A. E., E.E. Reilly, K.E. Daniel, S.D. Hollon, A. Jensen-Doss, D.S. Mennin, J. Muroff, et al. "Characterizing evidence-based practice and training resource barriers: A needs assessment." *Training and Education in Professional Psychology*, vol. 14, no. 3, 2020, pp. 200-208. https://psycnet.apa.org/record/2019-31605-001.

[65] Manatt Health and Anton Nigusse Bland. *Assessing the Continuum of Care for Behavioral Health Services in California: Data, Stakeholder Perspectives, and Implications.* Report prepared for California Department of Health Care Services. January 2022. https://www.dhcs.ca.gov/Documents/Assessing-the-Continuum-of-Care-for-BH-Services-in-California.pdf.

How is implementation progressing? What is the potential for impact?

The Behavioral Health Continuum Infrastructure Program (BHCIP) is a six-round initiative that targets various gaps in the state's behavioral health facility infrastructure. Round 4 of the BHCIP, funded through the CYBHI, focuses specifically on child and youth-serving facilities. In 2024, California voters passed Proposition 1, which expands BHCIP by up to $4.4 billion to support additional investments in behavioral health treatment infrastructure statewide.

Round 4 of the BHCIP focuses on expanding behavioral health treatment and service options for Californians aged 25 and younger, including pregnant and postpartum women, their children, and transition-age youth and their families. This workstream invested $480.5 million in the construction and expansion of facilities to provide a range of services, from wellness centers to crisis stabilization units. Eligible facilities offer outpatient services and residential clinical treatment and must serve Medi-Cal members. By investing in these projects, Round 4 of BHCIP aims to create a more comprehensive and accessible behavioral health infrastructure for California's youth, ultimately improving treatment outcomes and supporting overall mental health and well-being.

Building behavioral health infrastructure across California

BHCIP Round 4 (the CYBHI) is one of 5 rounds of BHCIP; as a whole, BHCIP funding totals $2.2 billion. The other four rounds of BHCIP are not part of the CYBHI but are intended to expand infrastructure to support the continuum as a whole.

- **Round 1: Crisis Care Mobile Units** provides funding for new and enhanced mobile crisis response teams.
- **Round 2: Behavioral Health County and Tribal** provides opportunities for counties and tribal entities to expand community or regional planning efforts for the acquisition and expansion of behavioral health infrastructure statewide.
- **Round 3: Launch Ready** provides funding to launch ready projects to construct, acquire, and rehabilitate real estate to expand the behavioral health continuum of treatment and service resources.
- **Round 4: Children and Youth (through CYBHI)** provides funding to expand treatment and service resources for Californians aged 25 and younger, pregnant and postpartum women and their children, and transition-age youth and their families.
- **Round 5: Crisis and Behavioral Health Continuum** provides funding for the construction and expansion of crisis and behavioral health facilities statewide, including Behavioral Health/Mental Health Urgent Care walk-in centers with voluntary stabilization-oriented services specific to individuals experiencing behavioral health and/or mental health crisis for less than 24 hours.

In addition to Round 4 projects supporting children and youth, an additional 19 awards across the other 4 rounds (totaling $301 million) focus on the needs of children and youth. Combined, these represent a considerable investment in the children and youth behavioral health infrastructure across the continuum of services.

In December 2022, BHCIP Round 4 funded 52 children- and youth-focused projects (some supporting multiple facilities), including four led by tribal entities. These projects will result in 509 new inpatient treatment beds and a total of 76,977 individuals projected to be served annually in an outpatient setting. As of October 2024, 14 projects have begun construction.

More information about the intended impact of BHCIP Round 4 is available on the BHCIP data dashboard. BHCIP investments that address key gaps identified by DHCS in the behavioral health continuum of care infrastructure[66] are shown in Exhibit 9.

[66] Manatt Health and Anton Nigusse Bland. *Assessing the Continuum of Care for Behavioral Health Services in California: Data, Stakeholder Perspectives, and Implications.* Report prepared for California Department of Health Care Services. January 2022. https://www.dhcs.ca.gov/Documents/Assessing-the-Continuum-of-Care-for-BH-Services-in-California.pdf.

Exhibit 9. Gaps in the continuum of care and relevant BHCIP investments

Gap in continuum of care	How does BHCIP Round 4 investment address this need?
Youth-specific substance use treatment beds	Three awards and 64 beds at adolescent residential treatment facilities for youth with substance use disorders. These three facilities included one existing construction project and two new constructions.
Short-term residential therapeutic programs	Three awards and 25 beds at short-term residential treatment programs. These three facilities included one existing construction project, one new construction, and one project with both new and existing construction.
Children's crisis residential program	Five awards and 62 beds at children's crisis residential programs. These five facilities included one existing construction project, three new constructions, and one project with both new and existing construction.

BHCIP = Behavioral Health Continuum Infrastructure Program.

In addition to projects in Exhibit 9, BHCIP Round 4 has also funded: three adolescent residential treatment facilities for SUD, seven perinatal residential SUD facilities, eight community mental health clinics, eight community wellness/youth prevention centers, five crisis stabilization unites, seven outpatient SUD treatment facilities, three partial hospitalization programs, and two school-linked health centers.

These facilities are complex projects, and the state has enlisted a third-party administrator to manage funding for each of the 52 projects throughout three phases: preconstruction planning, design development, and shovel-ready construction. Furthermore, the program administrator is required to evaluate the short- and long-term financial viability of the proposed facilities.[67] The BHCIP administrator collects data which may be used to understand the progress and success of individual projects funded under this program. To supplement information on the BHCIP data dashboard, review of workstream documentation may provide deeper insights into project implementation.

3.1.3. Integrating behavioral health care into primary care settings through dyadic services

What is the relevant background and need?

CYBHI workstreams discussed in this section:

- Enhanced Medi-Cal Benefits-Dyadic Services
- Scaling EBPs/CDEPs

The dyadic services benefit is one component of a larger strategy under the CYBHI and Medi-Cal's Strategy to Support Health and Opportunity for Children and Families, which aims to take a whole-child, prevention-oriented, family-centered, and integrated approach to care for children and families enrolled in Medi-Cal. The benefit aims to reduce barriers for families in accessing early intervention services, including behavioral health services, by supporting delivery of dyadic services to a child and their caregiver/parent. Establishing this benefit advances the state's efforts to integrate primary care and preventive behavioral health supports, as it allows both children and their parents/caregivers to receive behavioral health services within primary care settings. Before dyadic services became a Medi-Cal benefit, some primary care clinics already provided dyadic services as a best practice. Developing a payment mechanism will support these practices and expand the number of practices able to provide preventive services and support.

The benefit also addresses a state-level need. Medi-Cal provides health coverage for almost half of all the state's children, supporting broad access to primary care. However, despite adoption of the American Academy of

[67] California Department of Health Care Services. "Behavioral Health Continuum Infrastructure Program Round 4: Children and Youth Program Update." 2022. https://www.infrastructure.buildingcalhhs.com/wp-content/uploads/2022/04/BHCIP_Program_Update.Round4_FINAL_508.pdf.

Pediatrics/Bright Futures Guidelines and Periodicity Schedule,[68] most children are not receiving regular age-appropriate screenings and support. According to a September 2022 State Auditor analysis, from fiscal years 2014 to 2021, less than half of children in Medi-Cal received the required number of preventive services.[69]

What are dyadic services?[70]

Dyadic services reflect a comprehensive new set of benefits for Medi-Cal members under age 21 which, in general, must be provided by a licensed mental health clinical provider or associate. A dyad refers to a child and their parent(s) or caregiver(s). Dyadic care refers to serving both parent(s) or caregiver(s) and child together as a dyad. It is a form of treatment that targets family well-being as a mechanism to support healthy child development and mental health. The suite of dyadic services includes:

- **Dyadic behavioral health visits** which include a comprehensive screening for a child and caregiver(s)/parent(s) for behavioral health problems, interpersonal safety, tobacco and substance misuse, and social determinants of health (SDOH) such as food insecurity and housing instability. These visits can also include referrals for appropriate follow-up care.
- **Comprehensive Community Supports Services** are designed to support the child and parent/caregiver access and be connected with appropriate medical, social, education and other health-related services.
- **Dyadic Psychoeducational Services** are planned, structured interventions, using recognized treatment services with the goal of preventing or addressing behavioral health conditions and supporting mental health and resiliency.
- **Dyadic Family Training and Counseling for Child Development** refers to brief training and counseling related to a child's behavioral issues, developmentally appropriate parenting strategies, parent/child interactions, and related needs.

How is implementation progressing? What is the potential for impact?

In January 2023, Medi-Cal began covering **dyadic care services** for members. Based upon assumptions published in the Medi-Cal Estimate, the initial allocation for the Dyadic Services benefit was $543 million. These services combine behavioral health treatment with pediatric care for Medi-Cal members under age 21, to simultaneously support children and their caregivers. The benefits cover a range of services, including behavioral health, well-child visits, navigation and follow-up for referrals, psychoeducation, family training and counseling for childhood development, and specified services for caregivers.[71] The new benefits package intends to improve access to developmental and behavioral supports within a child and family's regular routine of health care settings and identify the impact of family stressors on healthy child development. The suite of dyadic services included in the benefit, described above, provides varied opportunities for primary care settings to offer dyadic services that best meet the needs of children and caregivers. Additionally, the benefit allows providers to deliver dyadic services to parents or caretakers who may not be independently eligible for Medi-Cal when these services are provided for the direct benefit of the child.

To support adoption of the new benefit, all Medi-Cal providers received guidance through the Medi-Cal Provider Manual, and MCPs received further guidance through an All Plan Letter outlining the provision of the benefit.[72] Additionally, DHCS submitted proposed State Plan Amendment (SPA) 23-0010 in March 2023, which would create a

[68] American Academy of Pediatrics. *Bright futures pocket guide* (4th ed.). (2017). American Academy of Pediatrics 2024. https://www.aap.org/en/practice-management/care-delivery-approaches/periodicity-schedule/.

[69] California State Auditor. "Follow-Up: Children in Medi-Cal: The Department of Health Care Services Is Still Not Doing Enough to Ensure That Children in Medi-Cal Receive Preventive Health Services." Report No. 2022-502, September 13, 2022. https://information.auditor.ca.gov/reports/2022-502/index.html#chapter3.

[70] California Department of Health Care Services. "Dyadic Services as a Medi-Cal Benefit." n.d. https://www.dhcs.ca.gov/provgovpart/Pages/Dyadic-Services.aspx. Accessed July 29, 2024.

[71] California Department of Health Care Services. "Dyadic Services as a Medi-Cal Benefit." n.d. https://www.dhcs.ca.gov/provgovpart/Pages/Dyadic-Services.aspx. Accessed July 29, 2024.

[72] California Department of Health Care Services. "All Plan Letter 22-029 (Revised)." March 2023. https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-029.pdf.

new Alternative Payment Methodology (APM) to reimburse Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Tribal Health Programs (THPs) at the Medi-Cal fee-for-service (FFS) rate on file,[73] in addition to their applicable Prospective Payment Services (PPS) rate or All-Inclusive Rate (AIR).[74] As of September 2024, DHCS is awaiting approval of SPA 23-0010 from the Centers for Medicare & Medicaid Services (CMS) to expand the benefit.[75]

Providers and the CYBHI workstream partners have noted that integration of a dyadic services model into pediatric practice, especially non-Federally Qualified Health Center settings, may require hiring, training practice clinicians and staff, and practice transformation efforts not otherwise funded in the service-based Fee Schedule for dyadic services.

DHCS has implemented measures to enhance use of the new dyadic benefit, including the following:

- **Structuring the dyadic services benefit to facilitate a range of implementation approaches aligned with available resources.** The suite of services included in the benefit allows flexibility in implementation, giving providers the opportunity to offer dyadic care in a way that aligns with the available resources as policies evolve. For instance, a provider may choose to invest in the implementation of an evidence-based model, such as Healthy Steps or Dulce, to support the full range of dyadic services covered under the benefit. Alternatively, a practice may choose to offer a single type of service (for instance, Dyadic Family Training and Counseling for Child Development) via existing licensed staff, expanding the range of dyadic services provided within the practice as resources permit.
- **Embedding dyadic health care services within the context of routine well-child care in pediatric settings.** Per the pending SPA, this would enable families to access dyadic services in their regular care setting and, ideally, on the same day as well-child visits.
- **Increasing awareness of and expanding access to evidence-based models recognized for delivering dyadic services.** In its guidance to plans and providers, DHCS highlighted recognized evidence-based models such as HealthySteps and Dulce as comprehensive models for integrating dyadic services for both parents and children within pediatric primary care settings. The CYBHI included funding for EBPs that may support providers and practices in developing capacity to provide dyadic services through the first three rounds of the Scaling EBPs/CDEPs grants; six organizations received grant funding to implement HealthySteps through Scaling EBPs/CDEPs Round 1.

Some managed care plans have also initiated efforts to promote access and availability of the new benefits in partnership with community providers and partners. The CalOptima Board, for example, approved funding in March 2024 with First 5 Orange County to promote scaling of the HealthySteps model and increased utilization of the dyadic service benefits.[76]

While some within the Medi-Cal delivery system have begun to use the benefit, the new APM proposed in the pending SPA is intended to incentivize FQHCs, RHCs, and THPs to provide dyadic services as part of an otherwise billable visit or on the same day as an otherwise billable visit. Approval of this SPA is necessary to establish an APM to reimburse FQHCs, RHCs, THPs, including IHS-MOA 638 clinics and Tribal FQHCs, at the Medi-Cal FFS rate in addition to their PPS rate or AIR, as applicable. Although the pending approval of the SPA does not impact non-FQHC providers, anecdotal evidence indicates the lack of SPA approval has nonetheless created confusion and hesitation among some providers

[73] California Department of Health Care Services. "Medi-Cal Rates." https://mcweb.apps.prd.cammis.medi-cal.ca.gov/rates. Accessed November 2024.

[74] California Department of Health Care Services. "State Plan Amendment (SPA) #: 23-0010." SPA-23-0010-Approval.pdf.

[75] California Department of Health Care Services. "State Plan Amendment (SPA) #: 23-0010." SPA-23-0010-Approval.pdf.

[76] CalOptima Health. "Regular Meeting of the CalOptima Health Board of Directors." March 7, 2024. https://www.caloptima.org/~/media/Files/CalOptimaOrg/AboutUs/Board%20Materials/2024/20240307_BoardBookArchive2_Sec.ashx.

and MCPs regarding the availability of the benefit and related payment requirements. To help alleviate some confusion and clarify policy, DHCS released a Provider Bulletin article in August 2024.[77] Nevertheless, DHCS may still benefit from additional public communications indicating which practice types are eligible to receive reimbursement for dyadic services and which practices are not eligible until SPA 23-0010 receives federal CMS approval.

With adoption still in early stages, evaluation of dyadic services in other contexts provides insight into the potential impact California may expect from implementation of the benefit. The design of this benefit was influenced by the Healthy Steps model, which offers an evidence basis for two-generation care in the pediatric office setting. Zero to Three, the Healthy Steps model's parent organization, reports that Manatt Health determined a positive return on investment to model implementations in several states that range from 66 percent to 267 percent.[78] This reported return on investment appears to be based upon a range of interventions associated with the Healthy Steps model, though implementation of the dyadic services benefit does not rely upon the full implementation of a model like Healthy Steps in a participating practice. Still, the evidence suggests that the implementation of dyadic models increases behavioral health and other non-medical referrals from the pediatric setting, with both parent and child experiencing these referrals at a rate of 1.4 times that of children receiving care in a traditional pediatric setting.[79] The addition of dyadic services as a covered benefit under Medi-Cal, with clarified guidelines as to the eligibility of providers and organizations to bill for the service, should promote expanded access to behavioral health services among children and parents/caregivers. To fully realize the intended impact of the benefit, key process milestones include approval of the pending SPA governing reimbursement for FQHCs and RHCs and additional monitoring, technical assistance, and guidance to support uptake of the benefit.

[77] California Department of Health Care Services. "Coming Soon: Billing Clarification for Dyadic Services and Timeless Waiver for FQHC, RHC and THP Programs." August 2024. https://mcweb.apps.prd.cammis.medi-cal.ca.gov/news/33075. Accessed November 2024.

[78] Zero to Three. "HealthySteps Interventions Drive Short-Term Medicaid Cost Savings." September 2021. https://www.healthysteps.org/resource/healthysteps-return-on-investment/.

[79] Guyer, B., M. Barth, D. Bishai, M. Caughy, B. Clark, D. Burkom, and C. Tang. "Healthy Steps: The first three years: The Healthy Steps for Young Children Program National Evaluation." Johns Hopkins Bloomberg School of Public Health, February 2003. https://www.healthysteps.org/wp-content/uploads/2025/01/2003-National-Evaluation-Report.pdf.

3.2. Educational settings

Educational settings are environments where children and youth spend a substantial portion of their lives and represent a key opportunity to expand access to behavioral health interventions beyond health care settings. The CYBHI aims to strengthen school-linked behavioral health services by increasing capacity for promotion, prevention, timely identification, and treatment of behavioral health needs. By bringing behavioral health services directly into educational settings, the CYBHI intends to create safe, supportive environments where students can thrive academically, socially, and emotionally. While the CYBHI's workstreams do provide some support for early childhood education and institutions of higher education, the bulk of the CYBHI's investments in educational settings focus on transitional kindergarten through 12th grade.

What is the relevant background, need, and potential for impact?

School-based mental health services have demonstrated positive outcomes for mental health, education, and parental well-being.[80,81] These services have led to improved school grades, improved school attendance,[82] reduced post-traumatic stress disorder and other mental health issues, increased access to services, and reduced strain on parents and caregivers.

The CYBHI leverages the fact that children and youth spend significant time at educational institutions. This strategy is reinforced by Mathematica's spring 2024 pulse survey, which showed that in the past year, 6 percent of youth reported accessing help from a counselor or therapist in school.[83] This finding could indicate a need to further bolster in-school behavioral health supports to improve access and uptake of these services.

Schools already provide a range of services, providing a foundation from which to expand behavioral health services through trusted community institutions, including school-linked partners and schools themselves. In this model, behavioral health services meet kids where they are rather than require youth or caregivers to find services elsewhere. This approach reduces some key barriers to access, such as transportation limitations. For example, Wisconsin students were found to be twice as likely to access services through schools once they were referred than if they were referred to community-based services.[84] Additionally, situating behavioral health prevention and treatment in schools leverages the youth development and socioemotional expertise of school staff who may have deep understanding of behavioral patterns, student assets, and day-to-day challenges experienced by the youth they serve. To effectively provide services to children and youth, schools require investments aligned with the core CYBHI strategies: investing in **promotion, prevention, and public awareness**; investing in **infrastructure** to support service delivery and developing **workforce capacity**. The CYBHI's school-linked workstreams address these needs in different ways; while some workstreams are

[80] Walker, S.C., S.E. Kerns, A.R. Lyon, E.J. Bruns, and T.J. Cosgrove. "Impact of School-Based Health Center Use on Academic Outcomes." *Journal of Adolescent Health*, vol. 46, no. 3, August 2009, pp. 251–257. https://doi.org/10.1016/j.jadohealth.2009.07.002.

[81] Sanchez, A.L., D. Cornacchio, B. Poznanski, A.M. Golik, T. Chou, and J.S. Comer. "The Effectiveness of School-Based Mental Health Services for Elementary-Aged Children: A Meta-Analysis." *Journal of the American Academy of Child and Adolescent Psychiatry*, vol. 57, no. 3, December 2017, pp. 153–165. https://doi.org/10.1016/j.jaac.2017.11.022.

[82] Lim, C., P. J. Chung, C. Biely, N. J. Jackson, M. Puffer, A. Zepeda, P. Anton, K. M. Leifheit, and R. Dudovitz. "School Attendance Following Receipt of Care From a School-Based Health Center." *The Journal of Adolescent Health,* vol. 73, no. 6, December 2023, pp. 1123-1131. https://doi.org/10.1016/j.jadohealth.2023.07.012.

[83] See section 2.2 for additional detail on survey methods and respondents. As part of this survey, youth were asked, "In the past year, where did you get help from a counselor or therapist?"

[84] Husky, M.M., M. Sheridan, L. McGuire, and M. Olfson. "Mental Health Screening and Follow-Up Care in Public High Schools." *Journal of the American Academy of Child and Adolescent Psychiatry*, vol. 50, no. 9, September 2011, pp. 881–891. https://doi.org/10.1016/j.jaac.2011.05.013.

designed to focus solely on one of these strategies (for instance, **Safe Spaces** focuses on building behavioral health capacity among educators), others are positioned to leverage multiple strategies to strengthen schools' ability to serve as centers for behavioral health care (for instance, **SBHIP** funding may be used to support projects aligned with each of these three categories). Recognizing the integration of these strategies within and across the CYBHI school-linked workstreams, we holistically discuss these investments in the sections below.

Recognizing schools as a key conduit for sharing information with students and families, the CYBHI has made notable efforts to disseminate initiative resources to and through education partners. For instance, the CYBHI has built a resource hub tailored to the informational needs of administrators and school health personnel, teachers and school staff, and students and families, linking these key audiences to relevant guidance, tools, and content sourced from across the initiative. To support educators in effectively navigating the many opportunities available through the initiative, the CYBHI has mapped workstreams such as Wellness Coaches, the CYBHI Fee Schedule, Cal-MAP, CalHOPE, Scaling EBPs and CDEPs, and Never a Bother to the relevant California Multi-Tiered System of Supports (MTSS) tiers, allowing schools to identify which resources may best align with local goals and efforts already underway.

To make school-based services an intentionally integrated and more comprehensive part of the behavioral health ecosystem, it is essential to (1) **increase their capacity to promote wellness, provide prevention services, and identify behavioral health needs** and (2) **facilitate the provision of behavioral health care in and near schools through infrastructure development and sustainable funding mechanisms.** The CYBHI has invested more than $1.7 billion in workstreams[85] aligned with these two primary approaches. Although the overarching goal of school-linked investments is to build a behavioral health care ecosystem in schools that can meet a diverse range of students' needs, it is helpful to consider the school-linked CYBHI investments as broadly aligned with one of these two aims. Exhibit 10 describes the mechanisms and activities through which the CYBHI's education setting workstreams advance each of these aims.

[85] This figure includes CalHOPE Student Supports and Schools Initiative; Mindfulness, Resilience, and Well-being Supports, Safe Spaces, Youth Peer-to-Peer Supports, the CYBHI Fee Schedule, SBHIP, School-Linked Partnership & Capacity Grants, and Certified Wellness Coaches. It does not include selected EBP/CDEP grants for which certain schools were direct recipients.

