Monterey County Case Study: Existing Multisector Collaboration Supports Early Implementation of the CYBHI

Authors: Nichole Sturmfels, Patrice Cachat, Ning Fu, Anna Gu, Ruchir Karmali, Eileen Kazura, Jessica Laird, Rick McManus, Cara Orfield, Gina Sgro, Marlena Smith-Millman, Annu van Bodegom, Deliya Wesley, and Amanda Lechner.

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

Background and methods for CYBHI evaluation and case study

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

Researchers conducted analyses of secondary data sources to capture population and behavioral health system characteristics of Monterey County and California as a whole (see Appendix A for data sources for each metric). In addition, between April and July 2024, the research team conducted the Network and Ecosystem Experiences Survey (NEES) and key informant interviews with local leaders in Monterey County. The NEES explored the connections between organizations in Monterey County to better understand how they work together to support children and youth behavioral health. Using results from the NEES, we conducted a social network analysis and developed a network map showing the average strength of the connections between organizations in Monterey County's behavioral health 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 Monterey County to understand 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, early childhood, juvenile probation, public health departments, and other behavioral health and child welfare leaders. Six individuals participated in both the survey and the interviews.

I. Summary of Findings

Behavioral health ecosystem multisector collaboration

In Monterey County, departments within the children and youth behavioral health ecosystem have strong and well-established 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. However, several of these efforts could benefit from increased cooperation between county departments and community-based organizations (CBOs) providing behavioral health services and supports. Barriers to collaboration include limited staff capacity due to workforce shortages and preexisting initiatives.

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

The CYBHI implementation in Monterey County is progressing and has had positive impacts on multisector collaboration 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.

The Student Behavioral Health Incentive Program (SBHIP) has been effective in promoting mental health awareness among staff and students and in providing counseling services. As of fall 2024, SBHIP implementation was occurring in two of 25 school districts.

Grantees of the Scaling Evidence-Based Practices (EBPs) and Community-Defined Evidence Practices (CDEPs) and the Broad Behavioral Health Workforce Capacity workstreams have made progress in training staff and delivering expanded and culturally responsive services.

Key progress with the CYBHI implementation

- **Student Behavioral Health Incentive Program (SBHIP)**: SBHIP-funded projects focus on hiring social workers and converting existing spaces into places for providing individual and group counseling services.
- **Scaling Evidence-Based and Community-Defined Evidence Practices (EBPs and CDEPs)**: The funded projects in Monterey County included specialty mental health services training, operational supports for after-school programs, and home visits. As of summer 2024, many of these projects were in the planning stages or the very early stages of implementation. However, some grantees that received funding through earlier grant rounds have already begun training clinicians and expanding services.
- **Broad Behavioral Health Workforce Capacity: Community-Based Organization (CBO) Behavioral Health Workforce Program:** Using this funding, a Monterey County CBO reported that it will offer professional development opportunities such as training in specialized modalities (for example, Cognitive Behavioral Therapy and Eye Movement Desensitization Reprocessing), staff bonuses, and loan repayment options to bolster staff retention and expand service modalities.
- **Certified Wellness Coaches:** Several entities in Monterey County received Certified Wellness Coach Employer Support Awards in summer 2024, including the Alisal Union School District, Monterey Peninsula Unified School District, and North Monterey County Unified School District. Wellness coaches are a new type of associate- and bachelor's-level behavioral health providers to fill gaps in youth services and promote mental health and overall well-being. The Alisal Union School District has hired several local wellness coaches to provide Tier 1 (for example, classroom presentations) and Tier 2 (for example, individual student check-ins) services to students.[1]

[1] Tier 1 practices and systems establish a foundation or regular, proactive support while preventing unwanted behaviors. Schools provide these universal supports for all students, school-wide. Tier 2 practices and systems support students who may need extra behavioral support to learn needed skills to access core programs at the school. Accessed at https://www.montereycoe.org/divisions-services/educational-services/leadership-and-school-systems/mtss/pbis

II. County Background

County characteristics

Monterey County is on the Central Coast of California, south of the San Francisco Bay Area (Exhibit 1). The Salinas Valley extends through the heart of the county, making Monterey the third-largest agricultural county in California.[2] The economy of the county is based predominantly on tourism in its coastal regions and on agriculture in the region of the Salinas River Valley. Much of Monterey County is sparsely populated and rural, with most developments being clustered at the northern end of the Salinas Valley and toward the Monterey Peninsula on the coast.[3]

Exhibit 1. Monterey County's geography

Monterey County has an overall population of 433,000 residents, which is small compared with other counties in California. The county is less population-dense than the state—with an average of 134 residents per square mile versus 254 statewide (Exhibit 2). The population of children and youth is proportionally larger than in the state, with more children ages 0 to 4 (6.6 percent versus 5.4 statewide), youth ages 5 to 19 (22.0 percent versus 19.0 percent statewide), and young adults ages 20 to 24 (7.1 percent versus 6.8 percent statewide).

Monterey County residents are predominantly Hispanic or Latino (60.8 percent), and compared with the state, a lower proportion of youth ages 5 to 17 are English-proficient (78.5 percent versus 91.6 percent statewide). Also, compared with the rest of the state, the adult population has lower rates of high school graduation (67.3 percent versus 78.8 percent statewide) and college graduation (25.2 percent versus 34.1 percent statewide).

Monterey 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 (33.4 percent versus 27.6 percent), and the county has a lower median income ($43,967 versus $52,520). The county is ranked 31st (out of 57[4]) in the Healthy Places Index within California, signifying that the county has lower than average access to health care, housing, education, and other characteristics that support a healthy population. Consistent with the economic conditions in Monterey County, a larger percentage of residents ages 0 to 25 is covered by Medi-Cal (52.7 percent) compared with the statewide average (39.3 percent).

