Humboldt County: Collaboration and Commitment Support Strong Early Progress on CYBHI Implementation

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This case study focuses on Humboldt 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 realize 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 Humboldt 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, and describe the county's experience implementing select CYBHI workstreams as of summer 2024.

Background on the data sources 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 started in November 2022 and continues through June 2026. As part of the evaluation, the research team completed county-level case studies of the CYBHI implementation in nine counties, including Humboldt 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 summer 2024.

The research team conducted analyses of secondary data sources to capture the population and behavioral health system characteristics of Humboldt County and California as a whole (see Appendix A for more detail). In addition, between April and July 2024, researchers conducted the Network and Ecosystem Experiences Survey (NEES) and key informant interviews with local leaders in Humboldt County. The NEES explored the connections between organizations in Humboldt 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 details on the network analysis methodology and measures.)

Between summer and late fall 2024, researchers also conducted 15 interviews with individuals in Humboldt 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. Six individuals participated in both the survey and an interview.

I. Summary of Findings

Behavioral health ecosystem multisector collaboration themes

In Humboldt County, agencies and organizations in the children and youth behavioral health ecosystem participating in this report described generally strong and well-established, although informal, relationships with each other. These existing connections facilitate collaboration on various programs and initiatives addressing children and youth behavioral health needs, including the CYBHI workstreams. Several of these efforts, such as the Humboldt Bridges to Success and the North Coast Health Improvement and Information Network's Humboldt Community Health Trust and Community Information Exchange, have helped increase collaboration across sectors. However, the county is still working to overcome some barriers to multisector collaboration, including limited staff capacity due to workforce shortages and other ongoing initiatives, restrictions on information sharing, and the historical trauma experienced by the tribal communities, with eight Indian reservations located within the county's borders.

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

Implementation of the CYBHI in Humboldt County is progressing and has had positive impacts on multisector collaboration, mental health awareness, and the expansion of behavioral health services. However, many workstreams are still in the early stages of implementation, and participating agencies and organizations have encountered some barriers.

Workstreams that are designed to facilitate the delivery of behavioral health services in and near schools, including the Student Behavioral Health Incentive Program (SBHIP), the CYBHI Fee Schedule, and School-Linked Capacity Grants, have been effective in initiating a productive relationship across the education and managed care plan sectors. The county has also successfully used additional education sector workstreams, including CalHOPE Student Supports and Schools Initiative and Mindfulness, Resilience, and Well-Being Supports, to promote wellness and mental health awareness among staff and students and provide prevention services. Collectively, these education sector workstreams have laid a foundation for the forthcoming implementation of the CYBHI Fee Schedule, and county leaders are optimistic about the potential for the CYBHI Fee Schedule to expand the provision of school-based behavioral health services. However, preparations for billing the CYBHI Fee Schedule are still in progress, and the county is contending with some contextual challenges. These challenges include capacity constraints among county office and local education agency (LEA) staff, shortages in the school-based behavioral health workforce, and short timelines that do not align with school calendars.

Implementation of home- and community-based workstreams, including Scaling Evidence-Based and Community-Defined Evidence Practices, Never a Bother, and Youth Suicide Reporting and Crisis Response Pilot Program, has just begun, with many grant-funded projects not yet fully underway. However, a handful of grantees have already demonstrated success in delivering needed services and have effectively engaged youth and families in shaping behavioral health services and ensuring that they are culturally responsive. Humboldt grantees have encountered some challenges with implementation, navigating delays in the grant administration process along with requirements that proved burdensome for those with limited administrative capacity. Of note, the California Department of Health Care Services (DHCS) has offered grantees a no-cost extension to mitigate the impact of the delays. Grantees have additional concerns about the sustainability of services after the grants have ended due to a lack of other funding sources.

Humboldt has completed initial work for the Transforming Together demonstration project, integrating the CYBHI workstreams with the California Community Schools Partnership Program. Participants are optimistic about its potential for addressing students' behavioral health needs but are grappling with limited staff capacity relative to the amount of work needed to achieve systemic change.

Key progress with the CYBHI implementation

- **Student Behavioral Health Incentive Program (SBHIP):** Implementation of infrastructure to support the provision of reimbursable behavioral health services is underway, including hiring staff and exploring third-party administrators to facilitate billing. The county is also on track to successfully achieve its behavioral health wellness program project goals for training school staff in "Be Sensitive, Be Brave," a culturally responsive mental health and suicide prevention program.
- **The CYBHI Fee Schedule:** Humboldt County Office of Education (HCOE) is currently working to develop the infrastructure needed to implement the CYBHI Fee Schedule and has successfully engaged superintendents, student support workers, and the county behavioral health department to increase awareness of the CYBHI Fee Schedule across Humboldt. The workstream is encouraging better integration across county agencies, including the creation of a new shared position between HCOE and the Department of Health and Human Services.
- **CalHOPE Student Supports and Mindfulness, Resilience, and Well-Being Supports:** The county has used CalHOPE and Mindfulness funding in a variety of ways, taking advantage of the funding flexibility to hold monthly virtual community of practice (CoP) meetings; provide social and emotional learning (SEL) resources, curriculum, and training to educators and staff; and offer student-facing resources and activities. A key success of these workstreams was HCOE's facilitation of a mental health symposium in May 2024 in partnership with tribes, the behavioral health department, and other organizations; the symposium was attended by around 165 participants and well received by the youth, according to respondents.
- **Scaling Evidence-Based and Community-Defined Evidence Practices (EBPs and CDEPs):** The Scaling EBPs and CDEPs-funded projects in Humboldt include the expansion of a school-based wellness center providing trauma-informed services, the continuation of an existing program providing crisis-triage services on school campuses, the scaling of parenting programs, and the expansion of a community-defined evidence practice designed for Native youth, among others. Many of these projects in Humboldt are still preparing for or in the earliest stages of implementation. However, some grantees receiving early-round grants are already providing services. The well-received delivery of parenting program sessions in a tribal community, as reported by the grantee, has been an early success.
- **Never a Bother (Youth Suicide Prevention and Media Outreach Campaign):** Humboldt County grantees are engaging in suicide prevention activities focused on the Native youth population. The grant-funded projects are still in the beginning stages of implementation. One CBO grantee with a project underway has used the funding to distribute suicide prevention materials at youth-facing events, increase staff capacity to support activities, and hold cultural and wellness events incorporating traditional tribal practices.

II. County Background

County characteristics

Humboldt County is located in the California North Coast region (Exhibit 1). Covering 3,568 square miles, the county is rural and stretches from the Pacific Ocean into rugged, sparsely populated coastal mountains.[1] The original inhabitants of the area now known as Humboldt County include the Native American Wiyot, Yurok, Hupa, Karuk, Chilula, Whilkut, Tsnungwe, Tolowa, and the Eel River Athapaskan peoples, including the Wailaki, Mattole, and Nongatl.[2]

[1] County of Humboldt. County Profile. n.d. Accessed on October 1, 2024. https://humboldtgov.org/DocumentCenter/View/128635/Section-A3---County-Profile

[2] County of Humboldt. County Profile. n.d. Accessed on October 1, 2024. https://humboldtgov.org/DocumentCenter/View/128635/Section-A3---County-Profile

Currently, eight Indian reservations lie within the county's borders.[3] Consistent with the rural designation, Humboldt County has lower population density relative to the state overall—with an average of 38 residents per square mile compared with 254 statewide and a higher proportion of the population living in rural blocks than statewide (31.5 percent versus 5.8 percent) (Exhibit 2). The county has seven incorporated cities.[4]

Relative to other counties in California, Humboldt County has a smaller but substantial population of 135,000 residents. The proportion of children and youth is also slightly smaller relative to the state as a whole, with children 0 to 4 years comprising 4 percent of the population (5.4 percent statewide) and youth 5 to 19 years comprising 17.1 percent (19.0 percent statewide). The county includes a slightly larger share of young adults (8.4 percent versus 6.8 percent statewide). The Humboldt population under age 24 has declined by 10.7 percent over the past five years, substantially more than the 5.4 percent decrease statewide.

Humboldt County residents are predominantly White and non-Hispanic (71.0 percent) in contrast to the statewide population of which only 33.7 percent are White and non-Hispanic. Humboldt also has proportionally more American Indian and Alaska Natives than the state as a whole (3.3 percent versus 0.3 percent). County residents are less likely to be foreign-born (1.2 percent versus 7.2 percent statewide) and more likely to be English-proficient (99.9 percent versus 91.6 percent statewide).

Humboldt County residents face more difficult economic conditions than residents across California. Relative to the state, a larger proportion of the population is below the 200 percent federal poverty line (36.3 percent versus 27.6 percent); the county has a lower median income ($41,181 versus $52,520), a higher unemployment rate (8.3 percent versus 5.3 percent), and higher food insecurity overall and for the population 0 to 18 years (16.0 percent versus 13.5 percent). In addition, Humboldt is ranked 25th (out of 57) in the Healthy Places Index within California, signifying that the county's access to health care, housing, education, and other characteristics that support a healthy population is close to average relative to other counties in the state.[5] Consistent with the economic conditions in Humboldt County, a larger percentage of residents ages 0 to 25 years is covered by Medi-Cal (48.5 percent) compared with the statewide average (39.3 percent).

