Implementation of CYBHI Workstreams Across Counties

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Executive Summary

California's Children and Youth Behavioral Health Initiative (CYBHI) represents a landmark statewide investment to strengthen behavioral health systems for children and youth. From summer to fall 2024, the CYBHI evaluation team examined local implementation of 10 CYBHI workstreams across nine diverse counties— Alameda, Fresno, Humboldt, Imperial, Los Angeles, Monterey, Shasta, Ventura, and Yolo—to inform future county-level strategies meant to improve behavioral health access and outcomes. Drawing on interviews with county agency leaders and other key organizations, the team distilled key lessons learned about workstream rollout and progress, innovative local implementation approaches, and solutions to implementation challenges. Focusing on core settings such as education, homes, and communities, this report highlights the behavioral health needs in the nine counties, what's working to address these needs, where counties have adapted CYBHI investments creatively, and the barriers they have overcome. These insights offer practical guidance for sustaining and scaling behavioral health supports for California's children and youth.

Key findings:

- **Counties leveraged CYBHI workstreams across settings to meet the needs of specific local populations and deliver services that resonated with communities.** This work is overcoming sociocultural and linguistic barriers for underserved populations and ensuring youth have a voice in shaping their care.

Growing a behavioral health workforce representative of the community

In **Monterey County,** one Local Education Agency (LEA) used the CYBHI funding to hire several Certified Wellness Coaches (CWCs) who are local to the area, where nearly two-thirds of the population is Hispanic or Latino.[2] Many new CWCs the LEA hired are bilingual in English and Spanish, which will help increase accessibility of behavioral health services for the high proportion of Spanish speakers in the community.

A **Ventura County** grantee used Never a Bother funding to educate and train Native youth on suicide prevention through culturally relevant youth-focused programming, such as youth talking circles, beading circles, and sweat lodge ceremonies. The grantee also hosted youth-focused and culturally adapted Question, Persuade, Refer training to develop youth capacity to support peers experiencing suicidal ideation. Youth who completed the training reported feeling more confident and competent in initiating conversations about suicide.

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[2] The research team analyzed secondary data sources to capture the population and behavioral health system characteristics of nine counties and California as a whole. For more information, see the case studies here: Children and Youth Behavioral Health Initiative. "CYBHI Spotlights: Early Success Supporting Kids and Families Across California." 2025. https://cybhi.chhs.ca.gov/cybhi-spotlights/.

- **Counties used CYBHI funding to expand behavioral health staffing and infrastructure, particularly in schools or school-linked sites and in remote or rural areas.** These investments helped them address widespread workforce shortages and overcome geographic and transportation barriers.

Leveraging Student Behavioral Health Incentive Program funding to construct bridges to behavioral health services

Los Angeles County used funding from the Student Behavioral Health Incentive Program (SBHIP) to implement a telehealth project expanding access to mental health services for students who lacked reliable broadband at home or faced barriers to obtaining in-person services. During the 2023-2024 school year, the program delivered approximately 30,000 clinical hours to roughly 3,000 students, with a majority from Latino and Black communities, which comprise a large proportion of county residents relative to the state overall.

- **Counties' implementation of education workstreams has strengthened the relationships between education agencies and managed care plans and improved cross-sector collaboration more broadly.** These efforts have built trust, improved coordination, and helped align systems that historically operated in silos.

Strengthening relationships

In **Humboldt County**, SBHIP funding supported the development of a new partnership between the County Office of Education and the Medi-Cal managed care plan. This collaboration helped improve communication and coordination between sectors that had previously been somewhat siloed, laying the groundwork for more aligned behavioral health services in schools.

Lessons for broader application: Strategies to address specific county contexts

The nine counties included in this analysis vary widely in geographic, population size, demographics, administrative capacity, and economic diversity. Their CYBHI implementation experiences offer practical strategies that may help other counties facing similar local dynamics improve behavioral health access and outcomes. As you read on, you will find concrete examples of how the nine counties are addressing common challenges by leveraging CYBHI resources, which could be applied more broadly outside of the initiative. For example:

- **Rural counties can expand access by investing in school-based services, which bring care directly to the places children and youth spend much of their time.** Across counties, rural districts used CYBHI education workstreams to increase access to care in school settings, such as through SBHIP-funded wellness centers and mobile mental health vans that provide services reimbursable through the CYBHI Fee Schedule. Telehealth services at school sites are another strategy to improve accessibility for more remote communities and to overcome transportation barriers.