[2] County of Monterey. "At A Glance: Monterey County." n.d. Accessed on October 21, 2024. https://www.countyofmonterey.gov/government/departments-a-h/administrative-office/economic-development/at-a-glance-county-facts#:~:text=Monterey%20County%20is%20located%20on,largest%20agricultural%20county%20in%20California

[3] County of Monterey. "The History of Monterey County." n.d. Accessed on October 21, 2024. https://www.countyofmonterey.gov/government/about/history

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

Exhibit 2. Monterey County's population characteristics

Metric	Monterey	California	Year(s)
Population			
Total population (N)	432,858	39,029,342	2022
Population, 0–4 years (N; %)	28,371; 6.6%	2,118,386; 5.4%	
Population, 5–19 years (N; %)	95,000; 22.0%	7,404,396; 19.0%	
Population, 20–24 years (N; %)	30,733; 7.1%	2,639,787; 6.8%	
Five-year population change (%)	-1.2%	-1.3%	2017–2022
Five-year population change, 0–24 years (%)	-3.3%	-5.4%	
Density (population per square mile)	134	254	2020
Race and ethnicity			
White, non-Hispanic (%)	27.6%	33.7%	2022
Black or African American, non-Hispanic (%)	1.7%	5.2%	
American Indian and Alaska Native, non-Hispanic (%)	0.2%	0.3%	
Asian, non-Hispanic (%)	5.4%	15.3%	
Native Hawaiian and other Pacific Island American, non-Hispanic (%)	0.5%	0.4%	
Some other race, non-Hispanic (%)	0.4%	0.6%	
Two or more races, non-Hispanic (%)	3.4%	4.3%	
Hispanic or Latino (%)	60.8%	40.3%	
Birthplace and language			
Foreign-born, 0–24 years (%)	9.3%	7.2%	2022
English-proficient, 5–17 years (%)	78.5%	91.6%	
Education (18+ years)			
High school or higher (including college) (%)	67.3%	78.8%	2022
College degree or higher (%)	25.2%	34.1%	
Economic indicators, socioeconomic, neighborhood characteristics			
Population within urban blocks (%)	85.8%	94.2%	2022
Population within rural blocks (%)	14.3%	5.8%	
Population below 200% of the federal poverty line (%)	33.4%	27.6%	
Median income (USD)	43,967	52,520	
Unemployment (%)	4.7%	5.3%	
Households with high housing cost burden (%)	42.3%	40.3%	2019
Food insecurity, overall (%)	9.8%	10.5%	2021
Food insecurity, 0–18 years (%)	13.8%	13.5%	
Healthy Places Index (rank)	31	N/A	2015–2019
Diversity Index (rank)	43	N/A	
Health status			
Population with a disability (%)	9.6%	11.7%	2022
Population with a disability, 0–17 years (%)	3.2%	4.0%	
Health insurance status (population 0–25 years)			
Medi-Cal or other means-tested public coverage (%)	52.7%	39.3%	2022
Private coverage (%)	44.5%	60.2%	
Uninsured (%)	6.7%	4.9%	

Metric	Monterey	California	Year(s)
TRICARE/military coverage (%)	2.4%	1.7%	
Medicare coverage (%)	0.6%	1.0%	

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

Monterey County children and youth are comparable to the statewide population across many behavioral health outcomes, but they have notably higher rates of emergency department visits for any behavioral health diagnosis (Exhibit 3). Monterey County children and youth have similar[5] overall mental well-being compared with children and youth statewide, with similar rates of students in grade 9 who feel they are doing things that make a difference, who feel they are doing interesting activities at school, and who feel they are close to people at school. Monterey County children and youth also have similar rates of behavioral health challenges to children and youth statewide, including similar rates of children and youth insured through Medi-Cal with a mental health diagnosis or emotional symptoms, similar rates of students who seriously considered attempting suicide, and similar rates of chronic absenteeism. However, compared with the state, Monterey County youth had higher rates of emergency department visits for any behavioral health diagnosis (41 versus 32 visits per 1,000 children and youth) according to the latest publicly available data, which may not reflect recent efforts to provide more crisis services, including a youth mobile response team, that are intended to prevent emergency department visits.

Exhibit 3. Prevalence of behavioral health outcomes

Metric	Monterey	California	Year(s)
County-level overall mental well-being for children and youth[a]			
Students in grade 9 who felt they were doing things that made a difference (%)	27%	28%	2017-19
Students in grade 9 who felt they were doing interesting activities at school (%)	44%	49%	
Students in grade 9 who felt close to people at school (%)	58%	61%	
Region-level overall mental well-being for children and youth[b]			
Youth ages 12 to 17 years old who felt their family stood by them during difficult times (%)	77%	73%	2022
Youth ages 12 to 17 years old who felt at least two non-parent adults took a genuine interest (%)	60%	58%	
Youth ages 12 to 17 years old who felt supported by friends (%)	72%	72%	
Behavioral health challenges			
Children and youth insured through Medi-Cal with a mental health diagnosis or emotional symptoms (%)	17%	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 (%)	12%	16%	2017-19
Students in grade 11 who reported seriously considering attempting suicide in the past 12 months (%)	16%	16%	2017-19

[5] While this report uses state-level statistics as points of comparison, the state-level statistics do not necessarily equate to a benchmark that denotes acceptable or healthy levels of prevalence.

Metric	Monterey	California	Year(s)
Emergency department visits and hospitalizations for children and youth with behavioral health-related conditions			
Inpatient hospitalization stays per 1,000 children and youth for any behavioral health diagnosis	12	12	2022
Emergency department visits per 1,000 children and youth for any behavioral health diagnosis	41	32	
School engagement, as measured through absenteeism and suspension			
Students in grades K–12 who were chronically absent (%)	22%	25%	2022-23
Students in grade 9 reporting school absences due to mental health issues (%)	8%	7%	2017-19
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 Monterey 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] County-level metrics of mental well-being are only available for some counties and are included in a subset of these case studies where possible. In Monterey County, 2019–2021 data from the California Healthy Kids Survey are not available, so both county and statewide metrics are provided from the 2017–2019 findings.

[b] These well-being metrics are only measured at the regional level. Monterey is part of the Central Coast region as defined by the California Health Interview Survey. This region also includes San Benito, San Luis Obispo, Santa Barbara, Santa Cruz, and Ventura counties.

Resource availability

Like many counties across California, Monterey County has a full shortage designation for both primary care and mental health care providers (Exhibit 4). Monterey County also has fewer child and adolescent psychiatrists per 100,000 children and youth than the state (10 versus 17), though it has more non-psychiatrist behavioral health providers licensed with County Medi-Cal Specialty Mental Health Services plans per 100,000 (58 versus 37).