Exhibit 10. CYBHI workstream alignment with approaches for supporting student behavioral health

Workstream	Approaches to support student behavioral health			
	Increasing school capacity to promote wellness, provide prevention services, and identify behavioral health needs		Facilitating the provision of behavioral health care in and near schools through infrastructure development and sustainable funding mechanisms	
	Promotion & Individual Capacity Development Increase schools' capacity to support wellness & address BH needs through staff training and development.	**Prevention & Organizational Capacity Development** Increase capacity to provide prevention services.	**Decrease administrative barriers to behavioral health care in/near schools** Develop funding mechanisms & partnerships, operational supports, & infrastructure to provide clinical care in or near schools.	**Provide reimbursable behavioral health care in/near schools**
Safe Spaces: Trauma-Informed Training	• Voluntary ACE and toxic stress training for childcare providers, educators, and school staff			
CalHOPE Student Support & Schools Initiative	• COEs receive funding, training, and resources, and join statewide SEL Communities of Practice* • Train teachers and school staff* • Free resources for teachers, students, and staff			
Mindfulness, Resilience, & Wellbeing Support	• COE funding, training, and resources • Train teachers, school staff, & leaders	• Resources for student social & emotional well-being (i.e. Kelvin Pulse survey)		
Youth Peer-to-Peer Support Program		• Fund pilot programs at 8 high schools • Create community of practice for educators and peer support specialists		
Scaling Evidence-Based & Community-Defined Evidence Practices		• Grants aim to increase school capacity to implement evidence-based early intervention programs	• Grants aim to increase school capacity to provide evidence-based BH services for students, including trauma-informed and youth-driven programs as well as parent/caregiver support and early intervention programs	
SBHIP		• Targeted Interventions (TIs) may support BH Wellness Programs, Screenings and Referrals, Pregnant Students and Teen Parents, and Parenting & Family Services.	• LEAs and MCPs collaborate to implement TIs that may support program expansion, clinician hiring, administrative process development, and IT infrastructure for claims transmission.	
School-linked Partnership & Capacity Grants		• Grants aim to increase availability, equity, and range of BH services in school-linked settings	• Grants aim to enhance collaboration between CBOs, LEAs, MCP, and county BH departments and increase LEAs meeting the operational readiness requirements for the fee schedule.	
CYBHI Fee Schedule Program		• Fee Schedule establishes specific BH services & rates by which Medi-Cal and commercial plans must reimburse schools and school-affiliated providers. The Fee Schedule includes prevention-oriented activities and services such as low-risk screenings, skills training and development, or preventive medicine counseling and/or risk factor reduction interventions.	• To support adoption of the Fee Schedule, LEAs and schools will build on infrastructure enhanced through SBHIP, School-Linked Partnership & Capacity Grants, or other development efforts.	• Fee Schedule establishes specific BH services & rates by which Medi-Cal and commercial plans must reimburse schools and school-affiliated providers. The Fee Schedule includes clinical behavioral health services such as psychological testing and evaluation, psychotherapy, and medication training and support.
Certified Wellness Coaches				• In 2025, Certified Wellness Coaches will be a new benefit in the Medi-Cal program (pending CMS approval of SPA) and added to the CYBHI Fee Schedule program

*Activity continuing under the Mindfulness, Resilience, & Wellbeing Supports workstream.

ACE = adverse childhood experience; **BH** = behavioral health; **CBO** = community-based organization; **COE** = county office of education; **CMS** = Centers for Medicare & Medicaid Services **LEA** = local education agency; **MCP** = Medi-cal managed care plans; **SPA** = state plan amendment.

3.2.1. Increasing schools' capacity to promote wellness, provide prevention services, and identify behavioral health needs

What is the relevant background and need?

CYBHI workstreams discussed in this section:

- CalHOPE Student Support and Schools Initiative
- Mindfulness, Resilience, and Well-Being Supports
- Safe Spaces
- Youth Peer-to-Peer Support Program
- CYBHI Fee Schedule (discussed further in 3.2.2)

Schools offer multiple opportunities for educators and professionals to recognize early signs of behavioral health issues and provide necessary support, making them an essential environment for promoting wellness and providing prevention services. The five workstreams that comprise this approach represent a $601 million investment and align interventions with current evidence to strengthen schools' capacity to serve as centers of social, emotional, and mental wellness. This approach aims to prevent serious behavioral health challenges and enable early intervention. This investment builds on additional efforts to provide SEL in California, which include Phase III of the California MTSS, for which the governor's budget allocated $50 million for schools beginning in the 2021-22 fiscal year.[86]

What workstreams align with this approach?

Five workstreams are collectively tasked with enhancing schools' capacity to support students' mental well-being through promotion, prevention, and early intervention.

Several CYBHI workstreams seek to strengthen educator capacity to support student socioemotional development and well-being. The **CalHOPE Student Support and Schools Initiative** workstream focuses on providing trainings and supports to educators to help them develop SEL environments, which build students' skills and destigmatize behavioral health concerns. By equipping educators with additional skills to bolster students' resilience, these programs increase mental health competency among some of the adults that children and youth interact with most. The workstream builds county of office education (COE) capacity to support local districts and schools statewide through a SEL-focused community of practice. The **Mindfulness, Resilience, and Well-Being Supports** workstream builds on this foundation by funding student-facing programs that promote SEL, mindfulness, and well-being in schools and data collection tools for schools to obtain real-time information about students' well-being. The workstream is also funding continuation of the SEL communities of practice, creating new mindfulness-centered learning modules, and supporting schools, districts, and COEs with the adoption of evidence-based tools, resources, and programs for students, families, and staff. The **Safe Spaces** workstream builds educators' capacity to recognize and respond to trauma and stress in children, supporting identification of students' behavioral health needs.

The **Youth Peer-to-Peer Support Program** workstream complements these educator capacity-building efforts by developing students to serve as an additional element of the behavioral health support system for their school peers, fostering connections and solidarity among students. The Youth Peer-to-Peer Support program will award $8 million in grants to eight schools across diverse Californian communities to initiate peer-to-peer support programs. These demonstration programs, which focus on grades 9 to 12, will help establish and standardize best practices for peer-to-peer mental and behavioral health support systems within the school environment.

Finally, the **CYBHI Fee Schedule** incorporates prevention-oriented activities and services in its schedule of behavioral health services and rates by which Medi-Cal and commercial plans must reimburse schools and school-affiliated

[86] California Department of Education. "Funding Results: Scaling Up Multi-Tiered System of Support Statewide Funding." Last reviewed July 2023. https://www.cde.ca.gov/fg/fo/r12/mtss21result.asp.

providers. This allows LEAs to seek reimbursement for services including behavioral health screenings, psychoeducation, skills training and development, or risk factor reduction interventions. This provides an avenue for reimbursement of services LEAs may already be providing to students as well as mechanism to support expansion of these supports and services. This workstream is discussed in greater detail in section 3.2.2.

How is implementation progressing? What is the potential for impact?

In July 2022, **CalHOPE Student Support and Schools Initiative** launched a SEL Community of Practice (CoP) comprising key statewide leaders and representatives of all 58 county offices of education (COEs). The CoP meetings provide space for COE representatives to connect to share ideas and resources and build collective capacity for SEL implementation. The meeting facilitation incorporates SEL practices, including a welcoming activity, engaging strategies, and optimistic closure;[87] and facilitators structured activities with the intention of developing participants' SEL competencies, such as curiosity, collaborative problem solving, and agency. Each COE is working with local LEAs to provide coordinated and direct SEL support to a small set of focal schools and generate learning opportunities to scale up systemic SEL. The workstream also provides no-cost, evidence-based online resources for educators, students, and families, including classroom materials, film series, and forums. These resources include three digital tools for California educators: *A Trusted Space*, a docu-training series that includes practical tools to support the development of healthy spaces for students; *Angst: Building Resilience,* a film-based program designed to raise awareness around anxiety; and *Stories of Hope: SHORTS,* a short story and conversation series featuring youth sharing real stories of their mental health journeys along with youth-led interactive conversations.[88] Activities under this workstream concluded in June 2024, but the digital resources remain accessible through the CalHOPE Schools website, and several core activities, including the communities of practice, continue under the **Mindfulness, Resilience, and Well-Being Supports** workstream.

Leveraging the intersection of schools and behavioral health: Transforming Together

The CYBHI is one piece of California's comprehensive statewide approach to address the negative effects of the COVID-19 pandemic on student learning and social and emotional well-being. With the passage of the California Community Schools Partnership Program (CCSPP) in 2021, the state allocated $4.1 billion to establish and expand community schools. Community schools are designed to connect students to local services and resources that address the needs of the whole child. The California Community Schools Framework, in alignment with most traditional community school models, incorporates four evidence-informed pillars: (1) integrated support services; (2) family and community engagement; (3) collaborative leadership and practices for educators and administrators; and (4) extended learning time and opportunities. Guided by this framework, the CCSPP awards grants to support schools' efforts to partner with community agencies and local government to address students' academic, cognitive, physical, mental, and social-emotional needs.

To integrate efforts to improve student behavioral health and well-being across the education and behavioral health sectors, CalHHS and the California Department of Education have partnered on a demonstration project called Transforming Together (T2). The project aims to learn how local sites can be supported to coordinate the implementation of the CYBHI and CCSPP and identify effective tools and approaches for facilitating integration across systems.

The Mindfulness, Resilience, and Well-Being Supports workstream began contracting processes with the 58 COEs in June 2023. Funds were distributed across the 58 COEs, and schools started implementing programming in the 2023–2024 school year. The funding has supported county, district, and school efforts across eight categories of preferred

[87] Collaborative for Academic, Social, and Emotional Learning. "SEL Three Signature Practices Playbook." 2019. https://casel.org/casel_sel-3-signature-practices-playbook-v3/.

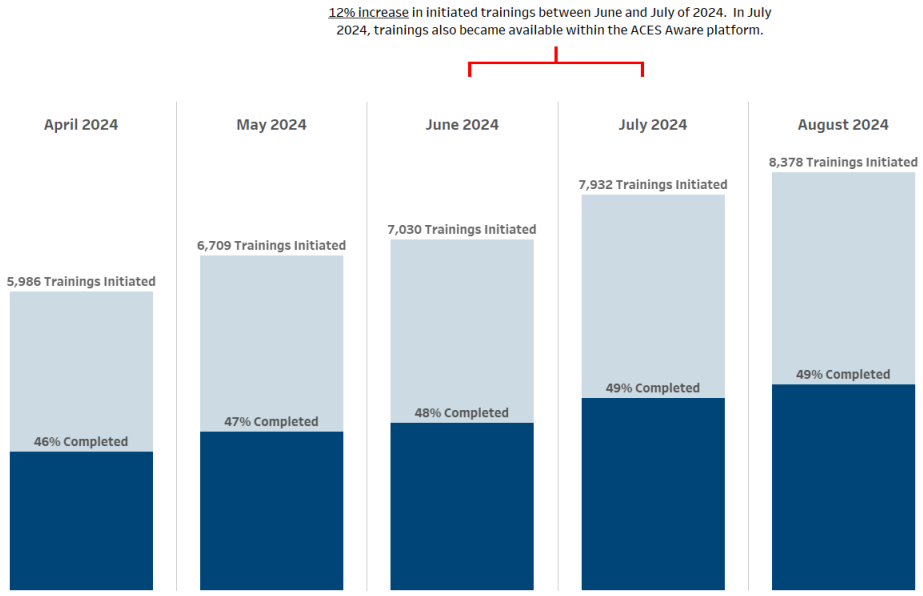
[88] Shapiro, V.B., A.M. Duane, M.X. Lee, T.M. Jones, A.N. Metzger, S. Khan, and C.M. Cook, et al. "We will build together: Sowing the seeds of SEL statewide." *Social and Emotional Learning: Research, Practice, and Policy*, vol. 3, June 2024. https://www.sciencedirect.com/science/article/pii/S2773233923000141?via%3Dihub.

activities and infrastructure (PAIs), including student-facing programming, professional development stipends for educators to complete graduate-level SEL courses, and school wellness centers. The workstream is currently providing schools and districts with free access to the Kelvin pulse survey, which provides real-time, actionable information about student well-being and facilitates progress monitoring to inform the improvement of SEL, mindfulness, and wellness programming. In May 2024, the workstream funded a statewide SEL and Wellness Summit hosted by the Sacramento County Office of Education that included expert speakers and interactive workshops and was attended by COE, district, school, and community SEL leaders and staff.

A meta-analysis examined 213 school-based universal social and emotional learning (SEL) programs and found that the programs enhanced students' SEL skills, attitudes, and positive social behaviors.[89] This also led to fewer conduct problems, lower levels of emotional distress, and gains in academic achievement. A follow-up meta-analysis assessed the longer-term outcomes (6 to 18 months post-intervention) for 82 school-based universal SEL programs and found positive impacts on students' social-emotional skills, attitudes, and indicators of well-being (for example, relationships, employment and income, school status, criminality, mental health, and so on).[90] CalHOPE and Mindfulness, Resilience, and Well-Being Grant funding and programming are positioned to increase capacity to provide high-quality school-linked SEL programming, and as such, have potential to have similarly positive effects on student well-being, depending on LEA-level implementation efforts.

Safe Spaces launched in July 2023 as a free voluntary online trauma-informed training for staff in educational and early care settings. In December 2023, the Expert Review Panel (first convened in June 2022 to inform workstream development and implementation) provided recommendations for continued scaling and implementation of Safe Spaces. Across both K-12 and early learning and care settings, the Expert Review Panel suggested approaches to increase module reach and uptake, including expanding the audience to include school administrators and operational staff; increasing module visibility through endorsements, educator testimonials, and conference presentations; offering staff incentives to promote module completion; embedding the training in required onboarding and training processes; and developing supported communities of practices to facilitate implementation of key principles. Promoting training access and uptake is an ongoing improvement activity; following initial launch, the

Exhibit 11. Safe Spaces cumulative initiated and completed trainings



[89] Durlak, J.A., R.P. Weissberg, A.B. Dymnicki, R.D. Taylor, and K.B. Schellinger. "The Impact of Enhancing Students' Social and Emotional Learning: A Meta-Analysis of School-Based Universal Interventions." *Child Development*, vol. 82, no. 1, February 2022, pp. 405–432. https://doi.org/10.1111/j.1467-8624.2010.01564.x.

[90] Taylor, R.D., E. Oberle, J.A. Durlak, and R.P. Weissberg. "Promoting Positive Youth Development Through School-Based Social and Emotional Learning Interventions: A Meta-Analysis of Follow-Up Effects." *Child Development*, vol. 88, no. 4, July 2017, pp. 1156–1171. https://doi.org/10.1111/cdev.12864.

course was placed on the ACEs Aware Learning Center in 2024. As of September 2024, 8,938 trainings had been initiated, with a completion rate of 49%. For perspective, in one large-scale study to increase visibility and access (see Exhibit 11), completion rates for Massive Open Online Courses (MOOCs), researchers found that completion rates varied widely, ranging from 0.7% to 52.1%.[91] Course completion rates are impacted by key factors including course design, relevance to participants, course length, and whether learners were incentivized to complete the course. Given these comparisons, a completion rate of roughly 50% for Safe Spaces appears favorable, especially for a voluntary program, and suggests the course provides value to its participants.

OSG has partnered with ACEs Aware in continued efforts to meet with County Offices of Educations and LEAs to promote district-wide training opportunities. To date, at least five districts, early care sites or schools have proactively expressed interest in implementing the training in the 2024/2025 school year. Dissemination efforts also include downloadable and customizable classroom aids, presentation slide decks, and newsletter articles.
Future data collection may include surveys and interviews to better understand barriers and facilitators of training uptake and completion by educational staff. A Pew Survey of teachers from April 2024 found that 84 percent of respondents had insufficient time during regular work hours to perform needed tasks.[92] While educational personnel identify student behavioral health needs as a concern,[93] voluntary training may not take precedence amid competing demands. To increase uptake and completion of the training, OSG may wish to establish partnerships with additional LEAs, and work with district leadership to prioritize course completion, for instance by providing protected professional development time or aligning with educator interest in increasing capacity to support student well-being.

As of fall 2024, the **Youth Peer-to-Peer Support Program** was in the process of selecting pilot schools. In educational settings, evidence suggests that peer support can increase self-confidence, self-esteem, self-management, hope, and empowerment as well as reduce loneliness.[94,95,96] Implementation at eight school pilot sites is forthcoming.

---

[91] Jordan, K. "Massive open online course completion rates revisited: Assessment, length and attrition." *The International Review of Research in Open and Distributed Learning*, vol. 16, no. 3, 2015, pp. 341-358. https://doi.org/10.19173/irrodl.v16i3.2112.

[92] Lin, L., K. Parker, and J.M. Horowitz. "What's It Like To Be a Teacher in America Today?" *Pew Research Center,* April 2024. https://www.pewresearch.org/social-trends/2024/04/04/whats-it-like-to-be-a-teacher-in-america-today/.

[93] California Department of Education. "California School Staff Survey, 2021-2023: Main Report." Prepared by WestEd, May 2024. https://calschls.org/docs/statewide_2123_csss.pdf.

[94] Johnson, S., D. Lamb, L. Martson, D. Osborn, O. Mason, C. Henderson, G. Ambler, et al. "Peer-supported self-management for people discharged from a mental health crisis team: a randomised controlled trial." *The Lancet,* vol. 392, no. 10145, August 2018, pp. 409-418. https://doi.org/10.1016/S0140-6736(18)31470-3.

[95] King, T. & M. Fazel. "Examining the mental health outcomes of school-based peer-led interventions on young people: A scoping review of range and a systematic review of effectiveness." *PLOS ONE*, vol. 16, no. 4, April 2021. https://doi.org/10.1371/journal.pone.0249553.

[96] White, S., R. Foster, J. Marks, R. Morshead, L. Goldsmith, S. Barlow, J. Sin, et al. "The effectiveness of one-to-one peer support in mental health services: a systematic review and meta-analysis." *BMC Psychiatry,* vol. 20, no. 534, June 2020. https://doi.org/10.1186/s12888-020-02923-3.

3.2.2. Facilitating the provision of behavioral health care in and near schools through infrastructure development, sustainable funding mechanisms, and increased workforce

What is the relevant background and need?

CYBHI workstreams discussed in this section:

- CYBHI Fee Schedule
- Student Behavioral Health Incentive Program (SBHIP)
- School-Linked Partnership and Capacity Grants
- Scaling Evidence-Based and Community-Defined Evidence Practices
- Certified Wellness Coaches

Historically, California's schools have focused their attention and funding on students with more acute behavioral health needs rather than on providing services to students with mild and moderate behavioral health needs. To the extent that public schools integrated with the broader behavioral health system, they typically did so by referring students to specialty mental health services offered by county behavioral health agencies and contracted CBOs that served as behavioral health providers. Historically, California LEAs have accessed, braided, and blended various funding sources, including Local Control Funding Formulas and one-time funds, to pay for behavioral health services. In 1993, California established the Local Education Agency Billing Option Program (LEA BOP) to help fund some of these behavioral health services. The LEA BOP allows LEAs (school districts, COEs, charter schools, and higher education) to receive reimbursement for the federal share of providing approved physical and behavioral health-related services to students eligible for Medi-Cal. About half the LEAs in California participate in the fee-for-service LEA BOP model.[97]

Under LEA BOP, LEAs had to certify funds were expended for LEA-provided health services that qualified for federal financial participation. Through DHCS, the state compared each LEA's total actual costs with interim Medi-Cal reimbursement from the previous year. There was no guarantee that LEAs would recoup the service delivery costs they had frontloaded, nor the substantial overhead costs associated with compliance and reporting requirements. As a result, some LEAs underwent audits, and some had to use general funds or reserves to pay unreimbursed costs. Consequently, many LEAs began to question the efficacy and sustainability of the LEA BOP model.[98]

The CYBHI has tasked several workstreams with implementing approaches that make provision of school-linked services more sustainable, predictable, and less administratively burdensome for LEAs.

What workstreams align with this approach?

Four of the CYBHI workstreams focus on enabling schools to provide behavioral health care services through infrastructure supports, sustainable funding mechanisms, and investments to expand workforce capacity and capability.

The **CYBHI Fee Schedule** program provides a consistent and predictable funding mechanism for school-linked services by establishing a specific set of behavioral health services and rates at which Medi-Cal, commercial health plans, and disability insurers must reimburse school-

Other ways the CYBHI Fee Schedule program reduces administrative burden on LEAs

- LEAs are not responsible for contract or rate negotiations with payers.
- A third-party administrator serves as the clearinghouse for claims processing and compliance, not LEAs.
- Reduced administrative burden means LEAs net more reimbursement for services.

[97] Butler, M., and I. Rolon. "Connecting Schools to the Larger Youth Behavioral Health System: Early Innovations from California" Health Management Associates for the National Association of State Mental Health Program Directors Technical Assistance Coalition, October 2023. Connecting-Schools-to-the-Larger-Youth-BH-System-October-2023.pdf.

[98] For additional detail on the challenges associated with LEA BOP, please see the rationale for proposed state legislation at https://www.sccoe.org/supoffice/government-relations/Documents/2023-AB_483-Fact-Sheet.pdf.

linked providers. The CYBHI Fee Schedule program provides guidance for LEAs and public institutions of higher education (IHEs) to receive reimbursement for school-linked behavioral health services using a fee-for-service model. Specifically, it (1) defines the scope of services for outpatient mental health and SUD treatment, (2) identifies applicable billing codes and rates for behavioral health services, and (3) specifies which providers may bill for behavioral health services. Through the CYBHI Fee Schedule program, California statute[99] requires the Medi-Cal delivery system, state-regulated commercial health plans and disability-insurers to reimburse school-linked providers based on the published Fee Schedule program rates. In addition, insurance companies may not require copayments, coinsurance, deductibles, or any other form of cost sharing for behavioral health services provided under the Fee Schedule program. Unlike the certified public expenditure approach of the LEA BOP program, LEAs receive the entire published rate, which could free up local funds for further investment in school climate supports and population health approaches or to cover costs for students not covered under the CYBHI Fee Schedule program (e.g. members of a federally-regulated health plan product or students without health insurance); additionally, this avoids the administrative burden of cost settlement reconciliation. By mandating a common fee-for-service rate structure for public and commercially insured students, the Fee Schedule program further reduces billing complexity for LEAs and IHEs and incentives to provide enhanced services to students based on their insurance status. Developing this type of sustainable funding stream, without any co-payment for students, is unprecedented.

The **SBHIP** and **School-Linked Partnership and Capacity Grants** aim to help LEAs build relationships with managed care plans and develop the needed infrastructure for service delivery and billing. These workstreams specifically provide support for and offset the costs of start-up activities such as establishing new lines of behavioral health services, contracting with new insurers, and data collection and billing infrastructure. Each of these programs are intended to position participating COEs and LEAs to leverage the Fee Schedule for long-term service reimbursement. These workstreams are described further in the callout box entitled **Workstreams increasing operational readiness for the CYBHI Fee Schedule program.**

[99] See W&I Code section 5961.4, H&S Code section 1374.722, and Insurance Code section 10144.53.