- **Counties serving diverse or underserved populations can improve reach and engagement by tailoring services to reflect cultural and linguistic needs.** Counties used CYBHI workstreams to engage youth and families in tailoring evidence-based and community-defined evidence practices, invest in growing a more representative workforce, and offer incentives to attract bilingual providers.

- **Smaller counties can strengthen administrative capacity by investing in shared infrastructure or partnering with external support.** Counties used CYBHI grants to fund shared billing roles across districts or to support planning through contracted consultants. These strategies helped lay the foundation for sustainable participation in the CYBHI Fee Schedule and other funding mechanisms.

On the road to strengthened behavioral health systems

The counties featured in this report are leveraging the CYBHI workstreams to address longstanding behavioral health challenges for children, youth, and families and are well positioned to see lasting impact. All nine counties faced critical workforce shortages, gaps in crisis and residential care, and limited access to culturally and linguistically responsive services, particularly in rural areas and among underserved populations. CYBHI investments are helping counties begin to close these gaps. As of fall 2024, counties were attracting and retaining behavioral health providers through community-based organization (CBO) behavioral health workforce incentives, hiring bilingual and culturally representative staff using CWC employer support grants, and expanding school-based behavioral health services through SBHIP and the CYBHI Fee Schedule. Funding through CalHOPE workstreams further enabled counties to tailor school-based wellness and social and emotional learning supports to meet the needs of Indigenous youth and other marginalized groups.

Looking ahead

With many CYBHI funding streams winding down, counties are focused on scaling and sustaining promising practices. They are beginning to submit claims under the Fee Schedule and exploring blended and braided funding strategies to sustain positions and services initiated with CYBHI grant funding. In parallel, other CYBHI investments are beginning to come to fruition. For example, behavioral health care facilities built through Behavioral Health Continuum Infrastructure Program (BHCIP) infrastructure grants are becoming operational and helping to close critical gaps in the continuum of care, while longer-term CYBHI provider pipeline investments, such as the Social Work and Psychiatric Education Capacity Expansion grant programs, are poised to strengthen the workforce over time. Counties that continue to leverage these resources and implement innovative tailored approaches to address their unique contexts will be well positioned to advance meaningful improvements in behavioral health access and outcomes for children, youth, and families.

Introduction

Assessing local implementation of CYBHI workstreams across California counties

A critical component of the CYBHI evaluation is understanding how local implementation of CYBHI workstreams has progressed and supported the behavioral health needs of children and youth in California's counties. In summer and fall 2024, the evaluation team completed interviews focused on the rollout of 10 CYBHI workstreams in nine counties: Alameda, Fresno, Humboldt, Imperial, Los Angeles, Monterey, Shasta, Ventura, and Yolo. These counties, which reflect a range of geographic regions, population sizes, demographics, economic diversity, and implementation experiences, include urban and rural areas and vary in the extent to which CYBHI workstreams were underway at the time of data collection, allowing for a nuanced understanding of implementation progress across diverse counties in the state. Although most of the workstreams were in early implementation at the time of interviews, the insights, successes, and lessons learned from implementation in these counties can inform organizations and departments in other counties working on meeting the needs of California's children and youth.

Ongoing challenges in the children and youth behavioral health system

Across California counties, children, youth, families continue to face barriers accessing timely and appropriate behavioral health care services. County-level data and interview insights reveal common structural and service gaps that necessitate the need for comprehensive, coordinated solutions such as those developed under CYBHI:

- **Counties across California are experiencing critical behavioral health workforce shortages, limiting access to timely and specialized care for youth. All nine counties face full or partial shortages of mental health providers, with gaps across the behavioral health continuum.** The statewide average is approximately 37 providers per 100,000 youth, yet several counties fell well below this level, including Imperial (23 providers) and Alameda (32 providers). Even in counties with higher staffing levels, local leaders cited persistent challenges retaining a stable workforce. Shortages span licensed psychiatrists, psychologists, marriage and family therapists, clinical social workers, and professional clinical counselors. Child and adolescent psychiatrists are especially scarce. For example, Fresno and Humboldt reported just seven to eight psychiatrists per 100,000 youth, while Imperial had 10, all well below the state average of 17. Only Alameda had a rate of child and adolescent psychiatrists similar to the statewide average. These shortages contribute to long wait times and strain local systems, particularly in rural or under-resourced areas where recruitment and retention are more difficult.