Exhibit 1. Humboldt County's geography

[3] County of Humboldt. County Profile. n.d. Accessed on October 1, 2024. https://humboldtgov.org/DocumentCenter/View/128635/Section-A3---County-Profile

[4] Humboldt County Association of Governments. n.d. Accessed on October 1, 2024. https://www.hcaog.net/

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

Exhibit 2. Humboldt County's population characteristics

Metric	Humboldt	California	Year(s)
Population			
Total population (N)	135,010	39,029,342	2022
Population, 0–4 years (N; %)	5,382; 4.0%	2,118,386; 5.4%	
Population, 5–19 years (N; %)	23,048; 17.1%	7,404,396; 19.0%	
Population, 20–24 years (N; %)	11,286; 8.4%	2,639,787; 6.8%	
Five-year population change (%)	-1.3%	-1.3%	2017–2022
Five-year population change, 0–24 years (%)	-10.7%	-5.4%	
Density (population per square mile)	38	254	2020
Race and ethnicity			
White, non-Hispanic (%)	71.0%	33.7%	2022
Black or African American, non-Hispanic (%)	1.3%	5.2%	
American Indian and Alaska Native, non-Hispanic (%)	3.3%	0.3%	
Asian, non-Hispanic (%)	2.7%	15.3%	
Native Hawaiian and other Pacific Island American, non-Hispanic (%)	0.0%	0.4%	
Some other race, non-Hispanic (%)	0.5%	0.6%	2022
Two or more races, non-Hispanic (%)	7.9%	4.3%	
Hispanic or Latino (%)	13.2%	40.3%	
Birthplace and language			
Foreign-born, 0–24 years (%)	1.2%	7.2%	2022
English-proficient, 5–17 years (%)	99.9%	91.6%	
Education (18+ years)			
High school or higher (including college) (%)	83.3%	78.8%	2022
College degree or higher (%)	28.7%	34.1%	
Economic indicators, socioeconomic status, neighborhood characteristics			
Population within urban blocks (%)	68.5%	94.2%	2022
Population within rural blocks (%)	31.5%	5.8%	
Population below 200% of the federal poverty line (%)	36.3%	27.6%	
Median income (USD)	41,181	52,520	
Unemployment (%)	8.3%	5.3%	
Households with high housing cost burden (%)	39.7%	40.3%	2019
Food insecurity, overall (%)	13.9%	10.5%	2021
Food insecurity, 0–18 years (%)	16.0%	13.5%	
Healthy Places Index (rank)	25	N/A	2015–2019
Diversity Index (rank)	41	N/A	
Health status			
Population with a disability (%)	19.9%	11.7%	2022
Population with a disability, 0–17 years (%)	8.7%	4.0%	
Health insurance status (population 0–25 years)			
Medi-Cal or other means-tested public coverage (%)	48.5%	39.3%	2022
Private coverage (%)	56.1%	60.2%	
Uninsured (%)	3.9%	4.9%	
TRICARE/military coverage (%)	1.8%	1.7%	

Metric	Humboldt	California	Year(s)
Medicare coverage (%)	0.4%	1.0%	

Note: Researchers conducted analyses of secondary data sources to capture population and behavioral health system characteristics of Humboldt 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).

Behavioral health needs and resource availability

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

The overall well-being of children and youth in the Northern and Sierra region, where Humboldt County is located, is similar to that of California as a whole (Exhibit 3). Northern and Sierra region youth have comparable rates of feeling connected and supported by adults; however, they report feeling less supported by friends relative to youth statewide (63 percent versus 72 percent).

At the county level, Humboldt children and youth experience higher rates of behavioral health challenges than children and youth statewide. More children and youth insured through Medi-Cal have a mental health diagnosis or emotional symptoms (26 percent versus 18 percent), and more students have seriously considered attempting suicide in the past 12 months in grade 9 (19 percent versus 15 percent statewide). Inpatient hospitalizations for behavioral health diagnoses relative to the number of children and youth in Humboldt are comparable to the statewide frequency; however, given the limited inpatient services available in the county, the frequency of inpatient hospitalizations may not reflect the relative need. Children and youth in Humboldt experience substantially more emergency department visits for any behavioral health diagnosis (53 per 100,000 children and youth versus 32 statewide). In addition, Humboldt students in grades K through 12 have higher rates of chronic absenteeism (31 percent versus 25 percent statewide). This may be partially due to mental health issues as more students in grade 9 reported school absence due to mental health issues (11 percent versus 9 percent statewide).

Exhibit 3. Prevalence of behavioral health outcomes

Metric	Humboldt	California	Year(s)
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 non-parent 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 (%)	26%	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 (%)	19%	15%	2019 –21
Students in grade 11 who reported seriously considering attempting suicide in the past 12 months (%)	17%	16%	

Metric	Humboldt	California	Year(s)
Emergency department visits and hospitalizations for children and youth with behavioral health-related conditions			
Inpatient hospitalizations per 1,000 children and youth for any behavioral health diagnosis	12	12	2022
Emergency department visits per 1,000 children and youth for any behavioral health diagnosis	53	32	
School engagement, as measured through absenteeism and suspension			
Students in grades K–12 who were chronically absent (%)	31%	25%	2022–23
Students in grade 9 reporting school absences due to mental health issues (%)	11%	9%	2019–21
Students in grade 9 reporting school absences due to alcohol or drug use (%)	1%	1%	

Note: Researchers conducted analyses of secondary data sources to capture population and behavioral health system characteristics of Humboldt 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. Humboldt is part of the Northern and Sierra region as defined by the California Health Interview Survey.

Resource availability

Like many counties across California, Humboldt County has a full shortage designation for both primary care and mental health care (Exhibit 4). Humboldt also has fewer than half as many child and adolescent psychiatrists per 100,000 children and youth compared with the state overall (eight versus 17), although it has more non-psychiatrist behavioral health providers licensed with county Medi-Cal Specialty Mental Health Services (SMHS) plans per 100,000 (65 versus 37 statewide). It also has a higher ratio of outpatient treatment programs for young adults (12 per 100,000 children and youth versus four) and substantially more school-based health programs with mental health services relative to the population size (24 per 100,000 children and youth versus four). A key provider of non-specialty mental health services in Humboldt County is a large federally qualified health center (FQHC), Open Door, and there are 69 FQHCs or FQHC look-alikes per 100,000 children and youth ages 0–25 years, more than 3 times the ratio statewide.

Exhibit 4. Availability of behavioral health care resources

Metric	Humboldt	California	Year(s)
Primary care health professional shortage area designation	Full shortage	N/A	2019
Mental health professional shortage area designation	Full shortage	N/A	
Number of FQHC or FQHC look-alike sites per 100,000 children and youth ages 0–25 years	69	20	2024
Number of child and adolescent psychiatrists per 100,000 children <18 years	8	17	2022, 2024
Number of non-psychiatrist behavioral health providers licensed with county Medi-Cal Specialty Mental Health Services Plans per 100,000 residents	65	37	2021
Number of outpatient treatment programs for young adults per 100,000 children and youth 0–24 years[a]	12	4	2021
School-based health programs with mental health services per 100,000 children and youth <18 years	24	4	2024

Note: Researchers conducted analyses of secondary data sources to capture population and behavioral health system characteristics of Humboldt 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 may pertain to children as well as young adults. (Manatt Health and Anton Nigusse Bland. *Assessing the Continuum of Care for Behavioral Health Services in California: Data, Stakeholder Perspectives, and Implications.* Report prepared for California Department of Health Care Services. January 2022. https://www.dhcs.ca.gov/Documents/Assessing-the-Continuum-of-Care-for-BH-Services-in-California.pdf).

Respondents across sectors perceived the availability of behavioral services in Humboldt to be limited across the continuum of care. The county faces gaps in access to all medical services due, in part, to the rural geography. Child welfare and education respondents described the lack of sufficient services relative to the needs of the county, with programs filling quickly and lengthy waiting lists for youth and families. For example, as of summer 2024, the wait time for a child to obtain intensive mental health care through the county was reportedly 3 to 4 months. Behavioral health respondents similarly highlighted the shortage of county behavioral health department clinicians for all youth, which they are trying to address with telehealth providers and increasing caps on organizational providers. An education respondent expressed optimism about the potential for the CYBHI to help close gaps by promoting Soluna and Brightlife Kids and expanding the availability of services through the Fee Schedule; however, another respondent worried that these resources would not be sufficient to address gaps in services.

Across sectors, respondents cited the county's lack of short-term behavioral health residential services, inpatient services, and crisis services as substantial gaps. However, they were encouraged by the ongoing development of a crisis residential facility funded, in part, by a CYBHI BHCIP Round 4 grant and noted that some mobile crisis services are available. The county does not currently have a short-term residential treatment facility or a crisis unit for youth, although a crisis facility is under development. Given that, youth need to leave the county to obtain residential and crisis services. Respondents expressed concern about the lack of crisis services, resulting in youth having to experience the trauma of being sent out of the area for these services, which can cause additional distress. Also, as one CBO respondent noted, youth need to be transported for several hours by ambulance out of the county to be hospitalized.

> "You'll hear horror stories of families, and I've had my friends where their youth has a mental health breakdown and needs to be hospitalized, and your ride there is strapped in an ambulance for four hours, out of county. That, itself, can be traumatic for families, and these are families that also have really good health care. There are just not enough services. I'm really hoping some of those crisis services that are starting to be brought to the county can be expanded for our youth."
>
> —CBO interview respondent

The lack of crisis residential facilities is a broader regional issue that extends beyond the county, making it even more difficult for Humboldt youth to access needed services. One CBO respondent noted that there is often nowhere to send youth who are in crisis, even outside the county. While the county does have some mobile crisis services, respondents expressed concern that those are sometimes limited, depending on daily staffing. They were encouraged by the county's ongoing construction of a 30-day crisis facility for youth, which is a partnership between Sorrel Leaf and Behavioral Health and is funded, in part, by a BHCIP Round 4 grant. That said, the lack of a psychiatric hospital specifically for youth is regarded as a major gap.

Additional gaps in services include detox and youth substance use disorder treatment services as well as services for the youngest children in the county. Behavioral health and CBO respondents noted that the county has no detox and very limited youth substance use treatment services, which are a critical need in the county, especially in the tribal communities. The county also lacks clinicians for the youngest children (0–5), as perceived by behavioral health respondents. Similarly, respondents from the CBO and education sectors described a particularly severe gap in services for very young children (0–2) while noting a lack of services for all youth in the county.