Workstreams increasing operational readiness for Fee Schedule program participation

SBHIP focuses on developing a behavioral health infrastructure by helping managed care plans and LEAs partner to address identified gaps in school-based behavioral health infrastructure through a set of targeted interventions. Counties and LEAs can select one to four targeted interventions from a list of 14 outlined by DHCS.[100] Depending on the interventions selected, SBHIP activities may support increasing capacity for promotion and prevention and/or decreasing administrative barriers to behavioral health care in/near schools and are intended to enhance partnerships between LEAs and managed care plans. For example, SBHIP projects may focus on establishing behavioral health wellness programs (inclusive of physical infrastructure development); developing telehealth infrastructure; strengthening partnerships between schools, MCPs, and county behavioral health plans; expanding the school-based behavioral health workforce via community health workers and/or peer support specialists; establishing or expanding care teams to conduct outreach and link to social services; or enhancing screening and prevention strategies, among other aims.

School-Linked Partnership and Capacity Grants are one-time investments intended to enhance school-linked behavioral health services and support operational readiness for the Fee Schedule. The Santa Clara County Office of Education, in partnership with the Sacramento County Office of Education, oversees fund distribution to all 58 COEs and provide training and technical assistance to help COEs successfully implement the Fee Schedule; counties and LEAs are responsible for drafting implementation plans that reflect and address locally defined infrastructure development needs.[101] A total of 70 percent of the funds allocated should be used to achieve LEA operational readiness to implement the Fee Schedule. This can include work in the following four areas: Medi-Cal enrollment, service delivery infrastructure and capacity building, data collection and documentation, and billing infrastructure.

Certified Wellness Coaches (CWC) are a new behavioral health professional role established under the CYBHI for people holding associate and bachelor's degrees. This workstream is linked to other investments in the CYBHI to overall scaling and innovation of the behavioral health workforce. Under the supervision of qualified providers, CWCs will serve children and youth and operate as part of a care team in a wide variety of settings, including school-linked settings. The creation and integration of this role into school-linked behavioral health provider teams is intended to help address workforce shortages and support the sustainability of the Fee Schedule by adding another reimbursable provider type. More information about the creation of the CWC role is available in the report's workforce development section (2.3).

Nearly $1.3 billion went to providing infrastructure for and coverage of school-linked services, with an additional $338 million to the CWC workstream, which helps support school-linked services. In the 2023–2024 school year, there were about 6.5 million children enrolled in public schools, including public charter schools and K–12 across 11,278 schools.[102] In total, that amounts to a one-time investment of approximately $270 per K–12 student or $150,000 per school, which could allow for both infrastructure and staffing enhancements.

The investment of $270 per child for a targeted set of services in the school setting represents a substantial investment in overall resources for children's mental health.[103] CYBHI's school-linked workstreams are well positioned to address commonly cited barriers to the effective provision of school-based behavioral health services, such as a lack of

---

[100] California Department of Health Care Services. "Student Behavioral Health Incentive Program (SBHIP) Application, Assessment, Milestones, Metrics." 2022. https://www.dhcs.ca.gov/services/Documents/DirectedPymts/SBHIP-Overview-and-Requirements-2-1LR.pdf.

[101] California Department of Health Care Services. "School-Linked Partnerships and Capacity Grants Funding Guidance Overview." 2024. https://www.dhcs.ca.gov/CYBHI/Documents/DHCS-CYBHI-SL-Grants-Funding-Guidance-Memo.pdf.

[102] California Department of Education. "Fingertip Facts on Education in California." Last reviewed May 2024. https://www.cde.ca.gov/ds/ad/ceffingertipfacts.asp.

[103] For context, a 2021 analysis of Medicaid spending found California's annual per-member expenditure for children was $2,763 for all services.

resources to establish and sustain data infrastructure and staffing, historically limited integration between the education and health care sectors including Medi-Cal and commercial plans, and concerns around data sharing and compliance with relevant HIPAA and FERPA regulations. The cohort model of the CYBHI Fee Schedule also provides opportunities to learn from early implementation and provide exemplars to later-adopting LEAs.

Enhancing school capacity to deliver high-quality, evidence-based care

In addition to investments intended to increase capacity to provide behavioral health care in and near schools, the CYBHI also seeks to support integration of evidence-based practices into school environments through grants made via the Scaling Evidence-Based and Community-Defined Evidence Practices (Scaling EBPs/CDEPs) workstream.

The **Scaling EBPs/CDEPs** grant program offers an additional mechanism to enhance the accessibility and quality of prevention services and clinical care offered in and near schools. In particular, Round 2 is focused on the expansion of evidence-supported and culturally responsive trauma-informed behavioral health services across various settings, including schools. In Round 2, DHCS awarded 46 grants to schools, LEAs, and COEs, totaling nearly $27 million. Most education sector awardees planned to implement Cognitive Behavioral Interventions for Trauma in Schools (CBITS) or Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). CBITS is a group intervention aimed at relieving symptoms of post-traumatic stress disorder, depression, and general anxiety among children exposed to multiple forms of trauma, while TF-CBT is an evidence-based treatment for children and adolescents impacted by trauma and their parents or caregivers. A smaller number of schools, LEAs, and COEs received Scaling grants to support implementation of early intervention programs and practices for students and their families (Round 5; 12 awards totaling nearly $8 million), youth-driven programs (Round 4; 9 awards totaling $7 million), and parent/caregiver support programs and practices (Round 1; 10 awards totaling nearly $5 million), and Early Childhood Wraparound Services (Round 3; 54 awards).

How is implementation progressing? What is the potential for impact?

How are efforts to increase operational readiness for Fee Schedule implementation progressing? What is the potential for impact?

Both the **SBHIP** and **School-Linked Partnership and Capacity Grants** are designed to increase operational readiness and support the implementation of the Fee Schedule.

SBHIP launched in January 2022 and is scheduled to conclude in December 2024. Supported by SBHIP, managed care plans, in collaboration with their partners, began implementing a selected 147 targeted interventions in 2023. In all, 30 percent of targeted interventions focused on expanding or creating behavioral health wellness programs, 16 percent were aimed at expanding the behavioral health workforce, and 14 percent were dedicated to building stronger partnerships. The remaining nine types of targeted interventions each represented less than 10 percent of targeted interventions. A total of 52 percent of the targeted interventions were designed to expand or enhance previous interventions, while 48 percent constituted new interventions.

The School-Linked Partnership and Capacity Grants established initial allocations to COEs in June 2024. COE implementation plans were due in summer 2024, with LEA implementation plans due November 2024. COEs and LEAs actively developed plans based on local needs to identify barriers to Fee Schedule implementation and propose approaches to achieve operational readiness via these grants.

How is early implementation of Fee Schedule progressing? What is the potential for impact given implementation to date?

The **CYBHI Fee Schedule** program scope of services and rates were published in December 2023. SPA 23-0027 was submitted to the CMS for approval on December 28, 2023, seeking to adopt Pupil Personnel Services (PPS) credentialed practitioners as a distinct provider type in the Medi-Cal program, which would allow them to provide

behavioral health services within their scope of practice as part of the CYBHI Fee Schedule. The draft Fee Schedule,[104] including service category, procedure code, service description, eligible practitioners, and reimbursement rates, is available here.

To implement the Fee Schedule, DHCS designed a cohort system to introduce the reimbursement system, beginning with a pilot cohort identified in January 2024. In all, 47 LEAs were determined to meet the readiness criteria to participate in Cohort 1, including participation in LEA BOP as one of the conditional requirements.[105, 106] Early implementation has focused on developing policies and procedures, including billing infrastructure and student health information collection methods; it is anticipated that a select number of LEAs will submit their first claims by end of calendar year 2024, but claims data are not expected to be sufficiently mature for evaluation until the end of calendar year 2025.

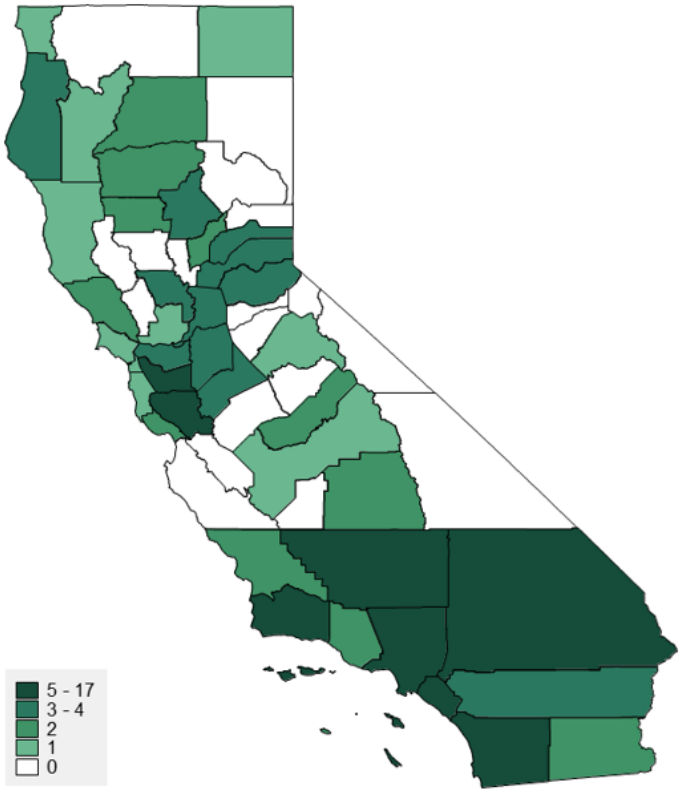
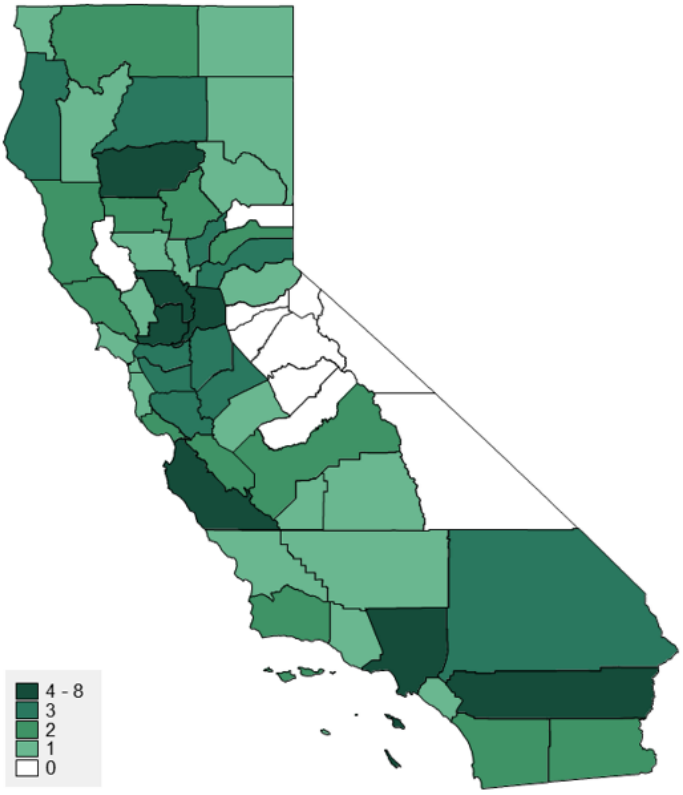
Another 91 LEAs were identified to participate in Cohort 2, which launched in August 2024. One hundred six LEAs identified to participate in this cohort demonstrated readiness via a variety of factors, including Medi-Cal enrollment, service delivery infrastructure and capacity building, data collection and documentation, and billing infrastructure. The left panel of Exhibit 12 shows the number of LEAs in each county that are participating in Cohort 1 or 2 of the CYBHI Fee Schedule program. Fifty-four of the 138 Cohort 1 and 2 Fee Schedule participants are located in Southern California.

[104] The CYBHI Fee Schedule is in draft pending CMS' approval of SPA 23-027; however, the codes and rates specified in the Fee Schedule are final.

[105] California Department of Health Care Services. "CYBHI Fee Schedule -Cohort 1 Local Education Agencies." 2023. https://www.dhcs.ca.gov/CYBHI/Documents/CYBHI-Fee-Schedule-Cohort-1-LEAs.pdf.

[106] According to state leaders, one LEA subsequently withdrew from participation.

Exhibit 12. Geographic distribution of Fee Schedule participation and Certified Wellness Coach Employer Support grants

Number of LEAs participating in CYBHI Fee Schedule (Cohorts 1 and 2) in each county[107]	Number of Certified Wellness Coach Employer Support grantees in each county[108]
	

Source: Mathematica analysis of the CYBHI documentation.
Note: This figure depicts raw counts of LEA participation and awardees per county and is not adjusted for population size or LEA concentration. As such, differences between urban/suburban and rural/frontier counties should be interpreted accordingly.

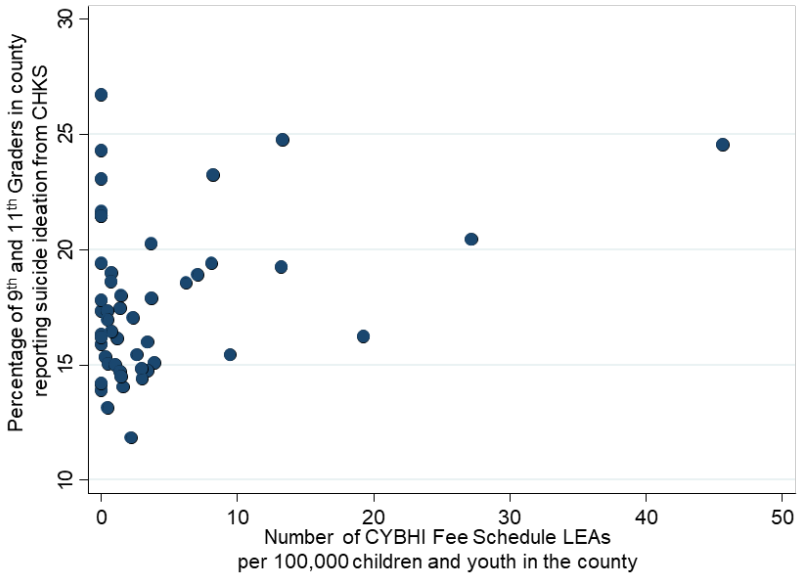
At the county level, higher participation in the Fee Schedule is moderately associated with measures of student need. We evaluated the relationship between the uptake of the CYBHI Fee Schedule among LEAs and the percentage of students in Grades 9 and 11 who reported suicidal ideation.[109] We found a weak positive correlation (0.25 correlation) between the percentage of students in Grade 9 and 11 reporting suicide ideation and the number of LEAs participating in CYBHI Fee Schedule Cohorts 1 & 2 (per 100,000 children and youth in the county). This indicates that areas comprised of students with higher levels of suicide ideation had more LEAs implementing the Fee Schedule; however, due to the strength of the correlation, this relationship should be interpreted with caution. Exhibit 13 depicts this relationship by plotting each county's percentage of students in Grade 9 and 11 reporting suicide ideation by the number of LEAs participating in the CYBHI Fee Schedule per 100,000 children and youth in the county.

[107] This analysis is accurate as of August 2024 and reflects Cohorts 1 and 2 participating in the CYBHI Fee Schedule.

[108] This analysis is accurate as of August 2024 and reflects the 64 Certified Wellness Coach Employer Support Grantees.

[109] This is based on Mathematica's analysis of the following data source: CalSCHLS. "California Healthy Kids Survey (CHKS) 2019-2021." Unpublished data. 2021.

Exhibit 13. Relationship between rates of suicide ideation and number of participating LEAs in CYBHI Fee Schedule Cohorts 1 and 2



Source: Mathematica analysis of the CYBHI documentation and CalSCHLS. "California Healthy Kids Survey (CHKS) 2019-2021." Unpublished data. 2021.

Fee Schedule participation is also moderately associated with receipt of previous investments in school-linked behavioral health [0.45 correlation with Mental Health Student Services ACT grants received per capita].[110] Taken together, these findings suggest that 1) early Fee Schedule adoption is concentrated in places where students may need more behavioral health services, and 2) LEAs participating in initial Fee Schedule cohorts may have been more prepared for adoption due to receipt and use of previous grant funding. The CYBHI's distribution of School-Linked Partnership and Capacity Grants to all counties is intended to support LEAs in need of additional infrastructure development to support successful Fee Schedule adoption. These early associations are consistent with the intention for Fee Schedule cohort 1 to serve as a learning cohort comprised of districts with requisite infrastructure already in place; as participation in the Fee Schedule broadens to include districts who may have been less operationally ready for implementation, correlation between Fee Schedule participation and geographic measures of student need and/or prior investment in school-linked behavioral health may evolve.

By January 2025, DHCS will begin a rolling opt-in and expand cohorts, which will open every 6 months, to include participants able to demonstrate operational readiness from any LEA (including charter schools) the California School for the Deaf and Schools for the Blind, California Community Colleges, and the California State University and University of California systems.

As LEAs begin to leverage the CYBHI Fee Schedule program across cohorts, it may be possible and valuable to assess the number of LEAs successfully being reimbursed for services via the Fee Schedule program and compare LEAs by status of participation in SBHIP and the School-Linked Partnership and Capacity Grants to gain insight into any impacts these grant programs may have had on operational readiness to leverage the Fee Schedule program. The time horizon for this assessment could extend beyond this evaluation, as mature claims are not expected from Fee Schedule reimbursement until the end of calendar year 2025 for Cohort 1.

[110] This is based on Mathematica's analysis of the following data source: Mental Health Services Oversight and Accountability Commission. "Report to the Legislature on the Mental Health Student Services Act." May 2022. https://mhsoac.ca.gov/wp-content/uploads/MHSSA-Progress-Status-Report-050422.pdf.

How is integration of Certified Wellness Coaches as a new school-linked provider type progressing? What is the potential for impact?

HCAI launched the **Certified Wellness Coach** certification portal in early 2024 and has begun certifying a limited number of CWCs. To help employers integrate CWCs as behavioral health providers while awaiting approval of the SPA to include Certified Wellness Coaches in the Fee Schedule (anticipated 2025),[111] HCAI awarded 64 Employer Support Grants to educational institutions and school-based and school-linked health and behavioral health agencies. Grantee implementation activities were slated to begin September 2024 upon execution of grant agreements; the first budget and activities report is due March 2025. The right panel of Exhibit 12 shows the number of grants each county received. There is a large degree of overlap between the counties that received Employer Support Grants and those with LEAs that are participating in Cohort 1 or 2 of the Fee Schedule. At the LEA level, 30 of the 64 Employer Support Grants went to LEAs participating in Cohort 1 or 2 of the Fee Schedule. This suggests that the Wellness Coach role is being adopted beyond the early Fee Schedule cohorts. Beyond the association with early participation in the Fee Schedule, at the county level, Certified Wellness Coach Employer Support Grant awards per capita are moderately correlated with student level measures of need [correlation of 0.28 with the percentage of students in grade 9 and 11 reporting suicidal ideation;[112] correlation of 0.46 with percentage of students in grades 9 and 11 reporting alcohol or drug use in the past month,[113]] suggesting that these resources are concentrated in areas where places where students need behavioral health support.

3.3. Homes and communities

Homes and communities are critical to a child's behavioral health development because they are where children grow, form foundational relationships, and develop their sense of identity. The CYBHI emphasizes the importance of community-based resources and family-centered supports that are culturally responsive and broadly disseminated. By focusing on prevention, promotion, and public awareness to build community capacity, the CYBHI's investments intended to affect this environment can foster collective resilience and ensure that behavioral health resources are embedded in everyday life.

What is the relevant background and need?

As settings where children and youth spend substantial amounts of their time, homes and communities profoundly influence behavioral health, well-being, and resilience. Parents, caregivers, and community members strong influence on children and youth's beliefs about behavioral health, positive skills development, understanding of when additional

[111] California Department of Health Care Services. "CYBHI Fee Schedule Draft Guidance for Public Comment." 2024. https://www.dhcs.ca.gov/CYBHI/Documents/CYBHI-Fee-Schedule-DRAFT-Guidance-FOR-PUBLIC-COMMENT.pdf.

[112] This is based on Mathematica's analysis of the following data source: CalSCHLS. "California Healthy Kids Survey (CHKS) 2019-2021." Unpublished data. 2021.

[113] This is based on Mathematica's analysis of the following data source: CalSCHLS. "California Healthy Kids Survey (CHKS) 2019-2021." Unpublished data. 2021.

supports are needed, and linkage to support.[114] Beyond parents and caregivers, the community can provide support to shape children and youth's well-being.[115,116]

Uplifting the voices of community members, the Youth at the Center Report calls for activities that build on communities as resources, promote culture as healing and a source of protective factors, broaden understanding of what encompasses behavioral health treatment to include culturally responsive healing modalities occurring within communities, and address stigma surrounding behavioral health problems.

To help aid caregivers and the broader community in supporting children and youth, the CYBHI's investments were designed to (1) **strengthen promotion, prevention, and public awareness;** and (2) **strengthen community-level workforce capacity**, which aligns with the core strategies. Additionally, the CYBHI invested to **strengthen community-level capacity to support children and youth's well-being and respond to behavioral health needs.**

3.3.1. Strengthening the capacity of individual community members to support well-being

Recognizing that collective attitudes influence children and youth's beliefs about behavioral health and that parents and caregivers profoundly impact children's development and emotional well-being, the CYBHI employs two main approaches to strengthening the capacity of individual members to support well-being: (1) **investing in public awareness campaigns** to change collective attitudes that contribute to stigma and to provide communities with the requisite knowledge to support young people; and (2) **strengthening parent and caregiver capacity** to help children and youth develop socioemotional skills and navigate behavioral health challenges.

Approach 1: Investing in public awareness campaigns

What is the relevant background and need?

A key barrier to obtaining needed behavioral health care is the stigma around behavioral health conditions and receiving behavioral health supports.[117,118]
A community's perception of behavioral health challenges form and reinforce stigma (or perceived stigma). As such, a key step in improving children and youth's well-being is addressing community-level

CYBHI workstreams relevant to this section:

- ACEs and Toxic Stress Awareness Campaign (Live Beyond)
- Public Education and Change Campaigns
- Youth Suicide Prevention Media and Outreach Campaign (Never a Bother)
- Positive Parenting, Thriving Kids Video Series
- Scaling EBPs/CDEPs Round 1 & 3
- Virtual Services Platforms (discussed further in section 3.4)

[114] Velez, G., T. Gibbs, L. Fortuna, B. Adam, L. De Faria, R. Elmaghraby, S. Garayalde, et al. "Social Determinants of Mental Health in Children and Youth." https://www.psychiatry.org/getattachment/a03e07c5-bba9-4ac7-b434-9183b1e0b730/Resource-Document-Social-Determinants-of-Mental-Health-Youth.pdf.

[115] Gopalkrishnan, N. "Cultural Diversity and Mental Health: Considerations for Policy and Practice." Frontiers in Public Health, vol. 6, June 2018, pp. 179. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6018386/.

[116] Castillo, E.G., R. Ijadi-Maghsoodi, S. Shadravan, E. Moore, M. Mensah, M. Docherty, M.G.A. Nunez et al. "Community Interventions to Promote Mental Health and Social Equity" *Current Psychiatry Reports*, vol. 21, no. 5, March 2019, pp. 1-14. https://doi.org/10.1007/s11920-019-1017-0.