Exhibit 4. Behavioral health care resource availability

Metric	Monterey	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	15	20	2024
Number of child and adolescent psychiatrists per 100,000 children <18 years old	10	17	2022, 2024
Number of non-psychiatrist behavioral health care providers licensed with county Specialty Mental Health Services plan per 100,000 residents	58	37	2021
Number of outpatient treatment programs for young adults per 100,000 children and youth ages 0–24 years[a]	4	4	2021
School-based health programs with mental health services per 100,000 children and youth ages <18 years	5	4	2024

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

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

> "If you just start looking at the resources within the school districts, compare Carmel and Pacific Grove School Districts, to Soledad and King City School Districts, there's going to be a huge difference in regards to their resources and how long children are waiting to access those resources."
>
> —CBO interview respondent

Workforce shortages have impacted organizations' ability to meet the behavioral health needs of children, youth, and families. Respondents agreed that all sectors of the behavioral health system of care have experienced the impacts of workforce shortages, with a particular need for more licensed psychologists, marriage and family therapists, clinical social workers, and professional clinical counselors. According to the respondents, one contributing factor to the shortages is that compensation for behavioral health staff across all sectors in Monterey County is not commensurate with other counties. Several noted that the neighboring county of Santa Cruz is "wealthier," and Monterey County is unable to compete with the salary and benefits they offer. One CBO respondent highlighted the county's stark economic disparities, noting that people who live in less affluent areas face greater barriers to accessing behavioral health services, regardless of insurance type. Although the workforce shortage affects all sectors, those with lower incomes face greater challenges securing timely care.

Respondents universally emphasized that the system of care in the county lacks sufficient, culturally representative providers and culturally relevant services for the county's ethnically and racially diverse families. Respondents noted concerns about preventive services and evidence-based practices. For example, one early childhood respondent indicated that evidence for these practices was demonstrated in White communities but not in the diverse communities it serves. A CBO respondent also noted attrition of some clinical staff in the county because they were expected to utilize a Eurocentric approach in their work with families, which is not culturally responsive and results in mistrust of providers and families not feeling heard. These concerns are aligned with research suggesting that, in general, there is a need for more cultural adaptation of interventions to provide effective care[6] and that culturally adapted interventions are more effective.[7] Respondents across sectors also noted that several specific populations do not receive needed behavioral health services, including Black and Latino youth, LGBTQ+ youth, Asian Pacific Islander youth, and those who speak Spanish and Indigenous languages. However, over the past 2 years, the county behavioral health department has used MHSA Innovations funding to develop the Rainbow Connections project, which creates an affirmative network of care for LGBTQ+ youth as well as education and supports for the adults in their lives. Although not rigorously evaluated, early training efforts showed promising signs of increased adult awareness, with most participants reporting high levels of familiarity with health risks LGBTQ+ youth face and confidence in explaining the impact of family rejection and acceptance on LGBTQ+ health and well-being.

Respondents perceived gaps in the continuum of behavioral health services, and the county behavioral health department is working to increase capacity. Several respondents mentioned gaps in residential and outpatient programs for youth with substance use disorders (SUD), as well as limited placement options for children and youth requiring group home and inpatient crisis and psychiatric beds. Some respondents shared that these service gaps have led to placement outside of the county for children and youth who require this level of care. Currently, there is only one six-bed Short-Term Residential Therapeutic Program (STRTP) in the county, and it is specifically for girls.

To address these gaps, the county behavioral health department has been engaged in efforts to add crisis and step-down services for children and youth. For example, it collaborated with its contracted provider to launch the child and youth mobile response team (MRT) in mid-2020. According to one behavioral health sector respondent, over the last few years, the MRT has helped stabilize many children and youth in the community so that they do not require

[6] Rathod, S., L. Gega, A. Degnan, J. Pikard, T. Khan, N. Husain, T. Munshi, and F. Naeem. "The Current Status of Culturally Adapted Mental Health Interventions: A Practice-Focused Review of Meta-Analyses." *Neuropsychiatric Disease and Treatment,* vol. 14, January 2018, pp. 165-178. https://doi.org/10.2147/NDT.S138430.

[7] Hall, G. C. N., A. Y. Ibaraki, E. R. Huang, C. N. Marti, and E. Stice. "A Meta-Analysis of Cultural Adaptations of Psychological Interventions." *Behavior Therapy,* vol. 47, no. 6, November 2016, pp. 993-1014. https://doi.org/10.1016/j.beth.2016.09.005.

hospitalization. For children and youth that are hospitalized, there is a post-hospital team that provides discharge and mental health after-care for all children and youth leaving the emergency department or inpatient facilities. In addition, there is a multi-year project to develop a youth Crisis Stabilization Unit and Children's Crisis Residential Program, which is anticipated to open late spring 2025 to serve children and youth on Medi-Cal. The final phase of this project includes the development of a two-bed Enhanced STRTP (E-STRTP); site demolition began in December 2024, with project completion anticipated early 2026. The infrastructure and start-up are funded through a combination of several grant sources awarded to the county behavioral health or Seneca (the county's contracted provider), including the California Health Facilities Financing Authority, Behavioral Health Continuum Infrastructure Program Round 5, and the Children's Crisis Continuum Pilot Program.

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

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

To better understand the behavioral health ecosystem and how connected systems are across sectors as the context for the CYBHI implementation in Monterey 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 12 organizations in Monterey County based on the ratings provided by the nine 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 Monterey County

In Monterey County, we invited 12 child- and youth-serving organizations to complete the NEES via email and received responses from nine. Invited organizations included government agencies and departments; a managed care plan; and CBOs, including organizations that serve diverse communities. We asked survey respondents, such as directors and executive directors, how their organizations currently work with the other organizations invited to complete the survey 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) coexist, (2), cooperate, (3) coordinate, (4) collaborate, and (5) integrated.[8]