Equity concerns: groups facing disproportionate access challenges

While respondents across sectors noted that all children and youth in the county have limited access to behavioral health services, primarily due to workforce shortages, they identified several specific populations of children and youth who face inequities in access to services.

Respondents across sectors indicated that Native youth, youth in rural areas, and youth from families with limited incomes face the greatest barriers to accessing behavioral health services in Humboldt. The remote, rural geography of the county leads to difficulties in accessing services for those youth who live in the most outlying areas, where many tribal communities are located. An education sector respondent noted that the Klamath-Trinity-Hoopa and Southern Humboldt areas are particularly far from services and difficult for providers to reach. Given how far away the county seat is from the outlying areas of the county, schools are widely perceived as critical sites for rural families and families with limited incomes to access mental health services.

> "So for children to access services in Eureka, which is where all of our services are accessible, parents have to take a day off work, pull their kids out of school for the day, drive into Eureka. Gas is expensive. We have no viable public transportation in our county. There are a couple of bus lines that run, but nothing that's reasonable. You lose an entire day's worth of work, if you're an hourly employee, and that is endangering your rent, your food budget for the month, your ability to pay for that counselling, to get their kid into mental health services. Without having them at the schools, families can't access them. The hurdles for low-income families are so high that whether or not they want to access them, it's impossible…we provide gas cards and transportation and assistance getting to those appointments. We know what it looks like, and we know it's still not viable for families with low incomes. So without that in-school, embedded support for families, the majority of our low-income children will never have the ability to access mental health services."
>
> —CBO interview respondent

Respondents across sectors emphasized that Native youth face not only limited access to services but also limited access to culturally relevant services. A CBO respondent pointed to gaps in the availability of culturally competent services from a Native provider. Experiences with non-Native providers can sometimes deter Native families from going back for services. The respondent indicated the need for a regional wellness center, specifically for tribal communities—plans for such a center are currently underway with support from a BHCIP Round 4 grant. Resources available to Native youth include organizations such as Two Feathers Native American Family Services that provide quality services, United Indian Health Services, and tribes that have behavioral health departments; however, education respondents explained that there are not enough culturally driven behavioral health services to meet the needs.

Child welfare, education, and juvenile justice respondents pointed to gaps in access for the most at-risk youth, including youth with complex care needs and foster youth more generally, as well as youth experiencing homelessness. Child welfare and juvenile justice respondents noted that youth with complex care needs do not have equitable access to care and often fall through the cracks in all systems. Although access to services is perceived as challenging for all children and youth, there are barriers for foster youth and those experiencing homelessness in particular. For example, foster youth qualify for screening and assessment but face wait times for those services and experience more access issues as they move in and out of the county or in and out of care. Connecting the hardest-to-serve youth from the child welfare system, who are often affected by substance use, to behavioral health services is challenging; it is difficult for the county to engage them. Beyond the access barriers for these groups of youth, respondents indicated that privately insured children and youth also experience some limitations in access to services given the lack of local service providers in commercial insurance networks.

III. Systems Change, Connections, and Multisector Collaboration Across the Ecosystem

Through the CYBHI, the California Health and Human Services Agency (CalHHS) seeks to inspire systems change 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 California's children and youth.

To better understand the behavioral health ecosystem and how connected systems are across sectors as context for understanding the CYBHI implementation in Humboldt County, Mathematica conducted the Network and Ecosystem Experiences Survey (NEES), which asked respondents from child and youth-serving organizations to rate the strength of their relationships with each other. Using information from the survey, a network map was created showing the connections between 14 organizations in Humboldt County based on ratings provided by the 12 organizations that completed the survey. The map depicts the average strength of the connection between organizations (Exhibit 5).

Understanding connections across the behavioral health ecosystem in Humboldt County

In Humboldt County, we invited 14 child- and youth-serving organizations to complete the NEES and received responses from 12. Invited organizations included government agencies and departments; a managed care plan; and CBOs, including organizations that serve Native populations and other diverse communities. 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 the other organizations invited to complete the survey on a 5-point scale: (1) co-exist, (2), cooperate, (3) coordinate, (4) collaborate, and (5) integrated.[6]

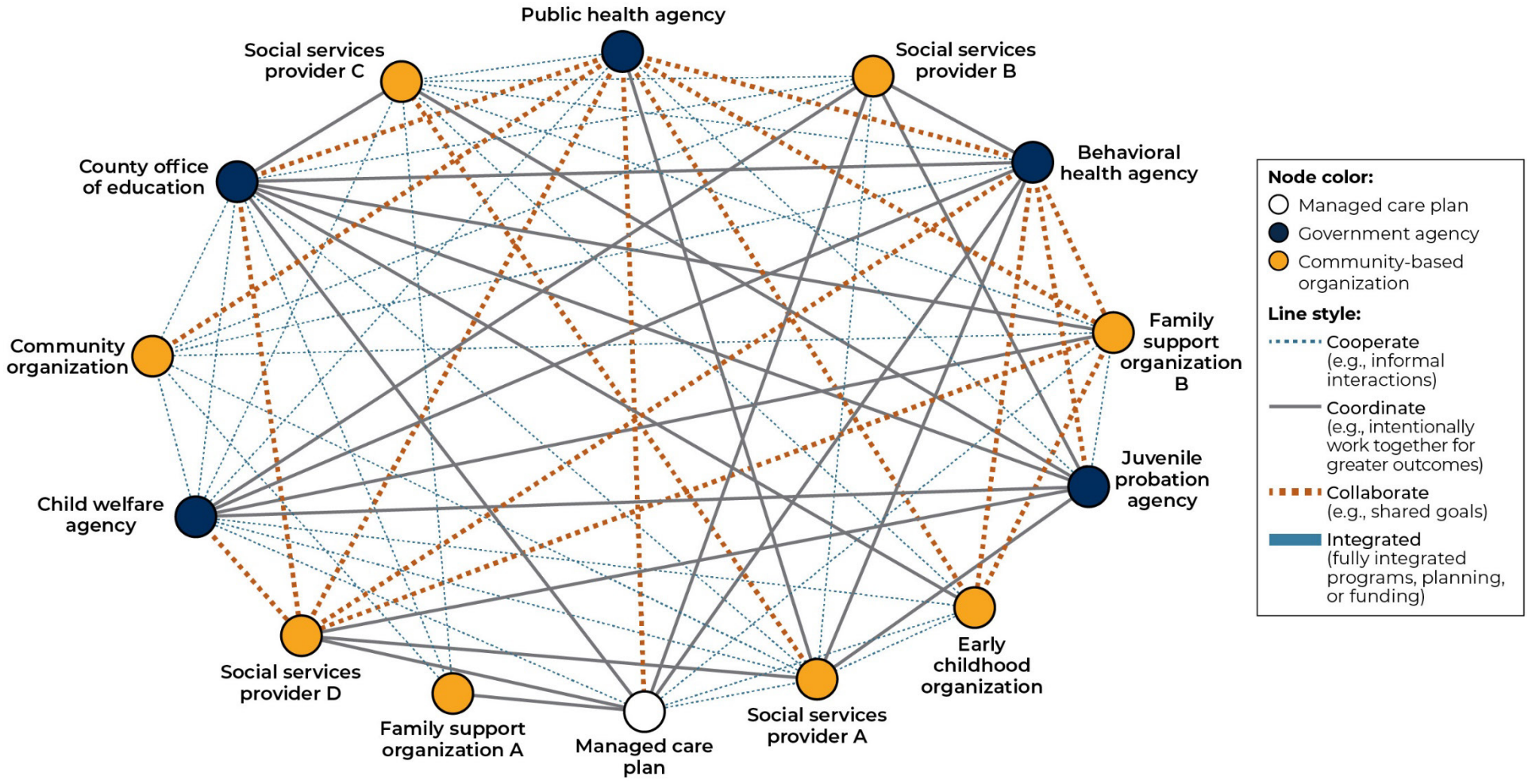
These ratings were used to conduct a network analysis and develop a network map showing the average strength of the connections between organizations, based on each organization's rating of the other.[7,8] A line between two organizations shows that a connection exists. No line indicates that the organizations 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.

[6] 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.

[7] In Humboldt 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 assert similar strengths of connections as each other. Based on this analysis, we concluded there was a high level of agreement in the observed data, and thus, we trusted that a connection rated by a single respondent was a reliable representation of the strength of the relationship between organizations.

[8] 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 Humboldt County behavioral health ecosystem



Note: Coexist = limited or no working relationship (no connection): Cooperate = informal interactions on specific activities or projects; Coordinate = intentionally plan/work together for greater outcomes; Collaborate = shared mission, goals, decision makers, 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 have regular interagency meetings. As a small community, I think the players—we all know each other from the different agencies. I think in terms of just coordination and the ecosystem of people working for children's issues, there are good relationships."
>
> —Behavioral health interview respondent

Most government agencies and organizations work well together to support children and youth behavioral health, and interview respondents across sectors perceive few silos in the ecosystem. These findings align with the network map, in which the average strength of all connections reported across the network is 2.65, indicating a high level of cooperation and coordination between organizations to support children and youth behavioral health. Across the network, most organizations (n = 13) have eight or more connections, though the strength of those connections varies (Exhibit 5).[9] Interview respondents identified strong relationships between organizations and government agencies in the ecosystem that facilitate collaboration on various programs and initiatives, including the CYBHI workstreams, and coordinated approaches to efficiently use limited county funding and resources. These relationships are built from years of organizations and agencies working together in a small county although they are often not formalized. Respondents acknowledged that it would be useful to establish more formal partner agreements, such as memorandums of understanding (MOUs), to continue strengthening these relationships. These insights are consistent with survey findings showing that more than one-third (35.8 percent) of connections in the network map have an average strength of "cooperate," reflecting informal interactions between organizations, and about one-fifth (19.8 percent) have an average strength rating of "collaborate," representing more formal partnerships between organizations.