[117] U.S. Department of Education. *Supporting Child and Student Social, emotional, Behavioral, and Mental Health Needs*. 2021. https://www2.ed.gov/documents/students/supporting-child-student-social-emotional-behavioral-mental-health.pdf.

[118] Gopalkrishnan, N. "Cultural Diversity and Mental Health: Considerations for Policy and Practice." *Frontiers in Public Health,* vol. 6, June 2018, pp. 179. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6018386/.

mindsets. Research shows that improving mental health literacy helps to enhance resource awareness, decrease stigma, and improves help-seeking behaviors.[119,120]

Experiences of behavioral health and well-being are influenced by cultural and community context. Local strategies might be more effective than generalized strategies, particularly for particular subpopulations, such as immigrant and AI/AN communities.[121,122,123] Optimizing promotion and prevention strategies requires building behavioral health supports across environments, including homes and schools. To ensure relevance, it is important to tailor messaging, supports, and services to align with cultural belief and practices,[124] build on strengths, and address local community needs. In particular, it is critical to invest in community-defined practices and opportunities to elevate youth and community voice and ensure they align with the beliefs, the assets, and an accurate understanding of the challenges that must be addressed.

How is implementation progressing? What is the potential for impact?

The **Live Beyond** campaign aims to increase awareness and understanding of Adverse Childhood Experiences (ACEs), toxic stress, and their potential impacts and to provide science-based, healing-centered resources for all Californians. As the California Surgeon General's Report on Adverse Childhood Experiences, Toxic Stress, and Health describes,[125] primary prevention tactics are key to addressing the adverse impact of ACEs because early action is "easier to implement, more effective, and less costly" than action taken later in life.[126] In designing the Live Beyond Campaign, FrameWorks Institute Research extensively researched the impacts of past ACEs campaigns.[127] Although the institute identified seven previous campaigns that aimed to increase awareness of ACEs, only one, the History and Hope campaign launched by Alaska Children's Trust, had evidence of its outcomes. The primary audience for this campaign was organization leaders, community leaders, and caretakers; follow-up surveys showed that participants had a

---

[119] Lindow, J.C., J.L. Hughes, C. South, E. Bannister, A. Minhajuddin, L. Gutierrez, M.H. Trivedi, et al. "The Youth Aware of Mental Health Intervention: Impact on Help Seeking, Mental Health Knowledge, and Stigma in U.S. Adolescents." *Journal of Adolescent Health,* vol. 67, no. 1, July 2020, pp. 101-107. https://doi.org/10.1016/j.jadohealth.2020.01.006.

[120] Weisman, H., M. Kia-Keating, A. Lippincott, and Z. Taylor. "Mental Health Stigma Prevention: Pilot Testing a Novel, Language Arts Curriculum-Based Approach for Youth." *Journal of School Health,* vol. 86, no. 10, October 2016, pp. 706-716. https://www.researchgate.net/publication/308044983.

[121] Pham, A.V., A.N. Goforth, H. Chun, and S.M. Castro-Olivo, "Acculturation and Help-Seeking Behavior in Consultation: A Sociocultural Framework for Mental Health Service." *Journal of Educational and Psychological Consultation,* vol. 27, no. 3, March 2017, pp. 1-18. https://www.researchgate.net/publication/315303215.

[122] Goodkind, J.R., B. Gorman, J.M. Hess, D.P. Parker, and R.L. Hough. "Reconsidering Culturally Competent Approaches to American Indian Healing and Well-Being" *Qualitative Health Research,* vol. 25, no. 4, April 2015, pp. 486-499. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4352372/.

[123] Rodriguez, D.X., J. Hill, and P.N. McDaniel. "A Scoping Review of Literature About Mental Health and Well-Being Among Immigrant Communities in the United States." *Health Promotion Practice,* vol. 22, no. 2, March 2021, pp. 181-192. https://journals.sagepub.com/doi/pdf/10.1177/1524839920942511.

[124] King, J., P. Masotti, J. Dennem, S. Hadani, J. Linton, and B. Lockhart. "The Culture is Prevention Project: Adapting the Cultural Connectedness Scale for Multi-Tribal Communities." *American Indian and Alaska Native Mental Health Research*, vol. 26, no. 1, January 2019, pp. 104-135. Research Gate-The Culture is Prevention Project Adapting the Cultural Connectedness Scale for Multi-Tribal Communities.

[125] Bhushan D., K. Kotz, J. McCall, S. Wirtz, R. Gilgoff, S.R. Dube, C. Powers, et al. "Roadmap for Resilience: The California Surgeon General's Report on Adverse Childhood Experiences, Toxic Stress, and Health." Office of the California Surgeon General, 2020. https://osg.ca.gov/wp-content/uploads/sites/266/2020/12/Roadmap-For-Resilience_CA-Surgeon-Generals-Report-on-ACEs-Toxic-Stress-and-Health_12092020.pdf.

[126] National Academies of Sciences, Engineering, and Medicine. Vibrant and Healthy Kids: Aligning Science, Practice, and Policy to Advance Health Equity. Washington, DC: National Academies Press, July 2019. https://www.ncbi.nlm.nih.gov/books/NBK551486/.

[127] Office of the California Surgeon General. ACEs and Toxic Stress Campaign Preliminary Research Report. October 2023. https://osg.ca.gov/wp-content/uploads/sites/266/2023/11/Formative-Research-Report-October-2023.pdf.

27 percent increase in knowledge of the impact of toxic stress in children, 52 percent used resources from the training, and 84 percent used techniques they learned in trainings. This provides some preliminary evidence that a campaign on ACEs could improve outcomes.

The Live Beyond campaign primarily addresses youth and young adults with a secondary audience of parents and caregivers who have experienced one or more ACEs. Live Beyond was launched in May 2024 after a planning phase with subject matter experts and youth. After the campaign's active period, the team behind the campaign plans to evaluate changes in public attitudes and awareness of ACEs and toxic stress.

The **Public Education and Change Campaigns** include statewide and local-level campaigns designed to promote awareness of behavioral health resources and services and to decrease stigma about behavioral health. In total, 28 grantees will develop and implement the local-level campaigns to support culturally appropriate messaging around prevention and early intervention. The statewide campaign, titled *Take Space to Pause,* will launch in November 2024 after an eight-month planning and co-creation process with advisory boards, including the Brain Trust (subject matter experts), Youth Co-Lab (youth), and local community-based organizations.

Local-level grantees, who were awarded funds in February 2024, are currently in the campaign planning stages and participating in Testing, Sharing, and Learning Labs. These projects and associated collaboration provide an opportunity to develop and share locally and culturally defined practices for decreasing stigma and building trust among the five priority populations: African Americans/Black, Asians and Pacific Islanders, Latinos, American Indian/Alaska Native, and people who are lesbian, gay, bisexual, transgender, queer and questioning (LGBTQ+). Projects also aim to address the unique needs of transitional-age youth, people with disabilities, justice-involved youth, foster care involved youth, and those living in rural areas. Exhibit 14 shows the distribution of populations reached by the 28 local campaign grantees; each campaign may reach multiple populations.

Exhibit 14. Populations reached by 28 local-level public education and change campaigns[128]

Population reached	# of grantees
Transitional-age youth	25
People who are LGBTQ+	22
Latinos	21
African Americans/Black	17
Asian and Pacific Islanders	15
Justice-involved youth	12
People living in rural areas	12
Foster care involved youth	10
People with disabilities	10
American Indian/Alaska Native	8
Middle Eastern and Northern African	5

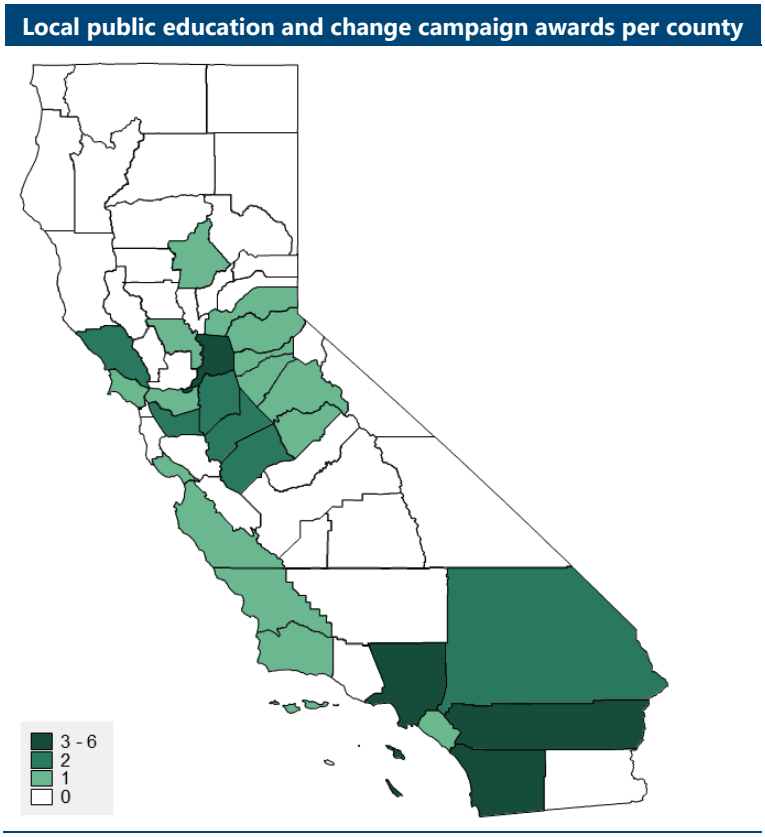
Exhibit 15 shows the number of local Public Education and Change Campaign grants that went to each county. Grants were concentrated in Southern and Central California. Analysis of per-capita awards related to county characteristics finds that Public Education and Change Campaign local awards predominantly went to counties with more acute need, including those with higher rates of death by suicide (correlation 0.30),[129] percentage of children and youth with

[128] This analysis is accurate as of August 2024 and reflects the 28 local-level Public Education & Change Campaign grantees. Each grantee may reach multiple populations.

[129] This is based on Mathematica's analysis of the following data source: CDPH Injury and Violence Prevention Branch. "*EpiCenter: California Injury Data Online* 2018-2020." 2020. https://skylab4.cdph.ca.gov/epicenter/

emergency department visits for behavioral health diagnoses (correlation 0.30),[130] and percentage of children and youth with inpatient discharges for behavioral health diagnoses (correlation 0.30).[131] Taken together with Exhibit 14, this analysis suggests that awards will support populations and areas in need of stigma reduction efforts.

Exhibit 15. Geographic distribution of local public education and change campaign awards per county[132]



Never a Bother is a multilingual marketing, education, and outreach youth suicide prevention campaign that includes a website, social media, content and resource creation opportunities, advertising, and partnership marketing. A significant portion of the campaign takes place in the digital space, helping to disseminate youth suicide prevention messaging and calls to action to a broad youth audience. To complement the statewide campaign, 34 CBOs and Tribal partners[133] received grants to help promote and implement the campaign's community-level suicide prevention strategies. CDPH's Office of Suicide Prevention launched Never a Bother in March 2024, following an eight-month planning phase that incorporated input from more than 400 youth in the co-creation process. Various activation points occurred throughout the year-long campaign, including Mental Health Awareness Month, Pride Month, and Suicide Prevention Awareness Month.

To guide and tailor campaign design and dissemination efforts to the needs of youth populations disproportionately impacted by suicide, CDPH analyzed suicide data from 2016 to 2021, and determined that the campaign would focus on AI/AN youth (who experienced the highest suicide rate), Hispanic and Latinx youth (who experienced the highest number of deaths by suicide), and African American and Black youth (who experienced the greatest increase in suicide

[130] This is based on Mathematica's analysis of the following data source: HCAI. "Emergency Department (ED) 2022." 2022.

[131] This is based on Mathematica's analysis of the following data source: HCAI. "Patient Discharge (PDD) 2022." 2022.

[132] This analysis is accurate as of August 2024 and reflects the 28 local-level Public Education & Change Campaign grantees.

[133] As of November 2024, the Never a Bother campaign is partnering with 33 CBOs and Tribal partners. Graphics and analyses, current as of August 2024, reflect the original 34 local-level grantees.

rate) over the time period.[134] In addition, the campaign aims to reach intersectional populations, including youth with mental health and/or substance use challenges; youth impacted by the foster care system; and two-spirit (2S)/LGBTQ+ youth. The populations of focus for the 34 original Never a Bother grantees are described in Exhibit 16 below.

Exhibit 16. Populations of focus among 34 Never a Bother grantees[135]

Population of focus	# of grantees
Youth with mental health or substance use challenges	33
Two-spirit/LGBTQ+ youth	28
Hispanic/Latinx	24
Youth impacted by the foster care system	21
African Americans/Black	17
American Indian/Alaska Native	11

Exhibit 17 shows the number of local suicide prevention grants awarded by county. Grants for local suicide prevention efforts were distributed across California including counties in Northern California and the Central Valley. Mathematica analyses find that counties with more awards per capita were more likely to have acute need [higher rates of death by suicide (correlation 0.37),[136] higher percentage of children and youth with emergency department visits for behavioral health diagnoses (correlation 0.39),[137] and a slightly higher percentage of children and youth with inpatient discharges for behavioral health diagnoses (correlation 0.12)],[138] indicating elevated need for suicide prevention efforts in these counties.[139]

[134] California Department of Public Health, Injury and Violence Prevention (IVP) Branch. *Youth Suicide Prevention Projects.* July 2024. https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/SACB/Pages/Youth-Suicide-Prevention-Projects.aspx.

[135] This analysis is accurate as of August 2024 and reflects the original 34 local-level Never a Bother CBO grantees. Each grantee may reach multiple populations of focus.

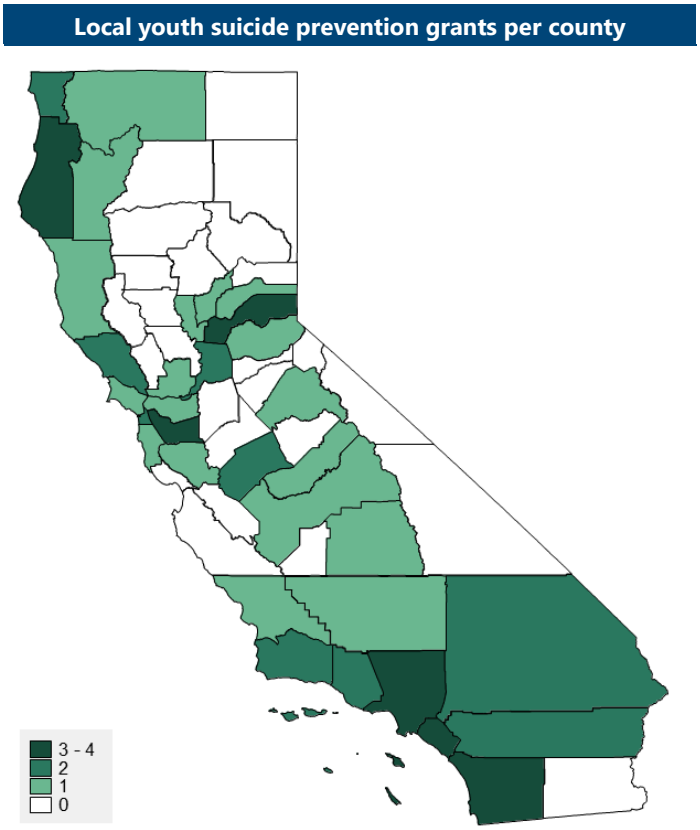
[136] Based on Mathematica's analysis of the following data source: CDPH Injury and Violence Prevention Branch. "*EpiCenter: California Injury Data Online* 2018-2020." 2020. https://skylab4.cdph.ca.gov/epicenter/.

[137] This is based on Mathematica's analysis of the following data source: HCAI. "Emergency Department (ED) 2022." 2022.

[138] Based on Mathematica's analysis of the following data source: HCAI. "Patient Discharge (PDD) 2022." 2022.

[139] These data points were not used by CDPH as selection criteria to inform award decisions.

Exhibit 17. Geographic distribution of local youth suicide prevention grants per county[140]



Across the initiative, the **CYBHI public awareness campaigns** broadly disseminate messaging to reduce stigma, prevent youth suicide, and raise awareness of ACEs and toxic stress. There is evidence that such strategies are effective. For example, a 2024 meta-analysis of the effectiveness of media campaigns for mental health awareness on youth found that campaigns can result in stigma reduction; increases in self-reported knowledge, skills, and abilities for help-seeking; and decreases in behavioral health outcomes such as anxiety and depression.[141] As a point of comparison, California Mental Health Services Authority (CalMHSA) implemented the Take Action for Mental Health and Know the Signs campaigns,[142] which addressed stigma and encouraged mental health support via social marketing campaigns, website creation, toolkits, media portrayals, and in-person educational training. A RAND evaluation found that these campaigns reached about one in four adults and led to changes in attitudes and help-seeking behaviors within a year.[143] Given this context, the CYBHI's prevention and early identification change campaigns are expected to have a similar impact.

[140] This analysis is accurate as of August 2024 and reflects the original 34 local-level Never a Bother CBO grantees.

[141] Tam, M.T., J.M. Wu, C.C. Zhang, C. Pawliuk, and J.M. Robillard. "A Systematic Review of the Impacts of Media Mental Health Awareness Campaigns on Young People." *Health Promotion Practice,* 2024. https://doi.org/10.1177/15248399241232646.

[142] California Mental Health Services Authority. "Public Awareness: Take Action for Mental Health" n.d. Accessed on July 28, 2024. Public Awareness - California Mental Health Services Authority (calmhsa.org).

[143] Eberhart, N.K., C. Crowley, E. Roth, and I. Estrada-Darley. "Evaluation of California's Statewide Mental Health Campaigns" Evaluation report prepared by RAND for CalMHSA. 2023. https://www.rand.org/content/dam/rand/pubs/research_reports/RRA2100/RRA2101-1/RAND_RRA2101-1.pdf.

The implementing departments have engaged external evaluators to monitor progress and effectiveness for each of these campaigns. As implementation of these campaigns proceeds, additional insights are expected to become available from evaluations conducted by Sentient (Public Education and Change Campaigns), RAND (Live Beyond), and UCLA (Never a Bother).

Approach 2: Investing in parents' and caregivers' capacity

What is the relevant background and need?

Caregivers are fundamental to fostering children and youth's well-being. Although caregivers are not specifically trained to provide behavioral health supports, many studies have shown the importance of caregivers and secure attachment for children's development.[144,145,146,147,148,149] In addition, positive parent–child interactions have been shown to improve resilience later in life, paving the way for future behavioral health well-being.[150] The CYBHI includes several workstreams intended to strengthen parents' and caregivers' self-awareness, ability to manage their own well-being, and increase knowledge and skills to support youth.

How is implementation progressing? What is the potential for impact?

At home and in the community, the **Positive Parenting, Thriving Kids** video series and **Scaling EBPs/CDEPs Round 1** (Parent and Caregiver Support Programs and Practices) strengthen the capacity for parents, caregivers, and caring adults to understand and support common challenges that children and youth face. The Positive Parenting, Thriving Kids video series launched in March 2024. To inform its development, a team of 40 experts identified topics, and IPSOS was contracted to survey 1,000 parents and caregivers to select meaningful topics for the video content. **BrightLife Kids**, which offers digital tools and resources to caregivers, is described in the section of this report on increasing accessibility of resources by creating and providing supports in the digital environment. Educational videos available to parents on the BrightLife Kids platform can provide parents with knowledge and skill-building opportunities.

In addition, **Scaling EBPs/CDEPs Round 3**, which focuses on early childhood wraparound services, intends to expand access to child home-visiting services with a focus on caregiver support and well-being. Scaling EBPs Round 1 awardees were announced in July 2023, and Round 3 awardees were announced in September 2024. While online and digitally delivered content focused on improving parenting have shown positive impacts on parental knowledge,

---

[144] Masten, A.S. "Ordinary magic. Resilience processes in development." *American Psychologist,* vol. 56, no. 3, March 2001, pp. 227-238. https://pubmed.ncbi.nlm.nih.gov/11315249/.

[145] Jaffee, S.R., L. Bowes, I. Oullet-Morin, H.L. Fisher, T.E. Moffitt, M.T. Merrick, and L. Arseneault. "Safe, stable, nurturing relationships break the intergenerational cycle of abuse: a prospective nationally representative cohort of children in the United Kingdom." *Journal of Adolescent Health,* vol. 53, no. 4, October 2013. https://pubmed.ncbi.nlm.nih.gov/24059939/.

[146] Diamond, M.C. "Response of the brain to enrichment." *Anais da Academia Brasileira de Ciências,* vol. 73, no. 2, June 2001, pp. 221-220. https://pubmed.ncbi.nlm.nih.gov/11404783/.

[147] Francis, D.D., J. Diorio, P.M. Plotsky, and M.J. Meaney. "Environmental Enrichment Reverses the Effects of Maternal Separation on Stress Reactivity." *The Journal of Neuroscience,* vol 22., no. 18, September 2002. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6758090/.

[148] Mesman, J., and R.A.G. Emmen. "Mary Ainsworth's legacy: a systematic review of observational instruments measuring parental sensitivity." *Attachment & Human Development,* vol. 15, no. 5-6, 2013, pp. 485-506. https://pubmed.ncbi.nlm.nih.gov/24299131/.

[149] Lieberman, A.F., E. Padron, P.V. Horn, and W.W. Harris. "Angels in the nursery: The intergenerational transmission of benevolent parental influences." *Infant Mental Health Journal,* vol. 26, no. 6, November 2005, pp. 504-520. https://pubmed.ncbi.nlm.nih.gov/28682485/.

[150] Traub F. and B.J. Renee. "Modifiable Resilience Factors to Childhood Adversity for Clinical Pediatric Practice." *Pediatrics,* vol. 139, no. 5, May 2017. https://pubmed.ncbi.nlm.nih.gov/28557726/.

behavior, and skills, [151] recent research suggests these benefits may be short-lived. A meta-analysis of universally-targeted online prevention-oriented programs found improvements in caregiver behavioral and mental health, but the effects were generally not sustained over time and did not significantly impact the parent-child relationship.[152] Therefore, while the Positive Parenting, Thriving Kids video series offers cost-effective, broad, and scalable access to parenting content, its potential for long-term impact may be limited without further efforts to sustain its benefits post-content delivery.

Research has consistently demonstrated a strong link between positive caregiver practices and improved behavioral health outcomes for children and youth. A recent global systematic review found that caregiver interventions directly enhance early childhood development, particularly in the first three years of a child's life, by improving cognitive, language, and motor development, fostering secure attachment, and reducing problem behaviors.[153] Evidence-based programs such as Triple P[154], Parent-Child Interaction Therapy[155], Incredible Years[156], and Help Me Grow[157] have a strong research base establishing the efficacy of caregiver interventions to improve child and youth outcomes. It is reasonable to assume that investments in Rounds 1 and 3 of the Scaling EBPs/CDEPs workstream are likely to yield similar results based on this robust body of evidence.