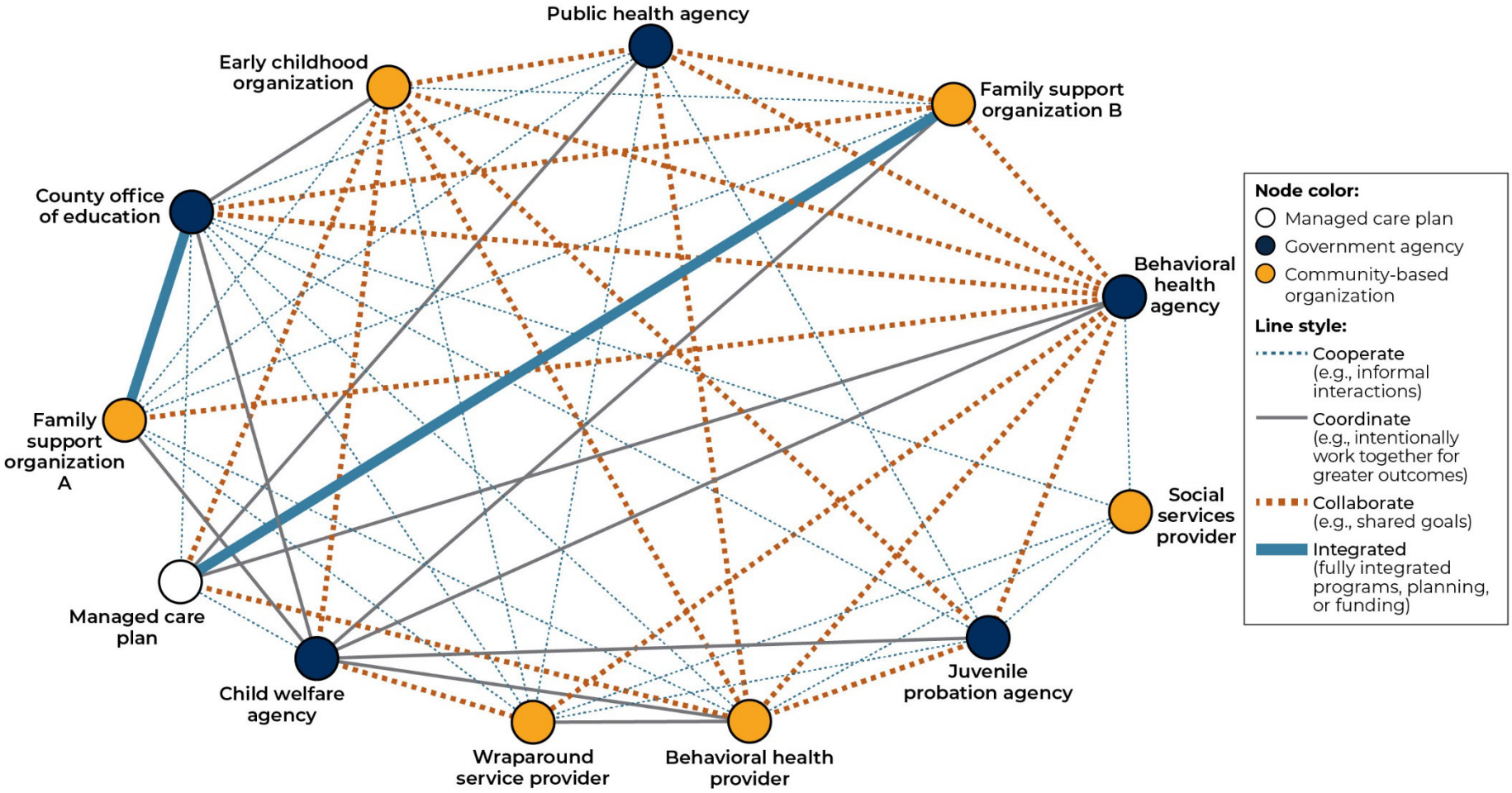
These ratings were used to conduct a network analysis and develop a network map showing the average strength of the connections between organizations, based on each organization's rating of the other.[9,10] A line between two organizations shows that a connection exists. No line indicates that the organizations 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.

[8] 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.

[9] In Monterey County, there were instances where only one organization rated a connection between two organizations. Using data that included responses from both sides of a connection, we conducted an agreement analysis to understand whether survey respondents tended to rate the strength of their relationships in similar ways. Based on this analysis, we concluded that there was a high rate 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.

[10] 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 Monterey County behavioral health ecosystem



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

Overview of connections across the behavioral health ecosystem

Across the behavioral health ecosystem in Monterey County, agencies and organizations tend to be well connected, with most actively working together. The average strength of the network is 2.82, indicating that, on average, there is a high level of cooperation among child- and youth-serving organizations to support children and youth behavioral health. Although one-third of connections in the network (34.4 percent) have an average strength of "cooperate," meaning that organizations interact informally, most connections (62.3 percent) suggest that organizations actively work together to support children and youth behavioral health. For example, one-third of connections in the network (31.1 percent) have an average strength of "collaborate," generally representing formal partnerships between organizations, with shared goals or resources. In addition, 16.4 percent of connections in the network have an average strength of "coordinate," suggesting that organizations intentionally work together for greater outcomes, and 14.8 percent of connections are integrated, meaning that organizations have fully integrated programs, planning, or funding. Furthermore, most organizations (75 percent; n = 9) have eight or more connections across the network. Of these, the behavioral health department and county office of education are the most networked, with connections to all other organizations in the network. Other government agencies and several CBOs also tend to be well connected, with eight to 10 connections each.

Perceptions of relationships and multisector collaboration

Monterey County's System of Care for Children's Mental Health created a foundation for agencies and organizations to work together to support children and youth behavioral health. Interview respondents from government agencies work together closely to serve the county's children and youth. As shown in the network map, the strongest connections in the network involve the behavioral health agency, which has collaborative relationships with juvenile probation services, the county education office, and the public health department. The strong relationship between public health and behavioral health may be due in part to the fact that both bureaus sit within the Monterey County Department of Health. The county behavioral health department, juvenile probation agency, and the office of education also coordinate with child welfare services. Although the network map shows that behavioral health and child welfare coordinate with each other, a respondent reported that the two entities are co-located and have a joint program where staff from behavioral health and child welfare work together in teams to serve families. Respondents explained that these relationships have been cultivated over many years, beginning with a federal grant that established the county's System of Care for Children's Mental Health, an interagency governance council, and a focus on providing comprehensive, coordinated, community-based, and the least restrictive care to children and their families. The system of care set the stage for the AB 2083 Interagency Leadership Team, which focuses on 1) children and youth with intensive needs who are involved in child welfare programs, 2) the integration of behavioral health clinicians into child welfare teams and juvenile probation collaborative court programs, and 3) a memorandum of understanding (MOU) between child welfare services and the county behavioral health department to provide behavioral health services to foster youth, including school-based mental health supports. Additionally, the county office of education has a foster care liaison who provides education support and coordination for all students involved in child welfare, except for behavioral health needs, as those services are supported by the MOU. Interview respondents noted that government agencies have a mindset of shared responsibility for children and youth with complex needs and that they collaborate on planning, programming, and funding initiatives to support the behavioral health of children and youth.

