Shasta County: Collaboration and Community Commitment Provide a Strong Foundation for CYBHI Implementation

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This case study focuses on Shasta County's experience implementing California's Children and Youth Behavioral Health Initiative (CYBHI). The CYBHI is an ambitious 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 serving children, youth, and families.

This case study starts with a description of Shasta County's demographic characteristics, behavioral health needs, and resource availability. We then discuss the behavioral health ecosystem in the county, including connections between child- and youth-serving organizations, findings related to multisector collaboration, and Shasta County's experience implementing select CYBHI workstreams as of late fall 2024.

Background and methods for the CYBHI evaluation and case study

Mathematica is evaluating the CYBHI on behalf of the California Health and Human Services Agency in partnership with Health Management Associates, James Bell Associates, and the Prevention Center of Excellence at the University of California, Los Angeles. The evaluation began in November 2022 and will continue through June 2026. As part of the evaluation, the research team completed case studies of the CYBHI implementation in nine counties, including Shasta County. The purpose of these case studies is to provide information about the relationships between entities in the children and youth behavioral health ecosystem at the county level and to gain insights into local implementation of the CYBHI workstreams in the planning or active execution phase as of late fall 2024.

The research team conducted analyses of secondary data sources to capture the population and behavioral health system characteristics of Shasta County and California as a whole (see Appendix A for more detail). In addition, between April and July 2024, the research team conducted the Network and Ecosystem Experiences Survey (NEES) and key informant interviews with local leaders in Shasta County. The NEES explored the connections between organizations in Shasta County to shed light on how they work together to support children and youth behavioral health. Using results from the NEES, the research team conducted a social network analysis and developed a network map showing the average strength of the connections between organizations in the ecosystem (see Appendix B for more detail on the network analysis methodology and measures).

Between summer and late fall 2024, researchers also conducted 10 interviews with individuals in Shasta County to understand the CYBHI workstream implementation and multisector collaboration. Respondents across the survey and interviews varied and included purposively selected leaders from county behavioral health departments, county offices of education, school districts, Medi-Cal managed care plans, community-based organizations, public health departments, and other behavioral health and child welfare leaders. Five individuals participated in both the survey and an interview.

I. Summary of Findings

Behavioral health ecosystem multisector collaboration

Children and youth in Shasta County face a higher burden of behavioral health challenges than children and youth across the state. Services and supports available to address these challenges do not meet the current level of need, and efforts are underway to augment services. According to findings from the Network and Ecosystem Experiences Survey (NEES) and key informant interviews, agencies and organizations in Shasta County's children and youth behavioral health ecosystem have historically worked together to coordinate efforts, pool resources, and address gaps in services and supports. Collaboratives originating in the health care and education sectors are prominent and play a key role in strengthening multisector relationships in the county. Apart from participating in formal collaboratives, child- and youth-serving agencies and organizations in Shasta County often implement joint initiatives and share resources to support each other's work. However, according to key informants, workforce capacity gaps and increasing community stigma against LGBTQ+ populations also affect organizations' ability to collaborate and partner with each other. Despite these challenges, leadership continuity at partner organizations and their commitment to working with others on behalf of children and youth help overcome barriers and sustain multisector collaboration in the county.

County's experience, successes, and opportunities with the CYBHI implementation

The CYBHI is providing support and resources to help partners build on past collaborative efforts, strengthen existing relationships, and mitigate the impact of ongoing and emerging challenges. Although implementation of the CYBHI in Shasta County is in its early stages, county agencies and community-based providers implementing CYBHI workstreams reported progress in increasing access to school-linked behavioral health services, strengthening relationships between agencies and organizations, facilitating conversations about workforce development opportunities and challenges, and allocating resources to support populations experiencing greater barriers to care.

Workstreams active in Shasta to facilitate the delivery of behavioral health services in and near schools include the Student Behavioral Health Incentive Program (SBHIP), the CYBHI Statewide Multi-Payer School-Linked Fee Schedule, and School-Linked Partnership and Capacity Grants. Through these workstreams, the Shasta County Office of Education (SCOE) has worked with the managed care plan, school districts, and community-based providers to increase access to behavioral health services in the county and nearby areas.

Shasta County organizations are also implementing workstreams in home and community settings, including Scaling Evidence-Based and Community-Defined Evidence Practices (Scaling EBPs and CDEPs) and the Broad Behavioral Health Workforce Capacity workstream. Scaling EBPs and CDEPs grantees in Shasta reported making progress in planning to implement programs. These grantees have worked with providers and schools to design programs that meet pressing needs and address existing barriers to behavioral health services in the community. On the other hand, one organization that received the CBO Behavioral Health Workforce grant delayed implementation of the program due to various organizational and community-level factors. At the time of the interview in summer 2024, the grant-funded work was on pause while the grantee reconsidered the focus of its efforts. In late fall 2024, the organization reported progress using the funding to provide sign-on and retention bonuses, along with scholarships and loan repayment support.

Key progress with the CYBHI implementation

- **Student Behavioral Health Incentive Program (SBHIP):** Shasta County Office of Education (SCOE) and its partners selected and have been implementing two targeted interventions under SBHIP: Care Teams and Building Stronger Partnerships to Increase Access to Medi-Cal Services. Under the Care Teams intervention, SCOE supports outreach, engagement, and home visits, and provides linkages to social services to address nonclinical behavioral health needs. Through the Building Stronger Partnerships intervention, SCOE and its partners

developed a toolkit to assist the county and school districts in selecting third-party vendors for billing Medi-Cal for school-based behavioral health services, which will facilitate their eventual participation in the CYBHI Fee Schedule. SCOE also plans to use the toolkit to select an electronic health records (EHR) vendor for the CYBHI Fee Schedule consortium.

- **School-Linked Partnership and Capacity Grants:** SCOE initiated the School-Linked Partnership and Capacity Grants by contacting all of Shasta's 25 school districts and 15 charter schools to learn about their interests and priorities for using these funds**.** Although SCOE is implementing the workstream as a "county-wide consortium" that will ultimately support billing for the LEA Medi-Cal Billing Option Program (LEA BOP), School-Based Medi-Cal Administrative Activities (SMAA), and the CYBHI Fee Schedule, local education agencies (LEAs) may individually decide whether to participate and whether to engage with the consortium or pursue the effort on their own.
- **The CYBHI Statewide Multi-Payer School-Linked Fee Schedule:** As noted above, SCOE is developing a county-wide consortium to implement the CYBHI Fee Schedule. LEAs interested in the program can opt in to participate in this consortium, with billing facilitated by SCOE. One of Shasta's LEAs that participated in the first cohort of the CYBHI Fee Schedule chose to implement the efforts independently and plans to begin reimbursing claims by fall 2025. Other LEAs may choose to similarly implement the Fee Schedule independently in the future.
- **Scaling Evidence-Based and Community-Defined Evidence Practices (EBPs and CDEPs):** Multiple organizations in Shasta County received funding under Round 2 of the Scaling EBPs and CDEPs workstream. Interview respondents from two of these organizations discussed programs that will focus on implementing two evidence-based practices: Cognitive Behavioral Interventions for Trauma in Schools (CBITS) and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). Both organizations interviewed about this funding are making progress in planning for implementation in collaboration with other service providers, SCOE, and school districts. This planning work includes establishing processes to integrate the delivery of trauma-informed services into regular school schedules, coordinating with SCOE to create referral pathways between schools and community-based organizations (CBOs), developing training content for providers at CBOs, and creating informational resources for school staff. Shasta also received a Scaling EBPs grant to implement the Infant and Early Childhood Mental Health Consultation (IECMHC) program with First 5 Shasta.
- **Broad Behavioral Health Workforce Capacity:** An organization receiving funding through the Broad Behavioral Health Workforce Capacity workstream (CBO Behavioral Health Workforce Program) planned to offer internships and job placement support to students finishing degrees in key behavioral health fields. At the time of the interview, those plans were temporarily on hold due to organizational transitions and other factors. As of late fall 2024, a representative from the organization reported that they made progress using the funding to provide sign-on and retention bonuses to behavioral health professionals. The organization also planned to continue paying annual retention bonuses and promoting scholarships for undergraduate degrees and certifications, stipends for graduate degrees, and loan repayment opportunities through the grant.

II. County Background

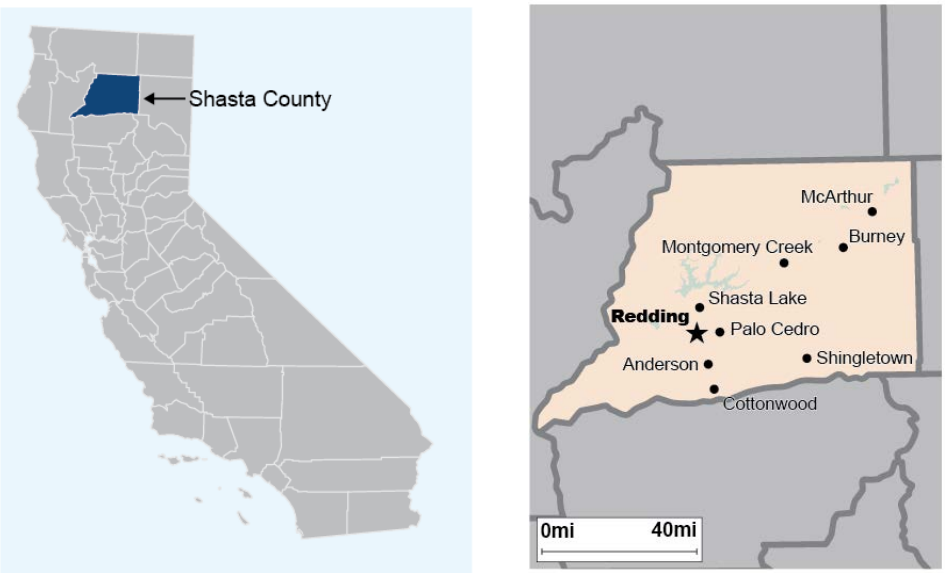
County characteristics

Shasta County is located in the Northern California region (Exhibit 1). The county covers more than 3,800 square miles of "diverse terrain, from rolling hills and fertile valleys to towering peaks and lush forests."[1] The largest city in Shasta County is Redding. The county is considerably less densely populated than the state as a whole—an average of

[1] County of Shasta. "County Profile." n.d. Accessed on October 15, 2024. https://www.shastacounty.gov/community/page/about-shasta-county.

