Los Angeles County: Early Progress on CYBHI Implementation Helps Address Needs in a Diverse and Complex Ecosystem

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This case study focuses on Los Angeles (LA) County's experience implementing California's Children and Youth Behavioral Health Initiative (CYBHI). The CYBHI is an ambitious multiyear $4+ billion systems change initiative focused on improving the behavioral health and well-being of children, youth, and families. To actualize the initiative's values and goals, the CYBHI is implementing 20 distinct workstreams, each designed to contribute to transforming the behavioral health ecosystem serving children, youth, and families.

This case study starts with a description of LA 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 LA County's experience implementing select CYBHI workstreams as of summer 2024. Note that interviews and data were collected before the January 2025 wildfires in LA County and do not reflect the additional need for behavioral health services and supports following a natural disaster.

Background and methods for the CYBHI Evaluation and case study

Mathematica is evaluating the CYBHI on behalf of California Health and Human Services Agency in partnership with Health Management Associates, James Bell Associates (JBA), and the Prevention Center of Excellence at the University of California, Los Angeles. The evaluation began in November 2022 and will continue through June 2026. As part of the evaluation, the research team completed case studies of the CYBHI implementation in nine counties, including LA 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 population and behavioral health system characteristics of LA County and California as a whole (see Appendix A for more details). In addition, between April and July 2024, researchers conducted the Network and Ecosystem Experiences Survey (NEES) and key informant interviews with local leaders in LA County. The NEES explored the connections between organizations in LA 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 24 interviews with individuals in LA County to understand the CYBHI workstream implementation and multisector collaboration. Respondents across the survey and interviews varied and included carefully selected leaders from county behavioral health departments, county offices of education, school districts, Medi-Cal managed care plans, community-based organizations (CBOs), public health departments, and other local 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

LA County has a highly complex children and youth behavioral health ecosystem, and agencies and organizations throughout the county vary in their perspectives on the strength of collaboration within this ecosystem. Those who participated in key informant interviews generally agreed that collaboration is improving, particularly among county agencies. They noted that the extensive geography and population size of LA County, along with fragmented funding and competition for resources, create barriers to collaboration and integration. However, respondents reported that a shared drive to improve children and youth behavioral health across organizations and agencies, combined with efforts such as the CYBHI, California's Family First Prevention Services Program, and the county's Community Schools Initiative (CSI), have helped increase collaboration. County-initiated efforts such as the LA County Student Behavioral Health Incentive Program (SBHIP) Steering Committee and the Prevention and Promotion Systems Governing Committee have also facilitated collaboration across sectors.

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

Implementation of the CYBHI in LA County is progressing, with early progress highlighting expanded access to school-based behavioral health services, enhanced capacity for the delivery of evidence-based practices, and increased youth mental health education. However, many workstreams are still at the beginning stages of implementation, with some uncertainty about impacts and sustainability in the face of contextual barriers.

The SBHIP, one workstream designed to facilitate the delivery of behavioral health services in and near schools, was perceived by respondents as particularly successful. SBHIP substantially expanded access to behavioral health services through a telehealth program and facilitated the construction of wellness spaces designed for delivery of prevention and intervention services. The workstream also strengthened relationships across the managed care sector, the education sector, and the LA County Department of Mental Health (LACDMH).

As of summer 2024, SBHIP successes were building the foundation for the then-nascent CYBHI Fee Schedule Program. At the time of interviews, local education agencies (LEAs) were engaged in the onboarding process for the Fee Schedule program and, with support from School-Linked Partnership and Capacity Grants, building up behavioral health workforces and billing capacities. Despite some execution concerns, county agencies and districts participating in the first cohort of the Fee Schedule were optimistic about the potential benefits for LA County and actively participating in learning collaborative sessions.

Additional education sector workstreams, including the CalHOPE Student Supports and Schools Initiative and Mindfulness, Resilience, and Well-Being Supports, are increasing capacity to support the mental well-being of students and staff in schools. With the support of approximately $1.7 million in funding across the two workstreams, the LA County Office of Education (LACOE) is partnering with five focal schools to pilot systemic Social and Emotional Learning (SEL), facilitating communities of practice for ongoing SEL implementation in the county, and developing countywide SEL guidance by leveraging lessons from the school partnerships.

Implementation of home- and community-based workstreams, including Scaling Evidence-Based and Community-Defined Evidence Practices (EBPs and CDEPs), Never a Bother, and the Youth Suicide Reporting and Crisis Response Pilot Program is underway. With 83 Scaling EBPs and CDEPs grants serving LA County, local agencies and organizations are well positioned to address gaps in services for specific populations of children and youth in the county. As of summer 2024, several Scaling EBPs and CDEPs grantees interviewed had completed or scheduled training for their behavioral health providers to facilitate new and expanded delivery of selected programs and practices. Likewise, a Never a Bother grantee has already begun partnering with youth on suicide prevention outreach,

and the county's Youth Suicide Reporting and Crisis Response Pilot Program has hosted youth mental health summits and initiated work on a syndromic surveillance system to monitor suicide data. Going forward, grantees were optimistic about sustaining the delivery of EBPs and CDEPs following the end of the grant period while also mindful about potential challenges, including limited funding and the risk of turnover among trained clinicians.

Key progress with the CYBHI implementation

- **Student Behavioral Health Incentive Program (SBHIP):** As of summer 2024, the county's four SBHIP projects were well underway, though at varying stages of implementation. The telehealth project, which focuses on providing services to students virtually through a vendor, reached 3,000 students across the county during the 2023–2024 school year. The behavioral health wellness project allocated funds to create 160 wellness spaces on 75 school campuses countywide for individual and group counseling, as well as universal prevention services. A workforce project focused on expanding LACOE's internship program that supports behavioral health services in schools was somewhat delayed. A project funding the construction of a countywide school wellness data dashboard and assessment of Local Educational Agency (LEA) technology infrastructure for documentation of services and billing was also in progress.
- **The CYBHI Fee Schedule:** LACOE has actively disseminated information to the county's LEAs about the CYBHI Fee Schedule and, as of summer 2024, was exploring options for adopting a consortium model, in which the county could bill on behalf of LEAs lacking the capacity to do so on their own. At the time of interviews, the county's three Cohort 1 districts—LACOE, Los Angeles Unified School District (LAUSD), and Montebello Unified School District—were working toward completing key administrative steps before full implementation of the Fee Schedule. These steps included executing agreements for data use and provider participation with the Department of Health Care Services (DHCS) and its third-party administrator, Carelon Behavioral Health, and, for one district, obtaining required board approvals and finalizing the selection of an electronic health record system. Since these interviews, DHCS has reported further growth in CYBHI Fee Schedule participation in LA County.[1]
- **CalHOPE Student Supports and Mindfulness, Resilience, and Well-Being Supports:** Using CalHOPE and Mindfulness funding, the county partnered with five focal schools to support systemic SEL implementation in those schools, with the goal of creating a model for integrating SEL in schools countywide. LACOE is currently developing guidance and best practices for other schools in the county based on lessons learned from the focal school partnerships. To further this work, LACOE established countywide communities of practice to provide ongoing support for SEL implementation among practitioners. Efforts to redefine SEL programming through the lens of Transformative SEL are also expanding.
- **Scaling Evidence-Based and Community-Defined Evidence Practices (EBPs and CDEPs):** Local implementation of the Scaling EBPs and CDEPs workstream in LA County is substantial, with 83 grants awarded that identify LA as a primary county served by the grant. The 12 Scaling EBPs and CDEPs-funded projects in the county covered by interviews in this report include integrating dialectical behavioral therapy (DBT) into an existing community-defined, evidence-based group program for young adult Black women; implementing the Blues Program, a school-based group intervention for high school students in Compton and Lynwood that aims to prevent depression; and expanding DBT provided by the county to the Department of Children and Family Services (DCFS)-involved youth, among others. In summer 2024, most grantees interviewed were still completing staff training in specific EBPs and CDEPs but expected to begin delivering services to children and youth within months.

[1] Since the interviews, DHCS has reported significant growth in CYBHI Fee Schedule participation among LA County LEAs and public colleges, with 54 entities in various stages of onboarding. Los Angeles Unified began submitting claims in spring 2025 totaling more than $15,000, with a larger volume expected in the 2025–2026 school year.

- **Youth Suicide Reporting and Crisis Response Pilot Program:** Following completion of a gap analysis with community partners and the creation of a work plan, the county has focused on initial implementation steps for the pilot. Using grant funding, the county hired an epidemiologist to create a syndromic surveillance system for suicide data, as well as four additional staff members to support implementation. The county also hosted five youth mental health summits for middle and high school students. In addition, it convenes monthly work group meetings on crisis response activities and rapid reporting.

II. County Background

County characteristics

LA County has the largest population of any county in the United States and is home to approximately one in four Californians, with more than 9.7 million residents living in 4,084 square miles[2] (Exhibit 1). The county is also substantially more population dense compared with the state of California as a whole (2,467 residents per square mile versus 254 residents per square mile) (Exhibit 2). The population of children and youth in LA County is proportionally similar to the rest of California but it has declined by 10.4 percent over the past five years, substantially more than the 5.4 percent decrease statewide. Geographically, the county extends from the Pacific Ocean to the desert, encompassing multiple mountain ranges that divide the county into numerous geographic locations and neighborhoods. The residents in LA County predominantly identify as Hispanic or Latino (49 percent) or White (24.5 percent). Across the statewide population of California, 40.3 percent identify as Hispanic or Latino and 33.7 percent as White. The county is linguistically diverse: there are 10 or more threshold languages spoken in LA County at any time, including Armenian, Cambodian, Chinese, English, Farsi, Korean, Russian, Spanish, Tagalog, and Vietnamese.[3]

Although LA County is home to the busiest seaport in the Western Hemisphere (Port of Los Angeles),[4] the Hollywood film industry, and some of the wealthiest neighborhoods in the state,[5] its residents experience generally more difficult economic conditions compared to residents across the state. For example, the county has a higher proportion of its population below the 200 percent federal poverty line (31.3 percent versus 27.6 percent at the state level), a lower median income ($47,775 versus $52,520), a higher unemployment rate (5.8 percent versus 5.3 percent), and higher food insecurity

Exhibit 1. LA County's geography

[2] County of Los Angeles. "About LA County." n.d. Accessed December 1, 2024. https://lacounty.gov/government/about-la-county/about/.
[3] LA County Department of Public Social Services. "Language Access Plan." February 2025. https://dpss.lacounty.gov/content/dam/dpss/documents/en/civil-rights/lap/DPSS%20LANGUAGE%20ACCESS%20PLAN%202025.pdf
[4] The Port of Los Angeles. "About the Port of Los Angeles." n.d. Accessed December 1, 2024. https://www.portoflosangeles.org/about.
[5] Santarelli, M. "24 Most Expensive Neighborhoods in California." Norada Real Estate. November 2024. https://www.noradarealestate.com/blog/most-expensive-neighborhoods-in-california/.