In Monterey County, some CBOs have strong relationships with other behavioral health services organizations, whereas others seek greater collaboration or coordination of care. Within the network, both family support organization respondents reported having integrated relationships—one with the county office of education and the other with the managed care plan. In addition, the early childhood organization has multiple collaborative relationships, including with all five government agencies, the managed care plan, and the behavioral health plan.

Other CBO service providers also have strong relationships. The behavioral health provider collaborates with the behavioral health agency, juvenile probation department, and the public health agency, whereas family support organization B collaborates with the behavioral health agency, public health agency, and county education office. The wraparound service provider collaborates with behavioral health and child welfare agencies. In interviews, CBOs had varying perspectives on the extent of collaboration within the county. Some described strong relationships with certain government agencies, including the behavioral health department. One respondent explained that relationships are built over time and that people in the county know each other. However, the respondent noted that it has been more challenging to develop relationships with behavioral health providers who are based in neighboring counties but serve Monterey County children, youth, and families. In addition, some CBO respondents expressed a desire for more collaboration meetings or greater coordination of care. These perspectives suggest that they could benefit from more structured and intentional collaboration opportunities in the county that include CBOs, along with other opportunities that bring together providers across neighboring counties.

Barriers to multisector collaboration

Systemic barriers, multiple funding streams, and inadequate funding create silos that impact the strengths of cross-sector relationships. Some interview respondents mentioned systemic barriers, such as regulations around confidentiality and sharing protected health information, limiting the ability of partners to effectively work together to meet the needs of children, youth, and families. In addition, some respondents noted that competition for resources and funding restrictions discourage multisector collaboration and lead to silos.

Facilitators of multisector collaboration and strategies to change mindsets

Funding from Mental Health Services Act (MHSA) of 2004 and Mental Health Student Services Act (MHSSA) has been instrumental in improving multisector collaboration between several county agencies. A behavioral health sector respondent shared that the behavioral health agency and the county office of education have continued their long-standing partnership and have utilized MHSA funding to partner with the office of education to implement Positive Behavior Intervention and Support (PBIS) in districts across the county. More recently, the behavioral health agency has utilized MHSSA funding to 1) implement, within several districts across the county, the Interconnected Systems Framework (ISF) and comprehensive suicide support; and 2) bring in a consultant team to provide training and technical assistance to interagency leaders on systems alignment and integration and on developing countywide guidance and support for local implementation of the CYBHI Fee Schedule. According to respondents, these efforts have resulted in engagement and buy-in by the school districts to invest in the behavioral health of students, and they are expected to enable interagency leaders to develop a sustainable approach to collaborative leadership.

Spotlight on multisector collaboratives that support children and youth behavioral health

Survey and interview respondents reported on multisector collaboratives that support children and youth behavioral health in Monterey County.

School Climate Transformational Leadership Team

The School Climate Transformational Leadership Team (SCTLT) oversees the implementation of a federal School Climate Transformation grant and helps integrate mental health services and supports into schools. The team is a collaboration between the Monterey County Office of Education, Monterey County Behavioral Health, school districts, and community-based organizations that provide on-campus interventions, such as restorative justice and parent partnerships. In the survey, respondents whose organizations participate in the SCTLT reported that the collaborative has developed a shared vision and goals for aligning services and systems with the needs and desires of the people being served and is defining transparent pathways for youth, families, and people who work with children to access and receive necessary behavioral health supports and services. Most survey respondents also reported that the SCTLT has made moderate-to-extensive progress on aligning resources and activities across child- and youth-serving organizations in the county and fostering creative problem-solving among partner organizations.

Assembly Bill 2083 Interagency Leadership Team

Assembly Bill 2083 (AB 2083), approved in 2018, requires each county to develop and implement a memorandum of understanding (MOU), outlining the roles and responsibilities of the various local entities that serve children and youth in foster care who have experienced severe trauma. The Interagency Leadership Team (ILT) ensures that public programs for children, youth, and families provide services in an integrated, comprehensive, culturally responsive, and evidence-based/best-practice manner. A respondent from juvenile probation services noted that county agencies have robust partnerships and collective responsibility for youth and families, regardless of through which "door" they enter the system. Another respondent noted that core members of the ILT work well together and collaborate on individual, challenging cases. For example, if an organization identifies a child in crisis, members are responsive and collaborative in identifying resources.

In the survey, respondents whose organizations participated in the ILT reported that the ILT establishes and strengthens relationships across sectors to deliver a comprehensive array of supports and services, from prevention to intensive levels, and works to implement upstream solutions. Some examples are behavioral health promotion, prevention, or early intervention to support the well-being and behavioral health of children, youth, and families. All respondents described the ILT as making at least moderate progress in reducing barriers for children, youth, and families to access behavioral health supports and services and in improving care coordination, with some respondents categorizing the progress in those areas as extensive.

Other multisector collaboratives

- The **Maternal Mental Health Taskforce**. This task force supports the professional development of maternal mental health providers. Respondents noted that it helps reduce silos and has led to new collaborations and projects, such as joint case conferences between public health and behavioral health services.
- The **Monterey County Children's Council** was born out of a community survey called Impact Monterey County that sought to understand the needs of the county. The council was assembled to coordinate the needs identified in the survey, such as mental health, and basic needs across the system of care.

A grassroots approach, **Bright Beginnings** that focuses on children ages 0 to 8 was created many years ago to develop the capacity of potential community leaders and existing community leaders to become better advocates for young children. Other collaboratives mentioned by interview participants include the Monterey County Behavioral Health provider group, the Monterey Integrated Systems Transformation Initiative (MISTI), Strong Start, and the Wellness Collaborative.

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 Monterey County

Overall, Monterey County is locally implementing eight CYBHI workstreams that involve the distribution of funding to county or community entities, including 20 grants as of September 2024.[11] This case study discusses Monterey County's implementation experiences with the SBHIP, Certified Wellness Coach Employer Support Grant Program, Scaling EBPs and CDEPs, and the Broad Behavioral Health Workforce Capacity workstream. Other workstreams active in the county include CalHOPE, Mindfulness, Resilience, and Well-Being Supports, Public Education and Change Campaign, and School-Linked Partnership Capacity Grants.