48 residents per square mile compared with 254 statewide. It also has a higher proportion of the population living in rural blocks than statewide (33.8 percent versus 5.8 percent) (Exhibit 2).

Exhibit 1. Shasta County's geography



Relative to other counties in California, Shasta County has a smaller but substantial population of 181,000 residents. The population of children and youth is also slightly smaller relative to the state, with fewer children ages 0 to 4 (5.1 percent versus 5.4 percent statewide), youth 5 to 19 (18.1 percent versus 19.0 percent statewide), and young adults (5.8 percent versus 6.8 percent).

Exhibit 2. Shasta County's population characteristics

Metric	Shasta	California	Year(s)
Population			
Total population (N)	180,930	39,029,342	2022
Population, 0–4 years (N; %)	9,132; 5.1%	2,118,386; 5.4%	
Population, 5–19 years (N; %)	32,775; 18.1%	7,404,396; 19.0%	
Population, 20–24 years (N; %)	10,460; 5.8%	2,639,787; 6.8%	
Five-year population change (%)	0.6%	-1.3%	2017–2022
Five-year population change, 0–24 years (%)	-2.1%	-5.4%	
Density (population per square mile)	48	254	2020
Race and ethnicity			
White, non-Hispanic (%)	76.1%	33.7%	2022
Black or African American, non-Hispanic (%)	0.3%	5.2%	
American Indian and Alaska Native, non-Hispanic (%)	0.7%	0.3%	
Asian, non-Hispanic (%)	2.1%	15.3%	
Native Hawaiian and Other Pacific Island American, non-Hispanic (%)	0.5%	0.4%	
Some other race, non-Hispanic (%)	0.6%	0.6%	
Two or more races, non-Hispanic (%)	8.0%	4.3%	
Hispanic or Latino (%)	11.7%	40.3%	

Metric	Shasta	California	Year(s)
Birthplace and language			
Foreign-born, 0–24 years (%)	2.4%	7.2%	2022
English-proficient, 5–17 years (%)	92.5%	91.6%	
Education (18+ years)			
High school or higher (including college) (%)	88.5%	78.8%	2022
College degree or higher (%)	22.0%	34.1%	
Economic indicators, socioeconomic, and neighborhood characteristics			
Population within urban blocks (%)	66.2%	94.2%	2022
Population within rural blocks (%)	33.8%	5.8%	
Population below 200 percent federal poverty line (%)	31.1%	27.6%	
Median income (USD)	43,543	52,520	
Unemployment (%)	5.4%	5.3%	
Households with high housing cost burden (%)	32.9%	40.3%	2019
Food insecurity, overall (%)	12.4%	10.5%	2021
Food insecurity, 0–18 years (%)	15.7%	13.5%	
Healthy Places Index (rank)	29	N/A	2015–2019
Diversity Index (rank)	48	N/A	
Health status			
Population with a disability (%)	17.5%	11.7%	2022
Population with a disability, 0–17 years (%)	4.7%	4.0%	
Health insurance status (population 0–25 years)			
Medi-Cal or other means-tested public coverage (%)	42.3%	39.3%	2022
Private coverage (%)	56.4%	60.2%	
Uninsured (%)	8.4%	4.9%	
TRICARE/military coverage (%)	2.6%	1.7%	
Medicare coverage (%)	0.6%	1.0%	

Note: Researchers conducted analyses of secondary data sources to capture population and behavioral health system characteristics of Shasta County and California as a whole, providing the most recent year available for each data source as of September 2024 (see Appendix A for more detail).

Shasta County's residents are predominantly White and non-Hispanic (76.1 percent) in contrast to the statewide population, of which only 33.7 percent are White and non-Hispanic. This difference is largely due to the relatively smaller proportion of Shasta residents who are Hispanic or Latino (11.7 percent versus 40.3 percent statewide). There are also fewer county residents identifying as Black or African American, non-Hispanic and Asian, non-Hispanic compared with the statewide population. Shasta County residents are much more likely to finish high school (88.5 percent versus 78.8 percent statewide) but less likely to receive a college degree (22.0 percent versus 34.1 percent statewide).

Shasta County residents face more difficult economic conditions than residents across California. Relative to the state, a larger proportion of the county's population is below 200 percent of the federal poverty line (31.1 percent versus 27.6 percent). The county has a lower median income ($43,543 versus $52,520 statewide) and higher food insecurity among residents overall (12.4 percent versus 10.5 percent statewide) and among those ages 0–18 years (15.7 percent versus 13.5 percent statewide). In addition, Shasta is ranked 29th (out of 57[2]) in the California Healthy Places Index,

[2] The Healthy Places Index does not include Alpine County and therefore ranks 57 of California's 58 counties.

signifying that the county has slightly below-average access to health care, housing, education, and other characteristics that support a healthy population. Consistent with the economic conditions in Shasta, slightly more residents ages 0 to 25 are covered by Medi-Cal (42.3 percent) compared with the statewide average (39.3 percent).

Behavioral health needs and resource availability

Prevalence of behavioral health needs in the county relative to California as a whole

Shasta County children and youth experience higher rates of behavioral health challenges than children and youth statewide (Exhibit 3). More county children and youth insured through Medi-Cal have a mental health diagnosis or emotional symptoms (27 percent versus 18 percent). More county students seriously considered attempting suicide in the past 12 months in grades 9 (26 percent versus 15 percent statewide) and 11 (27 percent versus 16 percent statewide). Inpatient hospitalizations for behavioral health diagnoses within the county relative to the number of children and youth are comparable to the statewide frequency. However, children and youth in the county have substantially more emergency department visits for any behavioral health diagnosis (57 per 1,000 children and youth versus 32 statewide). Although Shasta students in grades K–12 have slightly lower rates of chronic absenteeism (21 percent versus 25 percent statewide), a higher percentage of county students in grade 9 reported school absences due to mental health issues (16 percent versus 9 percent statewide) or to alcohol or drug use (4 percent versus 1 percent statewide).

Indicators of overall mental well-being for children and youth, which are based on a broader regional population and not specific to the county, show similarities between the Northern and Sierra region—where the county is located—and California as a whole (Exhibit 3). For example, Northern and Sierra region youth have rates of feeling connected and supported by adults comparable to those in the state as a whole. However, fewer report feeling supported by friends relative to youth statewide (63 percent versus 72 percent).

Exhibit 3. Prevalence of behavioral health outcomes

Metric	Shasta	California	Year(s)
Region-level overall mental well-being for children and youth [a]			
Youth ages 12 to 17 years old who felt their family stood by them during difficult times (%)	74%	73%	2022
Youth ages 12 to 17 years old who felt at least two nonparent adults took genuine interest (%)	57%	58%	
Youth ages 12 to 17 years old who felt supported by friends (%)	63%	72%	
Behavioral health challenges			
Children and youth insured through Medi-Cal with a mental health diagnosis or emotional symptoms (%)	27%	18%	2022
Children and youth insured through Medi-Cal with a substance use disorder diagnosis (%)	4%	3%	
Rates of suicidal ideation			
Students in grade 9 who reported seriously considering attempting suicide in the past 12 months (%)	26%	15%	2019–2021
Students in grade 11 who reported seriously considering attempting suicide in the past 12 months (%)	27%	16%	
Emergency department visits and hospitalizations for children and youth with behavioral health-related conditions			
Inpatient hospitalization stays per 1,000 children and youth for any behavioral health diagnosis	14	12	2022
Emergency department visits per 1,000 children and youth for any behavioral health diagnosis	57	32	

Metric	Shasta	California	Year(s)
School engagement, as measured through absenteeism and suspension			
Students in grades K–12 who were chronically absent (%)	21%	25%	2022–2023
Students in grade 9 reporting school absences due to mental health issues (%)	16%	9%	2019–2021
Students in grade 9 reporting school absences due to alcohol or drug use (%)	4%	1%	

Note: Researchers conducted analyses of secondary data sources to capture population and behavioral health system characteristics of Shasta County and California as a whole, providing the most recent year available for each data source as of September 2024 (see Appendix A for more detail).

[a] These well-being metrics are only measured at the regional level. Shasta is part of the Northern and Sierra region as defined by the California Health Interview Survey. This region includes 25 counties in mostly rural areas, including Humboldt, Mendocino, and Butte counties.

Resource availability

Like other counties across the Northern California region, Shasta County has a full shortage designation for primary care and a partial shortage for mental health care (Exhibit 4). Shasta County lacks child and adolescent psychiatrists (0 providers per 100,000 children and youth), although it has more non-psychiatrist behavioral health providers licensed with county Medi-Cal Specialty Mental Health Services (SMHS) plans per capita than the state overall (52 per 100,000 residents versus 37 statewide). The county has 62 Federally Qualified Health Centers (FQHCs) or FQHC look-alikes per 100,000 children and youth ages 0–25 years—more than three times the rate statewide. Shasta also has a higher ratio of outpatient treatment programs for young adults (9 per 100,000 children and youth versus 4) and similar rates of school-based health programs with mental health services (3 per 100,000 children and youth versus 4 statewide).

Exhibit 4. Behavioral health care resource availability

Metric	Shasta	California	Year(s)
Primary care health professional shortage area designation	Full shortage	N/A	2019
Mental health professional shortage area designation	Partial shortage	N/A	
Number of FQHC or FQHC look-alike sites per 100,000 children and youth ages 0–25 years	62	20	2024
Number of child and adolescent psychiatrists per 100,000 children <18 years old	0	17	2022, 2024
Number of non-psychiatrist behavioral health care providers licensed with county Specialty Mental Health Services plan per 100,000 residents	52	37	2021
Number of outpatient treatment programs for young adults per 100,000 children and youth ages 0–24 years[a]	9	4	2021
School-based health programs with mental health services per 100,00 children and youth ages <18 years	3	4	2024

Note: Researchers conducted analyses of secondary data sources to capture population and behavioral health system characteristics of Shasta County and California as a whole, providing the most recent year available for each data source as of September 2024 (see Appendix A for more detail).

[a] The numerator for this measure is based on the number of outpatient treatment programs for *young adults*, while the denominator is inclusive of all children and youth 0–24 years because documentation suggests that many of these programs many pertain to children as well as young adults. (Manatt Health and Anton Nigusse Bland. See: *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).