overall (11.3 percent versus 10.5 percent) and for the population 0 to 18 years (15.5 percent versus 13.5 percent). In addition, more than 75,000 residents of the county experienced homelessness in 2023.[6] Consistent with the challenging economic conditions in LA County, more residents ages 0 to 25 are covered by Medi-Cal (43.5 percent versus 39.3 percent statewide). The county is also ranked 30th (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 lower than average relative to other counties in the state.[7]

Exhibit 2. LA County's population characteristics

Metric	LA County	California	Year(s)
Population			
Total population (N)	9,721,138	39,029,342	2022
Population, 0–4 years (N; %)	488,393; 5.0%	2,118,386; 5.4%	
Population, 5–19 years (N; %)	1,735,432; 17.9%	7,404,396; 19.0%	
Population, 20–24 years (N; %)	651,510; 6.7%	2,639,787; 6.8%	
Five-year population change (%)	-4.4%	-1.3%	2017–2022
Five-year population change, 0–24 years (%)	-10.4%	-5.4%	
Density (population per square mile)	2,467	254	2020
Race and ethnicity			
White, non-Hispanic (%)	24.5%	33.7%	2022
Black or African American, non-Hispanic (%)	7.3%	5.2%	
American Indian and Alaska Native, non-Hispanic (%)	0.2%	0.3%	
Asian, non-Hispanic (%)	14.7%	15.3%	
Native Hawaiian and other Pacific Island American, non-Hispanic (%)	0.2%	0.4%	
Some other race, non-Hispanic (%)	0.7%	0.6%	
Two or more races, non-Hispanic (%)	3.4%	4.3%	
Hispanic or Latino (%)	49.0%	40.3%	
Birthplace and language			
Foreign-born, 0–24 years (%)	8.2%	7.2%	2022
English-proficient, 5–17 years (%)	88.6%	91.6%	
Education (18+ years)			
High school or higher (including college) (%)	75.1%	78.8%	2022
College degree or higher (%)	33.2%	34.1%	
Economic indicators, socioeconomic status, neighborhood characteristics			
Population within urban blocks (%)	99.1%	94.2%	2022
Population within rural blocks (%)	0.9%	5.8%	
Population below 200% of the federal poverty line (%)	31.3%	27.6%	
Median income (USD)	47,775	52,520	
Unemployment (%)	5.8%	5.3%	
Households with high housing cost burden (%)	46.3%	40.3%	2019
Food insecurity, overall (%)	11.3%	10.5%	2021
Food insecurity, 0–18 years (%)	15.5%	13.5%	

[6] Los Angeles Homeless Services Authority. "LAHSA Releases Results of 2023 Greater Los Angeles Homeless Count." June 2023. https://www.lahsa.org/news?article=927-lahsa-releases-results-of-2023-greater-los-angeles-homeless-count.

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

Metric	LA County	California	Year(s)
Healthy Places Index (rank)	30	N/A	2015–2019
Diversity Index (rank)	25	N/A	
Health status			
Population with a disability (%)	11.6%	11.7%	2022
Population with a disability, 0–17 years (%)	3.9%	4.0%	
Health insurance status (population 0–25 years)			
Medi-Cal or other means-tested public coverage (%)	43.5%	39.3%	2022
Private coverage (%)	54.3%	60.2%	
Uninsured (%)	5.8%	4.9%	
TRICARE/military coverage (%)	0.6%	1.7%	
Medicare coverage (%)	1.2%	1.0%	

Note: Researchers conducted analyses of secondary data sources to capture population and behavioral health system characteristics of LA 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 relative to California as a whole

Children and youth in LA County experience similar[8] rates of overall mental well-being and behavioral health challenges relative to those statewide; however, more children and youth insured through Medi-Cal have a mental health diagnosis or emotional symptoms relative to the state as a whole (23 percent versus 18 percent) (Exhibit 3). There is a slightly lower percentage of students reporting suicidal ideation compared to statewide (13 percent versus 15 percent), similar rates of inpatient hospitalizations (11 versus 12 per 1,000 children and youth), and lower rates of emergency department visits (24 versus 32 per 1,000 children and youth).

Exhibit 3. LA County prevalence of behavioral health outcomes

Metric	LA County	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 (%)	75%	73%	2022
Youth ages 12 to 17 years old who felt at least two nonparent adults took genuine interest (%)	60%	58%	
Youth ages 12 to 17 years old who felt supported by friends (%)	74%	72%	
Behavioral health challenges			
Children and youth insured through Medi-Cal with a mental health diagnosis or emotional symptoms (%)	23%	18%	2022
Children and youth insured through Medi-Cal with a substance use disorder diagnosis (%)	3%	3%	
Rates of suicidal ideation			
Students in grade 9 who reported seriously considering attempting suicide in the past 12 months (%)	13%	15%	2019–2021
Students in grade 11 who reported seriously considering attempting suicide in the past 12 months (%)	13%	16%	

[8] 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.

Metric	LA County	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	11	12	2022
Emergency department visits per 1,000 children and youth for any behavioral health diagnosis	24	32	
School engagement, as measured through absenteeism and suspension			
Students in grades K–12 who were chronically absent (%)	27%	25%	2022–2023
Students in grade 9 reporting school absences due to mental health issues (%)	10%	9%	2019–2021
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 LA 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 from the California Health Interview Survey (CHIS) are typically measured at the regional level, but LA County represents a single region in the CHIS.

Resource availability

The LA County Department of Mental Health (LACDMH) is the largest county mental health department in the United States. LACDMH oversees more than 85 directly operated sites, 300 collocated sites, and 1,000 contracted organizations.[9] On average, LACDMH serves more than 250,000 county residents of all ages annually.

Like other counties in California, LA County has a shortage of behavioral health providers (Exhibit 4). Relative to the state as a whole, the county has a similar number of child and adolescent psychiatrists per 100,000 children and youth (18 versus 17) and more non psychiatrist behavioral health providers licensed with county Medi-Cal Specialty Mental Health Services plans per 100,000 (45 versus 37). The county also has a higher ratio of outpatient treatment programs for young adults (five per 100,000 children and youth versus four statewide) and similar rates of school-based health programs with mental health services (three per 100,000 children and youth versus four statewide).

LA County is served by four Medi-Cal managed care plans under California's Two-Plan model. L.A. Care Health Plan serves as the local initiative, and Health Net Community Solutions is the commercial plan. In 2023, both plans met the state's network adequacy requirements for primary care providers. Molina Healthcare of California, which subcontracts a portion of Health Net's membership, and Kaiser Permanente also serve eligible Medi-Cal enrollees. These plans provide nonspecialty mental health services, including screening, brief interventions, and care coordination through networks of primary care clinics, community health centers, and telehealth platforms.

Exhibit 4. LA County behavioral health care resource availability

Metric	LA County	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 federally qualified health centers (FQHCs) or FQHC look-alike sites per 100,000 children and youth ages 0–25 years	21	20	2024
Number of child and adolescent psychiatrists per 100,000 children <18 years	18	17	2022, 2024

[9] LA County Department of Mental Health. "About." n.d. Accessed December 1, 2024. https://dmh.lacounty.gov/about/.

Metric	LA County	California	Year(s)
Number of nonpsychiatrist behavioral health providers licensed with county Medi-Cal Specialty Mental Health Services Plans per 100,000 residents	45	37	2021
Number of outpatient treatment programs for young adults per 100,000 children and youth 0–24[a]	5	4	2021
School-based health programs with mental health services per 100,000 children and youth <18 years[b]	3	4	2024

Note: Researchers conducted analyses of secondary data sources to capture population and behavioral health system characteristics of LA 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, whereas 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. See 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.

[b] Estimates of school-based health programs with mental health services per 100,000 children and youth rely on data from the California School-Based Health Alliance (CSHA). While CSHA conducts a periodic census of school-based health centers and wellness centers, the data may undercount programs, particularly newly opened wellness centers or those not meeting CSHA's definition of a clinical site. Additionally, these figures do not capture school-based mental health services provided outside of formal centers, such as those delivered directly by LEAs or through community-based partnerships. As such, this measure likely represents a conservative estimate.

Although LA County has a higher ratio of providers to children and youth than the state average, interview respondents indicated a shortage of behavioral health professionals to meet the growing demand for services. Many respondents mentioned that the county has experienced an increase in people seeking mental health services, along with access challenges and long wait times for services. For example, as of summer 2024 when they were interviewed, CBOs providing services in the county reported that some individuals seeking care encounter waitlists ranging from three to nine months until a behavioral health professional is available. Respondents attributed the increase in the number of people seeking services to the negative impact of the COVID-19 pandemic on mental health, as well as the reduction in mental health stigma since the pandemic. However, respondents believe the increase in individuals seeking treatment has exceeded the capacity of the behavioral health workforce. Although respondents indicated that LACDMH and other county agencies and organizations are working to attract a larger, more diverse workforce, they emphasized that recruitment efforts must be carried out with intentionality and informed by research to ensure agencies and organizations understand and support the needs of the county's large population, including the diversity of languages present in LA County. According to respondents, some provider organizations have difficulty sustaining their workforces due to low pay, high caseloads, and burnout. They also highlighted that administrative burden remains a challenge for providers across mental health services. Although California Advancing and Innovating Medi-Cal (CalAIM) documentation reforms have eased requirements for specialty mental health services and substance use disorder (SUD) treatment, the burden has increased in other areas due to expanded outcome measure reporting.

> "The reality is, if you look at the statistics in California for social workers, marriage and family therapists, there's not enough of them going into that field, period. And less than 1 percent speak Korean, so everybody's fighting for the same people…. It's like the funnel gets narrower and narrower."
>
> —CBO respondent

Respondents perceived gaps in the availability of behavioral health resources to fully address the needs of children and youth ages 0 and 5 and those facing severe behavioral health challenges. CBO and child welfare respondents expressed concern that behavioral health needs for children between ages 0 and 5 are overlooked, resulting in missed opportunities for early intervention. Respondents across sectors also described an increase in higher-acuity mental health issues among children and youth, such as suicide attempts, co-occurring SUDs, and other crises. However, intensive care options in the county to address these severe behavioral health needs were perceived as limited.

Access to behavioral health resources and the quality of behavioral health services for children and youth varies across communities within LA County. This variation is due, in part, to differences in the resources available in each community and includes school-based services. For example, an education respondent noted that larger school districts have better infrastructure and the ability to contract with LACDMH and managed care organizations for behavioral health services relative to smaller districts. Due to gaps in the availability of resources in some regions, children and youth might need to face traffic, congestion, and long travel distances to receive care. Additionally, the coverage from providers that aim to deliver home- and community-based services is inconsistent. According to respondents, in LA County, it can take an hour to drive 15 miles, but this travel time is not reimbursed through Medi-Cal, so providers may limit home visits to certain areas. Finally, the inconsistency in reliable internet access across the county means that telehealth services are less accessible in certain communities.