Education sector workstreams

The **SBHIP** focuses on developing a behavioral health infrastructure by helping managed care plans and LEAs partner to address identified gaps in school-based behavioral health infrastructure through a set of targeted interventions. Counties and LEAs can select one to four targeted interventions from a list of 14 outlined by DHCS; depending on the interventions selected, SBHIP activities may support increasing capacity for promotion and prevention or reducing administrative barriers to clinical care in and near schools and are intended to enhance partnerships between LEAs and managed care plans.

Certified Wellness Coaches (CWCs) 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 for 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 CYBHI Fee Schedule by adding another reimbursable provider type. In July 2024, through the Certified Wellness Coach Employer Support Grant Program, 64 grants were awarded to educational institutions and school-based and school-linked health and behavioral health agencies to support hiring of CWCs.

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

SBHIP implementation is well underway in two school districts where at least 90 percent of the student population is Medi-Cal members. The county's managed care plan is overseeing the implementation of four targeted interventions in two partner districts in the county: Alisal Union School District (USD) and Soledad Unified School District, both serving students in grades K–12. The four projects focus on behavioral health wellness programs, behavioral health screenings and referrals, building stronger partnerships to increase access to Medi-Cal services, and expanding the behavioral health workforce, with activities that include hiring six social workers (in one district) and offering group and individual counseling services in both districts. In Soledad, SBHIP funds were used to extend the workspace to accommodate the expansion of group and individual counseling services, including transforming classrooms and installing an outdoor wellness track. The Alisal USD has made the most progress on its wellness program intervention. The district is using SBHIP funds to work with the National Compadres Network to train social workers, school counselors, and parent education specialists to facilitate Tier 2-level support groups for 5th- and 6th-grade students, with a particular focus on Indigenous populations. The district has also taken steps to improve infrastructure for future billing for behavioral health services by securing a contract for an electronic health record system.

The SBHIP projects in Alisal USD faced early implementation challenges due to staffing, sustainability concerns, and differing partner perspectives, but strategic efforts to address these issues present opportunities for improvement. These challenges included early staff turnover due to noncompetitive salaries, which limited the full utilization of available funding and slowed workforce expansion, as concerns arose about the sustainability of new

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

positions. Additionally, a lack of alignment across all interested parties on the shared vision for behavioral health services has contributed to delays in implementation. Despite these challenges, the district is positioned to capitalize on several opportunities for improvement. For example, the district is making progress toward implementing an electronic health record system and billing Medi-Cal for behavioral health services, which offers a pathway to financial sustainability and expanded services.

Multiple preexisting partnerships and funding efforts for behavioral health in schools created both a strong foundation and a complex landscape for the SBHIP implementation. One behavioral health sector respondent noted that many school districts already had school-based mental health supports in place because of over 30 years of partnerships between county behavioral health services, county office of education, special education local area plan, and the 25 school districts. Services include mental health care for students with Individualized Education Program (IEP)-determined mental health needs, and many districts have established MOUs with the county behavioral health department to support the general education student population as well. The county behavioral health department has partnered and supported funding to bring the Positive Behavior Interventions and Supports and Interconnected Systems Framework into Monterey County schools. Further, both school districts that eventually opted into the SBHIP have had long-standing mental health service agreements with the county behavioral health department.

> "When you take Medi-Cal expertise and then school district expertise, there's not a lot of overlap. And so we're put together…On both sides, there's a sense of not knowing what you don't know… [The contractor] really generates the good questions and can dig in there and figure it out with you."
>
> —Managed care interview respondent e:

According to a managed care respondent, the introduction of SBHIP initially caused confusion in the education community due to the presence of overlapping initiatives, such as the California Department of Education's Multi-Tiered System of Supports (MTSS). Other respondents indicated that low participation in the SBHIP in Monterey County may have also been due to limited school district capacity and a need for a strong central champion. School districts implementing the SBHIP are partnering with external consultants to bridge knowledge gaps and provide technical support to improve implementation and uptake.

The Alisal USD recently hired seven staff members, who are reflective of the local community, through the Certified Wellness Coach Employer Support Grant Program to provide Tier 1 and Tier 2 services. All new hires are from the Salinas area, and many are bilingual in English and Spanish. Several of the newly hired CWCs were previously master's-level interns with the district, and several were educated in Alisal USD schools. They will provide Tier 1 services, such as positive behavioral interventions and support, classroom presentations, and mindfulness, as well as Tier 2 services, including friendship and social groups, bullying prevention, and check-ins with students. Wellness coaches were hired as contracted employees through a third-party organization (Effective School Solutions).

Implementation of home- and community-based sector workstreams

The Scaling EBPs and CDEPs workstream and the Broad Behavioral Health Workforce Capacity Community-Based Organization (CBO) Behavioral Health Workforce Grant Program provided funds for workforce training, increasing the capacity of providers to offer specialty services to families. One behavioral health respondent shared that Scaling EBPs and CDEPs funding enabled the training of five staff members in Parent Child Interaction Therapy, which is expected to result in about 30 more children served during the year. This same respondent also said this funding was used to train seven clinicians in Child-Parent Psychotherapy, which is anticipated to result in about 40 more families being offered this service during the year. The grant has allowed them to serve more children and youth with specialty services and expanded mental health services for young children. One CBO used Scaling EBPs/CDEPs funds to provide trauma-informed training for all existing staff and hire additional staff to support Medi-Cal billing and reimbursement to sustain expanded services. One CBO respondent said it uses its

Broad Behavioral Health Workforce Capacity workstream funding for staff bonuses, training in specialized modalities (for example, CBT and EMDR), and loan repayment options for staff.