Respondents across sectors reported that the services available to support children and youth behavioral health in Shasta County are not proportional to the level and type of need. When reflecting on the extent to which the county can address the behavioral health needs of children, youth, and families, most respondents agreed that there are gaps in services and resources overall. Several respondents emphasized that it is particularly challenging to find services for children whose needs are classified as mild or moderate, and therefore, not severe enough to qualify them for county-provided services. Similarly, several respondents noted that the county lacks sufficient residential facilities—particularly Short-Term Residential Therapeutic Programs (STRTPs)—to meet the level of need. A behavioral health sector respondent explained that Shasta County has only one STRTP facility, which often is either full (sometimes with out-of-county youth) or does not offer the services that a particular young person might need. Although this gap is not unique to Shasta, this respondent noted that agencies in the county do not have the funds to hold beds for their youth in out-of-county STRTP facilities, as do some bigger and better-resourced counties. Additional gaps in the behavioral health system in Shasta, as identified by respondents, include navigation case management, residential crisis services, teenage day care, and mental health facilities for children in detention.

> "But what about the kids that don't meet those criteria [to qualify for county services] but are still struggling? How do we identify them in the community and wrap support around them? Because based on things like our Adverse Childhood Experiences score for our county, I'm confident that there are kids who are struggling, and who don't necessarily meet those two criteria. And how do we support them?"
>
> —CBO interview respondent

Shasta County faces severe shortages of behavioral health providers, which substantially affect local organizations' and agencies' ability to meet the needs of the populations they serve. Some interview respondents attributed these shortages, at least in part, to challenges in recruiting and retaining behavioral health professionals. Respondents explained that it is difficult to incentivize providers to work in Shasta due to financial constraints and other resource limitations in the county. As several respondents explained, the salaries and benefits that organizations in Shasta can offer are not competitive with those in the surrounding areas. Resources such as transportation options and other amenities are also more limited in Shasta due to the rural environment. These factors affect organizations' ability to recruit and retain behavioral health providers in general and those with specialized training in particular. These challenges affect not only the current behavioral health workforce but also the pipeline of future service providers, as local students and emerging professionals leave the county for training and do not return. A few respondents also reported that the funding constraints that organizations in the county face decrease their capacity to hire staff and providers according to the level of need. Respondents further noted that although shortages affect all provider types, the county particularly lacks licensed psychologists, therapists, and clinicians with training in postpartum behavioral health care.

> "So, we're unable to draw them [providers] for income-based purposes unless they really want to live up here, because it is beautiful. So it can be difficult to get the services we need around behavioral health and mental health in general."
>
> —Early childhood interview respondent

Multiple respondents noted that the provision of behavioral health services and the stability of child- and youth-serving agencies and organizations are also affected by increased stigma and stereotyping beliefs about behavioral health, particularly against LGBTQ+ youth in the community. Additionally, several respondents said that they are increasingly impacted by audits, funding cuts, and hiring freezes, all of which are affecting their organizations' financial stability and make it challenging for agencies and organizations to attract behavioral health professionals to the county, retain providers and staff, and continue operating in Shasta.

Equity concerns: Groups facing disproportionate access challenges

Respondents across sectors noted that all children, youth, and families in the county have limited access to behavioral health services due to workforce shortages and organizational capacity challenges. However, they identified populations of children and youth who face additional barriers to accessing services and support.

Residents in more remote areas and LGBTQ+ children and youth face unique barriers to accessing behavioral health services in Shasta County. According to several respondents, Shasta's mountainous and rural geography makes it hard to serve residents in more remote parts of the county, particularly those who live far from Redding. Transportation barriers, weather events, and the lack of providers outside of the Redding area affect access to services among individuals in those parts of the county. One respondent noted that gaps in broadband internet availability also limit access to telehealth and virtual services in these areas. More recently, respondents serving the LGBTQ+ community reported that they are facing intensified audits and funding cuts that reduce their ability to provide services. In this context, respondents said they hope the resources provided through CYBHI workstreams to expand school-linked services, increase access to trauma-informed therapies, and connect families to early intervention supports will help address barriers to care for these populations.

> "Because people don't necessarily realize when they don't live up in here that it could take you two hours to get to some of the places that are in our surrounding areas. And then if there's weather, because we get snow and all of that here…then it's longer, or not at all. Because…you may not be able to travel. And when you're thinking about clinical work, a lot of times people will be like, well, just do it on Zoom. But unfortunately, these very remote areas don't even have access to those things."
>
> —Early childhood interview respondent

III. Systems Change, Relationships, and Multisector Collaboration Across the Behavioral Health Ecosystem

The California Health and Human Services Agency (CalHHS) aims to inspire systems change through the CYBHI by strengthening opportunities for partnership across sectors and building foundational elements for more coordinated efforts across the children and youth behavioral health ecosystem. When planning the CYBHI, CalHHS commissioned the Working Paper: California's Children and Youth Behavioral Health Ecosystem to gain insight into critical issues within the behavioral health ecosystem and identify ways to strengthen collective capacity and capability to transform the ecosystem, with a goal of improving the behavioral health and well-being of all of California's children and youth.

To better understand the behavioral health ecosystem and how connected systems are across sectors as context for understanding CYBHI implementation in Shasta County, Mathematica conducted the NEES, which asked respondents from child- and youth-serving organizations about their relationships with each other. Using information from the survey, we created a network map showing the connections between 10 organizations in Shasta County. The map depicts the average strength of the connection between organizations (Exhibit 5).

Understanding connections across the behavioral health ecosystem in Shasta County

In Shasta County, we invited 14 child- and youth-serving organizations to complete the NEES via email and received responses from 10. Invited organizations included government agencies and departments; a managed care plan; and CBOs, including organizations focused on abuse and violence prevention. We asked survey respondents, such as directors and executive directors, how their organizations currently work with other organizations in the county to support children and youth behavioral health. Respondents rated their organizations' working relationships with these other organizations invited to complete the survey on a 5-point scale: (1) coexist, (2), cooperate, (3) coordinate, (4) collaborate, and (5) integrated.[3]

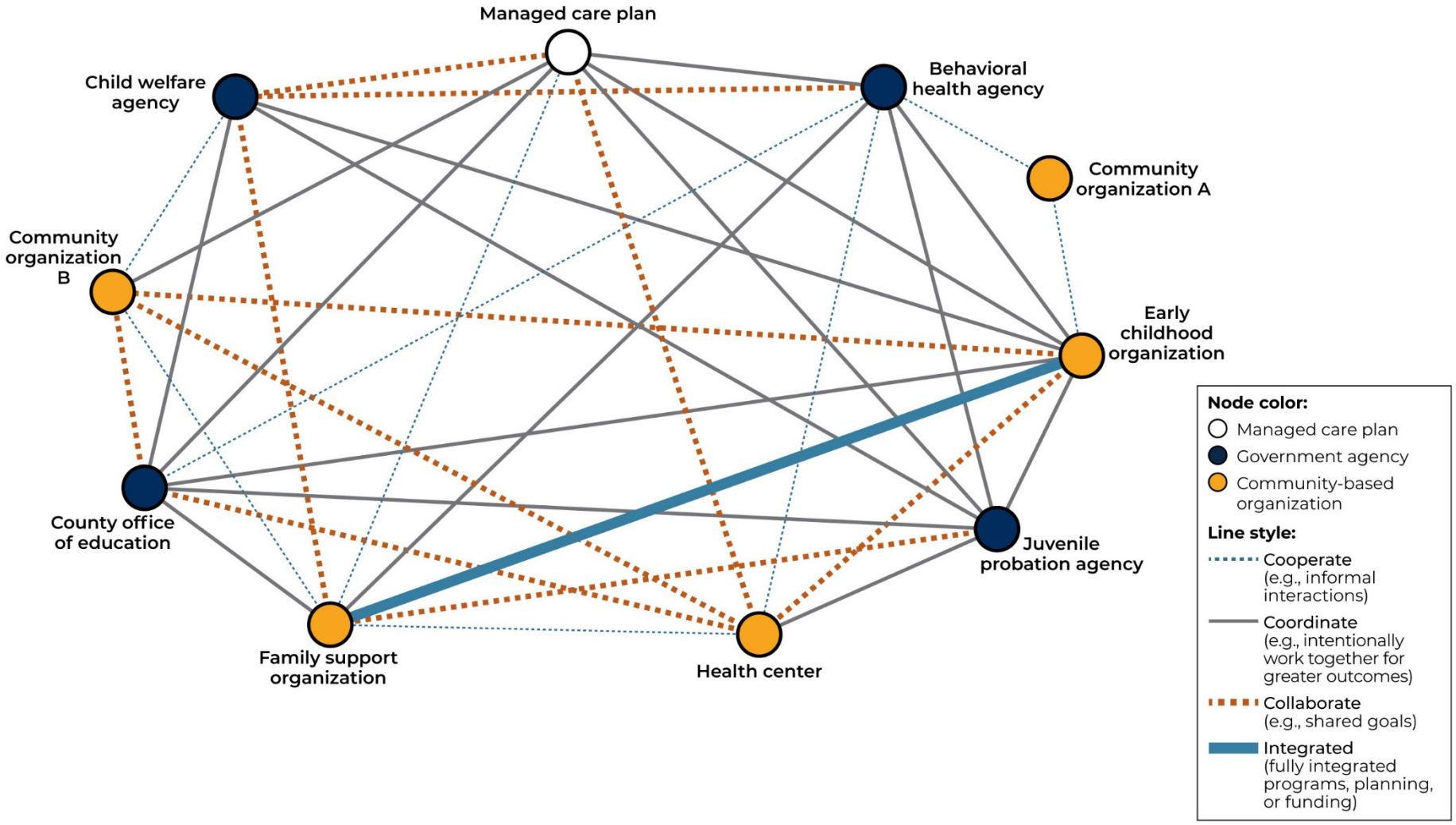
We used these ratings to conduct a network analysis and develop a network map showing the average strength of the connections between organizations that completed the survey based on each organization's rating of the other.[4,5] A line between two organizations shows that a connection exists. No line indicates that the organizations either coexist or no connection was reported (for example, missing data). Thicker, darker lines represent stronger connections in the network. See Appendix B for more information about the network analysis methodology and measures.