> "I think that the gaps [in the children and youth behavioral health system] would be more community based. Some areas have more agencies and services, some areas have less, some areas have none, and so it makes it difficult when you're trying to connect families to services if their area doesn't have as many services available."
>
> — Juvenile justice respondent

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 of California's children and youth.

To better understand the behavioral health ecosystem and how systems are connected across sectors as context for understanding the CYBHI implementation in LA County, Mathematica conducted the Network and Ecosystem Experiences Survey (NEES), which asked respondents from child- and youth-serving organizations about their relationships with each other. Using information from the survey, we created a network map showing the connections between 23 organizations in LA County based on the ratings provided by the 19 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 LA County

In LA County, we invited 23 child- and youth-serving organizations to complete the NEES via email and received responses from 19. Invited organizations included government agencies and departments, managed care plans, and CBOs, including several 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 five-point scale: (1) co-exist, (2), cooperate, (3) coordinate, (4) collaborate, and (5) integrated.[10]

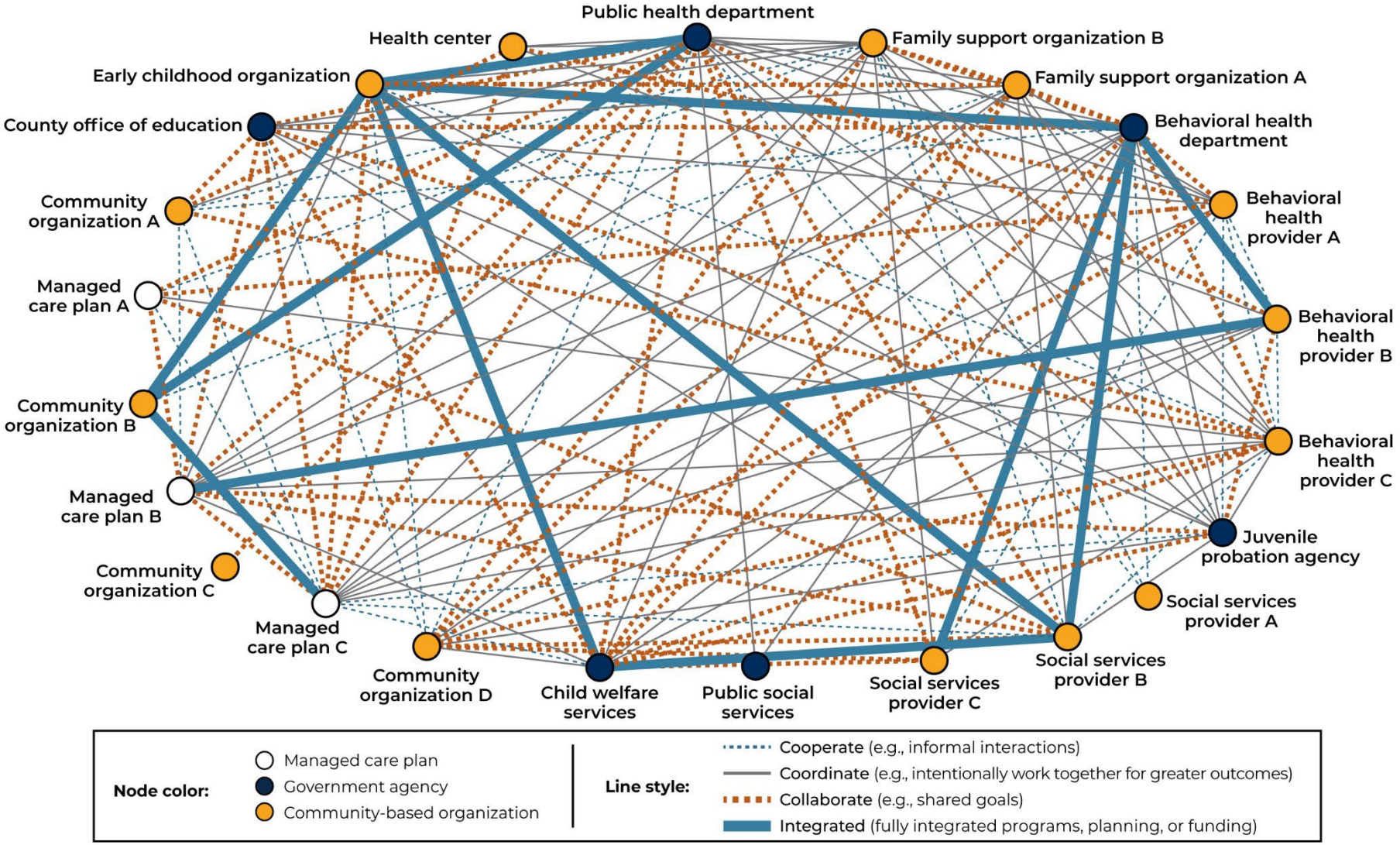
These ratings were used to conduct a network analysis and develop a network map (Exhibit 5) showing the average strength of the connections between organizations, based on each organization's rating of the other.[11,12] A line between two organizations shows that a connection exists. No line indicates 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.

[10] 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.

[11] In LA County, there were instances where only one organization rated a connection between two organizations. If we had responses from both sides of a connection, we conducted an agreement analysis of data to understand whether survey respondents tended to rate the strength of their relationship in similar ways. Based on this analysis, we concluded that there was a high level of agreement in the observed data. Thus, we trusted that a connection rated by a single respondent was a reliable representation of the strength of the connection between organizations.

[12] 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 LA County behavioral health ecosystem



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

Perceptions of multisector collaboration

The LA County behavioral health ecosystem comprises a complex network of child- and youth-serving agencies and organizations that operate at the county and community levels. Government agencies, managed care plans, and some CBOs serve the entire county, whereas other organizations operate at the local or community level. Due to its large size, LA County is divided into eight service planning areas (SPAs), which are specific geographic regions, to allow government agencies such as the LACDMH and the LA County Department of Public Health (LACDPH) to develop and provide more relevant services targeted to the specific health needs of residents in each of the areas. Perhaps due to these ecosystem complexities, respondents had mixed perspectives about the multisector collaboration in the county. The mixed perspectives may also partly reflect variation in the extent to which respondents were aware of the extent of collaboration across all of the SPAs and organizational entities.

Despite these complexities, agencies and organizations in the county demonstrated a variety of connections, varying in strength and reflecting the different ways in which they work together to support children and youth behavioral health (Exhibit 5). Most entities (78.2 percent; n = 18) have six or more connections with other organizations. The most networked organizations include CBO service providers, such as the three behavioral health providers and two family support organizations referenced in Exhibit 5, whereas most government entities have between six and nine connections each. The average strength of the connections between entities varies across the network. Consistent with the county's large size and complex network, 36.4 percent of connections have an average strength of "coexist," indicating no or a limited relationship between entities. An additional 11.7 percent of connections have an average strength of "cooperate," representing informal interactions between organizations. However, one-quarter of the connections (24.8 percent) have an average strength of "coordinate," indicating that organizations intentionally work together to achieve shared outcomes. Just over one-fifth of connections (21.4 percent) have an average strength of "collaborate," reflecting more formal partnerships with shared goals and resources between organizations, and 5.9 percent of connections have an average strength of "integrated," indicating that organizations have fully integrated programs.

The NEES findings suggest that agencies and organizations that operate at the county level often have strong relationships with one another. At the county level, government agencies, an early childhood organization, and managed care plans often collaborate and coordinate with each other to support children and youth behavioral health (see a simplified network map in Appendix B). The early childhood organization also has several integrated relationships with government entities, including the public health department, the behavioral health department, and child welfare services. Among the six government agencies, the DCFS has the strongest relationships, collaborating with four other government entities. As one interview respondent observed, child welfare services and the behavioral health department are partners under the county's Family First Prevention Services Program, which likely contributes to their collaborative relationship. The Medi-Cal managed care plans also have strong relationships at the county level and with each other. For example, surveyed respondents indicated that all three managed care plans collaborate with the LACDPH, and two collaborate with the LACOE and the early childhood organization.

Aligning with survey findings, some interview respondents reported strong coordination between agencies and organizations across sectors, particularly at the local level. They pointed to specific examples of established partnerships, many of which were in place to support referrals between schools, juvenile justice systems, health care providers, and county departments such as LACDMH and DCFS. In particular, schools appear to work well with other organizations to support children and youth behavioral health. As one public health respondent explained, schools typically reach out to LACDMH when students experience challenges, and other agencies and organizations are likely to connect with schools when trying to reach students and families in the community.

Other interview respondents observed little coordination and collaboration across the ecosystem but were encouraged by recent improvements. Specifically, respondents highlighted gaps in working relationships between government agencies and primary care and behavioral health service providers. One CBO respondent worried that state-level initiatives lacked county involvement in planning, which is needed to create connected and effective systems in the county. However, many interview respondents, including several who identified gaps in multisector collaboration, shared that there have been efforts to improve collaboration and integration, and observed progress toward systems change. For example, one CBO respondent cited DCFS's decision to fund other departments for program expansion as an indication of a shift toward integration between agencies.

> "Definitely progress [in collaboration]. I, as a provider, can see the difference. I know about it personally because I'm involved with it at the county level, but also, I can feel it as a provider on the ground, which is a really good thing."
>
> —CBO interview respondent

Barriers to multisector collaboration

The complexity and larger size of LA County's service landscape present challenges that make it difficult for organizations and agencies to collaborate effectively to serve children and youth across the county. These landscape characteristics have hindered funding coordination and communication and information sharing between organizations and agencies. One respondent noted that the size of the county has led some CBOs to use the same approach across the county instead of using more targeted approaches and partnering to meet local needs. A child welfare services respondent also observed that LA County departments are bigger, given the size of the county, which has led to some siloing between the departments and leadership, and can make it more challenging for departments to collaborate and integrate. To address these challenges, respondents emphasized the importance of maintaining clear communication through regular cross-sector meetings—which has helped several respondents in increasing collaboration—and establishing dedicated roles to facilitate coordination between organizations and agencies across the county. Several respondents suggested an overarching coordinating entity to help direct organizations and agencies to work toward common goals and reduce administrative burdens associated with multisector collaboration.

> "And our system is so large that it's really easy to trip up all over each other. So it makes sense to have that ongoing communication, so when there's issues that come up, there's a central place to be able to talk about them."
>
> —Behavioral health interview respondent

Respondents across sectors identified fragmented funding and competition for resources in LA County as primary barriers to multisector collaboration. Organizations and agencies must sometimes compete for the same funding and resources to support children and youth behavioral health, which can deter collaboration. Financial strain and lack of staff capacity also prevent organizations and agencies from dedicating time and focus toward developing partnerships and collaborating with other organizations and agencies despite their desire to do so. Respondents believe that long-term, sustainable funding, investments in workforce development, and continued strategic partnering and alignment across organizations will help overcome this barrier.