There are strong connections between organizations of a similar type, including government agencies and CBOs. Interview respondents generally noted that government agencies, including the county office of education, behavioral health, child welfare, and juvenile probation, work closely together to serve children and youth. In the network map (see Exhibit 5), all government agencies have a connection to each other, ranging in strength from "cooperate" to "collaborate." The strongest connections appear between public health and behavioral health, public health and the county office of education, and behavioral health and juvenile probation; public health and behavioral health are both housed under the Humboldt County Department of Health & Human Services, which may contribute to their connection. In addition, all government agencies report a connection to the managed care plan, which has the strongest connection to public health and coordinates with behavioral health and the county office of education. Similarly, organizations that serve Native youth and families often work together in addition to serving as contracted providers for some government agencies.

When asked about silos, interview respondents acknowledged gaps in relationships and collaboration with tribes. Respondents across sectors shared that agencies and organizations do not always meaningfully or respectfully engage tribes in initiatives and activities to address children and youth behavioral health despite Native youth being a vulnerable population in the county. A notable example is the development of the Humboldt County AB 2083 MOU without tribal involvement as state guidelines do not require tribes as partners—the MOU template is not inclusive of tribes. County leaders are now working to revise the MOU to include tribes while recognizing that individual tribes have different needs, behavioral health systems, and resources.

[9] The behavioral health agency, county office of education, public health agency, and child welfare agency are the most connected organizations in the network, with 11 to 13 connections each.

Barriers to multisector collaboration

Respondents across sectors identified staff capacity as the primary barrier to multisector collaboration. Agencies and organizations across the county have limited capacity due to staffing shortages, which can lead to unintended silos. As one behavioral health respondent noted, it can also be challenging to work across sectors and maintain relationships when there is high staff turnover. Respondents believe that more funding to increase and support the workforce will help overcome this barrier. One CBO respondent suggested that more project management support for coordination across sectors would ensure that assignments and action items do not fall through the cracks, and another CBO respondent echoed the need for support in taking on the administrative burden required to help multisector collaboratives or initiatives make progress.

Restrictive requirements around data sharing across organizations can hinder effective multisector collaboration to quickly connect children and youth to the services they need. A separate release of information (ROI) is needed for each organization to share medical data and other information about an individual, which can be time-consuming. A child welfare respondent highlighted an extreme example in which a social worker had to obtain 65 ROIs to refer a young person to a residential treatment program. Humboldt Bridges to Success, a collaboration between the education and behavioral health sectors to provide crisis intervention and support to students, helped address this issue by securing a multiagency ROI, which streamlines the data-sharing process. Respondents indicated that the Community Information Exchange and the AB 2083 interagency leadership team are also working toward a universal ROI (see spotlight on multisector collaboratives).

> "Part of it [is] capacity and scope of work, but there are also traditional barriers where they feel that they're not respected appropriately by county departments. Because tribes are aligned at the federal level. State agencies, local agencies are not sovereign nations. And so, we need to treat our Indigenous tribes, whether federally recognized or not, as sovereign communities. And that doesn't always happen."
>
> —CBO interview respondent

Historical failures to respectfully engage tribes and serve the needs of Native youth remain a barrier to forming and maintaining relationships. Although a few respondents believe that county agencies and organizations are now more actively engaging tribes, one respondent shared that their organization is still working to repair hundreds of years of historical trauma, noting this is difficult and painful but necessary work. This respondent also noted that other agencies and organizations still need to do the same to improve their relationships with tribes and better serve Native youth. It takes a lot to build trust in these relationships again, as one education respondent observed, and agencies and organizations need to continue to work on this.

Facilitators of multisector collaboration

Close working relationships and regular communication are facilitators of multisector collaboration. Due to the small size of the county, respondents felt that all the leaders of agencies and organizations know each other, enabling them to work closely and communicate regularly. As one CBO respondent described, they can easily pick up the phone and call agency and organization leaders whenever they want to discuss anything. Regular interagency forums and meetings also facilitate collaboration. Examples include AB 2083 interagency leadership meetings and interagency placement committee meetings, in which members review cases of youth who interact with multiple systems.

Current and past funding initiatives for children and youth behavioral health have strengthened relationships and improved multisector collaboration. One education respondent described how relationships evolved from agencies and organizations working together on different grant opportunities and programs, including a Substance Abuse and Mental Health Services Administration grant to improve the system of care for children and youth and Mental Health Services Act (MHSA) funding. Respondents widely agreed that Humboldt Bridges to Success increased the collaboration between the education and behavioral health sectors. CYBHI workstreams, including SBHIP, the CYBHI Fee Schedule, CalHOPE Student Supports, and Mindfulness, Resilience, and Well-Being Supports, have

increased collaboration in the county. Education respondents also viewed the Transforming Together demonstration project as a promising framework for future multisector collaboration.

Spotlight on multisector collaboratives that support children and youth behavioral health

Humboldt Bridges to Success (HBTS)

HBTS was established in 2018 with funding from a Mental Health Services Oversight & Accountability Commission grant. HBTS was a collaboration between the Humboldt County Children's Behavioral Health Program, the Humboldt County Office of Education (HCOE), and 32 school districts. HBTS staff worked with local schools to provide school-based mental health support and intervention to students in crisis or at risk of crisis and their families. Although the original grant funding has ended, HBTS and its services will continue as Humboldt Bridges to Wellness, which will be funded by a Scaling Round 5 grant awarded to the HCOE and will incorporate the use of Certified Wellness Coaches.

> "I think it took a year or two for people to trust that they…could call and things would happen. I just think trust was built once we saw that families were being served. I think as families and schools saw that it was a trusted service, it was built even stronger."
>
> —Education interview respondent

HBTS has helped align resources and activities across child- and youth-serving organizations, strengthen the capacity of organizations to work together toward shared goals for children and youth behavioral health, and improve care coordination so that children, youth, and families can access the supports and services they need, where they need them. Interview respondents felt that HBTS staff effectively worked across sectors to connect students and families to the appropriate mental health services, which helped build trust for HBTS in the community. In addition, they highlighted how HBTS improved care coordination by providing training on the referral process, facilitating communication between organizations, and securing a multiagency ROI.

Humboldt County Health Trust (HCHT) and the Community Information Exchange (CIE)

- The North Coast Health Improvement Information Network supports community health improvement and health information exchange initiatives, including the HCHT and the CIE. An Accountable Community for Health, the HCHT was formed in 2017 and has focused on addressing the substance use disorder epidemic. Most survey respondents reported that the HCHT is developing a shared vision and goals for aligning services and systems with the needs and desires of the people being served and has fully established guidance for the acceptable sharing of information across child- and youth-serving organizations.
- The CIE is a network of service providers partnering together to streamline care coordination. When patients consent to share information with the network, providers use a secure data platform and provide coordination and electronic referrals for services. Although implementation is still in the early stages, interview respondents expressed optimism over the CIE's potential to streamline referrals and increase information sharing. Interview respondents highlighted the robust representation in the collaborative as one of the notable efforts in the county to reduce siloes, with the participation of multiple agencies and organizations across sectors. The next steps include piloting the data-sharing system and obtaining buy-in and trust from those skeptical of data sharing.

> "I think the big systems do come together. I think the AB 2083 ILT is probably the future vehicle for that work. And the big systems are all engaged in that and we're now looking at how to build that out."
>
> —Child welfare interview respondent

Other multisector collaboratives

Several other multisector collaboratives support children and youth behavioral health in Humboldt County. Survey and interview respondents identified the Family First Cross-Sector Collaborative, which works to align early intervention services for families and children at risk to prevent entry into the child welfare system. Other collaboratives include the AB2083 Interagency Leadership Team (ILT), Multiagency Juvenile Justice Coordinating Council, Child Abuse Prevention Coordinating Council, Suicide Prevention Network, the 0 to 8 Mental Health Collaborative, and Live Well Humboldt.

IV. CYBHI Workstream Implementation Findings

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 are active to varying degrees across California counties.

Overview of workstream activity in Humboldt County

Overall, Humboldt County is locally implementing 11 CYBHI workstreams that involve the distribution of funding to county or community entities, including 51 grants, as of September 2024.[10] This case study discusses the county's implementation experiences with **education sector workstreams**, including the SBHIP, the CYBHI Fee Schedule, CalHOPE Student Support and Schools Initiative, and Mindfulness, Resilience, and Well-Being Supports. The case study also discusses the county's experiences with the Transforming Together demonstration project and select workstreams occurring in **home and community settings**, including Scaling EBPs and CDEPs and Never a Bother (Youth Suicide Prevention and Media Outreach Campaign). Other active workstreams in the county include programs under the Broad Behavioral Health Workforce Capacity workstream and the Behavioral Health Continuum Infrastructure Program (BHCIP) grants. For example, Humboldt has two BHCIP Round 4 grants intended to fill gaps in infrastructure by adding an integrated wellness center and a children's crisis residential program.

Implementation of workstreams designed to facilitate providing clinical care in and near schools

In Humboldt County, SBHIP, the CYBHI Fee Schedule, and School-Linked Capacity Grants are progressing but are largely still in early stages of implementation and have encountered some barriers. HCOE has made significant progress generating awareness among LEAs and the county behavioral health department about the CYBHI Fee Schedule and developing billing capacity and infrastructure. Supported by SBHIP funding, HCOE is hiring staff and creating systems to provide centralized billing support and technical assistance and exploring options for a closed-loop referral system.