[3] We did not ask interview respondents to define terms such as "collaboration" and "integration," so their use might vary from the definitions provided to survey respondents.

[4] In Shasta County, there were instances where only one organization rated a connection between two organizations. Using data where we had responses from both sides of a connection, we conducted an agreement analysis to understand whether survey respondents tended to rate the strength of their relationship in similar ways. Based on this analysis, we determined that the level of agreement did not meet our threshold to include ratings from one side of a connection in the network map. Therefore, the network map does not include connections rated by a single organization or connections with organizations that were invited to participate but did not complete the survey.

[5] The ratings of connections between organizations are subjective and reflect the perspectives of the individuals who completed the survey on behalf of their organizations at a single point in time.

Exhibit 5. Connections across the Shasta County behavioral health ecosystem



Note: Coexist = limited or no relationship between organizations (no connection); Cooperate = informal interactions on specific activities or projects; Coordinate = intentionally plan/work together for greater outcomes; Collaborate = shared mission, goals, decision makers, and/or resources; Integrated = fully integrated programs, planning, or funding.

Perceptions of multisector collaboration to support children and youth behavioral health

Multisector relationships and collaboration

> "We're all engaged in this conversation about how we best serve not just the whole youth population, but specific youth that are in our system, which I think is really helpful. And I think it really leads to that collaborative approach in the work that we're doing with the goal that the youth will benefit."
>
> —Juvenile probation interview respondent

Child- and youth-serving organizations in Shasta County have a history of multisector coordination and collaboration. Most interview respondents agreed that child- and youth-serving agencies and organizations in Shasta have historically collaborated to pool resources and address gaps in services and supports. Several interview respondents further noted that working with other entities is central to their organizations' functioning. One of these respondents described how they work with other organizations to connect children and youth with mild-to-moderate behavioral health challenges, or in need of post-adoptive services, to providers. Another respondent noted that from its inception, its advocacy and family support organization has partnered with criminal justice, education, public health, and behavioral health agencies to ensure a continuum of care for children and youth who have experienced violence or trauma. Survey respondents also reported on the strength of their organizations' connections or working relationships with other organizations in the county. Based on their ratings, survey findings show that the average strength of the network in Shasta County is 3.19, indicating that, on average, child- and youth-serving organizations "coordinate" to support children and youth behavioral health. The network map also shows that across the network, most survey participants (90.0 percent) reported six or more connections with other organizations participating in the survey. However, the strength of those connections varies (see Exhibit 5).[6] More than one-third (42.1 percent) of the connections in the network map have an average strength rating of "coordinate," suggesting that surveyed organizations intentionally work together to achieve shared outcomes. More than one-quarter of connections in the map (26.3 percent) have an average strength rating of "collaborate," representing more formal partnerships between organizations. In addition, about one-quarter of the connections (21.1 percent) represent an average strength of "cooperate," indicating informal interactions between these organizations.

Multisector relationships and collaborations originating in the health care and education sectors are prominent in Shasta County. Several interview respondents with knowledge about specific collaborative efforts in the county reported that initiatives originating in the health care and education spaces contributed to strengthening multisector relationships. In the health care space, respondents highlighted the role played by the Health Alliance for Northern California (HANC), a network of FQHCs in the region connecting Shasta's child- and youth-serving agencies. The network map (see Exhibit 5) reflects the average strengths of the connections between health care sector entities and other organizations in the county, showing collaborative relationships between the family support organization, the early childhood organization, and health center. In interviews, respondents from the early childhood and CBO-family support sectors also highlighted their relationships with this health care sector entity.

In the education space, several interview respondents described the efforts leading to the Community Connect program as an important example of multisector collaboration in the county. Community Connect is a school-based referral program that connects families in need of support with a Coordinator, who provides individualized guidance to get students and families the services they need. According to interview respondents, this initiative played a key role in

[6] The early childhood organization has a connection to the other nine organizations in the network, whereas the behavioral health agency, family support organization, county office of education, and managed care plan have connections to eight organizations each. Child welfare, juvenile probation, and health center follow with seven connections each. The strongest working relationship in the network occurs between the early childhood organization and the family support organization, which are integrated.

strengthening relationships and promoting partnerships between SCOE, the managed care plan, community-based service providers, and the juvenile probation division.

Child- and youth-serving agencies in Shasta County cooperate, collaborate, and share resources to support each other's efforts. Apart from participating in formal collaboratives, child- and youth-serving agencies in Shasta County often implement joint initiatives and share resources to support each other's work. For example, an interview respondent reported that SCOE used its funding to hire a coordinator for a workforce readiness program housed in the juvenile probation division. SCOE also funds training for probation staff on adverse childhood experiences (ACEs) and trauma-informed practices, among other topics. The network map supports these findings, showing that the four government agencies represented, including SCOE and the Shasta County Juvenile Probation Division, have connections to each other and the managed care plan, ranging in strength from "cooperate" to "collaborate." The map similarly shows that SCOE coordinates with both child welfare and juvenile probation sectors, and cooperates with the behavioral health agency. In addition, the managed care plan coordinates with the behavioral health agency, SCOE, and the juvenile probation division.

> "For this very rural area, there is a lot of collaboration in the health care space. And now that collaboration has spilled over into our educational space. We talked about the Shasta County Office of Education; they've gotten a couple of big community schools grants, and they have been really collaborative partners in that process as well."
>
> —CBO interview respondent

SCOE stands out as Shasta's most active representative of the education sector in ongoing collaborative efforts, with schools and school districts showing limited involvement. Although most interview respondents agreed that county agencies and organizations generally work across sectors to support children and youth behavioral health, several respondents noted that individual schools and school districts are typically not directly involved in existing collaboratives, and that the education sector is mostly represented by SCOE. One of these respondents considered that this could be due to the limited capacity of individual schools and school districts to directly participate in these efforts. Despite these circumstances, respondents noted that SCOE effectively represents school districts in collaboratives and keeps superintendents and staff updated on progress and activities.

Barriers to multisector collaboration

Multiple respondents noted that increasing stigma against LGBTQ+ populations and the organizations serving them has introduced challenges for cross-sector collaboration and behavioral health service delivery in the county. According to respondents, the current environment has introduced obstacles to sustaining partnerships between county agencies and CBOs. For instance, some CBOs reported experiencing audits beyond standard protocol, funding cuts, and payment delays for county-contracted services, which has impacted their financial stability and reduced their capacity to collaborate.

> "Additionally, we're allies to the LGBTQ+ community, so we've come under heavy scrutiny for that. So that's just been happening in the background. I say all of that to say, number one, there should never be a world in which politics preclude us from being able to serve our community. That's bananas. But number two, the way that that has impacted our relationship with [county agency] on a lot of levels has been pretty devastating."
>
> —CBO interview respondent

Facilitators of multisector collaboration

> "But early on, it was those kinds of conversations, like what are your hopes and dreams for your community? And then, that built this commonality amongst us; we all had common threads. So, pulling those out, and then pulling out what we viewed as the work that we needed to be doing at that table, and coming to consensus around that."
>
> —Early childhood interview respondent

Factors that facilitate multisector collaboration in Shasta County include the establishment of formal agreements, the availability of dedicated resources, and the experience acquired through specific initiatives. Respondents described how factors such as the existence of a charter or shared vision to guide the work, access to dedicated resources, and opportunities for in-person interactions supported multisector collaboration in the county. For example, respondents said that the resources provided by the Shasta Health Assessment and Redesign Collaborative (SHARC)—such as meeting facilitation, marketing and communication tools, and community engagement support—have strengthened multisector collaboration in the county. Interview respondents also hoped that relationships and processes established through SHARC might help protect the progress made in children and youth behavioral health from the recent leadership instability at the county government level. As noted above, respondents also highlighted initiatives such as the Community Connect program as a facilitator of multisector relationships in the education space. These earlier efforts facilitated connections between schools, CBOs, and the county's juvenile probation division. For example, a juvenile probation sector respondent described how their agency worked with SCOE to address school attendance issues and behavioral health needs among Native American youth. The respondent further described how this early work, funded by the Department of Corrections and SCOE, contributed to developing Shasta County's Community Connect program, which was subsequently expanded through the Care Teams/SBHIP targeted intervention. Community Connect allowed probation and school staff to work together to refer youth to behavioral health support, reduce school absences, and prevent future involvement with the juvenile probation system. Overall, respondents said these past efforts fostered a greater understanding of the need for multisector collaboration among county leaders and organizations.

> "You know what I think it is, when entities are forced to work together, we realize how much we need each other, and how helpful it is to get the perspective of the other agencies, because we, all, don't know what each other does."
>
> —Behavioral health interview respondent

Policies and funding requirements motivated agencies and organizations in the county to strengthen relationships and better coordinate efforts. Interview respondents highlighted specific policies and requirements as factors driving multisector collaboration in Shasta. These include AB 2083, the Children and Youth System of Care, which was passed in 2018 and required that all counties develop and implement a memorandum of understanding (MOU) outlining the roles and responsibilities of local entities that serve children and youth in foster care who have experienced severe trauma. One component of the MOU is the creation of a county-level Interagency Leadership Team (ILT) to "align interagency vision and trust."[7] According to one respondent, AB 2083 was a key facilitator of multisector collaboration in Shasta because the ILT provided a framework for agency leaders to work together to address the needs of children and youth in the county. The requirement to create an advisory committee as part of the process of applying for Proposition 47 grant funding also created an opportunity for agencies in the county to work together, pool resources, identify a common goal, and develop a strong application.[8]

[7] California Welfare Director's Association Conference. 2020. "AB 2083: Children and Youth System of Care. 2020." Accessed on November 12, 2024. https://www.cwda.org/sites/main/files/file-attachments/ab_2083__toward_effective_children_and_youth_system_of_care_1.45pm_draft3.pdf?1604511094.

[8] Proposition 47 was a voter-approved initiative passed in 2014 that reduced specified low-level drug and property crimes from felonies to misdemeanors. State savings generated through Proposition 47 are required to be awarded to public agencies to provide mental health services and substance use disorder treatment or diversion programs for those in the criminal justice system. See BSCC California. n.d. "Proposition 47 Grant Program." Accessed on November 12, 2024. https://www.bscc.ca.gov/s_bsccprop47/.