> "I think we all work very well together. I'm pausing a little bit, though, because I think the reality is we're also competitors. And that we go after, at times, the same dollars that are out there or if we're both at a school district seeing kiddos. And I will say, just overall, I think we're all here to serve children and families."
>
> —CBO interview respondent

Facilitators of multisector collaboration

Shared drive and aligned missions among organizations have helped facilitate multisector collaboration to improve children and youth behavioral health. Respondents emphasized that great willingness exists among many organizations and agencies to collaborate so they can better support children and youth behavioral health, even when capacity limitations pose challenges. Organizations have obtained further buy-in for multisector collaboration by articulating how their work aligns with and supports other organizations' missions, and by building a mutual understanding of efforts. Other strategies to increase support and capacity for collaboration include intentionally building an internal organizational culture of prioritizing partnerships, hiring a dedicated position within organizations for collaborative efforts, and elevating people with lived experience into leadership roles, which has helped promote trust in organizations' approaches.

Efforts under several federal, state, and local initiatives to improve children and youth behavioral health, including the CYBHI, have supported multisector collaboration and are promising vehicles for future collaboration. Several behavioral health and education respondents identified the CYBHI as one of the initiatives that has helped improve coordination between organizations by focusing on partnership building. In particular, respondents believed that efforts under SBHIP have strengthened partnerships between schools, the county office of education, and behavioral health and managed care programs (see the Spotlight on multisector collaboratives). Respondents also credited work on the CSI and the county's implementation of the Family First Prevention Services Act (FFPSA) program with increasing collaboration and reducing siloing. As one respondent noted, the county has historically faced challenges in collaboration, but the FFPSA program has significantly improved such collaboration between behavioral health and child welfare services. The CSI has also facilitated strong collaboration between school districts, which provided foundational support for early SBHIP efforts. Finally, several respondents highlighted the work First Five LA has done to bring organizations and agencies across sectors together. One managed care respondent suggested that First Five LA's efforts to break down silos through convening large cross-sector meetings focused on a specific age range could serve as a model and be replicated for organizations supporting other age groups

Spotlight on multisector collaboratives

Survey and interview respondents shared insights about multisector collaboratives in LA County that support children and youth behavioral health and work to create greater alignment and integration across the behavioral health ecosystem.

LA County SBHIP Steering Committee

Established in 2021, the LA County SBHIP Steering Committee is focused on integrating social and behavioral health services to improve community health outcomes (see the CYBHI Workstream Implementation section for more information about SBHIP). The committee aims to enhance collaboration among various interested parties, streamline services, and promote equitable access to resources. Its goals include addressing social determinants of health, improving service delivery, and fostering an integrated approach to well-being within the community. Members of the steering committee represent the county's managed care plans, the LACOE, and the LACDMH.

All survey respondents whose organizations participate in the steering committee reported that it establishes relationships across sectors to ensure the delivery of a comprehensive array of services and supports. In addition, most respondents reported that the committee is implementing the following strategies: (1) defining transparent pathways for youth, families, and people who work with children to access and receive necessary behavioral health supports and services; (2) developing or expanding referral systems to improve coordination of behavioral health care across partner organizations; and (3) expanding upstream solutions (for example, promotion, prevention, and early intervention) to support the well-being and behavioral health of children, youth, and families. Most respondents perceived that the committee has made moderate to extensive progress to date in two areas: (1) strengthening the capacity of organizations in the county to work together toward shared goals for children and youth behavioral health, and (2) reducing barriers for children, youth, and families to access behavioral health supports and services.

Prevention and Promotion Systems Governing Committee (PPSGC)

Established by the LA County Board of Supervisors in July 2023, the goal of the PPSGC is to improve coordination, multisector collaboration, and strategic investments to strengthen communities, make them safer and more connected, and help them thrive. The PPSGC aims to accomplish this through a prevention and promotion model that is holistic, equitable, and community driven. Key areas of focus include behavioral health, child welfare, family well-being, and homelessness and housing. The committee has representation from multiple county agencies, organizations, and leaders.

Most survey respondents whose organizations participate in the PPSGC reported that the committee includes diverse voices from multiple sectors. Even though the committee is relatively new, most survey respondents reported that it has already made minimal to moderate progress in several areas, including (1) enhancing trust between partner organizations and community members, (2) fostering a common desire among partner organizations to create a more inclusive and healing-centered behavioral health system, and (3) fostering creative problem solving among partner organizations.

Other multisector collaboratives

The survey and interview respondents identified other multisector collaboratives that support children and youth behavioral health in LA County. These collaboratives focus on the following:

- Child welfare reform (for example, Mandated Supporter Initiative)
- Systems of care (for example, the L.A. Care Child Health Advisory Council, the Youth Mental Collaborative, Asian American and Pacific Islander Equity Alliance, Healthcare Coordination Committee)
- School-based services (for example, Community Schools Regional Technical Assistance Team, School Health Policy Roundtable of the L.A. Trust)
- Prevention services (for example, Prevention and Promotion Systems, LA County Suicide Prevention Network, Asian and Pacific Islander Children, Youth and Family Council)

A couple of respondents noted that the county has many duplicative efforts and collaboratives, and expressed interest in streamlining and integrating these efforts and funds in the future.

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 workstreams in LA County

Overall, as of September 2024, LA County is locally implementing 12 workstreams that involve the distribution of funding to county or community entities, including 277 grants.[13] This case study discusses LA County's implementation experiences with the SBHIP; School-Linked Partnership and Capacity Grants; Fee Schedule; CalHOPE Student Supports; Mindfulness, Resilience, and Well-Being Grants; Scaling EBPs and CDEPs; and Youth Suicide Reporting and Crisis Response Pilot Program.

Other workstreams active in the county include programs under the Broad Behavioral Health Workforce Capacity workstream, Behavioral Health Continuum Infrastructure Program (BHCIP) grants, and Behavioral Health Virtual Service Platforms. Although not the primary focus of our summer 2024 interviews, these workstreams have also made notable progress, as in the following examples:

- Los Angeles has 13 BHCIP Round 4 grants intended to fill in gaps in infrastructure by adding community wellness and youth prevention centers, acute psychiatric hospitals, SUD treatment facilities, and integrated behavioral health centers. These projects are anticipated to add 167 beds to the region and serve 9,448 individuals in an outpatient setting on an annual basis. Specific projects include a youth wellness center located in Redondo Beach that will serve young people ages 12 to 25 in the South Bay service planning area (SPA 8) and the construction of a new facility led by the LACDMH and aimed at creating a broader continuum of child and family services, with a focus on those at risk of or experiencing homelessness.
- Broad Behavioral Health Workforce Capacity programs active in the county include the Community-Based Organization Behavioral Health Workforce Grant Program, Justice System-Involved Youth Pipeline Program, Health Careers Exploration Program Awards, Health Professional Pathways Program, Peer Personnel Training and Placement Program, Psychiatric Education Capacity Expansion Grants, Social Work Education Capacity Expansion Grants, and the SUD Earn and Learn Grant Program.
- Since the time of the interviews, the Behavioral Health Virtual Service Platforms (for example, Soluna and BrightLife Kids) have seen gains in LA County, including growth in new user registrations and coaching sessions delivered. For example, following multiple wildfires in January 2025, LA County intensified promotion of Soluna and BrightLife Kids to ensure children, youth, and families had timely access to support. These efforts yielded more than 5,000 new user registrations in January—more than a 50 percent increase from the prior month—and nearly 1,500 coaching sessions.

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

In LA County, SBHIP projects have facilitated and expanded school-based behavioral health services, and schools and districts are responding enthusiastically to opportunities to create a more comprehensive infrastructure for delivering these services. The county's telehealth project, which focuses on virtual delivery of mental health support to students, was perceived by education and managed care plan respondents as particularly

[13] 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.

successful in expanding access to services at school for students who lack reliable broadband at home or face barriers to obtaining in-person services. The project brought together a culturally responsive therapy team, which offers services in 10 of the county's threshold languages. During the 2023–2024 school year, the program provided approximately 30,000 clinical hours to roughly 3,000 students, with a majority from Latino and Black communities. Education respondents reported significant interest in the telehealth project across the county, with a majority of districts opting to participate. Although SBHIP funding ended in December 2024, the county identified additional funding and negotiated an extension of the telehealth project through June 2025.

The county is also making SBHIP funds available to districts to develop on-campus wellness spaces for individual and group counseling services and prevention programming. Districts and schools have responded positively to the project; as of summer 2024, more than 100 schools were in the process of creating SBHIP-funded wellness spaces, and LACOE was still fielding additional proposals from districts eager to take advantage of the opportunity. In addition, an SBHIP-funded effort to expand LACOE's mental health internship program is increasing the pool of trained and credentialed school mental health providers eligible to be employed by LEAs, with the goal of enhancing the current school mental health workforce and improving student access to multitiered school mental health supports. This program placed 76 social work and school-based family counseling interns in 51 schools within 13 LEAs for the 2023–2024 and 2024–2025 school years.

The SBHIP workstream was also credited with fostering increased collaboration across sectors in the county and elevating the need for more systemic integration of behavioral health in schools. Respondents across sectors highlighted the success of SBHIP in developing and strengthening relationships among LACOE, the managed behavioral health care organization, the telehealth provider, managed care plans, and LACDMH, as well as LAUSD and other school districts in the county. For example, LACOE and LACDMH had a strong existing relationship due, in part, to the county's CSI, which was perceived as a valuable foundation for the CYBHI efforts. SBHIP expanded on this collaboration to involve additional staff and departments within the agencies. LACDMH played a significant role in identifying and contracting with the telehealth platform provider and meets frequently with the managed care plans that are involved in the SBHIP projects. Education respondents also pointed to the role of SBHIP projects in building understanding, at both the district and school levels, around how to operationally integrate behavioral health services in schools, including increasing knowledge of the infrastructure needed to facilitate that integration. One respondent noted that despite the limited capacity and competing demands experienced by school administrators, they are prioritizing SBHIP opportunities around telehealth, staff training, wellness spaces, and intern support.

> "I think it [SBHIP] has really elevated the conversation and the understanding of what it takes to really build an infrastructure for students to participate in behavioral health beyond just partnering with a CBO. I think that's been the traditional [approach]. So now it's this understanding, like, hey, we could do prevention…It's important to have a comfortable place for kids to go, and it's important to train our staff. So I think it's really elevated what is required. And I think those that have participated, they're hungry for it, very happy to participate in everything."
>
> —Education interview respondent

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 plans to pay school-linked providers. In addition, behavioral health services provided under the Fee Schedule may not require copayments, coinsurance, 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.

The CYBHI Fee Schedule introduces a promising reimbursement model for school-linked behavioral health services in LA County. By shifting from cost-based contracts to fixed per-service reimbursement, the Fee Schedule marks a fundamental change in how school districts and their partners plan for and deliver behavioral health care in and near schools. For large LEAs, which have historically been limited by annual caps and reconciliation requirements under direct LACDMH contracts, the Fee Schedule opens a pathway to expand service delivery by offering standardized reimbursement for services. This approach is anticipated to reduce administrative burden while also introducing a new source of funding to support LEAs. The approach will help districts more effectively navigate multiple payers and overlapping funding streams.