- **Counties report significant gaps across the behavioral health care continuum, particularly in crisis care, residential treatment, and early intervention for young children.** Counties such as Yolo, Monterey, Humboldt, Shasta, and Ventura described a lack of inpatient, crisis, and residential behavioral health services and facilities, with some reporting only one or no short-term residential treatment facility. These gaps are particularly pronounced in rural counties such as Humboldt and Shasta, where families often travel out of the county to receive care, which is costly and disrupts local support systems. In counties such as Los Angeles, Alameda, and Imperial, respondents noted that more early intervention services are needed for children ages 0 to 5, a critical period for identifying behavioral and developmental concerns. Without sufficient local services, children and youth face both the risks of delayed support and the potential disruption of having to seek support out of county.

- **Counties face a shortage of culturally representative providers and culturally relevant services, limiting access to effective and equitable behavioral health care for ethnically and racially diverse families.** Across counties, systemic inequities and long-standing underinvestment have created significant disparities in behavioral health utilization and outcomes for underserved populations, such as Black and Latino youth, Asian Pacific Islander youth, and those who speak Spanish and Indigenous languages. In highly diverse counties such as Alameda, Imperial, and Monterey, as well as in counties with significant Indigenous populations such as Humboldt and

Ventura, respondents highlighted how language and cultural barriers continue to limit access to care, underscoring the need for more accessible and culturally responsive services.

The CYBHI workstreams were designed to address these ongoing challenges by strengthening the foundation for a more coordinated, preventive, and equitable behavioral health system. The following sections share how counties are implementing a selection of CYBHI workstreams (those in active planning or implementation across the nine selected counties during our data collection period), how the workstreams are meeting these broad needs, and what early lessons can inform efforts across the state to improve children and youth behavioral health.

How to read this report

CYBHI's **20** workstreams operate across four settings—digital, healthcare, homes and communities, and education—all of which are designed to support children and youth behavioral health. This report is organized by the two settings where CYBHI workstreams were actively being implemented at the county level at the time of our interviews: (1) education and (2) homes and communities. While some workstreams are reaching children, youth, and families through digital and healthcare settings, those are outside the scope of this report. For each included workstream, we include the following findings:

- **Workstream implementation progress:** An overview of workstream implementation in participating counties at the time of the interviews
- **Implementation highlights:** Examples of innovative and notable approaches counties have taken to implement workstream activities as well as successes in implementation

At the end of each setting section, we include a summary table outlining the **implementation considerations respondents raised** along with county strategies to address barriers and examples of state support.

Findings in Education Settings

Interconnected workstreams that meet youth and families where they are

Educational settings are a critical access point for behavioral health supports; they offer opportunities for daily contact with youth, can mitigate barriers to treatment such as transportation, and can yield higher follow-through on referrals compared with community settings. Yet many districts have historically focused resources on meeting acute needs, leaving gaps in early intervention, prevention, and social and emotional learning (SEL). To fill these upstream gaps, the CYBHI invested more than $600 million in five education workstreams that span promotion, prevention, and infrastructure—together forming a continuum from universal SEL to reimbursable clinical services.

Two SEL-centered workstreams were designed and sequenced to reinforce one another. The **CalHOPE Student Support and Schools Initiative** launched in July 2022, hosting an SEL Community of Practice (CoP) for all 58 County Offices of Education (COEs) and providing no-cost digital resources (film series, interactive toolkits) for educators, students, and families; while core activities concluded in June 2024, the CoP and digital resources remain active. The **Mindfulness, Resilience, and Well-Being Supports** workstream, initiated in June 2023, extended the impact of CalHOPE activities by continuing CoP facilitation, funding SEL courses for educators and student-facing mental health and wellness programming, and deploying real-time well-being surveys in schools. Complementary efforts—**Safe Spaces** trauma-informed training for educators and a **Youth Peer-to-Peer Support Program** in high schools—increase the capacity of school staff and students to support behavioral health promotion and prevention.

Additional workstreams were designed to sustain and scale these SEL and prevention efforts through grant and sustainable funding sources, with a significant focus on behavioral health infrastructure development. The **CYBHI Fee Schedule Program** creates a predictable reimbursement mechanism for screenings, psychoeducation, skills training, and

outpatient treatment in or near schools; 138 LEAs are enrolled in Cohorts 1 and 2 as of summer 2024, with additional cohorts to follow. The **Student Behavioral Health Incentive Program (SBHIP)** and **School-Linked Partnership and Capacity Grants** bolster LEA and COE capacity for billing, data systems, and wellness spaces; the latter launched in 2024 to address emerging infrastructure needs identified during Fee Schedule planning and early implementation. **Certified Wellness Coaches (CWC)**, a new behavioral health professional role established under the CYBHI, will help provide prevention and early intervention services. Many CWCs are expected to work in school-linked settings and will be reimbursable practitioners under the Fee Schedule. Together, these sequenced and overlapping investments support a comprehensive continuum of behavioral health promotion, prevention, and early intervention in California schools.