---

[151] Nieuwboer C.C., R.G. Fukkink, and J.M. Hermanns. "Online programs as tools to improve parenting: A meta-analytic review." *Children and Youth Services Review*, vol. 35, no. 11, 2013, pp. 1823-1829. DOI:10.1016/j.childyouth.2013.08.008.

[152] Opie, J.E., T.B. Esler, E.M. Clancy, B. Wright, F. Painter, A. Vuong, A.T. Booth, et al. "Universal Digital Programs for Promoting Mental and Relational Health for Parents of Young Children: A Systematic Review and Meta-Analysis." *Clinical Child and Family Psychology Review*, vol. 27, no. 1, March 2024, pp. 23-52. https://pubmed.ncbi.nlm.nih.gov/37917315/.

[153] Jeong, J., E.E. Franchett, C.V. Ramos de Oliveira, K. Rehmani, and A.K. Yousafzai. "Parenting interventions to promote early child development in the first three years of life: A global systematic review and meta-analysis." *PLOS Medicine,* vol. 18, no. 5, May 2021. https://pubmed.ncbi.nlm.nih.gov/33970913/.

[154] Sanders, M., J.N. Kirby, C.L. Tellegen, and J.J. Day. "The Triple P-Positive Parenting Program: A systematic review and meta-analysis of a multi-level system of parenting support." *Clinical Psychology Review,* vol. 34, no. 4, June 2014, pp. 337-357. https://pubmed.ncbi.nlm.nih.gov/24842549/.

[155] Rae, T., B. Abell, H.J. Webb, E. Avdagic, and M.J. Zimmer-Gembeck. "Parent-child interaction therapy: A meta-analysis." *Pediatrics,* vol. 140, no. 3, September 2017. https://pubmed.ncbi.nlm.nih.gov/28860132/.

[156] Menting, A.T.A., B. Orobio de Castro, and W. Matthys. "Effectiveness of the Incredible Years parent training to modify disruptive and prosocial child behavior: A meta-analytic review." *Clinical Psychology Review,* vol. 33, no. 8, December 2013, pp. 901-913. https://pubmed.ncbi.nlm.nih.gov/23994367/.

[157] Help Me Grow National Center. April 2023. "The Help Me Grow Model: A Selection of Evidence." https://helpmegrownational.org/resources/hmg-evidence-base-resources/#:~:text=The%20evidence%20base%20of%20HMG,on%20child%20and%20parent%20factors. Accessed October 2024.

3.3.2. Strengthening community-level workforce capacity

CYBHI workstreams discussed in this section:

- Youth Mental Health Academy
- Health Careers Exploration Program
- Health Professions Pathway Program
- SUD Earn and Learn Grant Program
- Peer Personnel Training and Placement
- SUD/Justice-System-Involved Youth Training Program
- CBO Behavioral Health Workforce Grant

Within communities, a number of organizations provide behavioral health care and address health-related social needs. CBOs play a key role in providing behavioral health services, offering an array of supports that reflect local community needs and preferences, alleviate barriers to care, and provide access points for those without other options. CBOs are deeply embedded in the communities they serve, which enables them to build trust, understand specific local needs, and deliver culturally responsive care. Their longstanding presence and on-the-ground delivery of care allows them to effectively reach and support marginalized groups, so investing in and strengthening community capacity directly enhances connections and support for local children, youth, and families.[158] By distributing funds locally, the CYBHI seeks to strengthen capacity to meet the behavioral health needs of children and youth in their home communities.

The workforce serving within CBOs plays a critical role in serving children, youth, and families, and many of the CYBHI workstreams seek to bolster the capacity of the community workforce by: (1) **promoting early interest in behavioral health careers through pipeline and exploration programs;** (2) **expanding and developing new workforce roles;** (3) **developing behavioral health capacity among non-behavioral health practitioners;** (4) **providing training and incentives for behavioral health clinicians working in CBO settings.**

Approach 1: Promoting early interest in behavioral health careers through pipeline and exploration programs

What is the relevant background and need?

California's behavioral health workforce is not representative of the state's diverse demographic makeup, with African Americans and Latinos particularly underrepresented.[159] A more diverse workforce has shown to improve access to and quality of care.[160] However, historically marginalized communities often lack access to opportunities that promote early exposure to behavioral health careers and are often underrepresented in the behavioral health workforce, resulting in limited access to demographically representative and culturally concordant providers. Pipeline programs seek to address this gap by providing students from these communities with mentorship, academic support, and career development pathways.

How is implementation progressing? What is the potential for impact?

The **Youth Mental Health Academy** is a 14-month community-based career development program for high school students. To promote equity and representation in the behavioral health workforce, the Youth Mental Health Academy provides mentorship, paid project-based learning, and paid internships to high school students from marginalized communities who are interested in pursuing behavioral health careers. The Youth Mental Health Academy engaged a

[158] California Health Care Foundation. "The Role of Community-Based Organization Networks in CalAIM: Seven Key Considerations." August 2022. https://www.chcf.org/wp-content/uploads/2022/08/RoleCBONetworksCalAIMSevenKeyConsiderations.pdf.

[159] Coffman, J., T. Bates, I. Geyn, and J. Spetz. "California's Current and Future Behavioral Health Workforce." The Healthforce Center at UCSF, February 2018. California's Current and Future Behavioral Health Workforce.pdf.

[160] National Center for Health Workforce Analysis. "Behavioral Health Workforce, 2023." December 2023. https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/Behavioral-Health-Workforce-Brief-2023.pdf.

pilot cohort of 300 students in summer 2023, to be followed by two additional cohorts in summers 2024 and 2025, engaging 1,000 and 1,200 students, respectively.

The **Health Careers Exploration Program** provides grant funding to organizations to support activities that expose students from underrepresented and disadvantaged backgrounds to health careers, such as health "career fair" experiences and workshops that introduce participants to a wide variety of health career options or fund hands-on experiences that facilitate direct interaction between students and health care professionals in real or simulated health care settings. The Health Careers Exploration Program awarded 34 grants in April 2022 and is planning for another round in 2024.

The **Health Professions Pathway Program** distributes grant funding to organizations to support the implementation of programs aimed at assisting students from underrepresented regions and backgrounds in pursuing careers in health, including pipeline programs comprising mentorship and advising, paid summer internships, and post-undergraduate fellowships. These programs aim to assist students from underrepresented regions and backgrounds in pursuing careers in health. The Health Professions Pathway Program announced grants to 20 organizations across 30 counties in September 2022 and 11 awards across 12 counties in January 2024.

Pipeline programs aim to promote interest in and ability to pursue behavioral health careers among high school and undergraduate students; intentional efforts to cultivate interest among and provide support to historically underrepresented populations should facilitate entry into relevant education and training programs. Due to the upstream nature of pipeline programs, the time horizon for impact on behavioral health workforce composition is lengthy. However, the evidence, while limited and primarily focused on short-term outcomes, suggests that pipeline programs can meaningfully support student experience and potentially reduce systemic barriers for students from underrepresented backgrounds.[161] A longitudinal analysis of a pipeline program found that nearly three-quarters of participants in the pipeline program matriculated in a master's or doctoral program, demonstrating the long-term outcomes of a pipeline program.[162] Recent research has found that delivering pipeline programs focused on mental health career options and clinical practice increases high school students' understanding of the various roles and pathways to pursuing a career in behavioral health.[163] Additionally, early exposure and engagement activities—such as internships, mentorships, experiential training, application assistance, and academic support can provide foundational knowledge and spark interest in behavioral health career pathways. More broadly, a systematic review of the effects of pipeline programs on the enrollment of historically marginalized students in health care found that these programs successfully increased enrollment in graduate-level health care programs. However, further research is needed to assess the long-term impact of pipeline programs.[164]

---

[161] Stephenson-Hunter, C., N.C. Rodriguez, A.H. Strelnick, L.A. Stumpf. "Dreams realized: a long-term program evaluation of three summer diversity pipeline programs." *Health Equity*, vol. 5, no. 1, August 2021, pp. 512-520. https://www.researchgate.net/publication/353725428_Dreams_Realized_A_Long-Term_Program_Evaluation_of_Three_Summer_Diversity_Pipeline_Programs.

[162] Stephenson-Hunter, C., N.C. Rodriguez, A.H. Strelnick, L.A. Stumpf. "Dreams realized: a long-term program evaluation of three summer diversity pipeline programs." *Health Equity*, vol. 5, no. 1, August 2021, pp. 512-520. https://www.researchgate.net/publication/353725428_Dreams_Realized_A_Long-Term_Program_Evaluation_of_Three_Summer_Diversity_Pipeline_Programs.

[163] Brenner, M., A. Schmidt-Brenner. "Inspiring Careers in Mental Health: Piloting a Pipeline Program for Underserved High School Students." *Academic Psychiatry*, September 2024. Published online ahead of print. https://pubmed.ncbi.nlm.nih.gov/39331232/.

[164] Tombers, N., J. Bauer, A. Boraas, J. Lundberg, R. Pfeifer, and C. Reinartz. "Effect of Pipelines on Enrollment of Underrepresented Students in Healthcare." *Education in the Health Professions,* vol. 6, no. 1, 2023, pp. 1-7. https://journals.lww.com/ehpf/fulltext/2023/06010/effect_of_pipelines_on_enrollment_of.1.aspx.

Approach 2: Expanding and developing new workforce roles

What is the relevant background and need?

A key approach to building out the workforce to meet behavioral health support needs involves investment in new or alternative behavioral health workforce roles. These programs aim to cultivate a larger, more representative workforce with lower barriers to entry into the field and new roles to meet the needs of youth. This approach encompasses diverse investments intended to support training and placement programs for SUD counselor and peer certification.

How is implementation progressing? What is the potential for impact?[165]

The **SUD Earn and Learn Grant Program** establishes a three-year agreement with grantee organizations to provide education and paid job experience for students earning their California SUD certification. Funded programs support the development of a culturally competent and diverse SUD workforce by providing stipends, training, mentorship, and internship placement support to SUD students. The program announced awards to six organizations in May 2023, resulting in education and paid job experience for roughly 475 SUD counselors.

The **Peer Personnel Training and Placement program** is a grant opportunity that supports peer personnel training programs that meet training requirements under the Medi-Cal Peer Support Specialist Certification Program and successfully places trained people in peer personnel positions. Peer personnel may be people with lived experience as behavioral health services consumers, family members, or caregivers. HCAI announced awards to 16 training programs in June 2023 and 9 programs in April 2024.

In 2020, the California Consortium of Addiction Programs and Professionals noted limited workforce supply and lack of adequate cultural representativeness within the SUD workforce as key dimensions impacting the supply of SUD services.[166] Additionally, most counties lack SUD providers with youth-specific training (68 percent).[167] The SUD Earn and Learn Grant program aims to address shortages in the SUD treatment workforce while providing participants with a path to California SUD certification. The authors of the Annapolis Coalition's *Action Plan for Behavioral Health Workforce Development* discuss the need for innovative training programs that integrate education with practice experience to build a robust and diverse behavioral health workforce.[168] Earn and learn programs, which provide paid internships, training, and other supports to students pursuing SUD certification, are well-positioned to provide this blend of academic and practical experience, lowering financial barriers to certification and improving student readiness to provide SUD counseling upon certification.

Over the last two decades, peer support services have become an essential component of the behavioral health workforce, demonstrating the significant value and impact of non-clinical services and supports. Peer support workers, especially those with lived experience, provide unique and effective services that complement traditional clinical services. Peers may offer a different type of connection, understanding, and acceptance that may not be found in

---

[165] See section 3.2.2 for further details on Certified Wellness Coaches, which are a critical component of the CYBHI's efforts to establish and expand new workforce roles in California.

[166] California Consortium of Addiction Programs and Professionals. *The Disease of Addiction Thrives on Isolation: A Report to Governor Gavin Newsom and the California Legislature on the Impact of COVID-19 on the State's Fragile Substance Use Disorder Treatment System*. May 12, 2020. https://ccapp.us/wp-content/uploads/2023/07/Addiction-Thrives-on-Isolation.pdf.

[167] California Hospital Association. "California Psychiatric Bed Annual Report." August 2018. https://calmatters.org/wp-content/uploads/2019/04/CHA-Psych-Bed-Data-Report-Sept.-2018.pdf.

[168] The Annapolis Coalition. *An Action Plan for Behavioral Health Workforce Development: A Framework for Discussion*. Prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA). 2007. https://annapoliscoalition.org/wp-content/uploads/2021/01/action-plan-full-report.pdf.

traditional professional relationships.[169] Peer personnel frequently serve the communities in which they live, fostering trust, engagement, and a deeper connection with those they support. These services have shown to improve engagement, quality of life, decreased hospitalization, and other improved outcomes.[170,171] Recent estimates suggest there are over 30,000 peer support specialists in the U.S. providing Medicaid reimbursable services in at least 43 states.[172]

CYBHI's efforts to support the expansion of traditional behavioral health workforce roles enables a more holistic approach to care providing individuals in or seeking recovery. These investments are well-positioned to increase accessibility and cultural relevance of services for historically marginalized communities. Furthermore, as the demand for behavioral health services continues to outpace the supply of licensed clinicians and counselors, developing new workforce roles can alleviate pressure on the system. By expanding the range of professionals available to provide care, behavioral health systems can increase access to services and possibly reduce wait times.

Approach 3: Developing behavioral health capacity among non-behavioral health professionals

What is the relevant background and need?

Non-behavioral health professionals, such as probation officers, correctional officers, law enforcement, foster system staff, and other housing system personnel, often encounter and work with youth who have behavioral health concerns. Youth involved in the juvenile justice system have disproportionately high rates of behavioral health disorders. Estimates suggest that about 50 to 75 percent of youth who come into contact with the juvenile justice system meet criteria for a diagnosable behavioral health disorder.[173,174] Similarly, youth in foster care[175] and those experiencing housing instability or homelessness experience a disproportionately high prevalence of behavioral health issues.[176]

How is implementation progressing? What is the potential for impact?

The **SUD/Justice-System-Involved Youth Training** program funds the development and delivery of behavioral health trainings for non-behavioral health professionals working closely with youth. The SUD Training Program seeks to educate non-behavioral health professionals about early SUD detection and equip them with resources for referring youth to appropriate care, while the Justice-System-Involved Youth Training for non-Behavioral Health Professionals seeks to increase behavioral health competency for non-providers to improve the continuum of care for youth in the justice, foster, and unhoused systems. HCAI is currently planning for development and implementation of this training, with potential trainees including probation officers, correctional officers, police officers, food bank staff, foster system

---

[169] Substance Abuse and Mental Health Services Administration. *Value of Peers*. November 2017. https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/value-of-peers-2017.pdf.

[170] Solomon, P. "Peer support/peer provided services underlying processes, benefits, and critical ingredients." *Psychiatric Rehabilitation Journal*, vol. 27, no. 4, 2004, pp. 392. https://pubmed.ncbi.nlm.nih.gov/15222150/.

[171] Mental Health America. Peer Support Research and Reports. n.d., https://mhanational.org/peer-support-research-and-reports.

[172] Fortuna, K.L., P. Solomon, and J. Rivera. "An update of peer support/peer provided services underlying processes, benefits, and critical ingredients." *Psychiatric Quarterly*, vol. 93, no. 2, June 2022, pp. 571-586. https://pubmed.ncbi.nlm.nih.gov/35179660/.

[173] Development Services Group, Inc. "Intersection Between Mental Health and the Juvenile Justice System." Prepared for the Office of Juvenile Justice and Delinquency Prevention. July 2017. https://www.ojjdp.gov/mpg/litreviews/Intersection-Mental-Health-Juvenile-Justice.pdf.

[174] Underwood, L.A. and A. Washington. "Mental Illness and Juvenile Offenders." *International Journal of Environmental Research and Public Health*, vol. 13, no. 2, February 2016, pp. 228. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4772248/.

[175] Engler, A.D., K.O. Sarpong, B.S.V. Horne, C.S. Greeley, and R.J. Keefe. "A Systematic Review of Mental Health Disorders of Children in Foster Care." *Trauma, Violence, & Abuse*, vol. 23, no. 1, January 2022, pp. 255-264. https://pubmed.ncbi.nlm.nih.gov/32686611/.

[176] Youth Gov. "Behavioral Health." n.d. https://youth.gov/youth-topics/homelessness-and-housing-instability/behavioral-health. Accessed October 8, 2024.

staff, shelter staff, homeless services coordinators, foster services coordinators, case managers, and justice system educational partners.

By providing training and resources to frontline staff who are not typically trained in behavioral health but serve as key touchpoints for these youth, non-behavioral health professionals can better identify early signs of mental health or SUD issues, provide immediate support and care, and refer youth to appropriate services. This type of early identification and intervention reduces the duration of untreated behavioral health issues, which is critical for improving long-term outcomes. Additionally, training these professionals in basic behavioral health knowledge and skills increases the likelihood that youth will receive timely, culturally competent care, which is of particular import given the racial and ethnic disparities within the juvenile justice system.[177]

Approach 4: Providing training and incentives for behavioral health clinicians working in CBO settings

What is the relevant background and need?

As the term suggests, community-based organizations (CBOs) are local, grassroots entities that provide essential services and care to children, youth, and families, focused on the communities in which they are situated. CBOs are trusted organizations, recognized as valuable partners and resources for schools, health care providers, social services, and other professionals who interact with children and youth. Typically operating as nonprofits, CBOs play a crucial role in addressing the behavioral health needs of their communities by offering culturally responsive services, advocacy, and direct care that are tailored to the populations they serve.[178]

CBOs often leverage their deep local knowledge and strong connections to build trust, foster coalitions,[179] coordinate with other providers, and address complex behavioral health needs.[180] Moreover, CBOs frequently serve historically marginalized populations, making their expansion and investment critical to advancing CYBHI's goals of reducing disparities, increasing access to care, and improving the overall well-being of children, youth, and families across California.

How is implementation progressing? What is the potential for impact?

CBOs are a major recipient of the CYBHI's grant funding for workforce training and capacity, with awards to CBOs supporting workforce investments, and expansion of EBPs and CDEPs through the **Scaling EBPs/CDEPs** workstream. EBP and CDEP expansion is focused on parent and caregiver support programs and practices (Round 1), trauma-informed programs and practices (Round 2), early childhood wraparound program (Round 3), youth-driven programs (Round 4), and early intervention programs and practices (Round 5).

The **CBO Behavioral Health Workforce Grant** program makes four-year grant funding available to CBOs to fund activities supporting behavioral health personnel recruitment and retention, including providing loan repayments,

---

[177] Development Services Group, Inc. "Racial and Ethnic Disparity in Juvenile Justice Processing." Prepared for the Office of Juvenile Justice and Delinquency Prevention. 2022. https://ojjdp.ojp.gov/model-programs-guide/literature-reviews/racial-and-ethnic-disparity.

[178] Wilson, M.G., J.N. Lavis, and A. Guta. "Community-based organizations in the health sector: a scoping review." *Health Research Policy and Systems*, vol. 10, no. 36, November 2012, pp. 1-9. https://pubmed.ncbi.nlm.nih.gov/23171160/.

[179] Foster-Fishman, P.G., S.L. Berkowitz, D.W. Lounsbury, S. Jacobson, and N.A. Allen. "Building collaborative capacity in community coalitions: A review and integrative framework." *American Journal of Community Psychology,* vol. 29, no. 2, April 2001, pp. 241-261. https://pubmed.ncbi.nlm.nih.gov/11446279/.

[180] Agonafer, E.P., S.L. Carson, V. Nunez, K. Poole, C.S. Hong, M. Morales, J. Jara, et al. "Community-based organizations' perspectives on improving health and social service integration." *BMC Public Health*, vol. 21, March 2021, pp. 1-12. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7937223/.

scholarships, and stipends to paid and volunteer CBO behavioral health staff. In March 2023, HCAI announced that 134 CBOs were awarded over $116 million in total funding for the four-year program.

CBOs often face challenges in securing sustainable funding, limiting their ability to maintain and expand the services they provide; many CBOs lack the necessary infrastructure and capacity to secure sustainable funds, making external investment essential.[181] Funding opportunities such as those available through the Scaling EBPs/CDEPs workstream can enable CBOs to provide specialized training to the behavioral health clinicians they employ, strengthening their service capacity and ability to provide culturally responsive care to vulnerable communities.

CBO's difficulties in securing sustainable funding can also pose challenges in hiring, expanding, and maintaining a competitively paid behavioral health workforce. As a care setting that often serves as a safety net for children, youth, and families who may struggle to obtain culturally relevant, affordable, and accessible care, CBOs are a critical resource for supporting equitable access to services. By providing funding to support behavioral health staff recruitment and retention, the CBO Behavioral Health Workforce Grants allow CBOs to provide financial and training supports to prospective or current employees.

3.3.3. Strengthening community-level capacity to support children and youth's well-being and respond to behavioral health needs

To effectively support all children and youth, communities must develop a robust continuum of behavioral health supports.[182] The CYBHI invests in two approaches: (1) **investing in safe spaces for youth and** (2) **strengthening community ability to respond to youth suicide attempts.**

Approach 1: Investing in safe spaces for youth

CYBHI workstreams relevant to this section:

- Scaling EBPs/CDEPs Round 4
- Youth Suicide Reporting and Crisis Response Pilot Program
- Virtual Services Platforms (discussed in section 3.4)

What is the relevant background and need?

Youth drop-in centers and other youth-driven programs can play a critical role in promoting the well-being of and social support for youth who may not have the supports they need at home. These resources can be of particular importance for marginalized youth, LGBTQIA+ youth, youth experiencing homelessness, and youth with lived experience of serious mental illness. For youth experiencing homelessness, shelters are typically not structured to meet their developmental needs, with youth typically preferring drop-in programs as they provide immediate basic needs, have fewer stringent requirements (such as curfews), and offer additional services such as case management.[183]

How is implementation progressing? What is the potential for impact?

Scaling EBPs/CDEPs Round 4 expands spaces and opportunities for youth peer connection via expansion of youth drop-in centers and additional community-based spaces for youth. The primary goals of the funded centers are to provide places for peer connection, reduce stigma, promote well-being, and increase access to physical and mental

[181] Substance Abuse and Mental Health Services Administration. Elevate Community Based Organizations (ECBOs). n.d. https://www.samhsa.gov/behavioral-health-equity/elevate-cbos. Accessed October 9, 2024.

[182] Castillo, E.G., R.I. Maghsoodi, S. Shadravan, E. Moore, M.O. Mensah, M. Docherty, M. Gabriela, et., al. "Community Interventions to Promote Mental Health and Social Equity." *Current Psychiatry Reports,* vol. 21, no. 35, March 2019, https://doi.org/10.1007/s11920-019-1017-0.

[183] Pedersen, E.R, J.S. Tucker, and S.A. Kovalchik. "Facilitators and barriers of drop-in center use among homeless youth." *Journal of Adolescent Health*, vol. 59, no.2, May 2016, pp. 144-153. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4958549/.

health resources. Funding decisions prioritized youth-centered programs, including those that were designed by and with youth, and focus on mild to moderate behavioral health needs. In all, DHCS announced 69 awardees in December 2023. Mathematica conducted key informant interviews in selected counties in June and July 2024 that revealed that local grant-funded projects are either just beginning or are early in implementation following some delays in award notification, contract finalization, and disbursement.