Leadership continuity within partner organizations and their consistent participation in collaborations help overcome barriers and contribute to the sustainability of multisector collaboratives in Shasta County. Respondents reported that individuals with long-term involvement, commitment to the collaboratives' goals, and decision-making power contributed to the sustainability of collaborations in the county. These respondents emphasized that leadership stability and continuity at partner organizations were key to achieving the consistent participation that is critical to sustaining a collaborative's vision and work. Respondents also considered that the characteristics of rural counties—including the smaller population size, lower population density, and tendency for the same individuals to play multiple roles in their organizations and communities—facilitate these dynamics. For example, a respondent noted that having the same individuals participating in collaborative efforts over a longer period helps build trust and promotes greater alignment.

> "I think something unique about Shasta is that I've been in my role since 2012, and a lot of other entities' leaders have also been in their role [for a long time]. And I think when you have stabilized leadership, you're able to work on this longer-term vision, and implement and make things happen. Whereas when you have a lot of transition in leadership, the vision changes, and progress stops or gets stalled. And so in Shasta, we have a very collaborative team, and we meet pretty regularly with a lot of our partners and we're always talking about improving services for our youth."
>
> —Juvenile probation sector respondent

Spotlight on multisector collaboratives that support children and youth behavioral health

Shasta Health Assessment and Redesign Collaborative (SHARC)

SHARC was first established in 2009 to build a more organized health care delivery system for Shasta County. Facilitated by the Health Alliance of Northern California (HANC), SHARC joined the California Accountable Communities for Health Initiative in 2023 in response to the mental health and substance use crisis occurring at that time. SHARC includes a wide range of partners and coordinates system change efforts to achieve a more integrated approach to care. Its subcommittee, the Community Health Alliance for Children and Youth (CHACY), is dedicated to the CYBHI. Key objectives include expanding access to behavioral health services, increasing funding, prioritizing upstream solutions, and streamlining referrals to enhance accessibility for families.

> "[SHARC leads] are effective. They get stuff done, and they have real, honest conversations. And so, I'm consistently inspired by them and everything that SHARC is doing."
>
> —CBO interview respondent

SHARC includes representation from health care agencies, social service providers, and education institutions, among other relevant sectors. Most survey respondents reported moderate progress in enhancing trust between partner organizations and community members, and reducing barriers for children, youth, and families to access behavioral health supports and services. Interview respondents also agreed that SHARC is a productive multisector collaborative doing important work in the county to support public health improvements in general and children and youth well-being in particular. These respondents highlighted the work of the CHACY subcommittee as a key component of its efforts to support children and youth behavioral health. One of these respondents said that this subcommittee will help partners involved in the Scaling EBPs and CDEPs workstream identify strategies to sustain the program after the CYBHI grant ends.

Shasta Strengthening Families Collaborative (SSFC)

Founded in 2011, the Shasta Strengthening Families Collaborative (SSFC) focuses on "strengthening families to overcome adversity by building hope and resilience."[9] SSFC promotes and enhances the well-being and resilience of families by providing support, resources, and education, and creating a nurturing environment for families to thrive. SSFC partners include government agencies, early childhood organizations, and CBOs.

SSFC supports a coordinated response to addressing the prevalence of adverse childhood experiences in the county. Most survey respondents reported that SSFC includes diverse voices and perspectives from multiple relevant sectors, such as education, juvenile probation, and nonprofit service providers. SSFC is also developing a shared vision and goals for aligning services and systems with the needs and desires of the people being served, and expanding upstream solutions (for example, promotion, prevention, and early intervention) to support the well-being and behavioral health of children, youth, and families. Interview respondents described activities that SSFC has implemented over past years, including community education events and training on adverse childhood experiences. Although respondents noted that the collaborative has experienced challenges establishing a shared agenda and recovering from the disruptions caused by the pandemic, its work is ongoing, and members meet regularly to continue advancing the collaborative's goals.

Other multisector collaboratives

Survey and interview respondents identified other multisector collaboratives that support children and youth behavioral health in Shasta County, including Reach Higher Shasta, which focuses on promoting children's and youth's well-being from cradle to career. Other collaboratives identified include the First 5 Commission, Healthy Shasta, the Homeless Youth Alliance, and Youth Options.

[9] Shasta Strengthening Families. n.d. "About Us." Accessed October 1, 2024. https://shastastrengtheningfamilies.org/about-us/.

IV. CYBHI Workstreams Implementation

The CYBHI is implementing 20 distinct workstreams, each designed to contribute to transforming the behavioral health ecosystem, with many intended to improve multisector collaboration. To date, the workstreams are at various stages of implementation and active to varying degrees across California counties.

Overview of workstream activity in Shasta County

Overall, Shasta County is locally implementing eight CYBHI workstreams that involve the distribution of funding to county or community entities, including 37 grants, as of September 2024.[10] This section of the case study discusses Shasta's implementation experiences with **education sector workstreams**, including SBHIP, the School-Linked Partnership and Capacity Grants, and the CYBHI Fee Schedule. It also discusses the experiences of organizations that are implementing workstreams in **home and community settings**, including two Scaling EBPs and CDEPs grants and a CBO Behavioral Health Workforce grant. Shasta County has grants under other Broad Behavioral Health Workforce Capacity programs, including the Peer Personnel Training and Placement Program, the Social Work Education Capacity Expansion Grants, and the SUD Earn and Learn Grant Program. Other workstreams in the county include CalHOPE Student Services; Mindfulness, Resilience, and Well-Being Grants; Wellness Coach Workforce; and Safe Spaces.

Implementation of education sector workstreams

In Shasta County, SBHIP, the CYBHI Fee Schedule, and School-Linked Partnership and Capacity Grants are in the early stages of implementation. SCOE has made progress

The CYBHI Fee Schedule, SBHIP, and the School-Linked Partnership and Capacity Grants

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. The Fee Schedule provides guidance for LEAs 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 substance use disorder treatment, (2) identifies applicable billing codes and rates for behavioral health services, and (3) specifies which providers may bill for behavioral health services. The Fee Schedule requires commercial and public payers to pay school-linked providers. In addition, behavioral health services provided under the Fee Schedule may not require co-payments, co-insurance, deductibles, or any other form of cost sharing. Unlike the certified public expenditure approach of the LEA Medi-Cal Billing Option Program (LEA BOP), LEAs receive reimbursement for the entire service rate, which frees up local funds for further investment in schools and prevents the administrative burden of cost settlement reconciliation.

SBHIP focuses on developing a behavioral health infrastructure by helping MCPs 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; depending on the interventions selected, SBHIP activities may support increasing capacity for promotion and prevention or decreasing administrative barriers to clinical care in or near schools and are intended to enhance partnerships between LEAs and MCPs.

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 provides training and TA 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. Seventy 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.

[10] The sum of CYBHI workstreams and grants operating in this county encompasses all awards to entities operating CYBHI workstreams in the county as of September 2024, including awards that seek to reach multiple counties. For the purposes of calculating the number of awards at the county level, we relied on publicly available award announcements or direct departmental confirmation of counties in which awardees operate or intend to use funding; as a result, these estimates do not reflect select Broad Behavioral Health Workforce programs for which this information is currently unavailable.

in working with the managed care plan to implement two SBHIP-targeted interventions: (1) Care Teams and (2) Building Stronger Partnerships to Increase Access to Medi-Cal Services (Building Stronger Partnerships). Through Care Teams, SCOE is building on the previously established Community Connect program by expanding access to school-based case coordination and referrals to behavioral health resources and community support. In alignment with the Building Stronger Partnerships intervention, SCOE developed a toolkit that helped LEAs select third-party vendors to bill for Medi-Cal-covered behavioral health services. In the future, SCOE plans to use the toolkit to select an EHR vendor for a county-wide CYBHI Fee Schedule consortium. In part due to the progress made through implementation of these targeted SBHIP interventions, SCOE and one Shasta LEA were accepted as participants in the first cohort of the CYBHI Fee Schedule.

To prepare for implementing the CYBHI Fee Schedule, SCOE engaged Shasta's 25 school districts/LEAs and 15 charter schools to learn about their interests and priorities for funding available through the School-Linked Partnership and Capacity Grants. An education sector respondent explained that the county plans to implement the CYBHI Fee Schedule as a "consortium," in which any interested LEA can participate, with billing facilitated by SCOE. The consortium will also support billing for LEA BOP and School-Based Medi-Cal Administrative Activities (SMAA). This consortium approach is designed to support smaller LEAs that may not have the resources to implement the CYBHI Fee Schedule without county-level support. However, participating in the consortium is voluntary and SCOE does not expect all county LEAs to join. As of late fall 2024, an education respondent reported that 34 of Shasta's LEAs and charter schools have opted into the consortium for the School-Linked Partnership and Capacity Grants, two others plan to implement the grant on their own, and a small number chose to forgo the grant entirely. If the consortium model does not work out, the respondent noted that SCOE will explore building a robust technical assistance program.

> "When this [the Fee Schedule] came out…in the spring, they [superintendents] panicked because it was too much too fast and then they were being asked to make a decision. I did a follow-up meeting just to say, here's what I know about it. They were all just deer in the headlights like, I've never even heard of this, and I don't have any idea what you're talking about, and how do I make a decision?"
>
> —Education interview respondent

Although Shasta organizations and agencies are taking steps to implement education sector workstreams, capacity constraints have introduced challenges to implementation. When discussing barriers to school-based workstream implementation, several respondents from the education and managed care sectors noted that Shasta County has many small LEAs that were functioning at or over capacity before introduction of the CYBHI. In this context, the amount of time available for LEAs to decide whether to participate in the School-Linked Partnership and Capacity Grants was limited, given school calendars and existing priorities. Similarly, an education respondent reported that county education agencies in Northern California had difficulty absorbing the rapid flow of information about the CYBHI Fee Schedule, given existing capacity constraints. This respondent also thought that superintendents from Shasta were less involved in the design of CYBHI workstreams and therefore were less likely to have timely access to information about implementation expectations. Relatedly, another respondent indicated that the level of effort required to make a transformational shift as significant as adoption of the CYBHI Fee Schedule is quite high in counties like Shasta, where organizations and agencies tend to have fewer resources and are also simultaneously implementing other major state-funded initiatives. CalHHS and DHCS efforts to support implementation of the educational workstreams are expected to help address some of these challenges. For example, in fall 2024, the agency clarified the deadline for expenditure of School-Linked Partnership and Capacity Grant funds was through June 30, 2027. These efforts also include the use of a cohort system to enable later cohorts to benefit from the lessons learned and promising practices established by earlier cohorts, offering technical assistance under the School-Linked Partnership and Capacity Grants, and releasing guidance outlining policies and operational requirements for the Fee Schedule and resources to support claims processing in partnership with the third-party

administrator. DHCS also plans to release the updated CYBHI Fee Schedule Program Manual in the first quarter of 2025 for county offices of education, LEAs, public institutions of higher education, designated providers/practitioners, and managed care plans and insurers to provide guidance on fee schedule policies and operational requirements. Finally, the CYBHI has undertaken a variety of activities to better understand and address implementation challenges across educational workstreams, including through supports and technical assistance for COEs and LEAs. For example, CalHHS and DHCS hold regular meetings with the California Department of Education and LEAs; contract with education entities to provide grant administration support and inform strategies to improve implementation; and engage frequently with a range of education stakeholders at meetings, conferences, and through other venues.