At the same time, the county has encountered barriers to implementation and identified opportunities where enhanced state support might be helpful. The county has experienced some contextual challenges, such as the small size of many districts, capacity constraints, and shortages in the school-based behavioral health workforce, along with implementation timelines that do not align with school calendars. The county has some very small districts that cannot bill for services on their own due to a lack of staffing and infrastructure. However, education respondents were optimistic about the potential for these smaller districts to form billing consortia to facilitate the provision and reimbursement of school-based services. A lack of sufficient administrative staff capacity at the county level is also hindering efforts to build a system to support districts with billing. In addition, recruiting and retaining school-based behavioral health providers are substantial impediments to district capacity for providing services and focusing on the CYBHI Fee Schedule implementation. Finally, the duration and timing of the workstream schedules have proven challenging and could be adapted to better fit the county's needs. Respondents perceive the state's timeline for implementation of the School-Linked Partnership and Capacity Grants to be too short given the pace of change in the education sector. Notably, 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

[10] The sums of CYBHI workstreams and grants encompass 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.

through other venues, including work with COEs on the CalHOPE and Mindfulness, Resilience, and Well-being workstreams. .

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 to receive reimbursement for school-linked behavioral health services using a fee-for-service model. Specifically, it (1) defines the scope of services for outpatient mental health and 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.

> "But to me, the most positive aspect of SBHIP in our experience has been it's created a new relationship where there was none. And some of my favorite meetings every week are with my school partners because they're so well-intended, and they care. They do care deeply about the wellbeing of their students, and I believe strongly they see [the managed care plan] as a partner in this. So they may not know everything we do or the different ways we can help, but they do come to us now, and we do have these conversations. And to me, that is the best outcome of all of this, is that we have a new relationship that's going to endure beyond SBHIP."
>
> —Managed care interview respondent

These workstreams are credited with facilitating multisector collaboration and a sense of urgency around addressing mental health in schools, both of which are viewed as important foundations for the CYBHI Fee Schedule implementation and the expansion of school-based services. A key success of the education sector workstreams has been the development of a new collaborative relationship between HCOE and a managed care plan. Respondents from both sectors reported that working together has cultivated a high level of trust and led to the sharing of valuable information for HCOE—for example, about different potential funding mechanisms for service provision. SBHIP has also funded multisector collaboration. HCOE reportedly contracted out needs assessment work and engaged different agencies, providers, and local CBOs in planning, which one respondent noted was important to HCOE not feeling as though it was doing this work in isolation. SBHIP has enabled important learning and collaboration with other county offices of education as well; respondents credited the monthly calls facilitated by the managed care plan with generating ideas for implementing critical CYBHI Fee Schedule infrastructure and strategies such as billing consortia. An education respondent also noted that SBHIP conversations have reinforced the urgency

around scaling up school-based mental health efforts, generating more of an impetus for LEAs and others to implement the Fee Schedule and other relevant efforts and initiatives.

> "And so our workforce is going to be limited because of that criteria, so that's concerning. Because I think that you could have somebody coming out with a BA that has some good experience with an agency and good supervision that certainly could do that work without having that particular child development course that makes them eligible."
>
> —Education interview respondent

> "I think, in rural communities, we have folks that are in these positions and have been doing these positions and are the most experienced, skilled folks, but that do not have a degree in those certain five areas [that are required]."
>
> —Education interview respondent

Certified Wellness Coaches are expected to play a key role in facilitating the provision of school-based services, but respondents raised concerns about the education requirements for certification limiting the potential workforce. Respondents across sectors expect the Certified Wellness Coach role to help address the behavioral health needs of children and youth in the county by increasing the number of providers available to offer nonclinical preventive services. Education respondents anticipate the inclusion of Certified Wellness Coaches in the CYBHI Fee Schedule, which will expand provider capacity for school-based services. Certified Wellness Coaches will also play an important role in the Bridges to Wellness collaborative that provides crisis triage services on school campuses. However, the current criteria to become a coach is perceived as too restrictive and will potentially exclude people in the community who have historically filled the role and have lived experience but do not have the required education credentials. Of note, the California Department of Health Care Access and Information has released new guidelines, effective as of 2025, that address this concern by expanding the original education requirements for the position to accept associate's and bachelor's degrees in any field of study for the workforce pathway.[11] The creation of opportunities to train people on the job and help them achieve certification was also suggested by respondents as a strategy to overcome barriers related to education requirements. Finally, respondents expect that hiring for the Certified Wellness Coach role will be difficult due to the compensation, which is perceived as too low, especially relative to the difficult nature of the work.

Certified Wellness Coaches (CWC)

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

Implementation of workstreams facilitating classroom and campus supports for behavioral health

Humboldt County has actively engaged educators and school staff in CalHOPE and Mindfulness activities and used funding to promote wellness among staff and students and provide prevention services. For example, HCOE partnered with tribes, the county behavioral health department, and other organizations to facilitate a variety of SEL and mindfulness activities and workshops, including tribal-based trainings and suicide prevention training for LGBTQ+ families. The symposium was well attended, with approximately 165 participants. HCOE has also held community of practice sessions, funded SEL curricula for their Therapeutic Learning Classroom program, and facilitated networking among school wellness centers in the county, among other activities. The CalHOPE and Mindfulness workstreams have offered substantial flexibility in how funding can be used. This flexibility has helped HCOE adapt to the limited availability of educators and staff and better facilitate engagement through offering

[11] This applies to the workforce pathway for becoming a Certified Wellness Coach, as described here: https://hcai.ca.gov/workforce/initiatives/certified-wellness-coach/cwc-pathways/.

stipends, providing virtual participation options, and scheduling training during nonwork hours. The workstreams have also facilitated multisector collaboration to plan the mental health symposium for youth. The primary challenge the county has encountered during the implementation of the workstreams has been the difficulty engaging school staff, who are overburdened and experience burnout because of many ongoing education initiatives that require time for training and implementation. The funding flexibility described earlier has helped overcome this barrier.

Workstreams facilitating classroom and campus supports for behavioral health

- The **CalHOPE Student Support and Schools Initiative** workstream focuses on providing training and support to educators to help them develop SEL environments, which build students' skills and destigmatize behavioral health concerns. By equipping educators with additional skills to bolster students' resilience, these programs increase mental health competency among some adults whom children and youth interact with most.
- The **Mindfulness, Resilience, and Well-Being Supports workstream** builds on this foundation by funding student-facing programs that promote SEL, mindfulness, and well-being in schools and data collection tools for schools to obtain real-time information about students' well-being.

Implementation of the Transforming Together (T2) demonstration to integrate CYBHI workstreams and the California Community Schools Partnership Program

Humboldt has completed initial work for the Transforming Together demonstration project, and participants are optimistic about its potential for addressing students' behavioral health needs but are grappling with limited staff capacity relative to the amount of work needed to achieve systemic change. The initial steps in planning for implementation, including asset mapping and a baseline survey, have helped HCOE leadership identify community resources, successful collaborative efforts, existing gaps in partnerships in the county, and schools' needs. Education respondents were largely optimistic that the demonstration could help address silos across agencies and organizations and better integrate the CYBHI workstreams and community school efforts. Ongoing participation in the Breaking Barriers symposium has laid a strong foundation for this work in the county. That said, all respondents acknowledged that the initiative is only just beginning, and that successful implementation would require a substantial amount of work.

Notably, education respondents identified several barriers to implementation, including a lack of staff capacity at both the county and LEA levels to move the work forward and challenges filling needed positions. Although the demonstration is ultimately intended to unify and streamline existing work, education respondents have found the initial activities somewhat

Leveraging the intersection of schools and behavioral health: Transforming Together

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

To integrate efforts to improve students' behavioral health and well-being across the education and behavioral health sectors and maximize their impact, CalHHS and the California Department of Education have partnered on a demonstration project called Transforming Together (T2). The project, administered by the San Bernardino County Superintendent of Schools, draws upon the principles of the Ecosystem Working Paper and seeks to break down silos and build coordinated systems that center children, youth, and families. T2 is intended to identify effective, scalable tools and approaches for enabling integration across systems.

burdensome to complete in addition to their other work and, at times, redundant with similar work for other initiatives, such as asset mapping. They also cited the challenges of maintaining the momentum of a collaborative effort in the face of interruptions such as the summer break and navigating the steep learning curve for the county behavioral health department to better understand how schools operate and vice versa. The next steps include convening key community partners to discuss how to move the work forward together and piloting the demonstration in the Court and Community Schools in preparation for applying lessons learned about integrating the CYBHI workstreams in other school districts.

> "And so, we are really realizing that we have a lot of good things going, but a lot of it seems to be informal partnerships. Where I see we're lacking is that we don't have a lot of MOUs. We sit on a lot of committees with Social Services and Mental Health, and DHHS, who takes care of all that, but we don't have a lot in place other than meetings where we share information. And so that was really highlighted through that baseline survey. We're doing a lot of the work together; there are just not formal agreements."
>
> —Education interview respondent

Implementation of home and community-based sector workstreams

Although many of the Scaling EBPs and CDEPs, Never a Bother, and Youth Suicide Reporting and Crisis Response grant projects in Humboldt are still preparing for implementation, a few grantees have already seen success delivering needed services. One Scaling EBPs and CDEPs Round 1 grantee shared their progress in delivering Triple P to a remote tribal community, with a relatively high attendance rate and positive feedback from participants for the first few sessions. For example, 31 families attended the first session, held in a community with a total Indigenous population between approximately 250 and 300.[12] A Never a Bother grantee focused on tribal youth also described progress in using funds for cultural wellness events, distributing suicide prevention materials at events, and increasing staff capacity. Other grantees were reportedly still in the early stages of implementation as of summer 2024. For example, the county's Youth Suicide Reporting and Crisis Response Pilot project had just completed the initial self-assessment to identify gaps in the existing suicide prevention and crisis response activities. The next steps include bringing in additional partners, analyzing the findings from the mapping, and beginning implementation of crisis residential treatment and the rollout of a mobile crisis benefit. Additional Scaling EBPs and CDEPs and Never a Bother grantees in the county were also still planning for implementation.