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

The **Scaling EBPs and CDEPs grant program**, administered by DHCS, distributes grants to organizations seeking to scale EBPs or CDEPs. EBPs are defined as having rigorous empirical evidence of effectiveness in improving children's and youth's behavioral health, whereas CDEPs are community-based behavioral health practices that have reached a strong level of support within specific communities. The program is distributing five rounds of grants to organizations seeking to scale EBPs or CDEPs to enhance the accessibility and quality of prevention services and clinical care offered in their communities. Many of these grant awards focus on training additional behavioral health care providers in EBPs. The five grant rounds cover (1) parent and caregiver support programs and practices, (2) trauma-informed programs and practices, (3) early childhood wraparound services, (4) youth-driven programs, and (5) early intervention programs and practices. To date, the Scaling EBPs and CDEPs workstream has awarded $248 million in CYBHI funding to 424 organizations across all 58 counties in California, with additional awards pending for early childhood wraparound services. The current grant awards support the delivery of more than 30 different evidence-based and community-defined evidence practices across the state. Note that the Scaling EBPs Round 3 grants, which focus on early childhood wraparound services, were announced in September 2024 and are not covered in this report.

Broad Behavioral Health Workforce Capacity: Community-Based Organization (CBO) Behavioral Health Workforce Grant Program

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

CBOs reported needing to work through operational details and encountering some challenges with contracts and understanding the specific program requirements for the Broad Behavioral Health Workforce Capacity CBO Behavioral Health Workforce Grant Program. For example, one area where respondents reported a need for more clarity upfront was the specific service obligation (for example, 12 months) to practice and provide care in underserved communities. As another example, one CBO respondent shared that their organization needed to determine how to pay staff (for example, directly or through the school) and the tax obligations associated with each option, while assessing organizational risk for disbursing funds to staff and receiving reimbursement from the state. Although webinars and grant guidelines provided by the California Department of Health Care Access and Information helped define and describe program requirements, such as service obligations, respondents indicated a need for additional technical assistance or other supports to effectively navigate these requirements in practice. To address staff communication, payment mechanisms, and organizational risk, one CBO assembled a team of administrative staff (for example, from its legal, contracts, finance, and communications teams) to work through the details for local implementation.

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

V. Conclusion

Children and youth in Monterey County experience higher rates of emergency department visits for behavioral health diagnoses compared with those statewide,[12] and there is limited availability of behavioral health services for children and youth across the continuum of care in the county, especially in the southern part of the county. Key informant interviews suggested limitations in prevention services and SUD treatment modalities, primarily due to a lack of

[12] Although this report uses state-level statistics as points of comparison, the state-level statistics do not necessarily equate to a benchmark that denotes acceptable or healthy levels of prevalence.

facilities and workforce capacity. Respondents highlighted that some populations, including youth impacted by SUD, Black and Latino youth, LGBTQ+ youth, and Asian Pacific Islander youth, are more likely to encounter barriers or face gaps in care.

While initial implementation is still underway, our analysis—drawing from available data, early implementation findings, and interviews with leaders and providers—indicates that Monterey County is using CYBHI resources to address resource gaps and increase access for populations that face substantial barriers. For example, CYBHI funding has helped (1) increase training and incentives for existing behavioral health providers, (2) expand behavioral health staff within school districts, and (3) create spaces within schools for group and individual counseling sessions. CYBHI resources have been used to strengthen the continuum of care through the addition of crisis services to provide immediate stabilization and step-down services to support youth transitioning from higher levels of care, along with the construction of new facilities to expand local capacity.

CYBHI implementation is also building on Monterey County's strong foundational relationships among agencies and organizations that work together to support children and youth behavioral health. Across the behavioral health ecosystem in the county, organizations were already well connected and actively working together. Existing and long-standing initiatives, such as the county System of Care for Children's Mental Health and decades of partnerships between behavioral health and county school districts to provide mental health services in schools, laid the foundation for the CYBHI implementation. More recent funding sources, such as MHSA and MHSSA, further enhanced this collaboration between local education agencies and the behavioral health department, along with other county agencies. In addition, the AB 2083 ILT has strengthened relationships within the county by bringing together agencies to support children and youth with child welfare involvement. These existing connections laid the groundwork for collaborative CYBHI efforts such as SBHIP.

Strong multisector relationships led by the county leadership fueled progress in implementing child- and youth-focused programs and initiatives despite persistent workforce shortages at various levels and a lack of services in the more rural areas of the county. However, based on the perspectives shared by CBO respondents, the county could benefit from increased collaboration between county agencies and CBOs. Building on existing collaboration efforts and CYBHI workforce investments, such as Monterey County's hiring of Certified Wellness Coaches who are bilingual and representative of their communities, will help position Monterey County to further address service gaps and reach populations such as youth impacted by SUD, Black and Latino youth, LGBTQ+ youth, and Asian Pacific Islander youth.

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 (%)		
Economic indicators, socioeconomic, neighborhood characteristics		
Population within urban blocks (%)	U.S. Census at https://www2.census.gov/geo/docs/reference/ua/2020_UA_COUNTY.xlsx	2020
Population within rural blocks (%)		
Population below 200% of the federal poverty line (%)	American Community Survey at https://data.census.gov/table	2022
Median income (USD)		
Unemployment (%)		
Households with high housing cost burden (%)	KidsData.org analysis of the American Community Survey	2019
Food insecurity, overall (%)	Feeding America's Map the Meal Gap data at https://map.feedingamerica.org/	2021
Food insecurity, 0–18 years (%)		
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 felt they were doing things that make a difference (%)	California Healthy Kids Survey County Reports at https://calschls.org/reports-data/search-lea-reports/ and Mathematica's analysis	2017–19
Students in grade 9 who felt they were doing interesting activities at school (%)		
Students in grade 9 who felt close to people at school (%)		
Students in grade 9 who reported seriously considering attempting suicide in the past 12 months (%)		
Students in grade 11 who reported seriously considering attempting suicide in the past 12 months (%)		
Students in grade 9 reporting school absences due to mental health issues (%)		
Students in grade 9 reporting school absences due to alcohol or drug use (%)		
Inpatient hospitalizations per 1,000 children and youth for behavioral health diagnosis	California Department of Health Care Access and Information; applied for data at https://datarequest.hcai.ca.gov/csm	2022
Emergency department visits per 1,000 children and youth for any behavioral health diagnosis		

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

Appendix B. Network Analysis Methodology and Measures

This appendix describes our network analysis methods and measures for Monterey County.

Methodology

We invited 12 child- and youth-serving organizations in Monterey County to complete the NEES via email and received responses from nine. Invited organizations included government agencies and departments; a managed care plan; and CBOs, including organizations that serve diverse communities. Administrators of child- and youth-serving organizations, such as directors and executive directors, rated the strength of their organizations' connections with the other organizations invited to complete the survey on a 5-point scale, ranging from (1) coexist to (5) integrated.[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 entire network.