In Shasta County, work completed through SBHIP is helping to increase access to school-linked behavioral health services in the county and nearby areas. Respondents reported that the funding accessed through the SBHIP Care Teams intervention allowed nearly every school in Shasta to have access to a Community Connect Liaison. These liaisons refer students and families to behavioral health services and other community resources, such as housing, food, utilities, and transportation. Similarly, the toolkit developed through the Building Stronger Partnerships intervention is helping Shasta LEAs select third-party vendors to bill for Medi-Cal-covered behavioral health services and will be used to help SCOE select an EHR vendor for the CYBHI Fee Schedule consortium. This toolkit is anticipated to support schools beyond Shasta County because SCOE plans to make it available to other counties in the region.

Scaling Evidence-Based Practices (EBPs) and Community-Defined Evidence Practices (CDEPs)

The **Scaling EBPs and CDEPs grant program**, administered by DHCS, distributes grants to organizations seeking to scale EBPs or CDEPs. EBPs are defined as having rigorous empirical evidence of effectiveness in improving children's and youth's behavioral health, whereas CDEPs are community-based behavioral health practices that have reached a strong level of support within specific communities. The program is distributing five rounds of grants to organizations seeking to scale EBPs or CDEPs to enhance the accessibility and quality of prevention services and clinical care offered in their communities. Many of these grant awards focus on training additional behavioral health care providers in EBPs. 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. To date, the Scaling EBPs and CDEPs workstream has awarded $248 million in CYBHI funding to 424 organizations across all 58 counties in California, with additional awards pending for early childhood wraparound services. The current grant awards support the delivery of more than 30 different evidence-based and community-defined evidence practices across the state. Note that the Scaling EBPs Round 3 grants, which focus on early childhood wraparound services, were announced in September 2024 and are not covered in this report.

Implementation of home and community-based sector workstreams

Shasta County organizations funded through the Scaling EBPs and CDEPs workstream have engaged providers to design interventions and plan for their implementation. The relationships previously established between implementing organizations facilitated these planning efforts and helped ensure that programs were tailored to local needs. Two Shasta County organizations that received funding under Round 2 of the Scaling EBPs and CDEPs grants reported that they are making progress in the design and planning of funded programs. This planning work includes establishing processes to integrate the delivery of trauma-informed behavioral health services into regular school schedules, coordinating with SCOE to create referral pathways between schools and partnering CBOs, developing training content for CBO providers, and creating informational resources for school staff.

> "It was really more about [leveraging] the relationship that Community Schools had already created, and our really good relationship with the school district. So, there was not as much legwork that had to be done there."
>
> —Early childhood interview respondent

One Scaling EBPs and CDEPs Round 2 grantee noted that an early success of their work to expand access to TF-CBT was bringing together SCOE and local service providers to design the initiative and plan for its implementation. This grantee emphasized that the school-based referral process that their organization is developing through this grant relies heavily on the relationships previously developed through the Community Connect initiative. Through this process, school staff will use the SCOE Community Connect system to receive information about available TF-CBT services and refer children and families to providers at partnering CBOs. Another grantee planning to implement CBITS described how this program could help address barriers to behavioral health services in the community. By providing services at schools, the organization expected to reach all students regardless of insurance status, mitigate transportation access issues, and support children with different needs, not just the most severe cases.

An organization that received a Broad Behavioral Health Workforce Capacity workstream grant is using the funding to provide recruitment, retention, and other supports to behavioral health professionals and students. A representative from the organization reported that during the 2024/2025 program year, they used grant funds to pay out $2,000 in sign-on bonuses and $20,000 in retention bonuses. As of late fall 2024, the organization also planned to continue paying annual retention bonuses and providing scholarships for undergraduate degrees, stipends for graduate degrees, and loan repayment opportunities through this grant. The grantee representative reported that they originally planned to use the funding to implement an internship program for students in case management, psychology, and related fields. However, the lack of a local pipeline of interns interested in participating in a previous workforce development program led them to re-focus the CYBHI-funded efforts on recruitment and retention. The grantee hoped that the lessons learned through that previous program will continue to facilitate the future implementation of workforce development activities under the CYBHI grant.

Community-Based Organization (CBO) Behavioral Health Workforce Program

The **Community-Based Organization (CBO) Behavioral Health Workforce Program** provides four-year grant funding to eligible CBOs to support the recruitment and retention of behavioral health personnel. The funding can be used to provide loan repayments, scholarships, and stipends for both paid and volunteer CBO behavioral health staff in exchange for a 12-month service commitment. In March 2023, approximately $116 million was awarded to 134 CBOs across the state.

Perceptions of workstream effectiveness in addressing behavioral health needs and equity

Although the implementation of education workstreams is still in the early stages in Shasta County, many respondents praised SCOE for playing a major role in bringing children and youth behavioral health programming to the county. In particular, SCOE's work facilitating the Community Connect program and expanding it using SBHIP funds helped address challenges in getting children and youth referred to appropriate behavioral health care. Shasta County schools are also using these resources to provide more prevention, early intervention, and social-emotional learning support.

Community-based workstreams have the potential to address the needs of children and youth who have experienced trauma, particularly those who live in more rural or remote parts of the county. Scaling EBPs and CDEPs Round 2 grantees in Shasta were hopeful that their programs could help increase access to TF-CBT and CBITS, and might reduce school absences due to mental health issues. Grantees also reported that a key objective of their programs is to connect children and families in need of trauma-informed care with support as early as possible. One of the grantees further noted that the CBITS funded through the grant will reach children attending two high-need

schools in the county. According to this respondent, the district identified these schools by the higher prevalence of behavioral health conditions among the student population. Another Scaling EBPs and CDEPs grantee expected that the provider training and referral process developed through the grant will help them reach populations in remote areas of the county where residents face transportation and technology barriers to care. By training providers at partner organizations across the county, the grantee expected to increase the availability of TF-CBT outside of Redding. The grantee also expected that the referral process developed in coordination with schools would facilitate access to these services among children and families in those areas.

V. Conclusion

Shasta County's children and youth face behavioral health challenges at higher rates than children and youth across the state, as well as difficult socioeconomic conditions, including high poverty rates, food insecurity, and transportation barriers. The available resources do not adequately address these challenges. Respondents highlighted insufficient services for children and youth with mild-to-moderate behavioral health conditions and those in need of residential care. These gaps are reportedly exacerbated by severe workforce shortages and, more recently, audits and funding cuts that hinder the efforts of CBOs to provide needed care are perceived as undermining efforts to strengthen the behavioral health ecosystem. Although these issues affect all residents, respondents noted that some groups, including children and youth in more remote areas of the county and members of the LGBTQ+ population, experience greater barriers and are particularly at risk for adverse outcomes.

Our analysis—drawing from available data, early implementation findings, and interviews with leaders—indicates that Shasta County is making progress in planning and implementing CYBHI-funded efforts to increase access to nonclinical and preventative services; address barriers to care in more remote areas; and support CBOs in delivering needed services to children and youth, including those populations particularly at risk for adverse outcomes. In particular, workstreams in the education and home and community-based sectors in Shasta County are contributing to the development of enhanced payment mechanisms, new provider trainings, and expanded referral systems to increase access to school-linked services, trauma-focused therapies, and supports for nonclinical behavioral health needs. These efforts are also helping strengthen relationships between the county office of education, the managed care plan, school districts, and CBOs. Finally, CYBHI funding is supporting behavioral health workforce development efforts tailored to the needs of rural counties and the realities of organizations serving these communities.

The successful implementation of these programs in the future will partially depend on the extent to which organizations, particularly those in more remote areas of the county, can recruit and retain needed behavioral health professionals, such as licensed psychologists and therapists. Respondents also noted that local investments and buy-in will be key to ensure that the CYBHI-funded efforts are maintained after aspects of initiative sunset and, ultimately, to better align the availability of behavioral health services in the county with the level of need. Despite the challenges their organizations face, interview participants emphasized their commitment to continue working in partnership and across sectors to raise awareness about these needs, address barriers to care, and improve behavioral health in Shasta County.