> "Triple P is the only thing that our local court system will accept as a parent education class, and, usually, families were waiting a really long time because it wasn't being offered regularly. We thought they would come to the first session, get that certificate, and then wouldn't come back because there's a lot going on for them, and that would have checked the box. And instead, we had 31 at the first session. We had 27 at the last session. And so it has been just a really fantastic experience for everybody involved. We're really grateful to the State of California for lifting up CYBHI—funding it and providing us that opportunity."
>
> —CBO interview respondent

[12] U.S. Census Bureau. "RACE." Decennial Census, DEC Demographic and Housing Characteristics, Table P3, 2020, https://data.census.gov/table/DECENNIALDHC2020.P3?g=860XX00US95556&d=DEC Demographic and Housing Characteristics. Accessed on January 6, 2025.

Home and community-based sector workstreams

The Scaling EBPs/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.

Never a Bother (Youth Suicide Prevention Media and Outreach Campaign) is a multilingual marketing, education, and outreach suicide prevention campaign that includes a website, social media, content and resource creation opportunities, advertising, and partnership marketing. To complement the campaign, 34 CBOs and tribal partners received grants to help promote and implement the campaign's community-level suicide prevention strategies. CDPH's Office of Suicide Prevention launched Never a Bother in March 2024, following an 8-month planning phase that incorporated input from more than 400 youth. Throughout the year-long campaign, various activation points are being planned, such as Mental Health Awareness Month. The campaign focuses on youth populations disproportionately affected by suicide: American Indian/Alaska Native youth, Hispanic and Latino youth, and African American or Black youth, as well as intersectional groups, such as youth with mental health conditions, substance use issues, or both; youth in the foster care system; and two-spirit/LGBTQ+ youth.

The **Youth Suicide Reporting and Crisis Response** workstream was established to develop and improve local-level planning for rapid suicide reporting. The California Department of Public Health allocated approximately $35 million to the 10 pilot counties, seven of which have youth suicide rates exceeding the state average. The pilot counties are developing and testing models that quickly report and respond to youth suicide and suicide attempts. The pilots are intended to develop or enhance equitable, timely, and culturally responsive suicide prevention and postvention strategies at the local level. By enhancing reporting and youth-focused crisis response systems after a suicide attempt or death, the program aspires to prevent further suicides and attempts.

Grant-funded projects are expanding the engagement of youth and families in shaping behavioral health services and ensuring that they are culturally responsive. Two Scaling EBPs and CDEPs grantees reported strategies to include youth and family perspectives in their service delivery. For example, one of the grantees is adapting Triple P for their Spanish-speaking community by working with community members to identify ways to make the model more accessible and welcoming. Similarly, the organization is soliciting input from their local Indigenous community on locally appropriate adaptations to Positive Indian Parenting. Two grantees working primarily with tribal youth also reported the intentional incorporation of traditional Indigenous practices into the services and activities supported by grant funding.

Across the Scaling EBPs and CDEPs and Never a Bother workstreams, grantees would benefit from reduced administrative burden and more tailored technical assistance, including guidance on sustainability strategies, to successfully implement their grant-funded projects. All Scaling respondents cited the heavy administrative burden associated with the grants, including participation in learning collaboratives and intensive data collection. Although DHCS has made an effort to be responsive to concerns across the state and streamlined data collection requirements for select groups of grantees that do not directly provide services or are delivering limited or light-touch behavioral health interventions, challenges with burden remain for some of the Humboldt grantees. As one behavioral health respondent noted, the Scaling EBPs and CDEPs grant program may be better designed for larger counties and

> "So, to do the work and all the things that that grant wants us to do, for me it's just super resource intensive on the administrative side. It seems like more work than it's worth to some degree, for small county and small programs. I can totally see where, if you're a big county like L.A., or something, and you're doing a really big program and taking this on, that all those kinds of supports are important. But…maybe have a different track for small counties, or something."
>
> —Behavioral health interview respondent

larger programs with more capacity. Smaller county offices and programs, like those in Humboldt County, do not have sufficient resources to fulfill all of the existing administrative grant requirements. CBO respondents implementing Never a Bother and Scaling EBPs and CDEPs grant projects also cited the short grant duration and restrictions on grant funding, which impede their ability to sustain and scale these efforts. Braiding funding from other sources is one strategy that grantees have used to overcome these restrictions, which include the exclusion of spending on food and other incentives for participating youth. Finally, CBO respondents perceived the technical assistance provided for the Scaling EBPs and CDEPs grants to be limited in value because it is not sufficiently tailored to specific programs or delivered by trusted individuals with relevant program delivery experience. A CBO respondent noted that they could benefit from more focused, longer-term grant technical assistance from a provider who is more knowledgeable about their program. For example, organizations that primarily serve Native youth and families could derive the most value from technical assistance providers who have substantial experience delivering culturally responsive programming to Native populations.

> "Coming up here, listening, learning, putting the right people in the position that have skills to add value to the programming, not putting people that haven't done what we're trying to do...Up here in our Native community, you've got to put the right people in front of the folks and there has to be a commitment where it's not just that fly-by one time."
>
> —CBO interview respondent

Perceptions of workstream effectiveness in addressing behavioral health needs and equity

Respondents across sectors shared some early indications that CYBHI workstreams have the potential to positively affect behavioral health needs and inequities in Humboldt County although implementation is still in the early stages. The Scaling EBPs and CDEPs grants in particular are facilitating an increase in the availability of culturally responsive behavioral health services. In addition, education respondents highlighted the potential for education sector workstreams to overcome existing barriers to access by expanding school-based behavioral health services that can meet students' needs where they are. Finally, behavioral health respondents anticipated that the Crisis Response Pilot Program would fund activities to help the county address gaps in its current system.

See Appendix C for additional details on the implementation of select workstreams in Humboldt County.

V. Conclusion

Children and youth in Humboldt County experience higher rates of behavioral health challenges compared to those statewide, and there is limited availability of behavioral health services for children and youth across the continuum of care. Key informant interview respondents highlighted substantial gaps in short-term behavioral health residential services, inpatient services, and crisis services, primarily due to a lack of facilities and workforce shortages. Although all children and youth in the county face challenges in accessing behavioral health services, respondents perceived that some populations, including Native youth, youth in the most rural areas of the county, youth from families with limited incomes, and youth with complex care needs experience greater barriers and are particularly at risk for inequitable outcomes.

While initial implementation is still underway, our analysis—drawing from available behavioral health data, early implementation findings, and interviews with leaders—indicates that Humboldt County is leveraging CYBHI resources in ways that are starting to mitigate the aforementioned disparities and resource gaps to address the behavioral challenges faced by its youth. For example, survey and interview respondents expressed optimism for how some programs and initiatives in the county, including CYBHI workstreams, have already helped (1) increase access to behavioral health services, including more culturally appropriate care; (2) streamline care coordination and reduce complications associated with referrals; and (3) strengthen the relationships and collaboration across sectors in the

county. Specifically, CYBHI funding has been used to deliver a culturally responsive, evidence-based parenting program to tribal families, sustain a critical program providing crisis-triage service on school campuses, and establish a new partnership between HCOE and a managed care plan, among other activities.

Other CYBHI programs and initiatives are still in the early stages of planning and implementation, but they have the potential to further support changes in the system of care. The CYBHI Fee Schedule is one such effort that is expected to help address the geographic barriers limiting access to behavioral health services in the county by facilitating service delivery in school settings. Additionally, although outside the scope of this particular case study, a BHCIP grant awarded to the Yurok Tribe to construct a Yurok Youth Center in Weitchpec has the potential to expand the availability of culturally informed services and supports for Humboldt's rural Native youth.

> "I feel like we have an incredible willingness to work together and a very stressed system."
> —CBO interview respondent

Strong multisector relationships in the county and the willingness of actors in the system to work together have enabled progress in implementing child- and youth-focused programs and initiatives so far despite widespread workforce shortages and the challenges associated with the rural, small nature of the county. However, more efforts are needed to bridge gaps and increase collaboration between county agencies and organizations and the local tribes. Continued commitment to enhancing multisector collaboration, along with investments to expand the workforce, will help the county build on early successes using the CYBHI to address the behavioral health needs of Humboldt's youth and their families.

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 https://maps.geo.census.gov/ddmv/map.html	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 (%)		
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 (%)	Feeding America's Map the Meal Gap data at https://map.feedingamerica.org/	2021
Healthy Places Index (rank)	Healthy Places Index at https://map.healthyplacesindex.org/	2015–2019
Diversity Index (rank)		

Variable	Source	Years
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 (%)		
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		
Percentage of students who were chronically absent	California Department of Education data at https://www.cde.ca.gov/ds/ad/filesabd.asp	2022–2023
Percentage of students reporting school absences due to mental health issues	California Healthy Kids Survey County Reports at https://calschls.org/reports-data/search-lea-reports/	2019–2021
Percentage of students reporting school absences due to alcohol or drug use		
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

Variable	Source	Years
Mental 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
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 non-psychiatrist 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 FQHC 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] Although 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 may pertain to children as well.

Appendix B. Network Analysis Methodology and Measures

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

Methodology

We invited 14 organizations to complete the NEES and received responses from 12 organizations (85.7 percent response rate). Invited organizations included government agencies and departments, a managed care plan, and CBOs, including organizations that serve Native populations and other diverse communities. Administrators of child- and youth-serving organizations, such as directors and executive directors, rated the strength of their organizations' connections with other organizations on a 5-point scale, ranging from (1) coexist to (5) integrated.[13,14] 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 survey that respondents used to rate their organizations' connections with other organizations.