In the section that follows, we detail findings from counties implementing six of these workstreams, showcasing overarching takeaways, detailed workstream findings, and promising strategies to address different implementation contexts.

Top Takeaways

Key Opportunity	*CYBHI Impact*
Systemic inequities and underinvestment have created significant disparities in behavioral health utilization and outcomes for underserved populations. Our sample included highly diverse counties, such as Alameda, Imperial, and Monterey, as well as several counties with prominent Indigenous populations, such as Humboldt and Ventura. Across these counties, marginalized groups, including Latino or Hispanic youths, Indigenous youths, and Asian American or Pacific Islander youths, face language and cultural barriers, underscoring the need for more readily accessible and culturally relevant services.	**Counties leveraged CYBHI workstreams in education settings to help provide increased and enhanced services to meet the needs of specific local populations.** For example, counties have used CalHOPE funding to provide SEL and wellness programming tailored to immigrant communities and Native youth. They have also used employer support grant funding to hire a more representative workforce, including bilingual CWCs who can service Spanish-speaking communities.
Fragmented partnerships and siloed systems hamper coordinated school-based behavioral health. In large counties such as Alameda and Los Angeles, the behavioral health system can be particularly complex, complicating communication and hindering connections between agencies and organizations. Counties and managed care plans said that, before the CYBHI, trust and communication between COEs and LEAs and managed care plans was limited, with a lack of shared language across sectors.	**County work on education workstreams has strengthened relationships between education agencies and managed care plans, leading to improved cross-sector collaboration.** For example, SBHIP required partnerships between COEs and Medi-Cal managed care plans, which have led to more collaborative relationships and increased information-sharing in some counties.

Key Opportunity	*CYBHI Impact*
Insufficient financing mechanisms and technological barriers constrain the expansion of school-based behavioral health. Five of the counties in our sample had fewer school-based health programs offering mental health services than the state average. Counties reported facing behavioral health workforce shortages, and many COEs and LEAs indicated limited capacity for billing.	**Counties expanded their capacity for school-based behavioral health services through the CYBHI Fee Schedule and related workstreams.** For example, counties were leveraging School-Linked Partnership and Capacity Grants to help fund electronic health records systems and address other barriers to Fee Schedule implementation and viewed the Fee Schedule as a mechanism to support the creation of additional school-based behavioral health positions.
Historical challenges and limited support have tempered enthusiasm for billing for school-based services. Some respondents expressed hesitation based on prior experiences entailing significant administrative burden for cost settlement reconciliation under LEA Billing Option Program, and many counties lacked the expertise and knowledge needed to implement a new billing system.	**Counties used CYBHI resources to increase their readiness to participate in school-based behavioral health billing.** For example, counties participated in learning collaboratives to share experiences and problem-solve together and with managed care plans. COEs and LEAs invested in external partners to bridge knowledge gaps and support implementation. Participation in the Fee Schedule continues to grow, with later cohorts building on the lessons learned and best practices established by earlier cohorts.

Deep Dive Implementation Progress and Highlights

Certified Wellness Coaches

Implementation progress

Lead state department: Department of Health Care Access and Information (HCAI)

Who we interviewed: Leaders and staff from county offices of education (COEs), local education agencies (LEAs), Medi-Cal managed care plans, and behavioral health departments in five counties: Alameda, Humboldt, Los Angeles, Monterey, and Yolo.

Implementation progress: Certified Wellness Coaches (CWC) are a new behavioral health professional role established under CYBHI intended to help address workforce shortages and support the sustainability of the Fee Schedule by adding another reimbursable practitioner type. In July 2024, through the Certified Wellness Coach Employer Support Grant Program, HCAI awarded 64 grants to educational institutions and school-based and school-linked health and behavioral health agencies across 48 counties to support hiring of CWCs; organizations were in early planning and implementation stages at the time of interviews.

Addressing county challenges

The original workforce pathway for CWC certification required associate or bachelor's degrees in specific fields such as social work, human services, or child development. In a comprehensive review of CWC workforce objectives prompted by stakeholder concerns about overly restrictive education requirements, HCAI updated guidelines (effective as of 2025) expanding the workforce pathway criteria to include associate and bachelor's degrees in any field of study. HCAI also expanded the list of majors accepted for education pathway certification.