Appendix A: Data Sources for County Population Characteristics, Prevalence of Behavioral Health Symptoms and Diagnoses, and Behavioral Health Resources

Variable	Source	Years
Population		
Total population (N)	American Community Survey at https://data.census.gov/table.	2022
Population, 0–4 years (N; %)		
Population, 5–19 years (N; %)		
Population, 20–24 years (N; %)		
Five-year population growth (%)	American Community Survey at https://data.census.gov/table.	2017–2022
Five-year population growth, 0–24 years (%)		
Density (population per square mile)	U.S. Census at 2020 Census Demographic Data Map Viewer.	2020
Race and ethnicity		
White, non-Hispanic (%)	American Community Survey at https://data.census.gov/table.	2022
Black or African American, non-Hispanic (%)		
American Indian and Alaska Native, non-Hispanic (%)		
Asian, non-Hispanic (%)		
Native Hawaiian and other Pacific Island American, non-Hispanic (%)		
Some other race, non-Hispanic (%)		
Two or more races, non-Hispanic (%)		
Hispanic or Latino (%)		
Birthplace and language		
Foreign-born, 0–24 years (%)	American Community Survey at https://data.census.gov/table.	2022
English-proficient, 5–17 years (%)		
Education (18+ years)		
High school or higher (including college) (%)	American Community Survey at https://data.census.gov/table.	2022
College degree or higher (%)		
Economic indicators, socioeconomic, and neighborhood characteristics		
Population within urban blocks (%)	U.S. Census at https://www2.census.gov/geo/docs/reference/ua/2020_UA_COUNTY.xlsx.	2020
Population within rural blocks (%)		
Population below 200% of the federal poverty line (%)	American Community Survey at https://data.census.gov/table.	2022
Median income (USD)		
Unemployment (%)		
Households with high housing cost burden (%)	KidsData.org analysis of the American Community Survey	2019
Food insecurity, overall (%)	Feeding America's Map the Meal Gap data at https://map.feedingamerica.org/.	2021
Food insecurity, 0–18 years (%)		

Variable	Source	Years
Healthy Places Index (rank)	Healthy Places Index at https://map.healthyplacesindex.org/.	2015–2019
Diversity Index (rank)		
Health status		
Population with a disability (%)	American Community Survey at https://data.census.gov/table.	2022
Population with a disability, 0–17 years (%)		
Health insurance status (population 0–25 years)		
Medi-Cal or other means-tested public coverage (%)	American Community Survey at https://data.census.gov/table.	2022
Private coverage (%)		
Uninsured (%)		
TRICARE/military coverage (%)		
Medicare coverage (%)		
Prevalence of behavioral health outcomes		
Children and youth insured through Medi-Cal with a mental health diagnosis or emotional symptoms (%)	Transformed Medicaid Statistical Information System Analytic Files at https://resdac.org/cms-virtual-research-data-center-vrdc and Mathematica's analysis	2022
Children and youth insured through Medi-Cal with a substance use disorder diagnosis (%)		
Youth ages 12 to 17 years old who felt their family stood by them during difficult times (%)	California Health Interview Survey (Center for Health Policy Research at the University of California, Los Angeles) and Mathematica's analyses; applied for data at https://healthpolicy.ucla.edu/our-work/california-health-interview-survey-chis/access-chis-data	2022
Youth ages 12 to 17 years old who felt at least two non-parent adults took genuine interest (%)		
Youth ages 12 to 17 years old who felt supported by friends (%)		
Students in Grade 9 who reported seriously considering attempting suicide in the past 12 months (%)	California Healthy Kids Survey County Reports at https://calschls.org/reports-data/search-lea-reports/ and Mathematica's analysis	2019–2021
Students in Grade 11 who reported seriously considering attempting suicide in the past 12 months (%)		
Students in grade 9 reporting school absences due to mental health issues (%)		
Students in grade 9 reporting school absences due to alcohol or drug use (%)		
Inpatient hospitalizations per 1,000 children and youth for behavioral health diagnosis	California Department of Health Care Access and Information; applied for data at https://datarequest.hcai.ca.gov/csm	2022
Emergency department visits per 1,000 children and youth for any behavioral health diagnosis		

Variable	Source	Years
Students in grades K–12 who were chronically absent (%)	California Department of Education data at https://www.cde.ca.gov/ds/ad/filesabd.asp.	2022–2023
Behavioral health care resources		
Primary care health professional shortage area designation	Agency for Healthcare Research and Quality's Social Determinants of Health Database at https://www.ahrq.gov/sdoh/data-analytics/sdoh-data.html.	2019
Mental health professional shortage area designation		
Number of child and adolescent psychiatrists per 100,000 children <18 years	American Academy of Child and Adolescent Psychiatry, U.S. Census, at https://www.aacap.org/AACAP/Advocacy/Federal_and_State_Initiatives/Workforce_Maps/Home.aspx.	American Medical Association Masterfile 2024, U.S. Census 2022
Number of nonpsychiatrist behavioral health providers licensed with county Medi-Cal Specialty Mental Health Services Plans per 100,000 residents	DHCS needs assessment at https://www.dhcs.ca.gov/Documents/Assessing-the-Continuum-of-Care-for-BH-Services-in-California.pdf.	2021
Number of outpatient treatment programs for young adults per 100,000 children and youth 0–24[a]	DHCS needs assessment at https://www.dhcs.ca.gov/Documents/Assessing-the-Continuum-of-Care-for-BH-Services-in-California.pdf.	2021
School-based health programs with mental health services per 100,000 children and youth <18	School-Based Health Alliance information at https://www.schoolhealthcenters.org/school-based-health/sbhcs-by-county/.	2024
Number of FQHCs or FQHC look-alike sites per 100,000 children and youth ages 0–25	Health Resources and Services Administration FQHC and look-alike locator at https://data.hrsa.gov/data/reports/datagrid?gridName=FQHCs.	2024

[a] While the numerator for this measure is based on the number of outpatient treatment programs for *young adults*, we use a more inclusive denominator of all children and youth 0-24 years since the original data (https://www.dhcs.ca.gov/Documents/Assessing-the-Continuum-of-Care-for-BH-Services-in-California.pdf, Table E-4) suggest that many of these programs many pertain to children as well.

Appendix B: Network Analysis Methodology and Measures

This appendix describes our network analysis methodology and the measures for Shasta County.

Methodology

We invited 14 organizations in Shasta County to complete the NEES via email and received responses from 10 organizations (for a 71.4 percent response rate). Invited organizations included government agencies and departments; a managed care plan; and CBOs, including organizations focused on abuse and violence prevention. Administrators of child- and youth-serving organizations, such as directors and executive directors, rated the strength of their organizations' connections with the other organizations invited to complete the survey on a 5-point scale, ranging from (1) coexist to (5) integrated.[11,12] After using R software to conduct a network analysis based on these ratings, we then produced and developed the network map using Kumu software. We also used ratings across all organizations to represent the average strength of the whole network.

Exhibit B.1 shows the 5-point scale that survey respondents used to rate their organizations' connections with other organizations.

Exhibit B.1. Connection ratings and description

Score	Rating strength	Rating description
1	Coexist	No or limited relationship between organizations
2	Cooperate	Informal interactions on specific activities or projects
3	Coordinate	Intentionally plan or work together for greater outcomes
4	Collaborate	Shared mission, goals, decision makers, or resources
5	Integrated	Fully integrated programs, planning, or funding

When two organizations rated their connection with each other, we calculated the average strength of their connection for inclusion in the network map. For example, if Organization A and Organization B rated their connection with each other as "cooperate" (2) and "coordinate" (3), respectively, the average strength of the connection between the two organizations would be 2.5, or "cooperate."

In Shasta County, sometimes only one organization rated a connection between two organizations. To determine whether to include these ratings in our analysis and network map, Mathematica conducted an agreement analysis using cases for which we had ratings from both sides of a connection (that is, both organizations rated the connection). This analysis showed us whether two organizations that reported a connection with each other tended to rate the strength of their relationship in a similar way. Because the 5-point rating scale is subjective, we defined agreement as two organizations providing the same rating or being 1 point apart. For example, if one organization rated the connection "cooperate" (2) and the other organization rated it "coordinate" (3), we considered them to be in agreement. Using this standard, we then calculated how often organizations agreed with each other about the strength of their relationships.

Across all nine counties included in the case studies, a high rate of agreement (70.0 percent or greater) suggests that connection ratings are generally in agreement with each other, and thus a single organization's rating of the strength of a relationship can be used to represent the actual strength as reported by both ends of the connection. In Shasta County, the rate of agreement was 60.5 percent. Because this rate did not meet our threshold for a high rate of agreement, we

[11] Adapted from the Tamarack Institute's Collaboration Spectrum Tool https://www.tamarackcommunity.ca/hubfs/Resources/Tools/Collaboration%20Spectrum%20Tool%20July%202017.pdf?hsLang=en-us.

[12] The connections in the network map may not represent the perspectives or experiences of all organization staff.

did not include ratings of connections in the network analysis or map when only one organization rated a relationship.[13]

Network measures

Exhibit B.2 shows the social network analysis summary statistics and descriptions for Shasta County.

Exhibit B.2. Shasta County's network analysis summary statistics

Network measure	Statistic	Description
Observed network size	10	The number of organizations included in the network map. This count includes organizations that responded to the survey.
Number of observed connections	76	The total number of connections reported by organizations that completed the survey. This reflects the number of connections that were bidirectional (that is, both organizations rated their connection with each other).
Average network strength	3.18	The average strength rating for the network, where the denominator is the number of observed bidirectional connections.

Exhibit B.3 shows the average connection strength range, rating, and the number and percentage of connections in the network map that fell under each rating category.

Exhibit B.3. Number and percentage of connections in the network map, by average strength rating

Average strength range	Rating strength	Number of connections	Percentage of connections
1.00–1.99	Coexist	3	7.9%
2.00–2.99	Cooperate	8	21.1%
3.00–3.99	Coordinate	16	42.1%
4.00–4.99	Collaborate	10	26.3%
5.00	Integrated	1	2.6%
Total		**38**	**100.0%**

[13] As a result, the network map does not include connections with organizations that were invited to participate but did not complete the survey.

Appendix C: Details on the Implementation of Selected Workstreams

The following tables summarize key implementation findings related to select workstreams.