Exhibit B.1. Connection ratings and descriptions

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 Humboldt County, sometimes only one organization rated the strength of a connection between two organizations. To determine whether to include these ratings in our analysis and network map, we 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 only one 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 respondents typically agree with each other about the strength of their connection; thus, a single organization's assessment of the strength of the relationship can be used to represent the actual strength as reported by both ends of the connection. In Humboldt County, the agreement score was 74.0 percent. Due to this high level of agreement among

[13] 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

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

respondents, we included those connections where only a single organization provided information about strength in the network analyses and map.

Network measures

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

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

Network measure	Statistic	Description
Possible network size	14	The number of organizations invited to take the survey.
Number of possible connections	182	The total number of possible connections between all 14 organizations invited to complete the survey. Because each organization rates its relationship with every other organization, there are two possible ties between any two organizations (that is, each organization's rating of the connection).
Observed network size	14	The number of organizations included in the network map. This count includes organizations that did and did not respond to the survey.
Number of observed connections	115	The total number of connections reported by organizations that completed the survey. This excludes missing data and "not applicable" responses.
Number of unidirectional connections	47	A unidirectional connection is observed when only one of the two organizations rates the strength of the connection.
Reciprocated connections	68	The number of connections that were bidirectional (that is, both organizations reported the strength of the connection with each other).
Reciprocity rate	0.59	The number of bidirectional connections out of the total number of observed connections.
Average strength of the network	2.65	The average strength rating for the network, where the denominator is the number of observed connections.

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

Exhibit B.3. The number and percentage of connections in the network map by average strength

Average strength range	Rating strength	Number of connections	Percentage of connections
1.00–1.99	Coexist	14	17.3%
2.00–2.99	Cooperate	29	35.8%
3.00–3.99	Coordinate	22	27.2%
4.00–4.99	Collaborate	16	19.8%
5.00	Integrated	0	0.0%
Total		**81**	**100.0%**

Appendix C. Details on the Implementation of Selected Workstreams

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

Workstream: Student Behavioral Health Incentive Program (SBHIP)	
Short overview	• The county's SBHIP projects focus on two areas: (1) behavioral health wellness (BHW) programs and (2) IT enhancements for behavioral health services. • The SBHIP projects focus on three local education agencies (LEAs): Court and Community Schools and Southern Humboldt Joint Unified School District, which are both part of Fee Schedule Cohort One, and Peninsula Union School District. • The work has included providing "Be Sensitive, Be Brave" trainings to the staff in the three LEAs, implementing infrastructure and staff at the COE to support the CYBHI Fee Schedule billing, and piloting a Community Information Exchange.
Key implementation findings	**Implementation of the county's infrastructure to support the provision of reimbursable behavioral health services is well underway.** • One early success has been hiring staff, including a programmatic funding analyst, to prepare for implementing billing infrastructure. • The county has also piloted a Community Information Exchange (a multi-organizational platform to track student intervention across entities) in two of the SBHIP LEAs. **The county is on track to successfully achieve its BHW program project goals.** • One LEA has already reached the project threshold of having 70 percent of staff trained. • The other two LEAs had trainings scheduled in August 2024, and education respondents anticipated that most staff would participate in these trainings. • One education respondent said that educators have found the "Be Sensitive, Be Brave" trainings very valuable, noting that the trainings provide important tools and insights into students' experiences and warning signs that every educator should have. "I think all educators need to have this level of training. It's a two-hour training, at the very least. How can we have people working with students that are dealing with so many stresses in life without any type of training for behavioral and mental health?" —Education interview respondent **The county has encountered some barriers to SBHIP implementation, including staff capacity and the grant program structure.** • Education respondents noted the difficulties of meeting training goals in some LEAs due to limited staff availability— educators have few professional development days, many ongoing initiatives, and limited time. • A managed care plan respondent pointed out that schools do not operate on calendar years, and a grant period that ends mid-school year does not work for schools. • Education respondents also noted that all of the SBHIP requirements are very burdensome for a small COE. **The resources provided through the SBHIP grant have helped HCOE collaborate with other agencies and organizations to conduct a needs assessment.** • HCOE was able to use SBHIP funds to contract out some of the work to the Humboldt IPA and NCHIIN as well as a local community data visualization specialist. HCOE also has strong partnerships with DHHS and local CBOs and was able to include them in SBHIP conversations, which was perceived as important to the COE not feeling isolated in that work.

Workstream: Student Behavioral Health Incentive Program (SBHIP)	
Sustainability and what is next	**A primary benefit of the SBHIP projects, from the perspective of both education and managed care plan respondents, has been the development of a productive relationship between the managed care plan and the COE that is expected to be sustained.** • For example, the managed care plan has helped HCOE's foster and homeless youth department explore the Enhanced Care Management (ECM) benefit as a funding option to expand its workforce. **SBHIP conversations and work engaging with the county's districts have reinforced the urgency of scaling up school-based mental health efforts.**
	"I already had the awareness that we needed to scale up mental health, but with our admin and across these conversations, and with our SBHIP partnership meetings, we are having these conversations that needed to happen around it. School-based mental health is coming, and we need to prepare for this. This is not an option. This is our mandate, really, and our ethical responsibility as educators. And so it really feels like everybody advanced because of those conversations and because of the way that we've been engaging our districts...Community schools, CalHOPE, all those things [that are part of the] CYBHI have really created a tapestry of awareness and I think SBHIP kicked it all off, in a way." —Education interview respondent
	Going forward, the managed care plan and education respondents anticipate wrapping up the SBHIP projects and transitioning into Fee Schedule implementation in January 2025. • The monthly meetings the managed care plan began facilitating for its COEs (24) as part of SBHIP implementation will sustain beyond the end of SBHIP funding as they move into Fee Schedule implementation.

Workstream: CYBHI Fee Schedule

Short overview	• Two of the county's SBHIP LEAs, Court and Community Schools and Southern Humboldt Joint Unified School District, are part of the CYBHI Fee Schedule Cohort One. The third SBHIP LEA was not eligible for Cohort One because it does not implement Medi-Cal billing. • The county also has two districts, Eureka City Schools and Northern United Charter Schools, participating in the CYBHI Fee Schedule Cohort Two. • HCOE is still determining different approaches to billing across its LEAs. It hopes to encourage smaller LEAs to group together as billing consortia.
Key implementation findings	**HCOE is currently engaged in work to develop the infrastructure needed to implement the CYBHI Fee Schedule, with the goal of beginning billing in January 2025.** • HCOE is currently hiring staff and creating systems to provide centralized billing support and TA. For example, it is moving forward with creating provider lists, registering, building the infrastructure, and identifying the third-party administrator. • Only a limited number of county LEAs demonstrate operational readiness for the CYBHI Fee Schedule billing. As a result, the county office will need to provide centralized support to help facilitate third-party administrators and provider enrollment, which will require a substantial increase in capacity to meet district needs. • Education respondents also expect that the CYBHI Fee Schedule implementation will necessitate the development of consortia so that small independent districts can create and use multi-district regional teams rather than trying to work through the county office. • Education respondents perceived that Humboldt is as on track as possible to implement the CYBHI Fee Schedule given its rural setting. They were hopeful about the potential for CYBHI Fee Schedule consortia to facilitate the hiring of licensed clinicians or wellness coaches, who will have smaller caseloads and can focus on preventative activities. **There is a growing awareness across Humboldt about the CYBHI Fee Schedule.** • HCOE initially worked to introduce the CYBHI and the Fee Schedule through existing meetings and forums with superintendents and has since extended communication to invite student support workers, such as school psychologists and counselors, and fiscal staff to a Zoom meeting to continue building awareness and introduce the idea of developing consortia. • The behavioral health department is also in communication with local school leadership about how to participate in the CYBHI Fee Schedule and use it to reimburse for the services it provides. One behavioral health respondent shared their excitement about the potential for the CYBHI Fee Schedule to address the gap in services for students who are not eligible for Medi-Cal. **Barriers to successful CYBHI Fee Schedule implementation in Humboldt include resource constraints and staffing challenges.** • Education respondents expressed some uncertainty about how they would fund the needed positions to work with the fiscal department to create a billing system for their districts. They hope that districts will create consortia, working directly with a third-party administrator for reimbursement and relying on HCOE only for technical assistance. However, they are uncertain exactly how much support HCOE will need to provide and how long it will take to get LEAs where they need to be. • LEA respondents expressed concerns about readiness for implementation due, in part, to turnover and staff shortages, especially among service providers. They have not had an opportunity to work on implementing the infrastructure to support those providers. One respondent also highlighted uncertainty around the extent to which Fee Schedule reimbursement will cover the costs of staff; they expect to need to find another source of funding and slowly build up staff as the CYBHI Fee Schedule ramps up. • In general, respondents expressed concerns about not having sufficient time to prepare for such a substantial shift in their current approach. "I think sometimes the timeline of the state is moving faster than the timelines of the educational system and the capacity in which we can do these things." —Education interview respondent

Workstream: CYBHI Fee Schedule	
Sustainability and what is next	**Respondents expressed some concerns about using the CYBHI Fee Schedule to fund a school-based behavioral health workforce.** • A managed care respondent noted that it is likely infeasible for a county to sustain a behavioral health workforce exclusively through the CYBHI Fee Schedule reimbursement and that it might need to look at braiding funding or contracting out. • Education respondents noted that compensating an internal service provider is probably not feasible within a typical school salary schedule structure. **At the same time, the CYBHI Fee Schedule may already be encouraging better integration across county agencies, including braided funding.** • HCOE now has a shared position with the Department of Health and Human Services, which is a programmatic funding analyst who works closely with another funding analyst in the COE's student services department. An education respondent cited this as an example of their spirit of collaboration, noting that they are using the Breaking Barriers white paper to look at how to braid funding and showing their commitment to such work through this shared position.