Although respondents were optimistic about the Fee Schedule's potential, district interest in participating in the CYBHI Fee Schedule and School-Linked Capacity Grants grew slowly in early phases of rollout. A draft program provider manual was released in February 2024; in summer 2024, DHCS began onboarding the county's three Cohort 1 LEAs and worked to finalize workflows for claims submission and payment remittance. By fall 2024, seven additional LEAs were approved for Cohort 2 and 16 more in Cohort 3, demonstrating momentum and interest in using the Fee Schedule billing model. Since the time of interviews, DHCS has reported continued growth in CYBHI Fee Schedule participation among LA County LEAs and public colleges, with 54 entities in various stages of onboarding. Los Angeles Unified began submitting claims in spring 2025, totaling more than $15,000, with a larger volume expected in the 2025–2026 school year.

Smaller LEAs may require additional supports to use the Fee Schedule to its fullest potential, but local models like the LACOE consortium approach offer promise. Unlike larger districts that already have electronic health records (EHRs), billing systems, and providers in place, many smaller LEAs face barriers to participation due to more limited infrastructure. The provider registration process, for example, requires Medi-Cal application completion,

National Provider Identifier (NPI) validation, CalAIM compliance, and Fee Schedule attestation, and can be cumbersome for smaller districts. This potential burden may result in community-based providers prioritizing partnerships with large districts such as LAUSD that have substantial infrastructure already in place. This type of situation poses a particular challenge for smaller or rural districts. In response, LACOE is exploring the CYBHI Fee Schedule consortium model, which would allow smaller LEAs and charter schools to share infrastructure, such as provider onboarding and billing systems, under a single lead agency. At the time of interviews in summer 2024, LACOE was also considering leveraging support from a School-Linked Capacity Grant to create an Electronic Health Record (EHR) system and billing infrastructure for these schools. This approach may offer a replicable strategy for expanding access and building administrative capacity for small districts over time.

LA County's early experience offers insight into areas where a targeted focus may help encourage broader participation in the CYBHI Fee Schedule, particularly in large, complex counties. For example, the CYBHI Fee Schedule includes a variety of licensed and credentialed school-based practitioners but currently does not include interns and trainees as reimbursable provider types. The CYBHI Fee Schedule relies on the same practitioner categories defined in the DHCS Non-Specialty Mental Health Services program, under which only licensed or registered practitioners are eligible for reimbursement. The exclusion of interns and trainees presents a challenge to broad Fee Schedule participation in LA County because LACOE's internship program deploys graduate students to extend behavioral health capacity in schools without permanent providers. Districts that rely on interns have fewer incentives to join the program if they cannot receive reimbursement. In addition, LACOE's role as a central coordinating agency for more than 400 LEAs requires a significant investment of labor and organizational resources. Respondents reported challenges meeting the administrative and communication demands of the educational workstreams due to this responsibility, underscoring the need for implementation strategies tailored to large, complex counties. Last, some community-based organizations shared concerns that the statewide Fee Schedule rates do not fully reimburse for the cost of delivering services in high-cost areas like LA County, potentially limiting provider engagement when providers can receive higher reimbursement through LACDMH.

To date, the state has taken active steps to support Fee Schedule implementation by facilitating regular communication across departments, engaging LEAs and education stakeholders, and offering technical assistance and grant administration support. The state has also contracted with a third-party administrator (TPA), Carelon Behavioral Health, to manage the network of school-linked behavioral health providers and act as a fiscal intermediary between all CYBHI Fee Schedule program LEAs and institutions of higher education and California's 42 health plans and insurers. As the model evolves, continued attention to practitioner eligibility, rate misalignment in areas where the cost of providing services is higher, and infrastructure needs, particularly for smaller LEAs and coordinating agencies, may help address early challenges and support broader uptake in areas with complex educational and behavioral health ecosystems.

Implementation of workstreams facilitating classroom and campus supports for behavioral health

LA County used CalHOPE Student Support and Mindfulness, Resilience, and Well-Being grant funding to promote systemic SEL in schools. LACOE worked directly with five focal schools to implement systemic SEL with the goal of creating a model for integrating SEL in schools countywide. The project focused on strategies for integrating SEL into all aspects of the school day and providing educators with trainings to enhance their SEL skills and relationships with students. Based on the experiences of the five pilot schools, the county is currently developing best practices and guidelines, and creating a learning series for educators focused on adult SEL that they plan to implement during the 2024–2025 school year.

The CalHOPE Student Support and Mindfulness workstreams have facilitated strong connections with other county offices of education and increased the county's capacity for supporting SEL, in large part due to the availability of highly valued technical assistance. The CalHOPE Student Support state-level community of practice has been particularly valuable as an opportunity to learn from and strategize with other counties throughout the state. LACOE has also appreciated the workstream's turnkey, educator-friendly resources and support with progress in monitoring and implementation strategies. An education respondent highlighted the excellent quality of support from Sacramento County Office of Education (SCOE), and University of California (UC) Berkeley, the technical assistance providers for the workstreams, which included the provision of very specific strategies to address barriers to SEL implementation.

> "I would stand with anything that has come through CalHOPE [Student Support]. Because it is very driven by the community of practice, the state-level community of practice that drives what resources and training [are] needed by us all. It has created a very strong link between county offices to support the implementation of SEL, meaning that we support each other and learn from each other in a real way."
>
> —Education interview respondent

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 home- and community-based sector workstreams

Scaling EBPs and CDEPs grantees anticipated beginning implementation in fall 2024 and expected to address gaps in services and culturally responsive providers for specific populations of children and youth in LA County. As of summer 2024, most grantees had completed or scheduled trainings for their service providers on the planned EBPs or CDEPs that they intended to scale or begin delivering.

A central focus of these projects is expanding access to evidence-based services within the school-based setting. Five of the 12 grantees interviewed were planning to provide services for the 2024–2025 school year, building on existing school partnerships and addressing perceived gaps in the availability of school-based prevention and early intervention services. For example, one grantee plans to train its providers to deliver the Blues Program psychoeducation groups in high schools in Compton and Lynwood; the program is prevention oriented and equips students with coping strategies and tools to support their mental well-being. Another CBO respondent was considering piloting an EBP in group therapy sessions to address clinician shortages.

Other grantees similarly sought to address the needs of specific populations in the county, including adolescents, transition-age youth, and DCFS-involved youth, among others. For example, one CBO identified a shortage of culturally responsive mental health providers and described a need to support young adult Black women college students in Predominantly White Institutions (PWIs).[14] To help address this gap, it is integrating DBT into an existing

[14] Predominantly White institutions (PWIs) refer to colleges or universities where White students make up 50 percent or more of enrollment. The term is widely used in education research, including by the U.S. Department of Education's ERIC (see https://eric.ed.gov/?qt=predominantly+white+institutions).

community-defined, evidence-based program to provide young adult Black women with tools and strategies to navigate these contexts and support their mental health.

Home and community-based sector workstreams

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.

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. California Department of Public Health's (CDPH) Office of Suicide Prevention launched Never a Bother in March 2024, following an eight-month planning phase that incorporated input from more than 400 youth. Throughout the year-long campaign, various activation points were 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. CDPH allocated approximately $50 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.

Grantees appreciated the inherent sustainability of the Scaling EBPs and CDEPs grant projects, which are increasing their organizational capacity for delivering evidence-based practices. In addition to training staff to deliver EBPs and CDEPs, some grantees plan to use the grant funding for a train-the-trainer approach, certifying their staff as trainers of particular EBPs to facilitate continued capacity building. Respondents also highlighted the value of the grants for professional development and capacity building of bachelor's-level behavioral health providers and Pupil Personnel Services Credential (PPSC) staff, such as school counselors, who might not otherwise have access to extensive training in supporting students' mental health. To sustain service delivery after the end of the grant period, many grantees expected to use Medi-Cal or CYBHI Fee Schedule billing.

> "If there's an opportunity for a train the trainer, then we're definitely using this funding to increase our internal capacity to train future cohorts. And then it's also allowing us to carve out time to have an internal champion…. Even if there's no train-the-trainer component, we can invest time in an internal person to be that point person to make sure we're staying on track with data reporting, and people are getting retrained as needed, or that kind of a thing. It's helping, really, with all of those start-up capacity building activities. But the idea being that when the funding ends, staff in any program just has yet one more tool that they can use to work with the kids. And then those services are billed to their normal funding source anyway, like DMH."
>
> —CBO interview respondent

Respondents noted an opportunity for improvement in integrating the Scaling EBPs and CDEPs grants within the LA County context in a more equitable way. The lack of opportunity for county-level coordination in grant distribution increases the risk of inequity in supports for behavioral health, especially in a large, diverse county where some service areas may receive disproportionate funding. The grant administration challenges, including substantial funding delays, were also highlighted as potential equity concerns, given that smaller organizations are less equipped to handle the administrative burden and navigate funding delays. To mitigate the impacts of these administrative delays, DHCS is offering grantees an option for a no-cost extension to their grant period.

> "I think one of the biggest challenges I'm having with some of the grants being released is the lack of coordination at the local level because CBOs are able to respond and get funding, and it could be 90 percent of the funds go to a specific service area. We have eight service areas, we have a lot of diversity throughout the county, and because of the lack of coordination, either at the state level or with the local behavioral health plan, local managed care plan, whatever, there's no way to ensure an equitable distribution of those resources. To me, at a time when we're trying to really look at equity…that has really done us a disservice."
>
> —Behavioral health interview respondent

Implementation of the Never a Bother grant program and the Youth Suicide Reporting and Crisis Response Pilot was underway in LA County, and grantees reported early successes connecting with youth and delivering mental health education. One grantee's project for Never a Bother has focused on implementing outreach strategies using social media with an emphasis on youth voice and building youth capacity, particularly among youth of color. Young people involved in the project have completed trainings to help them understand prevention, public health, and risk factors that can contribute to behavioral health concerns. As part of its Youth Suicide Reporting and Crisis Response Pilot, LA County used grant funding to host five youth mental health summits for middle and high school students, providing suicide prevention education to approximately 500 young people. The county has also reviewed data to identify SPAs with higher rates of suicide for targeting resources and made progress creating a syndromic surveillance system for suicide data to facilitate monthly reviews of patterns in suicide attempts across the county.

The Youth Suicide Reporting and Crisis Response Pilot has also helped facilitate new partnerships and strengthened existing relationships across county agencies and organizations. Monthly work groups have helped bring together new partners who regularly share input, such as staff from DCFS, the LA County Department of Health Services (LACDHS), and crisis networks. The pilot has also helped expand LACDPH's relationship with the LACDMH and increased its understanding of collaboration opportunities. Similarly, the pilot supports a partnership between LACDPH and LACOE to develop a curriculum to train schools in crisis response.