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

Exhibit B.1. Connection ratings and description

Score	Rating strength	Rating description
1	Coexist	No or limited relationship between organizations
2	Cooperate	Informal interactions on specific activities or projects
3	Coordinate	Intentionally plan/work together for greater outcomes
4	Collaborate	Shared mission, goals, decision makers, and/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 the connection between the organizations using each organization's rating of the other for inclusion in the network map. For example, if Organization A and Organization B rate their connection with each other as "cooperate" (2) and "coordinate" (3), respectively, the average strength of the connection between the two organizations is 2.5, or "cooperate."

In Monterey County, sometimes only one organization rated 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 where 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 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% or greater) suggests that connection ratings are generally in agreement with each other, and thus, a single respondent's rating of the strength of a relationship can be used to represent the actual strength as reported by both ends of the connection. In Monterey County, the agreement score was 77.4%. Due to this high rate of agreement, we included connections in the network analysis and map when only one organization rated the strength of the relationship.

[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.

Network measures

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

Exhibit B.2. Monterey County network analysis summary statistics

Network measure	Statistic	Description
Possible network size	12	Number of organizations invited to take the survey.
Number of possible connections	132	The total number of possible connections between all 12 organizations invited to complete the survey. Since each organization rates its relationship with every other organization, there are two possible connections between any two organizations (i.e., each organization's rating of the connection).
Observed network size	12	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	92	The total number of connections reported by organizations that completed the survey. This excludes missing data and "not applicable" responses.
Number of unidirectional connections	30	A unidirectional connection is observed when only one of the two organizations rates the strength of the connection.
Reciprocated connections	60	The number of connections that were bidirectional (that is, both organizations reported the strength of the connection with each other one).
Reciprocity rate	0.67	The number of bidirectional connections out of the total number of observed connections.
Average strength of the network	2.82	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 under each rating category.

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

Average strength range	Rating strength	Number of connections	Percentage of connections
1.00–1.99	Coexist	9	14.8
2.00–2.99	Cooperate	21	34.4
3.00–3.99	Coordinate	10	16.4
4.00–4.99	Collaborate	19	31.1
5.00	Integrated	2	14.8
	Total	**61**	**100.0**

Appendix C. Details on the Implementation of Selected Workstreams

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

Exhibit C.1. Workstream: Student Behavioral Health Incentive Program

Workstream: Student Behavioral Health Incentive Program	
Short overview	Monterey is implementing SBHIP projects in two districts: Alisal USD and Soledad Unified School District. The projects are focused on four interventions for students in grades K–12: (1) behavioral health wellness programs, (2) behavioral health screenings and referrals, (3) building stronger partnerships to increase access to Medi-Cal services, and (4) expanding the behavioral health workforce. Given that more than 90 percent of the students in these districts are Medi-Cal members, both districts are focusing their efforts on the full student population. Additionally, the Alisal USD district is prioritizing the relatively large proportion of Indigenous youth in its student body.
Key implementation findings	The Soledad Unified School District hired six social workers to offer group and individual counseling services. Given the increase in providers and number of sessions offered, they ran into space challenges. Using SBHIP funds, they were able to convert some classrooms into dedicated areas for counseling and invest in an outdoor wellness track. The Alisal USD is using SBHIP funds to work with the National Compadres Network to train social workers, school counselors, and parent education specialists to facilitate Tier 2-level support groups for 5th- and 6th-grade students, with a particular focus on Indigenous populations. The district has also made recent progress on billing by executing a contract for an electronic health record, which will eventually be linked to billing for behavioral health services. The district faces some challenges with staff retention, sustainability concerns, and aligning vision with the teachers' union.
Sustainability and what is next	In the Soledad Unified School District, the spaces created for counseling services (for example, an outdoor wellness track) will remain beyond SBHIP funding. In the Alisal USD, several assistant principals received the National Compadres Network training and found it very impactful. One respondent was hopeful that including administrators in trainings would increase their knowledge and understanding of student behavioral health and why it is so important, leading to the continued prioritization of these efforts.

Exhibit C.2. Workstream: Certified Wellness Coach Employer Support Grant Program

Workstream: Certified Wellness Coach Employer Support Grant Program	
Short overview	The Alisal USD used Certified Wellness Coach Employer Support Grant funding to hire seven staff members (of 12 total) to provide Tier 1 and Tier 2 services.
Key implementation findings	The Alisal USD hired Certified Wellness Coaches through a third-party contractor, Effective School Solutions. All new hires are from the Salinas area, and many are bilingual in English and Spanish. Several were previously master's-level interns with the district, and several were educated in Alisal USD schools. Certified Wellness Coaches will be providing both Tier 1 and Tier 2 services, including Positive Behavioral Interventions and Support (PBIS), classroom presentations and mindfulness workshops, bullying prevention, and check-ins with students.
Sustainability and what is next	Since these are one-time funds, the Alisal USD hired contract workers through Effective School Solutions rather than creating permanent positions within the district.

Exhibit C.3. Workstream: Broad Behavioral Health Workforce Capacity: Community-Based Organization (CBO) Behavioral Health Workforce Program

Workstream: Broad Behavioral Health Workforce Capacity: Community-Based Organization (CBO) Behavioral Health Workforce Program	
Short overview	One CBO Behavioral Health Workforce Program grantee employs staff and contractors to provide in-person and telehealth services to clients residing in Monterey and Santa Cruz counties. The CBO is using grant funds to expand training in other techniques within Eye Movement Desensitization and Reprocessing (EMDR) and ensure staff are fully certified by completing the consultations and patient care hours.
Key implementation findings	The Monterey County grantee is using funding to support staff bonuses, professional development opportunities (such as training in specialized modalities (for example, CBT and EMDR), and loan repayment options for staff to pursue bachelor's and master's degrees. Additionally, it is increasing the number of staff to prevent burnout, serve more children and youth, and begin offering services to younger children. Reported barriers to implementation stemmed from unanticipated administrative decision making, such as legal considerations for work obligations (for example, 12 months providing services to underserved populations). To overcome this challenge, the CBO assembled an internal team comprising finance, contracts, legal, and communications staff to work through the specific grant requirements.
Sustainability and what is next	Providers trained in EMDR techniques can continue to offer those services to families into the future.

Let's Progress Together.

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