Workstream: CalHOPE and Mindfulness, Resilience, and Well-Being Supports

Short overview

- HCOE has used CalHOPE funding to hold monthly virtual community of practice (CoP) meetings and provide social and emotional learning (SEL) resources, curriculum, and training to educators and staff. The monthly CoP meetings are open to everyone—although educators are the primary attendees—and serve to introduce resources and tools to support attendees' ability to incorporate SEL into their professional and personal capacity. CalHOPE funding has also been used for student-facing resources and activities, including a mental health symposium.
- Although CalHOPE funding ended in June 2024, Mindfulness, Resilience, and Well-Being Supports funding is being used to continue CalHOPE activities, support wellness centers, and implement Kelvin, a survey tool for schools to obtain real-time information about students' well-being.

Key implementation findings

CalHOPE and Mindfulness, Resilience, and Well-Being Supports activities have been successfully implemented and well received by educators, school staff, and students.

- CoP meetings have been well attended, with 25 to 30 people attending monthly. The stipends that the COE has been able to provide helped facilitate meeting attendance.
- The mental health symposium, which was attended by around 165 participants and well received by youth, has been a key success. The symposium offered different SEL and mindfulness activities and workshops, including tribal-based trainings. HCOE used a blend of CalHOPE and Mindfulness, Resilience, and Well-Being Supports funding and partnered with tribes, the behavioral health department, and other organizations to plan this event, demonstrating multisector collaboration.
- The flexibility of workstream funding and the support of the grant administrator have helped the COE meet the differing needs of school districts.

On the mental health symposium:

"We also had a very holistic approach to social-emotional learning and mental health. We had some different traditional ecological knowledge, tribal-based trainings…And we had a good amount of youth that were actually able to attend, and it was really well received…you could see the little bits of healing that were able to happen just in those moments. And that was really, really amazing and empowering for the youth, I think."
—Education interview respondent

Engaging educators and school staff can be challenging due to burnout, and the Kelvin rollout has been slow due to data-related concerns from schools.

- Engaging educators and school staff in trainings, CoP meetings, and other workstream activities can be difficult because they are so burnt out from their work. The county has tried overcoming this challenge by providing flexibility in the timing of trainings and meeting people where they are, including traveling to meet people in more rural areas and holding virtual trainings.
- Uptake of the Kelvin survey tool has been slower than expected due to LEA concerns about the validity and confidentiality of the data collected.

Sustainability and what is next

"People really have gotten the message that we need to support students on a holistic level, as well as our staffs on holistic levels."
—Education interview respondent

Although funding is needed to sustain some activities and CoP participation, an education respondent believed that many of the resources and tools created under CalHOPE and Mindfulness, Resilience, and Well-Being Supports are sustainable without funding and that the workstreams have successfully imparted the ideas and importance of SEL upon people in the county.

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

Short overview

- Humboldt's Scaling EBPs and CDEPs grant awards include two Round 1 grants, three Round 2 grants, two Round 4 grants, and one Round 5 grant.
- The funded projects addressed in interviews include the expansion of a school-based wellness center providing trauma-informed services, the continuation of an existing program providing crisis triage services on school campuses, the scaling of parenting programs, and the expansion of a community-defined evidence practice designed for tribal youth.

Key implementation findings

While implementation is in the early stages for many of the grant projects in Humboldt, a few grantees have started providing grant-funded services.

- Ongoing services funded through grants include parenting programs and a tribal CDEP.
- Other grantees are hiring staff and preparing for implementation.

Grant-funded projects are expanding the engagement of youth and families in shaping behavioral health services and ensuring that they are culturally responsive.

- One grantee is working with the Spanish-speaking community to adapt Triple P in ways that are more accessible and welcoming for Spanish speakers. Similarly, the organization is soliciting input from their local Indigenous community on locally appropriate adaptations to Positive Indian Parenting, such as using the term "baby basket" instead of "cradleboard."
- Another grantee incorporates local Indigenous cultural traditions in its CDEP and is engaging older Native youth in facilitating the programming.

Grantees shared some early successes in their work delivering services to underserved communities.

- For example, one grantee partnered with an isolated Indigenous community to provide Triple P paired with other services. Thirty-one families attended, which is a large number given the size of the community, which includes a total Indigenous population between approximately 250 and 300.[a] Participants reported very positive feedback and expressed their appreciation to the organization for coming to the community, listening, and creating a space where they could talk. Most families attended a second session as well.

Grantees cited many barriers to the successful implementation of their funded projects.

- All respondents cited the heavy administrative burden associated with the grants, including participation in learning collaboratives and intensive data collection. Of note, DHCS has been fielding concerns from grantees across the state and streamlined data collection requirements for select groups of grantees that are not using funds to deliver ongoing or more comprehensive behavioral health interventions.
  - One CBO respondent noted that it could benefit from either a technological solution or some additional resources to develop an interface between its databases and the grant administrator database to avoid the burden of double entry.
  - For another grantee, the heavy administrative burden required by the grant in the context of its limited capacity may result in a grant award being declined.
- Respondents also noted that substantial delays in receiving information from the state about the data collection requirements have made implementation more challenging. For example, one grantee noted that if it had known how extensive the data collection and other requirements would be, it would have budgeted its project differently to cover increased administrative capacity.
- CBO respondents have not found the technical assistance worthwhile as it was not sufficiently tailored to their needs and not provided by individuals with experience delivering similar programs. That said, one education respondent found some value in learning collaboratives that included other LEAs, noting that they have some unique needs relative to a clinical setting.
- Finally, implementation has been delayed due to delays in grant notification and acceptance of the sub-award agreement, which prevented one grantee from recruiting and hiring for the relevant clinical positions. To mitigate the impacts of these types of administrative delays, DHCS is offering grantees an option for a no-cost extension to their grant period.

> "I recognize it's a huge, huge lift to create this kind of program, follow up and implement with just a beautiful design that allows a lot of local input and creativity and then try to fit it into a box that will also create outcomes that can be measured across incredibly diverse programs. So I'm not attaching blame at all. Just recognizing that it's been rocky."
>
> –CBO interview respondent

Workstream: Scaling Evidence-Based and Community-Defined Evidence Practices (EBPs and CDEPs)	
Sustainability and what is next	**Grantees expressed mixed perspectives on the sustainability of funded services after the end of the grant period.** • Some grantees are confident in their structural supports for sustainability. For example, one grantee is exploring the potential of the CalAIM community health worker benefit to help sustain grant services. • Other grantees have serious concerns about the short grant period and their ability to sustain the provision of services without grant funding.

Note: The grant implementation experiences described in the table are based on the subset of grantees participating in interviews.

[a] U.S. Census Bureau. "RACE." Decennial Census, DEC Demographic and Housing Characteristics, Table P3, 2020, https://data.census.gov/table/DECENNIALDHC2020.P3?g=860XX00US95556&d=DEC Demographic and Housing Characteristics. Accessed on January 6, 2025.

Workstream: Never a Bother (Youth Suicide Prevention and Media Outreach Campaign)	
Short overview	• Humboldt County grantees have used workstream funding on suicide prevention activities focused on the Native youth population, a vulnerable population in the county. • One grantee has used the funding to distribute suicide prevention materials at youth-facing events, increase staff capacity to support activities, and hold cultural and wellness events incorporating traditional tribal practices. • One grantee is planning to have tribal youth ambassadors create a youth-focused suicide prevention video to facilitate youth empowerment, youth suicide prevention, and a sense of agency and belonging.
Key implementation findings	• One grantee highlighted its incorporation of tribal practices and culture in its program activities, which brings a sense of wellness, identity, connection, and healing to Native youth who may not have been exposed to their culture before or who are repairing their relationship with their culture; respondents believe that cultural exposure and connection to identity are all connected to suicide prevention. Although the grant funding has expanded the grantee's capacity to conduct prevention activities, it is restrictive: food and other incentives for the youth are not covered under the funding, necessitating the use of funding from other programs to cover these items. • The other grantee is still early in implementation but noted that reaching the most vulnerable and at-risk youth has been a challenge. A planned wellness site, funded by a Scaling EBPs and CDEPs grant, may facilitate that outreach. "[Our colleague] will provide these workshops to teach some young men and even young adults—there might be some folks who have struggled with alcohol and other drug abuse or mental health issues, who've never had a chance to learn their culture…I believe cultural exposure, connection to identity, that's all suicide prevention. To me, it's a sense of wellness, sense of identity, sense of connection, healing. Because, unfortunately, I think in our tribal communities, not all—I don't want to speak for everybody—but you might have an abusive home, or domestic violence, or something. Sometimes the perpetrators of that violence are the abused. Those who struggle with unmedicated mental health issues—they were connected to culture. Sometimes we're doing reparative experiences where our cultural groups can help people get reconnected, and that becomes very healing." —CBO interview respondent
Sustainability and what is next	**Both grantees believed that more funding and longer grant duration would help sustain and scale the work they are doing.** • The first grantee plans to work on training tribal youth in using the Gathering of Native Americans curriculum and providing events and curriculum for a planned tribal youth center in the county. The grantee will continue to pursue additional grant opportunities and other funding sources to sustain and further its program work. The organization is documenting the program's impact on the community as evidence to obtain more funding. The current grant funding does not support the administrative work required to seek out more funding, which is necessary for sustainability. • After creating a suicide prevention video, a second grantee plans to rent out a movie theatre for a premiere and invite local news media, similar to a previous effort for a substance use video. From the grantee's perspective, a longer grant duration would support their efforts to scale and create a community-wide impact. For example, the grantee suggested that grants with a five-year duration rather than a two-year duration would provide more opportunity to achieve systemic change.

Note: The grant implementation experiences described in the table are based on the subset of grantees participating in interviews.

Let's Progress Together.

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