> "When we were assembling the work group, I think we were under the impression that we would be bringing people to the table to help us with our work, but everyone who's a part of the work group is equally as invested in this…. I will be in other meetings and people will bring up, oh, this could inform the youth suicide work that you're doing. And so it's really exciting to see that there's a very high level of buy-in across a variety of departments in a way that I don't know we were expecting and because of it, there's almost been this organic push for things to happen or push to connect us with folks who can make those things happen, if we don't know who they are or have access to them on our own."
>
> —Public health interview respondent

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

V. Conclusion

LA County is unique in the state, characterized by the largest population of any county in the country and a substantial diversity of experiences and needs among its residents. With more than 10 threshold languages, a majority Latino population, and some of the wealthiest and poorest neighborhoods in California, treatment of behavioral health needs in children and youth requires a diverse, comprehensive approach. Interview respondents highlighted substantial gaps in care, including workforce shortages relative to the growing demand for services, inconsistent quality and access to services and resources across subregions within the county, insufficient services for children ages 0 to 5, and the need for better treatment options for severe behavioral health needs. Youth and families who do not speak English as their primary language face access barriers that could be addressed through increased availability of language-concordant care.

Despite these challenges, survey and interview respondents perceived positive progress across the county's highly complex behavioral health ecosystem. Although initial implementation is still underway, our analysis—drawn from available data, early implementation findings, and interviews with leaders—indicates that LA County is leveraging CYBHI resources in ways that are addressing the diverse behavioral health needs of the county's children and youth, and reducing barriers to access. For example, the county's SBHIP-funded telehealth project has expanded access to culturally responsive and language-concordant services at school for students who face barriers to obtaining in-person services or unreliable internet service at home. Other CYBHI-funded digital supports for families in the county include Soluna and BrightLife Kids, both of which offer services across a range of languages. Several Scaling EBPs and CDEPs-funded projects are similarly addressing gaps in access for specific populations and expanding provider capacity. Respondents described these projects, among others, as expanding prevention-oriented services for high school students, increasing the use of evidence-based practices to support youth with complex care needs, and providing evidence-based mental health supports for young adult Black women college students attending PWIs. In addition, although silos and opportunities for improved connectedness remain, county agencies and organizations are increasing their collaborative efforts through several of the CYBHI workstreams, as well as other state-led initiatives such as California's FFPSA program, CalAIM Reentry, BH-CONNECT, the Behavioral Health Transformation (BHT) effort, and local networks and work groups.

Respondents were implementing the CYBHI workstreams with an eye toward sustainability, where feasible, and noticed promising potential for long-term impacts. Going forward, the county could benefit from continued focus on working toward more consistent access to services and resources across subregions within the county. In addition, efforts to continue to grow the behavioral health workforce, particularly support services for children ages 0 to 5 and treatment options for severe behavioral health needs, will help the county address reported gaps. The county is well positioned to keep building on the great willingness among many organizations and agencies to collaborate so they can better support children and youth behavioral health.

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 accessed 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 status, neighborhood characteristics		
Population in urban blocks (%)	U.S. Census at https://www2.census.gov/geo/docs/reference/ua/2020_UA_COUNTY.xlsx	2020
Population in rural blocks (%)		
Population below 200 percent 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 reported seriously considering attempting suicide in the past 12 months (%)	California Healthy Kids Survey County Reports at https://calschls.org/reports-data/search-lea-reports/ and Mathematica's analysis	2019–2021
Students in Grade 11 who reported seriously considering attempting suicide in the past 12 months (%)		
Students in grade 9 reporting school absences due to mental health issues (%)		
Students in grade 9 reporting school absences due to alcohol or drug use (%)		
Inpatient hospitalizations per 1,000 children and youth for behavioral health diagnosis	California Department of Health Care Access and Information; applied for data at https://datarequest.hcai.ca.gov/csm	2022
Emergency department visits per 1,000 children and youth for any behavioral health diagnosis		
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

Variable	Source	Years
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 ages 0–25	Health Resources and Services Administration FQHC and look-alike locator at https://findahealthcenter.hrsa.gov/?hmpgtile=hmpg-hlth-srvcs	2024

Appendix B. Network Analysis Methodology and Measures

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

Methodology

We invited 23 organizations to complete the NEES and received responses from 19 organizations (for an 82.6 percent response rate). Invited organizations included government agencies and departments; a managed care plan; and CBOs, including organizations that serve youth and 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.[15,16] 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 the ratings to calculate the average strength of the entire network.

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

Exhibit B.1. Connection ratings and description

Score	Rating strength	Rating description
1	Coexist	No or limited relationship between organizations
2	Cooperate	Informal interactions on specific activities or projects
3	Coordinate	Intentionally plan/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 their connection 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 LA County, there were instances where 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 data that included 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 connection ratings are generally in agreement with each other, and thus a single organization's assessment of the strength of the relationship can be used as a representation of the actual strength as reported by both ends of the connection. In LA County, the agreement score was 73.9 percent. Due to this high rate of agreement among respondents, we concluded that a connection rated by a single respondent was a reliable representation of the strength

[15] 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.

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

of the connection between organizations. Therefore, we included connections in the network analysis and map where only a single organization rated the strength of a relationship.

Network measures

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

Exhibit B.2. LA County network analysis summary statistics

Network measure	Statistic	Description
Possible network size	23	Number of organizations invited to complete the survey.
Number of possible connections	506	The total number of possible connections between all 23 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	23	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	298	The total number of connections reported by organizations that completed the survey. This number excludes missing data and "not applicable" responses.
Number of unidirectional connections	114	A unidirectional connection is observed when only one of the two organizations rates the strength of the connection.
Reciprocated connections	184	The number of connections that were bidirectional (that is, both organizations reported the strength of the connection with each other).
Reciprocity rate	0.62	The number of bidirectional connections out of the total number of observed ties.
Average network strength	2.68	The average strength rating for the network, where the denominator is the number of observed connections.

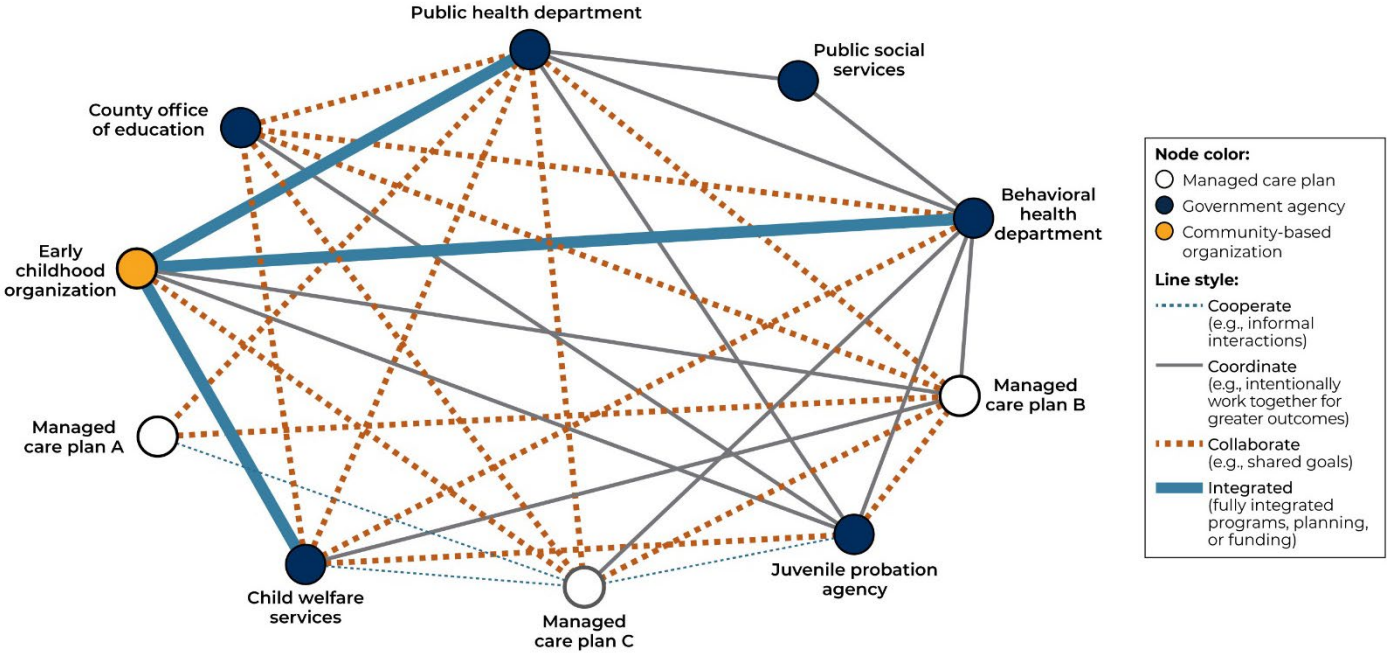
Exhibit B.3 shows the average connection strength range, rating, and the number and percentage of connections in the full network map (Section II, Exhibit 5) that fell under each rating category.

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
1.0–1.99	Coexist	75	36.4
2.0–2.99	Cooperate	24	11.7
3.0–3.99	Coordinate	51	24.8
4.0–4.99	Collaborate	44	21.4
5.0	Integrated	12	5.8
Total		**206**	**100.0%**

Exhibit B.4 is a network map showing the connections between a subset of organizations in LA County, including the six government entities, three managed care plans, and the early childhood organization in the county. This network map offers a closer view of the strength of the relationships between these entities.

Exhibit B.4. Connections between government entities, managed care plans, and the early childhood organization



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

Appendix C. Details on the Implementation of Selected Workstreams

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

Workstream: Student Behavioral Health Incentive Program	
Short overview	• The county's SBHIP projects focus on four areas: (1) telehealth infrastructure to enable services, (2) behavioral health wellness (BHW) programs, (3) expansion of the behavioral health workforce, and (4) IT enhancements for behavioral health services. • The telehealth project focuses on providing services to students virtually through a vendor (Hazel Health). The project is available countywide and, as of summer 2024, more than half of the county's 80 districts had expressed interest in participating. • The BHW project allocated funds of up to $400,000 per district to 15 partner districts to create wellness spaces on campuses for individual and group therapy sessions or broad Tier 1 prevention services. The project also funds technical assistance and behavioral health training for schools, with a focus on developing operational guides for suicide prevention, intervention, postvention crisis response, threat assessment, and comprehensive safe school plans. • The workforce project includes both (1) an expansion of LACOE's Well-Being and Support Services Internship Program that places aspiring social workers and counselors at schools across the county to support or implement MTSS and (2) training and funding to increase mental health-related peer-to-peer programming on campuses. • The IT infrastructure project funds district participation in the California Health Kids Survey with the behavioral health module and builds a countywide dashboard that incorporates data from the surveys, along with other school and community data, to create dashboards that are accessible to school districts and can be used to identify school needs. The project also supports districts that are part of the CYBHI Fee Schedule Cohorts 1 and 2 with the development of an EHR system.
Key implementation findings	**LA County's telehealth project has been particularly successful in delivering services to students and addressing access barriers, according to respondents.** • Respondents reported that, as of summer 2024, the program had provided roughly 20,000 therapy sessions to approximately 3,000 students. For participating students who had moderate to severe symptoms of anxiety and depression, 71 percent showed improvement. • Respondents reported that the telehealth program prioritizes a culturally responsive therapy team, which provides services in 10 of the county's threshold languages, and approximately 70 percent of the students receiving services as of summer 2024 were students of color. • By providing reliable access to telehealth in or through school, the program helps ensure access to services for students without access to reliable internet at home. **Districts and schools throughout the county have responded enthusiastically to opportunities to create wellness spaces.** • More than 100 schools are creating wellness spaces through the SBHIP project, with principals advocating to move these efforts forward despite the administrative burden of submitting a proposal and overseeing a refurbishment project. "Overall, the response to a wellness center in their school has been overwhelming. Every principal has made it happen. And I have to credit our therapists, who have been without a wellness center and have had to be in a confidential space. Their work and their commitment to build that community within their school and be a part of has created that space where principals are saying no, no, no, we need to have a space for them. This is important for our children." —Education interview respondent **Collectively, the SBHIP projects have facilitated multisector collaboration and elevated the need for an integrated, comprehensive approach to behavioral health in schools.** • Respondents across sectors highlighted the effectiveness of SBHIP in developing and strengthening relationships among LACOE, the managed behavioral health care organization, the telehealth provider, managed care plans, and LACDMH, as well as LAUSD and other school districts in the county.