Projects funded through this grant round show potential for improving behavioral health outcomes, particularly for populations experiencing behavioral health disparities. For example, research indicates that, for LGBTQIA+ youth, participation in CBOs and similar drop-in centers resulted in improved mental health outcomes, increased feelings of social connectedness, and reduced experiences of discrimination and stigma.[184] Furthermore, the literature indicates that formal and informal peer support in a variety of youth mental health and community settings lead to improved psychological well-being, empowerment, self-esteem, and social functioning.[185,186]

Approach 2: Strengthening community ability to respond to youth suicide

What is the relevant need and background?

Since 2010, suicide rates have increased among California's youth. The Centers for Disease Control and Prevention's WONDER data indicates that youth suicide rates in California have increased from 3.76 deaths per 100,000 youth (ages 12 to 25) in 2010 to 4.49 in 2023. Although there is annual variation, the trend line over this period shows a sustained increase. More recently, suicide rates among California youth ages 10 to 19 increased during the COVID-19 pandemic, and pandemic-era increases for youth outpaced all other age groups.[187] Rates of death by suicide among children and youth in California mirror national trends; however, California's rates are consistently lower than the national average.[188]

While suicides most frequently occur as isolated events, they can occasionally spur suicide clusters, in which additional attempts follow an initial suicide attempt or death. These geographically and time-constrained point clusters often involve male youth and young adults. Rapid response to an initial attempt or death by suicide is necessary to support community members and prevent additional deaths by suicide. The Centers for Disease Control and Prevention has recently updated its guidance for community assessment and response to suicide clusters, indicating that "monitoring these suicide-related events (including plans, attempts, and deaths) is a key component of prevention."[189] Infrastructure and planning are needed to establish or enhance real-time suicide data reporting and implement effective crisis response and postvention protocols. In 2023, CDPH's Office of Suicide Prevention released a summary of its stakeholder needs assessment, which gathered insight from more than eighty people representing various local

[184] Fish, J.N., R.L. Moody, A.H. Grossman, and S.T. Russel. " LGBTQ Youth-Serving Community-Based Organizations: Who Participates and What Difference Does It Make?" *Journal of Youth and Adolescence,* vol. 48, no. 12, December 2019, pp. 2418-2431. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8091042/.

[185] Gopalan, G., S.J. Lee, R. Harris, M.C. Acri, and M.R. Munson. "Utilization of peers in services for youth with emotional and behavioral challenges: A scoping review." *Journal of Adolescence,* vol. 55, no. 1, February 2017, pp. 88-115. https://doi.org/10.1016/j.adolescence.2016.12.011.

[186] Jeremie, R., R. Rebinsky, R. Suresh, S. Kubic, A. Carter, J.E. Cunningham, A. Ker, et al. "Scoping review to evaluate the effects of peer support on the mental health of young adults." *BMJ Open,* vol. 12, no. 8, August 2022. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9358944/.

[187] Lund, J.J., E. Tomsich, J.P. Schleimer, and V.A. Pear. "Changes in suicide in California from 2017 to 2021: a population-based study." *Injury Epidemiology,* vol. 10, no. 19, March 2023. https://doi.org/10.1186/s40621-023-00429-6.

[188] Based on Mathematica's analysis of the following data sources: CDC Wonder Data (2018-2023).

[189] Ballesteros, M.F., A.Z. Ivey-Stephenson, E. Trinh, and D.M. Stone. "Background and Rationale — CDC Guidance for Communities Assessing, Investigating, and Responding to Suicide Clusters, United States, 2024." *Morbidity and Mortality Weekly Report*, vol. 73, no. 2, February 2024, pp. 1–7. http://dx.doi.org/10.15585/mmwr.su7302a1.

organizations and CBOs across California, identifying a critical need for "local, timely data on suicide risk, attempts, and deaths" to address resource and infrastructure gaps in local communities.[190]

How is implementation progressing? What is the potential for impact?

In an effort to develop and improve local-level planning for rapid suicide reporting and response, the CYBHI launched the **Youth Suicide Reporting and Crisis Response Pilot Program**, which aims to address the urgent need for rapid, local-level suicide response by developing systems to more quickly report and comprehensively respond to youth suicides and suicide attempts in these counties. The program aims to streamline and enhance reporting and response efforts toward youth suicide attempts and deaths across participating communities.

In 2023, the Youth Suicide Reporting and Crisis Response workstream conducted data analysis, selected 10 counties to participate in the pilots, and began engaging these counties. In September 2023, CDPH finalized contracts with Alameda, El Dorado, Humboldt, Kern, Los Angeles, Riverside, Sacramento, San Diego, San Joaquin, and Solano counties to pilot county-level approaches for reporting and responding to youth suicide and suicide attempts. The pilot projects are intended to develop or enhance equitable, timely, and culturally responsive suicide prevention and postvention strategies at the local level. By enhancing reporting and youth-focused crisis response systems after a suicide attempt or death, the program aspires to prevent further suicides and attempts. CDPH allocated about $38 million to these 10 counties, seven of which have suicide rates among children and youth 0-25 that exceed the state average.[191] During the first year of the pilot project, implementation plans were approved for each pilot county; implementing counties developed baseline process maps depicting the reporting and response process that occurs within the community, school, and other systems following youth suicide attempts or deaths. In the coming year, pilot counties will continue to implement activities based on gaps identified through process mapping to strengthen the crisis response systems, supported by technical assistance from the Center for Applied Research Solutions (CARS). Implementation progress will be assessed by the counties themselves and by the Agile Visual Analytics Lab at UCLA, the independent evaluator for the workstream; these assessments will characterize systems change and adaptation across key domains. The workstream evaluation report is due in June 2025; ongoing insights into site implementation progress may be gained from the quarterly progress reporting processes.

[190] California Office of Suicide Prevention. "2023 Stakeholder Needs Assessment Results Summary." 2023. https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/SACB/CDPH%20Document%20Library/Suicide%20Prevention%20Program/OSP_StakeholderSurveySummary_2023.pdf.

[191] Based on Mathematica's analysis of the following data sources: CDC Wonder Data (2020-2022) and California Department of Finance Demographic Projections (2020-2022).

3.4. Digital environment

Digital environments are becoming increasingly important within the behavioral health ecosystem, offering virtual care, telehealth, consultation, and digital therapeutic supports and tools. The CYBHI's direct investment in digital supports is designed to address behavioral health symptoms that may not arise to the threshold of an official clinical diagnosis as well as increase the accessibility of promotion and prevention resources, particularly for those in remote or underserved areas. Digital environments provide children, youth, and families with on-demand, innovative supports and educational tools that promote behavioral health and well-being and may serve as an alternative entry point into the behavioral health care system.

What is the relevant background and need?

CYBHI workstreams discussed in this section:

- BrightLife Kids and Soluna
- Next Generation Digital Therapeutics

Not all children and youth experiencing behavioral health concerns will meet the threshold for a clinical diagnosis, yet they still benefit from support to manage challenges and prevent escalation of symptoms. Addressing mild emotional distress, anxiety, or difficulties in emotional regulation through universal interventions are an important component of the prevention and early intervention continuum. Much of the CYBHI's direct investments in digital supports are designed to engage children, youth, and families at these critical early stages by providing tools and resources that promote resilience and emotional well-being.

Research shows that most mental health disorders begin to emerge during the developmental transition from childhood to young adulthood. Nearly 1 in 5 young people experience clinically significant mental health issues before the age of 25, with half of these individuals showing symptoms by the age of 14.[192] This underscores the importance of prevention and early intervention strategies to address concerns before they escalate into more serious conditions. These digital platforms provide an important entry point for addressing behavioral health needs before they escalate.

In addition, digital platforms can help bridge the gap in access to care and supplement care, particularly in underserved or remote communities where traditional behavioral health services may be lacking. In California, disparities exist in access to behavioral health services for children and youth: a national study from 2019 revealed that 47 to 53 percent of children and youth with mental health disorders in the state did not receive care, placing California in the third-highest quartile in the nation.[193] While the CYBHI's digital investments do not constitute or replace clinical behavioral health services, they are positioned to reduce the likelihood of more severe behavioral health conditions by providing supports and services for sub- or pre-clinical issues that are accessible to all, including rural or otherwise underserved communities.

Recognizing the breadth of the need and potential for digital innovations to provide accessible, scalable supports, the CYBHI includes several workstreams that create and disseminate digital behavioral health resources and pre-clinical services. The activities under these workstreams are intended to support socioemotional skill-building and address behavioral health issues before children and youth require clinical-level support, while also reducing the overall unmet need for clinical support by supplementing care received elsewhere or supporting access to care, depending on the needs of the individual user. Services include synchronous and asynchronous sub- or pre-clinical counseling, coaching

[192] Colizzi, M., A. Lasalvia, and M. Ruggeri. "Prevention and early intervention in youth mental health: is it time for a multidisciplinary and trans-diagnostic model for care?." *International Journal of Mental Health Systems*, vol. 14, no. 23, March 2020, pp. 1-14. https://pubmed.ncbi.nlm.nih.gov/32226481/.

[193] Whitney, D.G. and M.D. Peterson. "US National and State-Level Prevalence of Mental Health Disorders and Disparities of Mental Health Care Use in Children" *JAMA Pediatrics,* vol. 173, no. 4, April 2019. https://doi.org/10.1001/jamapediatrics.2018.5399.

and consultation, and on-demand education content and supports. Digital services have several potential advantages that can help improve access to pre-clinical behavioral health care and help children and youth experiencing behavioral health concerns connect to resources. First, they can be accessed from almost any device with a data connection, enabling access to pre-clinical coaching and wellness resources from home, school, or the location of a family's choice. Digital services can also provide anonymity, allowing children, youth, and families to receive behavioral health support in a manner that reduces stigma and can enhance perceptions of safety. Furthermore, digital services may also be a means to provide access to sub-clinical support in areas without a conventional alternative due to provider shortages or transportation limitations.

What workstreams align with this approach?

The CYBHI's digital environment covers platforms for youth and caregivers; tools to connect pediatricians with behavioral health specialists; and various tools, resources, and training for parents, educators, and students. The CYBHI allocated about $468 million[194] to fund multiple digital supports, services, and care navigation tools. Two virtual service platforms form the core of the digital supports, services, and care navigation strategy. In addition to these core services, the two platforms offer supplements such as on-demand video content, self-care guides, and journaling spaces. Digital tools similar to these platforms have potential to address key barriers to accessing behavioral health support by reducing stigma, increasing access to culturally competent care, mitigating prohibitively high cost of care or lack of insurance coverage, and improving ability to find and receive care. These potential benefits may be realized through these types of tools given that they are scalable, readily accessible, potentially less stigmatizing, cost-effective, and culturally adaptable.[195]

The cornerstone of the CYBHI's digital environment is the **Behavioral Health Virtual Services** workstream. This workstream features two types of digital services: (1) digital behavioral health platforms and (2) digital tools that aid delivery of behavioral health services and supports. The CYBHI also supported the development of digital training and resources for parents and educators through the Positive Parents, Thriving Kids, and Safe Spaces workstreams, respectively. We highlight each type of digital service here:

- **Digital behavioral health platforms.** Two virtual services platforms were developed under this workstream: BrightLife Kids and Soluna. Both platforms offer free behavioral health services and enhanced features to Californians and can be accessed via an app or web browser. BrightLife Kids is designed for children ages 0 to 12 and their caregivers, and Soluna is for youth ages 13 to 25. Both platforms offer live coaching sessions and care navigation services, which provide one-on-one support to youth and families to connect to digital care options or community-based care, including their health plan's network providers. BrightLife Kids and Soluna also offer features such as moderated peer forums, wellness resources, guided meditation, mindfulness tools, and journaling. One of the key innovations of BrightLife Kids and Soluna is the provision of free one-on-one live behavioral health coaching sessions with qualified behavioral health coaches in English and Spanish, along with telephone-based coaching in a total of 19 Medi-Cal threshold languages.
- **Digital tools that support delivery of behavioral health services and supports.** Next Generation Digital Therapeutics is a suite of digital tools designed to support digital behavioral health care, researchers, and clinicians. The suite features MindLogger, a platform that will enable clinicians to administer mental health assessments and provide interventions and educational resources. Mirror, a digital journaling application, enables youth to share

[194] This amount includes funding allocated for the Next Generation Digital Therapeutics and Virtual Services Platform workstreams, minus reductions made during the FY2024-25 budget act as documented by DHCS here.

[195] Jacobson, N.C., R.E. Quist, C.M. Lee and L.A. Marsch. "Using digital therapeutics to target gaps and failures in traditional mental health and addiction treatments." *Digital Therapeutics for Mental Health and Addiction*, 2023, pp. 5-18. https://doi.org/10.1016/B978-0-323-90045-4.00005-8.

video, audio, and text-based journal entries via the app, which will provide personalized guidance and insights using artificial intelligence. Kandoo, a behavioral modification app, will engage youth and teens in games integrating Behavior Activation to address depression, helping them develop healthy habits through fun, positive augmented reality experiences.

As designed, the CYBHI seeks to balance necessary innovations to improve access to immediate pre-clinical and sub-clinical behavioral health support for children and youth statewide, while also ensuring that long-term investments are based on robust and independently validated evidence. An evaluation of an application similar to Soluna (piloted in the UK and produced by Kooth, the developer of Soluna), drawing on early survey and qualitative interviews, found improvements in measures of well-being such as reductions in psychological distress, suicidal ideation, and loneliness.[196] Another study, conducted in collaboration with researchers at Brightline, the producer of BrightLife Kids, and based on retrospective analysis of standardized survey data, showed reliable improvement in measures of youth psychosocial functioning and caregiver strain in conjunction with digital behavioral health coaching.[197] More robust evidence is needed to assess the specific supplemental functionality offered in the CYBHI's behavioral health platforms. Research on similar tools, however, offers the following additional insights:

- Live one-on-one coaching, as part of an employer-based intervention, has been shown to lead to rapid initial improvements followed by slower growth in self-awareness, self-efficacy, social connection, emotion regulation, and a reduction of stress.[198]
- Tools to link young adults to appropriate online and offline sources of mental health information and care, as part of the *Link* online intervention, was found to lead to lower health professional consultation costs at 1-month follow-up.[199]
- Peer forums and chatrooms are a key part of ReachOut.com, which was found to result in modest yet significant reductions in depression, anxiety, and stress over a 12-week period.[200] Although modest, the reductions in adverse behavioral health symptoms were comparable to costlier and more resource-intensive mental health programs.
- Guided meditation and mindfulness applications are associated with long-term significant reductions in several anxiety symptoms, including rumination.[201]

This suggests that the CYBHI platforms, which have similar functionality, could have positive impacts on children and youth; with rate of uptake, adoption, and consistent use influencing potential to achieve desired outcomes at scale.

---

[196] Stevens, M., J. Cartagena Farías., C. Mindel, F. D'Amico. and S. Evans-Lacko. "Pilot evaluation to assess the effectiveness of youth peer community support via the Kooth online mental wellbeing website." *BMC public health*, vol. 22, no. 1, October 2022. https://doi.org/10.1186/s12889-022-14223-4.

[197] Loo, T., J. La Guardia, D. Grodberg. "1.28 The Effect of a National Pediatric Telehealth Service on Child Clinical Outcomes and Caregiver Strain Across Race/Ethnicity and Gender Identity." *Journal of the American Academy of Child & Adolescent Psychiatry*. vol. 62, no. 10, October 2023. https://www.jaacap.org/article/S0890-8567(23)01519-8/fulltext.

[198] Jeannotte, A.M., D.M. Hutchinson, and G.R. Kellerman. "The Time to Change for Mental Health and Wellbeing via Virtual Professional Coaching: Longitudinal Observational Study." *Journal of Medical Internet Research,* vol. 23, no. 7, July 2021. https://doi.org/10.2196/27774.

[199] Le, L.K.D., L. Sanci, M.L. Chatterton, S. Kauer, K. Buhagiar, and C. Mihalopoulos. "The cost-effectiveness of an internet intervention to facilitate mental health help-seeking by young adults: randomized controlled trial." *Journal of Medical Internet Research*, vol. 21, no. 7, https://doi.org/10.2196/13065.

[200] Kahl, B.L., H.M. Miller, K. Cairns, H. Giniunas, and M. Nicholas. "Evaluation of ReachOut.com, an Unstructured Digital Youth Mental Health Intervention: Prospective Cohort Study." *JMIR Mental Health,* vol. 7, no. 10, June 2020. https://doi.org/10.2196/21280.

[201] Litke, S.G., A. Resnikoff, A. Anil, M. Montgomery, R. Matta, J. Huh-Yoo, and B.P. Daly. "Mobile Technologies for Supporting Mental Health in Youths: Scoping Review of Effectiveness, Limitations, and Inclusivity." *JMIR Mental Health*, vol. 10, August 2023. https://doi.org/10.2196/46949.

How is implementation progressing? What is the potential for impact?

The **Behavioral Health Virtual Services Platforms**, BrightLife Kids and Soluna, launched in January 2024. The development process involved more than 1,000 stakeholders, including more than 500 children and youth, who provided input to inform the platform design and product decisions. BrightLife Kids leveraged Brightline's past experience providing behavioral health services to children and their parents and caregivers, along with EBPs, and research with caregivers and experts in the field. To promote the program to youth in the community, BrightLife Kids partnered with more than 250 schools and CBOs. Soluna incorporates an evidence-informed theory of change and input from young people and their families gained via focus groups, surveys, and advisory board meetings. As of September 2024, 94,661 children and youth have registered on the platforms and 13,025 coaching sessions have been provided. Currently, the workstream is focused on promoting platform usage and expanding functionality.

The Next Generation Digital Therapeutics workstream is currently in the process of developing its digital products. After a rigorous youth, expert, and research-informed product development phase, the workstream has launched MindLogger, an assessment platform. It has begun beta-testing and plans to release the remaining products, Mirror (a digital journaling app) and Kandoo (a behavior modification app), in June 2025. To inform development, researchers conducted ethnographic research by visiting the homes of youth and families, held a youth and expert panel, and distributed surveys during virtual focus group sessions with youth ages 13 to 21.

While the services and supports provided through CYBHI's virtual services platforms are preventive and pre-clinical in nature, evidence suggests that California can expect positive outcomes associated with virtual services,[202] particularly if they are adopted in areas where access to behavioral health care is limited or of concern. Since 2020, at the outset of health care delivery flexibilities associated with the COVID-19 pandemic and subsequent response, virtual delivery of substance use and mental health services has remained much more durable than in other clinical disciplines[203] and is proving a reasonably effective substitute to more conventional care settings.[204]

Though implementation has just begun, the youth pulse survey conducted by Mathematica in spring 2024[205] suggests that these digital supports and services could impact access to care:

- Nearly 40 percent of young adults reported using online tools for their behavioral health in the prior 12 months, and young adults reported lower skills and lesser probability of seeking care when needed than youth and caregivers did. Soluna represents an opportunity to leverage young adults' familiarity with online tools to increase access to pre-clinical care and behavioral health resources, helping to address this gap.
- In addition, 20 percent of young adults indicated they would not feel comfortable talking with a licensed behavioral health professional, citing stigma and discomfort as barriers. Only 48 percent reported that it would be easy to ask for help with a mental health problem. Through peer forums and similar functionality, Soluna will facilitate access to informal resources and peer support in a relatively anonymized environment, which may help overcome stigma.

---

[202] McCord, C., F. Ullrich, K.A.S. Merchant, D. Bhagianadh, K.D. Carter, E. Nelson J.P. Marcin, et al. "Comparison of In-Person vs. Telebehavioral Health Outcomes from Rural Populations Across America." *BMC Psychiatry*, vol. 22, no. 1, December 2022, p. 778. https://doi.org/10.1186/s12888-022-04421-0.

[203] Lo, J., M. Rae, A. Krutika, C. Cox, N. Panchal, and B.F. Miller. "Telehealth Has Played an Outsized Role Meeting Mental Health Needs During the COVID-19 Pandemic." Kaiser Family Foundation, March 2022. https://www.kff.org/mental-health/issue-brief/telehealth-has-played-an-outsized-role-meeting-mental-health-needs-during-the-covid-19-pandemic/.

[204] McCord, C., F. Ullrich, K.A.S. Merchant, D. Bhagianadh, K.D. Carter, E. Nelson J.P. Marcin, et al. "Comparison of In-Person vs. Telebehavioral Health Outcomes from Rural Populations Across America." *BMC Psychiatry*, vol. 22, no. 1, December 2022, p. 778. https://doi.org/10.1186/s12888-022-04421-0.

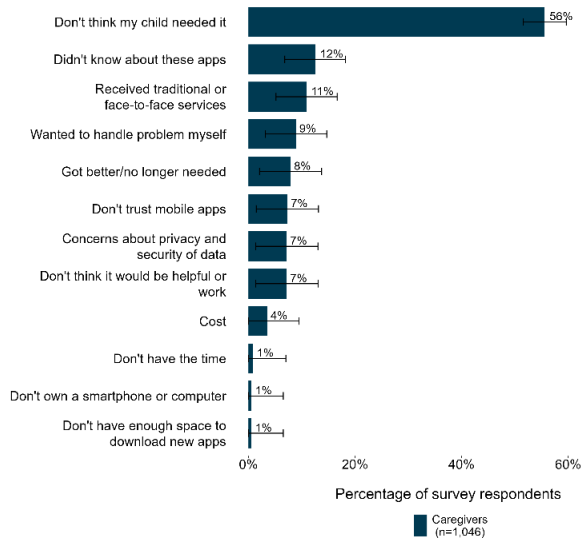
[205] See callout box in section 2.2 for additional details on Mathematica spring 2024 pulse survey methodology

- About 7 percent of youth reported accessing online tools for themselves, and 7 percent of caregivers accessed online tools to support their child's behavioral health. According to the survey, 5 percent of caregivers reported that their child needed to consult a behavioral health professional but did not. The most common reasons cited were difficulties finding a provider, problems getting an appointment, and lack of services in their area. The virtual services platform, BrightLife Kids, is designed to overcome these obstacles.