Workstream: Student Behavioral Health Incentive Program	
Short overview	• As its SBHIP targeted interventions, SCOE is implementing (1) Care Teams and (2) Building Stronger Partnerships to Increase Access to Medi-Cal Services. All Shasta school districts are participating in both SBHIP interventions. • SCOE identified these interventions as promising strategies to address service gaps in the county, based on a needs assessment conducted in 2022. Through this assessment, officials identified (1) limited access to clinicians and therapists in more rural or remote areas, and (2) a gap in communications and awareness of available services as major issues in the county. • To address these needs, the Care Teams intervention will expand on an existing program called Community Connect to provide outreach, engagement, home visits, and linkages to social services to address non-clinical behavioral health needs. Through the Building Stronger Partnerships intervention, SCOE developed a toolkit to help LEAs select third-party vendors to bill for Medi-Cal-covered behavioral health services. In the future, SCOE plans to use the toolkit to select an EHR vendor for the CYBHI Fee Schedule consortium.
Key implementation findings	**Flexible funding and strong relationships were critical to implementing the two SBHIP interventions.** • Respondents said flexible workstream funding and the ability to undertake efforts that best address community needs have been critical to Shasta County's implementation of SBHIP • The strong relationship forged between SCOE and the managed care plan, and the resource SCOE accessed through this partnership, including high-quality technical assistance and subject matter experts, facilitated the implementation of SBHIP in Shasta County. "Any time you're going to give me earned, unrestricted dollars, that's worth its weight in gold. That's a beautiful thing. That allows us to do the types of things that are best practice around social, emotional, and mental health for students that most of the money that we can access [does] not allow us to do." —Education interview respondent
Sustainability and what's next	• **Funding constraints and workforce shortages raise concerns about the sustainability of the SBHIP Care Teams intervention,** which will depend on the future availability of funding and behavioral health professionals to support program infrastructure and service delivery. • **Shasta will share the toolkit developed through the SBHIP Building Stronger Partnerships intervention with other counties in the region to support their implementation of the CYBHI Fee Schedule.**

Workstream: School-Linked Partnership and Capacity Grants	
Short overview	To prepare to implement the School-Linked Partnership and Capacity Grants, SCOE contacted all 25 school districts and 15 charter schools to learn about their interests and priorities. LEAs decided individually whether to participate, either on their own or as part of SCOE's consortium model. As of fall 2024, 34 LEAs and charter schools opted into the countywide consortium, two others plan to implement the grant on their own, and a small number of others chose to forgo the grant entirely.
Key implementation findings	**Respondents agreed that the rollout of the School-Linked Partnership and Capacity Grants was challenging, citing tight timelines and incomplete information.** • Shasta has many small LEAs that functioned at or over capacity before the introduction of the CYBHI. In this context, the amount of time available for LEAs to decide whether to participate in the Capacity Grants was limited, given school calendars and existing operational priorities. • CalHHS and DHCS efforts to support implementation of the School-linked Participation and Capacity Grants are expected to help address some of these challenges. "The requirements for getting money through the Capacity Grant are that you have to [do] outreach [to] every single district and charter school and go and see if they want to participate in the Capacity Grant efforts, which is not a bad thing. But the timeline to have done that was really short and not realistic for schools…. I know from talking with Shasta's leaders that it's been a huge extra burden for them to meet those tight timelines." —Managed care plan interview respondent
Sustainability and what's next	A total of 34 LEAs and charter schools opted into the countywide consortium. SCOE leaders are looking to hire consultants to support planning and developing a billing consortium for LEA BOP, SMAA, and the CYBHI Fee Schedule. If the consortium model does not work out as planned, SCOE will explore building a robust technical assistance program.

Workstream: CYBHI Statewide Multi-Payer School-Linked Fee Schedule	
Short overview	• Shasta County plans to implement the CYBHI Fee Schedule as a "consortium," in which any interested LEA can participate, with billing facilitated through SCOE. This consortium approach is designed to centralize claims processing in support of smaller LEAs with limited capacity, but it is voluntary and will not be used by all LEAs. • One LEA participating in the first cohort plans to implement the CYBHI Fee Schedule on its own because it feels well prepared to begin processing claims by fall 2025.
Key implementation findings	**Officials at SCOE and the LEA participating in Cohort 1 of the CYBHI Fee Schedule are enthusiastic about this workstream's potential to improve access to services in the county. Key stakeholders are mobilizing resources and using existing infrastructure to support implementation for the Cohort 1 LEA.** • An education respondent reported that the Cohort 1 LEA has the resources and infrastructure needed to begin submitting claims and troubleshooting any issues that might arise as it implements new processes. • Every school in the Cohort 1 LEA has a counselor who is a marriage and family therapist, social worker, or Pupil Personnel Services credentialed counselor. All counseling staff have a National Provider Identifier (NPI), which facilitates billing. "I just immediately was like 'we need this' [Fee Schedule]. If there's any chance we can get on board here, let's do it. I totally expect [the] first cohort is going to be a lot of…there's going to be a lot of fumbles, I would expect that." —Education interview respondent • For the Cohort 1 LEA, a robust in-house technology department ensured data-sharing systems and protocols were in place to collect needed data and comply with data collection, storage, and transmission requirements. The LEA collected student forms at the beginning of the 2024/2025 school year via its digital student information system. • The Cohort 1 LEA has existing relationships with organizations that bring mental health services onto campus and plans to continue contracting with them through the CYBHI Fee Schedule. • SCOE hosted special meetings to increase awareness and understanding of the CYBHI Fee Schedule, and share the experience of the LEA participating in Cohort 1. **Respondents across the education and managed care sectors agreed that SCOE's strong leadership and commitment to increasing access to school-based behavioral health services are key facilitators of this workstream's progress in the county.**
Sustainability and what's next	• The Cohort 1 LEA will begin service provision and billing under the CYBHI Fee Schedule in fall 2025 and amend its systems as it learns through the process. This LEA recommended that future LEAs looking to implement the CYBHI Fee Schedule create space to work through the complexities of the program and take advantage of the monthly onboarding meetings to ask questions. • SCOE leaders are looking to hire consultants to support planning and developing a billing consortium for LEA BOP, SMAA, and the CYBHI Fee Schedule. If the consortium model does not work out, SCOE will explore building a robust technical assistance program.

Workstream: Scaling EBPs and CDEPs	
Short overview	• Two Shasta County organizations who received funding under Round 2 of the Scaling EBPs and CDEPs workstream discussed their efforts to implement two evidence-based practices: CBITS and TF-CBT. • The organization implementing the CBITS intervention plans to provide psychotherapy counseling, group counseling, neurofeedback, and mentoring to 6th- through 8th-grade students in two high-need schools in the Redding School District. The district identified these schools for the program because of the higher prevalence of behavioral health conditions in the student population. • The organization implementing the TF-CBT program plans to train providers at partnering CBOs to deliver TF-CBT to children and youth attending county schools who have experienced traumatic or violent events.
Key implementation findings	**Organizations in Shasta County are making progress in their plans to provide trauma-focused services in schools using workstream funding.** • The planning includes establishing processes to integrate service delivery into regular school schedules, coordinating with SCOE to create referral pathways through the Community Connect program, developing training content for providers at CBOs, and creating informational resources for school staff. • Organizations receiving funding through the Scaling EBPs and CDEPs workstream are confident that they have the needed staff and resources to implement activities successfully during the grant period. **The strong relationships developed between SCOE and community-based service providers in the county facilitate the implementation of the grant-funded efforts.** • The referral process that one organization is developing to connect children and families to services relies heavily on the relationships previously developed through the Community Schools/Community Connect initiative. Through this process, school staff will use the SCOE Community Connect system to receive information about available TF-CBT services and refer children and families to providers at partnering CBOs.
Sustainability and what's next	**Although implementers expect that the relationships and infrastructure developed through the grants will help sustain the programs after the grant period ends, local-level investments and buy-in also are needed to ensure these efforts are institutionalized.** • An implementing organization expects that the billing infrastructure developed for school-linked behavioral health services and the strong relationships between community-based service providers and SCOE will help sustain the efforts after the Scaling EBPs and CDEPs grant ends. • The long-term sustainability of the work done through the Scaling EBPs and CDEPs grants will depend on the future availability of resources, support, and leadership buy-in for these practices from entities such as SCOE, the county behavioral health agency, and school districts. "I think that part of the hesitancy around how we build sustainability [is that] we're not sure if we're going to get buy-in from the larger [county agency].... And this [county agency] used to be...innovative. They were doing brain mapping...they're doing the more innovative kind of things around behavioral health and mental health. And now you can't say that anymore." —Early childhood interview respondent

Workstream: Broad Behavioral Health Workforce Capacity: Community-Based Organization (CBO) Behavioral Health Workforce Program	
Short overview	• An organization receiving funding through the Broad Behavioral Health Workforce workstream (CBO Behavioral Health Workforce Program) planned to offer internship opportunities and job placement support to county students finishing their master's-level programs in case management, psychology, and related fields. At the time of the interview, the respondent reported that their original plans for the grant were on hold while the organization reassessed its approach to workforce development and underwent a restructuring period. • As of late fall 2024, a representative from the organization reported that although they continued to face challenges recruiting billable behavioral health professionals, they used this grant to pay out $2,000 in sign-on bonuses and $20,000 in retention bonuses during the 2024/2025 program year. They also planned to continue paying retention bonuses annually and promoting scholarships for undergraduate degrees and certifications, stipends for graduate degrees, and loan repayment opportunities through this grant.
Key implementation findings	**The organization funded through the CBO Behavioral Health Workforce Program in Shasta delayed implementation and re-assessed the focus of the efforts due to community-level factors and internal organizational challenges.** • The grantee organization proposed to use the funding to recruit students finishing graduate programs in case management and related fields to intern at their organization. However, the lack of a local pipeline of interns interested in participating in a previous behavioral health workforce development program led the grantee to reconsider the focus of the CYBHI-funded effort and put planned activities on hold. • Recent restructuring at the organization posed additional challenges that affected its ability to implement the program as proposed. "One of the things that I attempted to do is I assigned it to two staff leaders and said, this is yours, get this off the ground, help us get going.... But that was not a new person with that sole responsibility. They also had other responsibilities. And it was just a hard lift because it wasn't as easy as we thought it was going to be to get people to want to do paid internships in this field." —CBO interview respondent **Resource limitations at the community and organizational levels are barriers to implementing workforce development efforts in Shasta County.** • Apart from the challenges of recruiting local participants for a previous workforce development program, other community-level barriers include limited transportation options for students who live, train, or intern in remote parts of the county. • Organizational-level barriers include the lack of sufficient resources to dedicate staff to student intern outreach or hire full-time clinicians to provide the required supervision to student interns. • The organization originally proposed to use grant funding to provide internship opportunities to psychology doctoral students in efforts to address a major provider gap in the county. However, the organization faced barriers in implementing these original plans in compliance with the State Psychology Board's rules around supervision for interns. The respondent noted that the board requires the supervisor to be a full-time employee of the organization where the student is interning, which was cost prohibitive for the grantee. As a result, in summer 2024 the grantee was considering revising the original plans for the grant and expected to resume efforts soon.
Sustainability and what's next	**The experience in a previous workforce development initiative led the grantee to reconsider the focus of its work under the CBO Behavioral Health Workforce Program.** • This experience helped the grantee better understand what is needed to recruit and retain behavioral health professionals, particularly in rural areas. The organization expected that these lessons learned would help it better implement CYBHI-funded efforts in the future.

Let's Progress Together.

For any questions regarding this evaluation, please email CYBHIEvaluation@mathematica-mpr.com.