Workstream: Student Behavioral Health Incentive Program	
Key implementation findings *(continued)*	• Education respondents also highlighted an increased awareness among schools that integrating behavioral health in schools requires a more intentional infrastructure, such as staff training and dedicated wellness spaces, beyond simply partnering with a CBO to provide services. • A managed care respondent noted that the 18 months of weekly conversations with LACOE for SBHIP work has been a valuable facilitator for the CYBHI Fee Schedule implementation. **Contextual factors such as the county's Community Schools Initiative (CSI) and school enrollment patterns have facilitated implementation of the SBHIP projects.** • Respondents highlighted the county's CSI, with one behavioral health respondent describing those efforts by LAUSD, LACDMH, and others as "a backbone of some of our early SBHIP work," given the relatively high level of engagement of the community schools and the existing county resources already deployed in those schools. • Declining enrollment at schools in the county enabled the SBHIP-funded reconfiguration of empty classrooms for school wellness spaces. **Respondents also praised LACOE's support for districts and attentiveness to the sustainability of the SBHIP projects.** "The process has been very useful with LACOE and they've been very supportive. And I have to say, as far as LACOE is concerned with SBHIP, I've made very good connections with people there that are readily available and understand…the restrictions or limits that we have. What has helped with SBHIP is the one-to-one support. I have people's names on my cell phone. And they are very responsive. Kudos to them because I know they're also working with a system that is creating things as they come and working within state limitations and so forth. But I think the understanding is there. I think the flexibility is there. I think the outreach and the response is there…. We're hearing from them all the time and there's that guidance that happens. And I don't feel alone or at a loss doing it." —Education interview respondent **The large number of districts in LACOE with wide variation in their capacity for and experience with behavioral health service delivery and billing has led to challenges with implementation.** • For example, LAUSD already has many wellness centers, including Federally Qualified Health Centers (FQHCs), within its system. Due to this existing infrastructure, it has proposed using wellness space project funding for an innovative approach involving the use of mobile wellness vans to better meet the district's needs. The process of obtaining approval and fulfilling administrative requirements for this approach, which is unique relative to other districts, has been slow. • The county has also experienced some delays in implementing some aspects of its SBHIP projects, especially the peer leadership aspect of the workforce project, due to staffing challenges. However, the county had recently filled a position to lead the peer leadership efforts, and the newly hired staff member had begun to develop a curriculum for implementing peer-to-peer programming in schools.
Sustainability and what is next	• The workforce project to expand the intern program and provide additional technical assistance and training has resulted in 76 interns being trained and placed in schools during the 2023–2024 and 2024–2025 school years. • From their inception, the county prioritized sustainability across the SBHIP projects. The countywide dashboard was designed for continued, long-term use. The wellness centers are also expected to continue to function because they were purpose-built at schools using SBHIP funding. • The telehealth project has been extended for six months and will continue through June 2025. The county identified funding and the managed care plan engaged in negotiations with both LACOE and the telehealth vendor to continue the project. • The CYBHI Fee Schedule program offers a potential funding source to help sustain the SBHIP-funded expansion of school-based services, such as those offered via wellness centers or telehealth, after the end of the grant period.

Workstream: Fee Schedule	
Short overview	• LA County has three LEAs that are part of the CYBHI Fee Schedule Cohort 1: LAUSD, Montebello Unified School District, and the schools operated by LACOE. • Seven additional LEAs in the county are participating in Cohort 2 and 16 are participating in Cohort 3.
Key implementation findings	**As of fall 2024, LACOE had actively disseminated information to LEAs to encourage and support their participation in the CYBHI Fee Schedule but encountered some hesitation.** • The county has held information sessions and communicated with individual LEAs to encourage them to apply to participate. However, as a managed care respondent explained, the county includes 80 districts among 451 unique LEAs, which might limit the extent of individual outreach that can be provided relative to a smaller county. • Respondents observed that smaller districts are hesitant to take on the burden of participation in the CYBHI Fee Schedule due to overall capacity limits, as well as a lack of providers and the necessary infrastructure for billing and administration. **The county's three Cohort 1 LEAs were still preparing for the CYBHI Fee Schedule implementation as of summer 2025. The remaining activities include finalizing workflows for claims submission and payment remittance, obtaining school board approval for data use and provider participation agreements, and pursuing next steps for EHR system development and use.** • At the time of the interviews, LAUSD was still engaging in some financial analyses to help determine the balance of Fee Schedule billing and other funding sources that would allow the district to retain behavioral health staff and also cover the supervision and other administrative work associated with the delivery of services. Respondents noted that the CYBHI Fee Schedule as designed is useful for cost recovery but cannot be used as a single source for funding staff sustainably, even for a staff member billing 100 percent of their time. **Respondents across sectors were optimistic about the potential benefits of the CYBHI Fee Schedule for LA County.** • The CYBHI Fee Schedule is expected to expand the coverage and delivery of prevention and early intervention services in schools, such as education about mental health, family meetings, and group interventions provided by non-clinicians, such as community health workers or wellness coaches. This may address concerns raised by respondents about the current lack of universal supports and prevention services, such as suicide prevention policies, available at many schools in the county. • The CYBHI Fee Schedule also has the potential to address service and reimbursement limits for large districts contracted to provide non-specialty mental health services to Medi-Cal beneficiaries. LAUSD, for example, currently staffs approximately 800 psychiatric social workers and receives reimbursement for services through a contract with LACDMH. However, the contract is capped at a certain amount for service reimbursement. In recent years, the district has been exceeding that maximum amount and has been seeking a strategy for facilitating full-service delivery and reimbursement. **LA County faces a handful of contextual barriers that may limit the value of the CYBHI Fee Schedule for the county.** • One important consideration is the exclusion of interns and trainees from the list of reimbursable provider types under the CYBHI Fee Schedule. The program currently mirrors the practitioner categories defined under DHCS's Non-Specialty Mental Health Services program, which includes only licensed or registered practitioners. This limitation presents a challenge in LA County, where LACOE oversees a large internship program that enables the placement of social worker and family therapist interns in schools to support mental health programs and extend behavioral health capacity, particularly in schools without permanent providers. Districts that rely heavily on interns have limited incentive to participate in the CYBHI Fee Schedule if they cannot receive reimbursement to help offset the infrastructure and staffing costs required for billing. • The provider registration process under the Fee Schedule may also pose barriers to equitable access in larger counties. In a large county such as LA, where more than 80 LEAs vary in size and administrative capacity, community-based providers may be more inclined to work with large districts such as LAUSD that already have strong infrastructure in place. Smaller districts, by contrast, may lack the infrastructure needed to onboard providers or manage billing independently. One education respondent suggested that allowing LACOE to register providers centrally and enabling those providers to bill for services delivered across multiple districts and through memoranda of understanding could promote more equitable access.

Workstream: Fee Schedule	
Key implementation findings *(continued)*	The CYBHI Fee Schedule consortium model presents an opportunity to support this approach, and the county is currently exploring it as a strategy to help smaller LEAs and charter schools share the administrative load of provider registration and billing through a single lead agency. • Some community-based providers expressed concern about the financial viability of participating in the Fee Schedule, citing misalignment between statewide rates and the cost of delivering services in LA County. Providers noted that reimbursement through LACDMH contracts often exceeds CYBHI Fee Schedule rates, which may make the program less attractive without adjustments for regional cost differences.
Sustainability and what is next	• Going forward, LACOE, Montebello Unified, and LAUSD are expected to finalize preparations for the Fee Schedule implementation, including finalizing EHR system selection and refining infrastructure and staffing for billing. • LACOE is currently exploring adopting a consortium model for the CYBHI Fee Schedule. Under this approach, the county would implement an EHR system that could be used by any district interested in participating but lacking the capacity for their own EHR system, and LACOE would be responsible for billing after district staff submit their data. • To support implementation and sustainability across diverse districts, DHCS and CalHHS have taken several steps at the state level. These steps include contracting with Carelon Behavioral Health as a third-party administrator to streamline provider network management and claims processing, facilitate cross-agency coordination, and offer technical assistance to LEAs.

Workstream: CalHOPE Student Support and Mindfulness, Resilience, and Well-Being Grants	
Short overview	LACOE used CalHOPE Student Support and Mindfulness, Resilience, and Well-Being funding to support partnerships with five focal schools. LACOE worked directly with the schools on implementing systemic SEL to create a model for integrating SEL in schools countywide. The project focused on strategies for integrating SEL into all aspects of the school day rather than in stand-alone 20-minute lessons, and provided educators with training to enhance their SEL skills and relationships with students. It also supported schools with infusing cultural responsiveness, identity, and belonging into the learning environment.
Key implementation findings	**LACOE has completed its CalHOPE and Mindfulness projects with the five focal schools and is working to create and disseminate lessons learned for the county.** • The county is currently developing best practices and guidelines for other schools based on its work with the focal schools. • After learning from its CalHOPE project that staff wellness and SEL skills and relationships with students are critical aspects of SEL programming, the county has created a series for adult SEL and plans to implement the series during the 2024–2025 school year, with support from some of the focal schools. **The CalHOPE and Mindfulness workstreams have helped facilitate strong connections with other county offices of education, developed the county's understanding of implementation, and equipped the county with useful resources for supporting SEL in schools.** • The state-level community of practice has been very beneficial for LACOE, providing opportunities to learn about SEL implementation from other counties. • Working with the Center for Implementation, a provider of implementation technical assistance, has increased LACOE's capacity to understand the key aspects of implementation and engage in progress monitoring. • The workstream has provided the county with turnkey, educator-friendly SEL resources that a busy county office of education such as LACOE can distribute directly to districts. "I would advocate for it [CalHOPE] to continue, if anything. I think it's demonstrated across the state, levels of impact that I haven't seen." —Education interview respondent

Workstream: CalHOPE Student Support and Mindfulness, Resilience, and Well-Being Grants	
Key implementation findings *(continued)*	**A highlight of LACOE's experience with the CalHOPE and Mindfulness workstreams was the perceived quality of support from the technical assistance providers, SCOE, and UC Berkeley.** SCOE and UC Berkeley provided LACOE with specific strategies to address barriers. For example, when a school lacked the capacity to create a school-level SEL implementation team, technical assistance providers supported LACOE in developing a contingency plan in which the county provided substitutes to free up time for staff to participate. "I will tell you my experience with CalHOPE, and my interactions with SCOE and UC Berkeley have been nothing but positive. As far as implementation goes, the tools and resources that are provided, and the research and the impact that we're able to demonstrate, has been phenomenal. There's operational stuff that can be a challenge for any grant…. But in terms of impacts, resources, and TA that's provided through the leads in CalHOPE, it's been phenomenal. Probably the best experience I've had of a grant, and I've operated and overseen plenty of grants." —Education interview respondent
Sustainability and what's next	Although the CalHOPE-funded partnerships with the five focal schools have ended, LACOE plans to continue the work by supporting the scaling of systemic SEL to other schools in the county. It will also be publishing a journal article on the implementation experiences and outcomes for one of the focal schools.