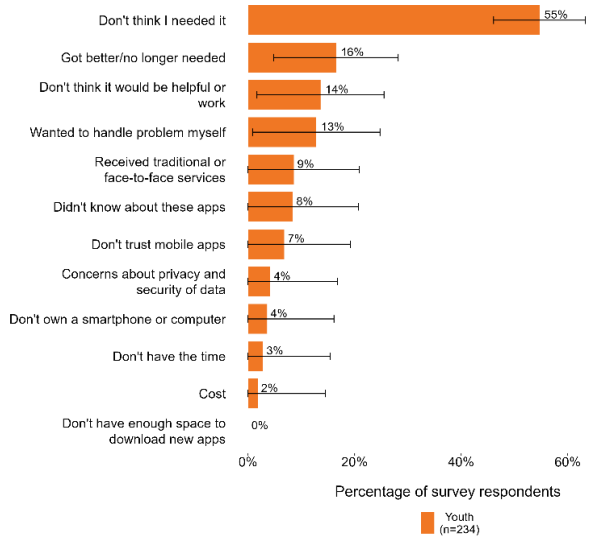
The relatively high use of online tools by young adults suggests that digital supports and services may add value for this group as they offer no-cost supportive resources, including screening, coaching, and care navigation, assuming children and youth openness to direct-to-digital adoption of services. Relatively low rates of use of online tools among caregivers (7%) and youth under 18 (7%) identified in the spring 2024 pulse survey suggest that the CYBHI virtual platforms will require ongoing marketing and engagement of potential users, providers, educational sites, and community organizations to build awareness and promote use. Marketing and communication efforts may also seek to address potential barriers to use including insufficient awareness of the platforms, low perceived benefit of use, or privacy concerns associated with platform use. The most commonly cited reason for not using an online behavioral health tool for caregivers, youth, and young adults was that they didn't think they needed it for themselves or their child (56, 55, and 36 percent, respectively, Exhibit 18). For caregivers, other barriers were less commonly cited, with about 1 in 10 caregivers reporting one of the following reasons: they didn't know about online tools for children's behavioral health, their child received face-to-face services instead, they wanted to handle the problem themselves, the problem got better, they didn't trust mobile apps, they had concerns about privacy, or they didn't think it would be helpful for their child (Exhibit 18a). Youth had similar responses to caregivers (Exhibit 18b). For young adults, about 1 in 5 cited the following reasons for non-use: wanting to handle the problem themself, the problem got better, they didn't think it would be helpful, and they didn't know about online tools for behavioral health (Exhibit 18c).

Exhibit 18. Caregivers', youths', and children's reasons for not receiving support for their child from an online behavioral health tool, including mobile apps or texting services.

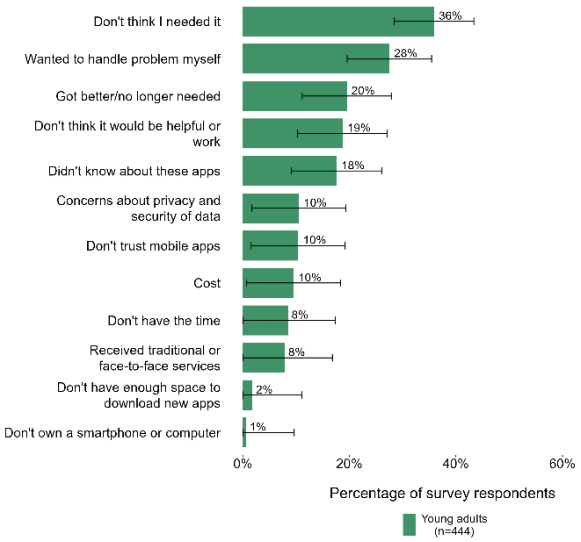
18a. Caregivers' reasons for not receiving support for their child from an on-line behavioral health tool, including mobile apps or texting services (n = 1,046)



18b. Youths' reasons for not receiving support from an on-line behavioral health tool, including mobile apps or texting services (n = 234)



18c. Young adults' reasons for not receiving support from an on-line behavioral health tool, including mobile apps or texting services (n = 444)



Source: Mathematica's analysis of the spring 2024 CYBHI pulse survey of caregivers, youth, and young adults in California. Respondents were asked to select all that apply, so percentages do not add up to 100.

The digital services made available through the CYBHI lack the same degree of independent supporting evidence as other CYBHI strategies, but the historical nature of the behavioral health crisis merits serious consideration of innovative strategies. Further, the CYBHI mitigated some of the potential risk of investment in new technologies by tying payments for the Virtual Services Platform to how many Californians use the platforms. Early in platform implementation, close attention to promoting awareness and uptake of the CYBHI's digital supports and services is merited, particularly given pulse survey findings indicating low awareness of online behavioral health tools and concerns about tool utility, privacy/security, and trust. Given the innovative nature of these investments and nascent evidence base for comparable interventions, it will be important to assess whether these investments will lead to better outcomes for children, youth, and families. As rollout and adoption of these applications proceed, the CYBHI should closely monitor user feedback and, to the extent possible, near-term outcomes.

Specifically, near-term monitoring may support ongoing adjustments to the suite of digital investments and complementary efforts, including the following considerations:

- Using a combination of outcomes data, child, youth, caregiver, and provider opinion surveys, utilization, and other measures of program success to inform continuation or modification of supplemental education and on-demand services.
- Allowing potentially overlapping sets of resources (i.e., behavioral health skill-building videos) to be offered across multiple digital spaces or streamlining a single desired set of services onto a reduced selection of platforms.

Implementation of these tools is still in early stages. Monitoring will be crucial to support iteration of the platform itself, shape promotional efforts, and ultimately inform the extent of the state's investment in these services.[206]

[206] DHCS and its partners are monitoring uptake of the virtual services platforms.

4 | Reflections on CYBHI Design and Early Implementation

The CYBHI faces the challenge of providing near-term relief for an acute behavioral health crisis while also seeking to effectuate longer-term transformational change. The initiative seeks to sow the seeds for a reimagined ecosystem through ambitious efforts to shift where and how children and youth access behavioral health supports and services (CYBHI Fee Schedule and creation of the Certified Wellness Coach role), investments in innovative ways of providing behavioral health support (BrightLife Kids and Soluna), and several pilot and demonstration programs intended to provide opportunities for learning and potentially identify generalizable best practices (Youth Peer-to-Peer Support Program, Youth Suicide Reporting and Crisis Response, Transforming Together). The initiative also seeks to address gaps and challenges in the system as it currently exists by funding investments that will be felt in the short-term (efforts to expand public awareness and behavioral health knowledge and skills both statewide and at the local level) and medium-term (physical infrastructure and workforce expansion investments). While implementation is in progress across nearly all of the CYBHI workstreams, some of the more significant and ambitious changes within the CYBHI will require additional time, collaboration, and adaptation to take root and realize their full potential.

This section highlights findings about the overall design and early implementation of the CYBHI as a systems change initiative focused on supporting multisector collaboration, aligned and integrated funding, and efforts to improve access and coordination. It also offers recommendations for immediate opportunities to support the successful implementation of the CYBHI and lessons learned to date that can inform large systems change initiatives in the future.

As a large-scale, broad initiative reliant on multiple departments and operational teams, the CYBHI faced myriad implementation risks: an accelerated timeline to achieve ambitious goals, departmental resource and data constraints, diverse needs across California's 58 counties, and requirements to implement 20 distinct workstreams within an already complex policy landscape. Many of these risks stemmed from the original design of the initiative. With the benefit of hindsight, we can reflect on how these challenges influenced initial implementation.

Recommendations are presented in two sections. First, we explore suggestions for continued improvement within the bounds of the initiative. Second, we document lessons learned that leaders within California and across the nation may wish to keep in mind to support state agencies with the efficient, coordinated roll-out of similar initiatives in the future.

4.1. Reflections and recommendations to strengthen the CYBHI

At the design stage, the CYBHI brought together a mix of new and established policies and programs under a shared umbrella. Participants in state key informant interviews noted that the investment in this space, coupled with the joint efforts across multiple departments, helped to change the conversation around behavioral health. The time and energy that CYBHI and its partners invested in gathering input from youth, community partners, and leaders within the child- and youth-serving ecosystem appear to have further cemented this perception of positive change.

While it is too soon to assess whether CYBHI implementation has accomplished the significant systems-level transformation the initiative hopes to achieve, the interim findings in this report supports the assessment that the CYBHI has the potential to contribute significantly to strengthening the behavioral health ecosystem across multiple environments of care. Mathematica has identified the following particular "bright spots" in CYBHI implementation:

- **Workforce investments** have infused funding across the state for expanding and training the behavioral health workforce. Key approaches include the development of the Certified Wellness Coach position, substantial investments in training and educating future behavioral health professionals, and investments in strengthening and retaining the existing behavioral health workforce. The investments are designed to bear fruit in both the short and long-term, providing an encouraging sign that California's workforce investments can alleviate near-term workforce capacity constraints while building toward a more diverse and sustainable workforce in the long-term.
- **New, sustainable funding mechanisms for behavioral health services** are intended to facilitate the provision of behavioral health services in convenient, familiar settings, such as educational and primary care settings. The CYBHI has developed two such sustainable mechanisms: the **CYBHI Fee Schedule** and the **Dyadic Services Benefit.** Service providers making use of these mechanisms will require ongoing support to strengthen uptake and utilization.

Looking ahead, we have identified the following opportunities to strengthen the CYBHI.

Reduce complexity and administrative burden for state and local actors

In interviews, leaders across the state indicated that the complexity of the CYBHI, along with parallel behavioral health initiatives, posed risks for the effective and efficient use of resources. The complexity also poses challenges to sustainability in the future, as there is likely a need for ongoing coordination across and within departments for successful implementation.

- **Identify and realize synergy between related initiatives across departments.** Systems change initiatives require shared leadership and governance to be successful at supporting multisector collaboration, aligned and integrated funding, and efforts to improve access and coordination. Further efforts are needed to develop a holistic vision and understanding of how parallel behavioral health initiatives can work in tandem with the CYBHI, identify potential overlap, and unify communication to department staff and those working at the local level. By aligning the efforts of the CYBHI with other initiatives, the state can better address the complex needs of children, youth, and families in a more integrated and efficient manner.
- **Support counties in strategically navigating funding opportunities to complement local assets and meet local needs.** Given the complexity of understanding and navigating varied funding streams and the importance of local community involvement amid limited administrative capacity, the state may wish to provide additional support to counties and local multisector collaboratives to develop and implement tailored strategic plans for how best to leverage and align various funding and programmatic opportunities. While the CYBHI's school-linked investments are structured to support cross-sector collaboration and provide some implementation support, the funding landscape both within and beyond the CYBHI is complex, evolving, and may be challenging to strategically navigate amid competing priorities. This may be particularly notable for counties and organization with less robust infrastructure for funding administration, coalition building, and strategic execution. Providing tailored support to help counties determine how to effectively leverage and align various funding opportunities may support a more equitable distribution of funds, allowing counties with relatively less mature multisector collaboration to strategically access and use funding for capacity development.
- **Develop structures to facilitate collective sustainability planning.** Many of the CYBHI workstreams include one-time grant funding. As non-recurring funding is expended, counties and the state will need to determine how the innovations will be sustained into the future. As behavioral health leaders begin to plan for sustainability beyond the CYBHI, data collection and evaluation activities can help direct future investments. Sustaining the highest performing activities with greatest potential for impact and sunsetting others will reduce the operational complexity associated with maintaining a broader than necessary suite of programs.

Identify and pursue opportunities to align communications and cross-promote resources

With 20 workstreams, 15 outcome objectives, and 5 implementing departments, the CYBHI is complex, posing challenges for clear communications and alignment.

- **Clarify and align messages and communication channels.** Bringing multiple programs together under the CYBHI increased opportunities for cross-department collaboration and information sharing. However, it complicated communications externally, particularly as departments also manage communications for workstreams under their purview alongside initiative-level efforts. This workstream-level approach may help explain some of the feedback from state leaders, who, in interviews, voiced a desire for clearer communications; this fragmented structure may also contribute to missed opportunities for cross-promotion of resources.

  The volume of efforts underway may also obscure some of the ways that the CYBHI directly benefits children, youth, and families. In response to some early feedback, CalHHS strengthened efforts to share and coordinate across departments, including hosting quarterly public webinars to share updates and hiring a communications director in January 2024. CalHHS is actively working with a communications partner (Fenton) to continue to find ways to leverage the initiative's monthly newsletter, centralize resources on the CYBHI website, and develop additional landing pages to share progress and updates on the CYBHI's workstreams.
- **Identify and pursue opportunities for cross-promotion.** As the initiative continues to roll out new toolkits and digital resources, CalHHS may wish to expand the cross-promotion of resources. For instance, the Never a Bother campaign public awareness campaigns direct visitors to the BrightLife Kids and Soluna platforms; other public awareness campaigns may be similarly well-positioned to encourage individuals to access these platforms. Similarly, there may be opportunities to create a closer linkage between the Positive Parenting, Thriving Kids video series, and the BrightLife Kids platform.

Streamline and ease data sharing within the CYBHI

The complex organizational structure of CYBHI results in fragmented information and data about workstream activities. Each of the 20 workstreams gather and track data about their programs, often with support from external partners and under the purview of a department with data stewardship responsibilities. The CYBHI does not have a central warehouse or process for tracking and sharing those data among partners; as such, gathering comprehensive data about CYBHI activities and beneficiaries requires complex administrative processes and data use agreements with external partners, resulting in significant administrative burden. This results in data delays which pose challenges for ongoing monitoring of progress and evaluation efforts for the initiative as a whole as well as across its workstreams.

- **Strengthen data infrastructure to support monitoring and transparency.** While CalHHS originally envisioned the CYBHI as an initiative grounded in rapid-cycle learning and improvement, sharing necessary workstream-level data and administrative data between CalHHS departments and key contractors has been a long and complex process which has, in some cases, limited the ability of this evaluation team to support just-in-time analysis and cross-workstream learning. Differences in processes for data acquisition, release, and clearance for public release also vary widely by department, which increases administrative burden and introduces risks of delay. Streamlining data acquisition and release processes across the agency will help facilitate evaluation and future cross-department efforts involving external contractors potentially required to sustain the CYBHI's workstream activities. While CalHHS has led significant efforts to promote a culture of collaboration through the CYBHI, additional structural and process improvements are needed to fully realize initiative-level monitoring, improvement, and evaluation efforts. When designing future large-scale, cross-department initiatives, it will be critical for CalHHS to champion and facilitate early establishment of data sharing provisions across involved departments and key external partners.

- **Identify opportunities to align with or leverage existing or planned data collection efforts.** At the initiative level, increased access to both large data sets and analytic products produced across workstreams will result in greater understanding of the initiative, decrease duplication of effort for data collection and analysis, and increase opportunities to link data sets for additional insight on implementation and outcomes. Generating cross-cutting, centralized insights and coordinating efforts across multiple departments requires both internal and external coordination. Early collaboration between the CYBHI evaluation and implementation partners has identified opportunities for alignment and design of complementary efforts. As CalHHS seeks to understand patterns of behavioral health service access among various subgroups of children and youth, the agency may wish to consider ways to align the CYBHI's data needs with planned metrics for Medi-Cal monitoring and compliance when developing program management and reporting for the CMS Medicaid Managed Care and Access to Care Rules.[207]

Further support the adoption of key investments such as the Fee Schedule and Dyadic Services

The CYBHI increases the availability of evidence-based and innovative services for children, youth, and families in California. The CYBHI Fee Schedule and the introduction of the Dyadic Services Benefit are innovative investments that have the potential to improve behavioral health outcomes. Promoting uptake will require sustained engagement by CalHHS and its partners.

- **Educate and support providers and partners to adopt the new Fee Schedule.** In interviews, state leaders expressed concerns regarding challenges to implementing the Fee Schedule, suggesting both the need for increased clarity on how it will work in practice and anticipated challenges to adoption. To work through policy and operational considerations and proactively identify strategies to support Fee Schedule success, DMHC and DHCS convened a series of formative workgroups between 2022 and 2023, representing diverse perspectives including education, health plans, county behavioral health organizations, CBOs, and other providers. With the selection of Fee Schedule Cohort 1 in early 2024, efforts shifted toward engagement with MCPs and early adopter LEAs to identify barriers to implementation and collaboratively develop solutions.

  In the next phase of implementation, CalHHS could consider opportunities to further disseminate learnings to amplify awareness among providers and communities; for instance, there may be ongoing opportunities to ensure school staff, parents, and community partners are aware of the Fee Schedule's intention to increase access and reduce financial burden for both schools and individuals. Technical assistance provided alongside the School-Linked Partnership and Capacity Grants may also be used to clarify understanding of and address perceived barriers and disincentives to Fee Schedule adoption. For instance, technical assistance efforts may wish to communicate the Fee Schedule's straight fee-for-service reimbursement structure and the intention for the Fee Schedule's third-party administrator to manage claims and payment statewide in an effort to reduce LEA burden of engagement with multiple plans.
- **Continue to explore opportunities and investments needed to scale the Fee Schedule, with focus on recent adopters and higher education settings.** Given the focus of School-Linked Partnership and Capacity Grants on K–12 settings, DHCS may consider identifying additional approaches to support higher education institutions in developing capacity to implement the Fee Schedule. The considerations for Fee Schedule implementation are likely to differ between K-12 settings and institutions of higher education; the planned inclusion of California Community Colleges in Fee Schedule Cohort 2 provides an opportunity for the CYBHI to identify key facilitators of adoption in these settings.

[207] In 2024, the Center for Medicare and Medicaid Services released a rule requiring states demonstrate that services provided through Medicaid are accessible and available to everyone enrolled in the program. As DHCS invests in defining the metrics for Medi-Cal, we see an opportunity for CalHHS to coordinate on how to best measure the behavioral health and well-being of children, youth, and young adults served by Medi-Cal.

- **Strengthen guidance and technical assistance to facilitate uptake of the Dyadic Services benefit.** The dyadic services benefit introduced under the CYBHI offers a new opportunity to further integrate behavioral health and primary care for children and caregivers. However, anecdotal evidence indicates that there remains confusion among providers and managed care plans about use and billing processes that may hinder uptake. As the CYBHI monitors uptake and utilization of dyadic services code sets, it should consider opportunities to clarify guidance, strengthen technical assistance to providers and managed care plans, and assess the need for additional start up grants to address barriers to benefit adoption in areas with lower-than-expected uptake.

4.2. Key implications for future large-scale state initiatives

Evaluation of the early implementation efforts of the CYBHI offers insights for both the state of California as they anticipate other large-scale systems change initiatives and other states who may be considering similar investments.

Allocate sufficient time and resources for early strategic design and planning

When planning for complex and large-scale initiatives responding to urgent public need, desire for rapid implementation and near-term relief should be counterbalanced with constructing a solid foundation for achieving ambitious aims.

- **Budget sufficient time and effort to support a coordinated design phase.** As a large-scale, broad-based initiative reliant on distinct departments and teams to design and operationalize key workstreams, the CYBHI offers lessons learned to support efficient and coordinated rollout of similar initiatives. Sufficient time, staff capacity, and cross-department collaboration structures are necessary preconditions for coordination. While early collaboration represents a significant upfront investment, jointly assessing needs and designing coordinated, integrated interventions may prevent silo formation and duplication of effort. For instance, the CYBHI intentionally engaged youth and experts to inform campaign and concept development across multiple public awareness campaigns over a similar period. Additional coordination in the design phase may support the alignment of efforts to engage individuals with lived and subject matter expertise, support bidirectional learning, facilitate greater alignment of campaign timelines and messaging, and enable amplification of consistent action steps for audiences.
- **Ensure sufficient staffing and timeline for early planning and contract execution.** Initial workstream implementation timelines were ambitious and challenging to meet, given staffing constraints and administrative barriers. To support the high volume of simultaneous design and planning efforts, some administering departments needed to hire and train additional staff. This required pausing work on existing implementation efforts. Future large-scale initiatives may consider outlining infrastructure and staff development needs as foundational steps that precede the rollout of programs reliant on trained staff and infrastructure for success. Finally, large-scale initiatives requiring external approvals (for instance, grant guidelines, contract amendments, or Medicaid SPAs) should allow ample timeline for these activities, taking into consideration seasonal variation in federal calendars, the status of federal appropriations acts, or natural changes in staff due to administrative turnover.
- **Sequence efforts and develop strategic contingency plans.** Many of the CYBHI workstreams were funded and initiated simultaneously, resulting in rapid development and roll-out of the CYBHI umbrella. This left less time for sequencing, coordination of workstreams, and administrative and operational start up activities. State leaders shared that some workstreams that needed to work stepwise were not sequenced in an optimal way for implementation. Future initiatives should consider the types of activities that should happen first and those that should follow initial preparatory steps. Recognizing the inevitability of unanticipated delays and operational

challenges including staffing constraints, it is equally crucial for large-scale, complex initiatives like the CYBHI to invest in contingency planning and be prepared to strategically adapt planning and communications to reflect shifting implementation context.

As an example of strategy adaption, the Fee Schedule, SBHIP, and the School-Linked Partnership and Capacity Grants aim to help local education agencies build relationships with managed care plans and develop the needed infrastructure for service delivery and billing. The CYBHI planned to implement School-Linked Partnership and Capacity Grants prior to the launch of Fee Schedule Cohort 1, allowing LEAs and COEs to leverage this funding to support operational readiness for Fee Schedule adoption. While the timeline for this workstream was significantly delayed from initial projections, this shift allows DHCS and education partners to integrate learning from the initial Fee Schedule cohort to inform priorities for grant funding.

- **Gauge and adapt to local implementation partner capacity to manage and implement change.** Workstream coordination activities, key informant interviews, and other data collection efforts have given early insight into the risk of implementation fatigue within this complex initiative. Increasingly, state and federal policies, as articulated through funding opportunities, are increasing the role of local governments as implementation partners in a way that both increases strain on existing local administrative capacity and intensifies the volume and variety of activities needed to implement and monitor health and social service programs.[208] Further, county, municipal, and local entities including LEAs do not present a uniform capacity to implement new policies and programs. Small and rural governments are generally less capable of rapid scaling to absorb new funding or initiatives.[209] Future initiatives would benefit from early implementation planning between state and local implementation partners to develop plans and timelines that meet current capacity and ability to scale, taking into account the implementation burden associated with related reforms (for instance, CalAIM and Proposition 1), particularly in counties experiencing significant resource constraints (for instance, modeling after or expanding upon DHCS efforts to engage both state and local partners in planning for implementation of the school-linked CYBHI workstreams). Where notable capacity constraints are identified, the state should look to develop state-level or regional supports, or alternative models such as public/private partnerships, to facilitate implementation in less well-resourced counties. Recognizing that community desire for systems transformation may outstrip local capacity to navigate funding opportunities and implement change, it is important for the state to serve as a strategic thought partner and support counties in accessing the highest-yield opportunities for their particular goals and context. This type of collaborative prioritization is particularly critical when aiming to address both high acuity needs and structural challenges in an overtaxed system.

Develop structures and processes to support coordination and collaboration

Large-scale initiatives require intentional investment in structures and processes to facilitate both collaboration within the initiative and strategic alignment with efforts beyond the initiative.

- **Establish cross-department structures and workgroups to coordinate design and implementation efforts.** Sufficient time, staff capacity, and cross-department collaboration structures are necessary preconditions for coordination. Five departments within CalHHS are implementing the CYBHI, and many workstreams that span departments share similar strategic goals and leverage similar types of activities. As such, the CYBHI has engaged in regular cross-department collaboration, which is critical to facilitate efficient and coordinated implementation.