Workstream: Scaling EBPs/CDEPs	
Short overview	The county's Scaling EBPs and CDEPs grant awards cover all five grant rounds, addressing parent and caregiver support programs and practices, trauma-informed programs and practices, early childhood wraparound services, youth-driven programs, and early intervention programs and practices. The funded projects addressed in interviews include the following: • The new implementation of Positive Parenting Program (Triple P) with children ages 0 and 5 years (Round 1) • The expansion of Child–Parent Psychotherapy (CPP) (Round 2) • The new implementation of Managing Adaptive Practice (MAP) and Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH-ADTC) in select county schools (Round 2) • The expansion of Functional Family Therapy (FFT) in South Central Los Angeles (Round 2) • The expansion of dialectical behavioral therapy (DBT) for complex care youth (Round 2) • The expansion of a community-defined, evidence-based practice for young Black women, including the incorporation of DBT (Round 2) • The new implementation of the Transition to Independence (TIP) model in select county schools (Round 4) • The new implementation of Resourceful Adolescent Program-Adolescent (RAP-A) in select county schools (Round 5) • The pilot of a transition-age youth (TAY)-led program in SPA 8 (Round 4) • The new implementation of Culturally Informed and Flexible Family-Based Treatment for Adolescents (CIFFTA) (Round 5) • The new implementation of a prevention-focused group intervention (Blues Program) for adolescents with symptoms of anxiety or depression in select county schools (Round 5) • The integration of the Blues Program into existing high school support groups (Round 5)
Key implementation findings	**Implementation is in the early stages for the grant projects in LA County; most grantees planned to begin providing services in fall 2024.** • At least 10 of the interviewed grantees had completed implementation plans and completed or scheduled trainings on the EBPs for their service providers between August and October 2024. • The grantees focused on school-based settings were expecting to provide services during the 2024–2025 school year.

Workstream: Scaling EBPs/CDEPs	
Key implementation findings *(continued)*	**Grantees designed their projects to address gaps in services for specific populations of children and youth in LA County.** • One CBO identified a shortage of culturally responsive mental health providers and a need to support young adult Black women in PWIs in particular. The CBO is focusing its Scaling grant project on Black women college students between the ages of 18 and 25 years in PWIs and integrating DBT into an existing community-defined, evidence-based program with the goal of providing young adult Black women with DBT tools and strategies to navigate and reduce mental health stigma and isolation. • Another CBO in the county has noticed a particularly high level of need and referrals among adolescents between the ages of 12 and 18–19 years relative to other populations. These young people are struggling with school, peers, and family situations. The CBO's grant project will address this need by focusing on implementing the Blues Program for high school students in Compton and Lynwood. • LACDMH is using a Scaling grant to address needs among the high number of youth with complex care needs who are involved with DCFS, probation, or both. DBT is an effective EBP for this population and is already used for probation-involved youth but not DCFS-involved youth. The grant will allow the county to ensure that both DCFS and probation staff are using the same model with the same youth population. **Expansion of evidence-based programming and services for students in schools is a key focus area of the grant projects in the county.** • Five of the grant projects addressed in interviews are designed to deliver services in school-based settings. Several grantees are building on existing partnerships with schools where they already provide services. • As one education respondent noted, this scaling of school-based services helps fill a substantial gap in the availability of prevention and early intervention services in schools. • The grants also provide an opportunity for nonclinical school staff, such as school counselors, to receive training and deliver evidence-based practices such as the Blues Program. These staff members can also bill for reimbursement for such services outside of the grant, which will facilitate the sustainability of the services. • One CBO respondent noted the high potential for group therapy sessions held in schools and elsewhere to address shortages in clinicians and behavioral health care providers relative to the level of need. Implementing an EBP in a group setting could be a highly efficient strategy, and the Scaling grant provides an opportunity to assess the effectiveness of this approach. **The Scaling grant program is particularly appealing as a means of elevating CDEPs in LA County.** • A CBO grantee that operates statewide noted that although some counties seem to be funding and proactively engaging organizations to partner on CDEPs, the grantee has struggled to identify similar supports in LA County. The Scaling EBPs and CDEPs workstream has provided a valuable opportunity to elevate CDEPs. **Respondents raised some concerns about equity issues related to the lack of local coordination on the distribution of grants—a particular issue for a large, diverse county like LA.** • A behavioral health respondent noted that when CBOs apply directly for grant funding, without local coordination there is a risk that some of the county's service areas will receive a disproportionate amount of funding.

Workstream: Scaling EBPs/CDEPs	
Key implementation findings *(continued)*	• Another grantee cited the grant administration challenges, including substantial funding delays, as a potential equity concern. Although larger organizations are more likely to have sufficient resources to continue work while awaiting funding, smaller organizations are not equipped to handle the administrative burden and weather-related funding delays. In an effort to mitigate the impacts of administrative delays, DHCS is offering grantees an option for a no-cost extension of their grant period. "Everybody could apply for this. But really, maybe not, because everybody doesn't have the staffing or their finances are not as robust. They're not as large an organization. But yet some of these little programs may be right in the community that could just so benefit from this…. It absolutely brings up equity concerns. These mom-and-pop organizations for some of these things where they are best connected with the community…it's really driving some of these smaller businesses to close their doors, or it's shutting them out of some of these opportunities." —CBO respondent
Sustainability and what is next	Grantees were generally enthusiastic about the inherent sustainability of the Scaling grant projects, which facilitate the training of their own staff and increase organizational capacity to implement evidence-based practices going forward. Some grantees are also using the grant funding to implement a train-the-trainer approach and certify their own staff as trainers for particular EBPs, which will not only enable sustainability but may also help them continue to increase their capacity for delivering these EBPs. Many grantees anticipated sustaining service delivery through Medi-Cal or CYBHI Fee Schedule billing. One CBO respondent expressed concern that grantees without this option would not be able to sustain services and suggested that greater attention to supporting grantees through sustainability presents an opportunity for improvement.

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

Workstream: Youth Suicide Reporting and Crisis Response Pilot Program	
Short overview	LA County was one of 10 counties selected for the Youth Suicide Reporting and Crisis Response Pilot Program. The LACDPH is overseeing the implementation of the grant. Its work is focused on building a syndromic surveillance system to track data on suicide attempts, providing suicide prevention education, and developing a curriculum to train schools on crisis response in partnership with LACOE.
Key implementation findings	**The grant is addressing a gap in the capacity of organizations in the county, especially schools, to support families immediately after a suicide attempt or death.** • Families in this situation often face waitlists or lack the funds or transportation to obtain services following a suicide attempt. Given the competition for limited funding, CBO staff and capacity for providing services often change every year. • The county also lacks a coordinated response to suicide attempts and deaths across the large number of districts and schools in the county despite LACOE's efforts to draft manuals and provide training on developing a comprehensive school safety plan. **As of summer 2024, the county was in the early implementation phase after conducting a gap analysis informed by community partners and creating a work plan. Initial progress has included hiring staff, hosting youth mental health summits, and convening a monthly work group to inform implementation.** • Using grant funding, the county has created and filled an epidemiologist position to work with its Acute Communicable Disease Control Syndromic Surveillance Program to create a syndromic surveillance system for suicide data. The system will help mitigate delays in accessing data on hospitalizations or emergency department visits and facilitate monthly reviews of patterns in suicide attempts across the county. The county has also hired four additional staff members to support the grant. • The county has hosted five youth mental health summits for middle and high school students, during which they provided two hours of suicide prevention education to approximately 500 young people. • LACDPH has also been convening monthly work group meetings on crisis response activities and rapid reporting, with at least 15 people attending every work group meeting.

Workstream: Youth Suicide Reporting and Crisis Response Pilot Program	
Key implementation findings *(continued)*	**The grant has facilitated new partnerships for LACDPH and strengthened existing relationships.** • LACDPH has built new relationships with staff from DCFS and LACDHS who have been attending work group meetings. • LACDPH was already connected with LACDMH, but the grant has helped expand their relationship, connected LACDPH with new programs at LACDMH, and increased their understanding of opportunities for collaborating. **The county is currently developing the data system and identifying areas and populations with high levels of need.** • Working with local partners to gather data, the county has identified specific SPAs with higher rates of suicide and is exploring options to concentrate contracts for work in those SPAs. • The county is intentionally including transition-age youth in its population of focus as these youth are sometimes left out of other county services. • LACDPH is also working with LACOE to develop a curriculum to train schools in crisis response. **LACDPH has encountered some implementation challenges related to the county context, including data access issues and contracting restrictions.** • Although the county has a large amount of data available, LACDPH has had difficulty accessing some of the data due to privacy issues and technological barriers—for example, as a result of the medical examiner's office switching to a new data system. • LACDPH is also experiencing some challenges in identifying county contractors with the right resources and locations to help implement the grant work. The county requires contractors to complete a process to be included on an eligibility list for receiving a contract, which limits the available pool. • Given the extent of preparation and hiring required, and the need to navigate county processes for contracting, LACDPH has found the two-year timeline challenging.
Sustainability and what is next	• The county has been intentional in creating programs and resources that can be sustained beyond the end of the grant period, such as a caregiver psychoeducation curriculum to be used in a support group for caregivers of youth experiencing suicidal behaviors and the crisis response training curriculum for county schools. • However, funding for the staff who were hired to support the grant ended in June 2025, and LACDPH lacks funding for a dedicated, full-time suicide prevention staff member within its office. Respondents indicated that LA County could significantly benefit from a separate, funded office of suicide prevention with dedicated staff, particularly given the size of the county. • Respondents also raised concerns about the sustainability of the syndromic surveillance program for real-time monitoring of suicide data after the end of the grant.

Let's Progress Together.

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