---

[208] Lobao, Linda. "The Rising Importance of Local Government in the United States: Recent Research and Challenges for Sociology." *Sociology Compass*, vol. 10, no. 10, Oct. 2016, pp. 893–905. https://doi.org/10.1111/soc4.12410.

[209] Lobao, L., and K. Paige. "Local Governments Across Rural America: Status, Challenges and Positioning for the Future" In *Investing in Rural Prosperity,* n.d., https://www.stlouisfed.org/-/media/project/frbstl/stlouisfed/files/pdfs/community-development/investing-rural/chapters/chapter05.pdf. Accessed July 29, 2024.

During CYBHI planning, many of the implementing teams participated in weekly workgroups, facilitating information sharing and creating sightlines between workstreams. For instance, early CYBHI cross-department working sessions were effective in bridging planning efforts between two public awareness campaigns being planned by different functional teams, facilitating the sharing of lessons learned and thought partnership on strategies for assessing progress.

- **Align processes and resources to support equitable decision-making and coordinate awards across funding opportunities.** Many of the CYBHI workstreams thoughtfully and intentionally designed grant application processes and grant selection criteria to prioritize allocating resources to counties with high needs. Actions taken to support equitable funding decisions included designing application fields and score criteria to assess relative need, promoting funding opportunities in under-resourced communities, and developing decision-making processes that value the use of funds to build capacity for less mature organizations. Future initiatives can invest in tools that facilitate understanding of where gaps in services and funding may exist at the local level and guide data-driven decision-making.
- **Align with other related initiatives and develop overarching strategic vision.** Because many concurrent efforts are happening alongside the CYBHI, participants from state interviews identified opportunities to improve alignment across efforts to maximize impact. Leaders across the state emphasized a desire for more alignment across initiatives and a deeper understanding of how they can work together. In planning future large-scale initiatives, state policymakers could consider conducting strategic planning to vision and message how parallel efforts can work together for collective impact.

Create the necessary conditions for collective insight and data-driven decision-making

Systems change initiatives of this scale offer a historic opportunity to innovate, learn, and glean insight. Maximizing accountability and potential for learning in this context requires crafting the mandate and necessary conditions to ensure (1) high-quality data to support decision making, (2) structures to centralize information to derive insight, and (3) processes to facilitate timely, strategic action.

- **Engage early to ensure availability of high-quality, timely data.** In the context of a large initiative consisting of many varied workstreams and myriad state and external implementation and evaluation partners, aligning and rationalizing data collection efforts is a necessary and challenging undertaking. To mitigate the risk of misaligned monitoring and evaluation efforts, the state should seek to (1) define key milestones for measurement and reporting across programs, (2) outline clear expectations for data collection and measurement, (3) seek opportunities for metric adequacy and consistency across programs and over time to facilitate longitudinal assessment and comparison, and (4) ensure alignment of metrics with priority questions. Given the distribution of funding and accountability for workstream implementation across various departments in CalHHS, early initiative-level efforts focused on convening departmental partners to align on shared outcome objectives, early planning and implementation, and opportunities for collective impact. Nascent collaboration across various teams and departments placed the primary focus on creating shared vision, understanding the breadth of CYBHI implementation, and facilitating learning and connection across workstreams. While the CYBHI convened departmental partners to collectively develop workstream-specific causal pathways and support identification of key metrics to monitor and communicate workstream progress, the initiative's ability to define and operationalize consistent performance benchmarks was hampered by a short time horizon for planning and implementation, variation in workstream focus and timeline for evaluation, and workstream-level responsibility for contracting and defining scope of work for evaluation and implementation partners. Future initiatives may wish to define shared or consistent performance targets earlier in planning to facilitate alignment of data collection and measurement across distributed programs and teams.

- **Authorize structure and process to rationalize and derive insights from distributed data.** A key challenge to the CYBHI is differing department-level processes and standards for data sharing both within CalHHS and with external partners. Developing data-driven insights requires clear and direct access to data collected and managed by various actors. When authorizing legislation for future initiatives, the state may wish to explore requiring and establishing processes to define specific, shared goals and facilitate data centralization, analysis, and evaluation. These structures and processes may alleviate barriers to data sharing and collaboration and will strengthen the ability to monitor leading indicators, improve implementation, and strengthen insight into program value and effectiveness.

5 | Conclusion

The CYBHI is an historic multi-year, $4+billion systems change initiative focused on improving the behavioral health and well-being of children and youth as well as their families. California is the first state in the nation to undertake such a significant investment across the entire ecosystem of child and youth behavioral health. The myriad workstreams and intended outcomes represent a remarkably comprehensive, yet complicated, investment in systems change.

Regardless of the time that must pass to evaluate the effect of systems change interventions on individual outcomes, the CYBHI and its 20 workstreams have made substantial progress in an effort to address the escalating behavioral health crisis affecting California's children and youth:

- The CYBHI has undertaken activities to ensure that its work is **guided by the diverse voices of California's youth, their families, and their caregivers**. Workstreams have developed grant programs with a focus on equity and diversity in funding **across regions and populations**.
- The CYBHI has focused on **upstream, prevention-oriented interventions**, with more than $3.5 billion supporting implementation efforts with a prevention or health promotion focus.
- The CYBHI is beginning to **strengthen and diversify the behavioral health workforce landscape** through the creation of new roles (such as the Certified Wellness Coach) and through numerous grant, scholarship, and loan repayment opportunities to train and educate the next generation of behavioral health professionals.
- Two interventions within the CYBHI that are focused on improving access to behavioral health services have progressed in implementation and hold promise for expanding access to behavioral health services. The **Dyadic Services Benefit** reduces barriers for families in accessing early intervention services, including behavioral health services, by supporting delivery of dyadic services to a child and their parent or caregiver. The **CYBHI Fee Schedule** provides a consistent and predictable funding mechanism for school-linked services by establishing a specific set of behavioral health services and rates at which Medi-Cal and commercial plans must reimburse school-linked providers. While these interventions have yet to reach full implementation, they hold promise for expanding access to critical services.
- The workstreams that comprise the CYBHI are engaged in interventions that span the settings where children, youth, young adults, and their families live, learn, grow, play, and flourish: **homes and communities, educational settings, health care settings, and the digital environment.** The CYBHI's comprehensive, multi-faceted supports are intended to surround children, youth, and families, increasing the likelihood that they will come into contact with the prevention messaging, resources, and supports they need when, where, and how they most need it.

The CYBHI is now more than halfway through the five-year initiative. As the evaluation of the CYBHI continues, Mathematica will continue to seek opportunities to provide evaluation insights that will allow leaders to make strategic decisions about ongoing implementation and support for key strategies and workstreams. As the CYBHI is beginning to shift its focus from rapid planning and funding disbursement to supporting implementation of the most complex CYBHI workstreams with greatest potential for long-term impact, it will be critical for the CYBHI to continue to monitor progress, assess early evidence of impact, and strategically address barriers to adoption of the investments with the highest potential to reshape the children and youth behavioral health ecosystem.

Appendix 1. Workstream Glossary

Exhibit A.1. Workstream glossary

Workstream	Description
DHCS/DMHC will jointly implement the multi-payer fee schedule for school-linked behavioral health services	
The CYBHI Fee Schedule	This workstream provides a transparent fee-for-service model of behavioral health coverage and reimbursement for outpatient mental health or substance use disorder services to students 25 years of age or younger at or near a school site by qualified categories of BH personnel. It will also develop and maintain a school-linked statewide provider network of behavioral health counselors.
DHCS operates 12 workstreams	
CalHOPE Student Support and Schools initiative	This DHCS workstream includes two programs: CalHOPE Student Support provides training to teachers and school staff to offer effective counseling through social-emotional learning (SEL) environments and engages leaders from all 58 County Offices of Education (COEs) in statewide SEL Communities of Practice (CoP). CalHOPE Schools Initiative provides a range of additional resources to support educators, caregivers, and youth. Materials include the SEL curriculum (teacher guides, classroom materials); resource pages; forums for educators, parents, and youth; and mini professional development modules.
Mindfulness, Resilience, and Well-Being Grants	This workstream will distribute $65 million among California's 58 COEs to promote local wellness, mindfulness, resilience, and well-being programs that support teachers and students in TK–12 schools. It also offers California schools free access to a survey tool that provides real-time, actionable information about students' well-being and training and courses for educators on supporting students' social and emotional well-being.
Youth Peer-to-Peer Support Program	Through this program, CYBHI will award $8 million in grants to eight schools across diverse Californian communities to initiate peer-to-peer support programs. These pilot programs, which focus on grades 9–12, will help establish and standardize best practices for peer-to-peer mental and behavioral health support systems within the school environment.
Student Behavioral Health Incentive Program (SBHIP)	SBHIP is a program intended to address behavioral health access barriers for Medi-Cal students through targeted interventions that increase access to preventive, early intervention, and behavioral health services by school-affiliated behavioral health providers for TK–12 children in public schools.
School-Linked Partnership and Capacity Grants	The capacity grants are a one-time investment to strengthen school-linked behavioral health services by providing California public K–12 schools and institutions of higher education with resources to support institutional readiness for the statewide multi-payer school-linked fee schedule. These funds will provide resources to schools to expand their provider capacity, develop critical partnerships, and build the necessary infrastructure to achieve a long-term and sustainable funding model.
Behavioral Health Continuum Infrastructure Program (BHCIP) Round 4	BHCIP Round 4 aims to expand the continuum of behavioral health treatments and services for Californians ages 25 and under, including pregnant and postpartum women, their children, and transition-age youth and their families, by investing in infrastructure that fosters a spectrum of services—from wellness centers to crisis stabilization units. The program has funded 52 child- and youth-focused projects, including four led by tribal entities.
Enhanced Medi-Cal Benefits—Dyadic Services	This workstream is responsible for implementing dyadic care services as a covered benefit under Medi-Cal. The benefit combines behavioral health treatment with pediatric care, primarily for children 0–5, to simultaneously support children and their caregivers by covering services including behavioral health well-child visits, navigation and follow-up for referrals, psychoeducation, family training and counseling, and specified mental and behavioral health screenings for caregivers.

Workstream	Description
Scaling Evidence-Based and Community-Defined Practices	Under this workstream, DHCS will distribute an estimated $429 million in grants to organizations seeking to scale evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) that improve youth behavioral health based on robust evidence for effectiveness, impact on racial equity, and sustainability. Six grant rounds are planned with different areas of focus: (1) parent and caregiver support, (2) trauma-informed programs and practices, (3) early childhood wraparound services, (4) youth-driven programs, (5) early intervention, and (6) community-defined programs and practices.
Health Care Provider Training and eConsult (Cal-MAP)	Cal-MAP, administered by UCSF, provides remote and real-time consultation support for pediatric and primary care providers to connect with behavioral health clinical experts. The statewide platform is intended to improve the capacity of pediatric, primary care, and other health care providers by offering them access to learning opportunities via resources, tools, training, and additional support.
Next Generation Digital Therapeutics	Under this workstream, the Child Mind Institute will develop three different tools designed to improve how behavioral health services and supports are delivered: (1) a multimodal journaling app; (2) an augmented reality-enhanced behavioral activation game; and (3) a platform for developing, testing, and administering behavioral health assessments, interventions, and educational resources.
Parent Support Video Series (Positive Parents, Thriving Kids)	Parent Support Video Series is a collection of approximately 20 videos designed to provide parents with practical, evidence-based skills and strategies to support their children's behavioral health. The videos cover a variety of topics ranging from self-care and parent–child relationships to family and community stress. They are available in both English and Spanish and are accompanied by print resources.
BH Virtual Services Platforms (BrightLife Kids and Soluna)	Through this workstream, CYBHI supports two virtual platforms that provide free app and web-based behavioral health services and wellness supports for children, youth, and their families. BrightLife Kids serves children 0–12 and their parents or caregivers while Soluna serves youth ages 13–25. The platforms provide live coaching sessions, educational content, stress management tools, clinically validated assessments, care navigation services, peer community programs, and crisis protocols.
OSG operates 2 workstreams	
Live Beyond (ACEs and Toxic Stress Awareness Campaign)	The Live Beyond campaign aims to increase awareness and understanding of Adverse Childhood Experiences (ACEs), toxic stress, and their potential impacts and provide science-based, healing-centered resources for all Californians. The campaign's primary audience is youth and young adults, and its secondary audience is parents or caregivers who have experienced one or more ACEs.
Safe Spaces (Trauma-Informed Training for Educators)	Safe Spaces is a free training designed to help early care providers, TK–12 educators, and other school personnel recognize and respond to trauma and stress in children. Participants who complete the training will have a greater awareness of the impact of stress and trauma on health, development, and learning and have the tools and strategies to respond with trauma-informed principles while creating safe and supportive learning environments.
CDPH operates 3 workstreams	
Public Education and Change Campaigns	The public education and change campaigns include both statewide ("macro") and local campaigns designed to promote awareness of behavioral health resources and services while also decreasing stigma about behavioral health (BH). Launch of the statewide campaign, titled "Take Space to Pause," is planned for late fall 2024. Twenty-eight (28) grantees will develop and implement local campaigns to support culturally appropriate messaging around prevention and early intervention.
Never a Bother: Youth Suicide Prevention Media and Outreach Campaign	The youth suicide prevention campaign—titled Never a Bother— is a multilingual marketing, education, and outreach campaign that includes a website, social media, content and resource creation opportunities, advertising, and partnership marketing. It was developed and implemented in close collaboration with 34 youth-serving community-based organizations and tribal partners in partnership with the Center at Sierra Health Foundation.
Youth Suicide Reporting and Crisis Response Pilot Program	This program will develop and test models for making youth suicide and attempted suicide reportable events. The pilot will also support models for rapidly and comprehensively responding to these events by providing crisis services and follow-up support in school and community settings.

Workstream	Description
HCAI operates 3 workstreams	
Wellness Coach Workforce	The Certified Wellness Coach is a new profession established to increase California's overall BH workforce capacity through wellness promotion, screening, and crisis referral. To support this new profession, this workstream includes (1) a scholarship program that supports students pursuing a certificate in exchange for a 12-month service obligation at a qualified site and (2) an employer grant effort that aims to support educational institutions and school-linked behavioral health agencies in employing Wellness Coaches, particularly in the year before the position is eligible for Medi-Cal reimbursement.
Youth Mental Health Academy	The Youth Mental Health Academy (YMHA) is a 14-month, community-based career development program for high school students. To promote equity and representation in the behavioral health workforce, YMHA provides mentorship, paid project-based learning, and paid internships to high school students from marginalized communities who are interested in pursuing behavioral health careers.
Broad Behavioral Health Workforce Capacity (Broad BH Workforce)	The Broad BH Workforce Capacity workstream includes 18 distinct subprograms with a shared goal of expanding the number of BH providers in California, with particular emphasis on engaging underserved communities. This workstream comprises programs awarding scholarships and loan repayments to individuals, as well as programs awarding grants to organizations.
Broad BH Workforce: Promoting early interest in behavioral health careers through pipeline and exploration programs	
Health Careers Exploration Program *(HCEP)*	The HCEP provides grant funding to organizations to support activities that expose students from underrepresented and disadvantaged backgrounds to health careers, such as health "career fair" experiences and workshops that introduce participants to a wide variety of health career options or fund hands-on experiences that facilitate direct interaction between students and health care professionals in real or simulated health care settings.
Health Professions Pathways Program *(HPPP)*	The HPPP distributes grant funding to organizations to support the implementation of programs aimed at assisting students from underrepresented regions and backgrounds in pursuing careers in health—such as pipeline programs comprising mentorship and advising, paid summer internships, and post-undergraduate fellowships. These programs aim to assist students from underrepresented regions and backgrounds in pursuing careers in health.
Broad BH Workforce: Expanding and developing new workforce roles	
Peer Personnel Training and Placement	This grant opportunity supports peer personnel training programs that meet training requirements under the Medi-Cal Peer Support Specialist Certification Program and successfully place trained individuals in peer personnel positions. Peer personnel may be individuals with lived experience as mental or behavioral health services consumers, family members, or caregivers.
SUD Earn and Learn Grant Program	This program establishes a 3-year agreement with grantee organizations to provide education and paid job experience for students earning their California SUD certification. Funded programs support the development of a culturally competent and diverse SUD workforce by providing stipends, training, mentorship, and internship placement support to SUD students.
Broad BH Workforce: Providing scholarships to support students in pursuing behavioral health careers	
Public Behavioral Health MSW Training Stipend and Fellowship Program	The Public Behavioral Health MSW Training Program supports behavioral health training, MSW stipends, and post-graduate fellowships for persons seeking clinical licensure in exchange for a 12-month service obligation (per year of program participation) in publicly funded behavioral health settings in California. The program is intended to support MSW students at up to 22 universities in California.
Advanced Practice Healthcare Scholarship Program *(APHSP)*	The APHSP provides scholarships to students pursuing eligible graduate and post-graduate health professional degrees in exchange for a 12-month service obligation practicing and providing direct patient care in an underserved community.
Allied Healthcare Scholarship Program *(AHSP)*	The AHSP provides scholarships to students pursuing careers in allied health (a broad group of health professionals) in exchange for a 12-month service obligation providing direct patient care in an underserved community.
Behavioral Health Scholarship Program *(BHSP)*	The BHSP provides scholarships to students seeking to advance their training as behavioral health practitioners through a certificate, associate's, bachelor's, master's, and doctoral degree program. Scholarship recipients commit to a year of providing direct patient care in an underserved community.

Workstream	Description
Justice- and System-Involved Youth BH Training Program *(JSIY BH Pipeline)*	The JSIY BH pipeline distributes grants to organizations to support system-involved and economically, environmentally, or educationally disadvantaged youth in pursuing behavioral health careers by providing a comprehensive range of supports. Grant funding can be used to provide income and rent support, academic enrichment, career development, mentorship, and advising to students with current or recent system involvement.
Broad BH Workforce: Expanding the capacity of education programs to train new providers	
Psychiatric Education Capacity Expansion Grant *(PECE)*	The PECE grant opportunities provide funding to educational institutions, medical sites, or other organizations to expand or create new psychiatry residency grant programs or psychiatric mental health nurse practitioner training programs. In addition to expanding training slots, these funds can be used to recruit culturally and linguistically diverse students and modify curriculum or augment efforts to prepare providers to work with unserved and underserved children and youth, in alignment with PECE guiding principles.
Social Work Education Capacity Expansion Grant *(SWECE)*	The SWECE grant opportunity provides educational institutions with funding to create or expand social work (MSW or bachelor's) programs. In addition to expanding training slots, these funds can be used to recruit culturally and linguistically diverse students and modify curriculum or augment efforts to prepare providers to work with unserved and underserved children and youth, in alignment with SWECE guiding principles.
Broad BH Workforce: Providing incentives to work in underserved areas through loan repayment/stipend programs to offset educational debt	
Community-Based Organization (CBO) BH Workforce Program	This program makes four-year grant funding available to CBOs. These grants can be used to fund activities supporting BH personnel recruitment and retention, including providing loan repayments, scholarships, and stipends to paid and volunteer CBO BH staff.
California State Loan Repayment Program (SLRP)	The SLRP provides loan repayment support to licensed care providers for a 2-year service obligation in federally designated California Health Professional Shortage Areas. Eligible providers include primary care physicians, dentists, dental hygienists, physician assistants, nurse practitioners, certified nurse midwives, pharmacists, and behavioral health providers.
Steven M. Thompson Physician Corps Loan Repayment Program	This program provides eligible physicians with loan repayment support in exchange for a 36-month service obligation in a medically underserved area or qualified facility, with the aim of increasing the number of licensed physicians and surgeons providing direct patient care in a qualified facility.
Licensed MH Services Provider Education Program *(LMHSPEP)*	The LMHSPEP offers loan repayment support to eligible health care providers in exchange for a 2-year service obligation to provide direct client care in a medically underserved area or qualified facility. Eligible providers include psychiatric nurses, psychiatric mental health nurse practitioners, behavioral disorder counselors, mental health counselors, rehabilitation counselors, and substance use disorder counselors.
Broad BH Workforce: Developing behavioral health capacity among non-behavioral health practitioners	
Open Doors Training *(SUD/JSIY)*	This program funds the development and delivery of BH trainings for nonclinical staff working closely with youth. The SUD Training Program seeks to educate non-BH professionals about early SUD detection and equip them with resources for referring youth to appropriate care.
Train New Trainers Primary Care Psychiatry Fellowship *(TNT PCP)*	TNT PCP Fellowship is a year-long clinical education certificate program for primary care-oriented trainees and providers who wish to receive advanced training in primary care psychiatry. Fellows participate in case-based discussions, small group mentoring, and other learning opportunities to strengthen their ability to diagnose and treat common psychiatric conditions in primary care settings and learn how to teach these principles to their primary care colleagues.
Train New Trainers Primary Care Training and Education in Addiction Medicine *(TNT PC-TEAM)*	TNT PC-TEAM is a year-long clinical education program for primary care providers working in internal medicine, family medicine, emergency medicine, pediatrics, neurology, or pharmacy. Trainees develop the skills to prevent, screen for, diagnose, and treat common substance use and pain-related disorders in primary care and general medical settings, and learn how to teach these principles to their primary care colleagues.

Appendix 2. The CYBHI Evaluation

In November 2022, CalHHS contracted with Mathematica to conduct an evaluation of the CYBHI. Mathematica is partnering with Health Management Associates, James Bell Associates, and the UCLA Prevention Center of Excellence. The evaluation comprises four key activities:

- **Primary data collection.** To understand the progress and impact of the CYBHI at a broader level, we are collecting primary data at the state and county level using qualitative methods, such as interviews and focus groups, and quantitative methods, such as surveys. State-level data collection includes key informant interviews with state policymakers and key decision makers, youth and family focus groups to understand their experiences with behavioral health services, and a pulse survey on behavioral health experiences of youth, caregivers, and young adults. County-level data collection involves case studies of California counties that summarize findings related to workstream implementation at the local level and multisector collaboration and system integration efforts.
- **Workstream coordination.** Mathematica coordinates closely with staff across the five California departments implementing the CYBHI. This involves identifying and obtaining data to monitor implementation and track progress, linking department staff to evaluation products, maintaining responsive communication related to evaluation data, and collaboratively developing workstream performance metrics to provide insight into how workstream implementation progress contributes to overall initiative aims.
- **Outcomes analysis.** To understand how the CYBHI workstreams are individually and collectively contributing to changes in system-level support and collaboration, access to and experience of care, and behavioral health and well-being, our evaluation incudes analysis of 15 overarching outcomes. We are using several secondary data sources to track the 15 CYBHI outcome objectives over time.
- **Input and guidance from the CYBHI Equity Advisory Group and a State Leadership Committee.** Building on the work of an initial Equity Working Group, Mathematica, and the Center for the Study of Social Policy (CSSP) assembled the CYBHI Evaluation Advisory Group (CEAG) to guide the evaluation's design and implementation. Furthermore, the CYBHI evaluation will also be guided by the State Leadership Committee (SLC). Comprising key leaders from various state departments, agencies, and groups involved in children's and youth's behavioral health, the SLC provides strategic direction, ensures alignment, and facilitates cross-sector collaboration.