Implementation highlights

Counties were leveraging the CWC Employer Support grants to help build a more representative behavioral health workforce. Two counties described how the grants enabled them to hire bilingual and culturally representative staff, supporting more equitable and accessible care. In Monterey County, one LEA used the funding to hire several CWCs local to the area, in which nearly two-thirds of the population is Hispanic or Latino. Many new CWCs hired by the LEA are bilingual in English and Spanish, which will help increase accessibility of behavioral health services for the high proportion of Spanish speakers in the community. In Alameda County, which is among the top five most diverse counties in California, with significant proportions of Asian and Hispanic or Latino residents, respondents see the grants as an opportunity to increase the number of behavioral health professionals who share relevant lived experience and common cultural identities with the children and youth they are serving.

Counties were planning to extend the reach of behavioral health services in schools through CWCs. By delivering Tier 1 (universal promotion and prevention) and Tier 2 (secondary prevention or early intervention) services, CWCs enable other credentialed and licensed behavioral health providers to focus on students with more complex needs. In Monterey County, which faces a full shortage designation for behavioral health providers, CWCs will provide Tier 1 and Tier 2 services, including Positive Behavioral Interventions and Support (PBIS), classroom presentations and mindfulness workshops, bullying prevention, and check-ins with students. In Alameda County, where the supply of licensed non-psychiatrist behavioral health care providers falls below the state average, respondents expect that CWCs will help take on prevention work, freeing up other credentialed and licensed providers to provide more complex services.

CalHOPE Student Support and Schools Initiative and Mindfulness, Resilience, and Well-Being Supports for Children, Youth, and Parents

Implementation progress

Lead state department: Department of Health Care Services (DHCS)

Who we interviewed: Leaders and staff from county offices of education (COEs in six counties: Alameda, Fresno, Humboldt, Imperial, Los Angeles, and Ventura.

Implementation progress: From July 2022 to June 2024, the CalHOPE Student Support and Schools Initiative workstream provided training and support to educators to help them develop social-emotional learning (SEL) environments, which build students' skills and destigmatize behavioral health concerns. Activities and funding associated with the CalHOPE Student Support and Schools Initiative workstream concluded in June 2024, but certain activities continued under the Mindfulness, Resilience, and Well-Being Supports workstream.

Addressing county challenges

Some COEs faced challenges securing buy-in for the Kelvin tool and using its data to inform decision-making. In response, DHCS partnered with the Sacramento COE (SCOE) to provide implementation support for COEs using the Kelvin tool. This support includes virtual communities of practice, office hours, direct access to Kelvin representatives, and resources such as Kelvin Pulse survey templates.

The Mindfulness, Resilience, and Well-Being Supports workstream builds on the foundation established through the CalHOPE workstream by funding wellness centers, programming for educators and school staff, and student-facing programs that promote SEL, mindfulness, and well-being in school. The workstream also provides funding for the Kelvin survey, a data collection tool that enables schools to obtain real-time information about students' well-being; Kelvin data can serve to measure impact and help improve SEL, mindfulness, and wellness programming. Activities are projected to end in June 2025.

All of California's 58 COEs received funding under these two workstreams.

Implementation highlights

Flexible CalHOPE funding supported counties' implementation of more responsive and community-driven SEL programs and activities. Counties used this flexibility to align programming with local priorities and populations, demonstrating that adaptable funding structures is a key enabler of effective, equity-focused implementation. Examples of ways counties used funding to meet the needs of local communities include the following:

- **Alameda County:** Focal school sites used funding for after-school programming, with activities designed to reflect the county's cultural diversity and engage its large foreign-born population. In one school district, the COE contracted with Soccer Without Borders to offer an evidence-based soccer program for high school students who were from newcomer refugee or immigrant communities. Programming included dedicated time for developing social and emotional skills. Funding also supported the development of a SEL curriculum for after-school art programming.
- **Fresno County:** Funding enabled elementary schools to introduce calm spaces and literature focused on SEL into classrooms.

Implementation highlights

- **Humboldt County:** Funding supported the Redwood mental health symposium for youth, educators, and community members that offered different SEL and mindfulness activities and workshops, including trainings oriented to Native youth in the county, which has eight Indian reservations within its borders. About 165 participants attended the symposium.
- **Ventura County:** Funding supported social-emotional programming that incorporates Indigenous healing and wellness practices, such as therapeutic drum circles, to help meet the needs of the county's substantial population of Indigenous people of the Mixteco/Indigena community of farmworkers.

Counties leveraged ongoing funding flexibility under the Mindfulness, Resilience, and Well-Being workstream to sustain and expand efforts launched through CalHOPE. Counties used the funding to build on existing initiatives and implement new activities aligned with local needs and opportunities. For example, Alameda County and Humboldt County, in which the chronic absenteeism rate exceeds the state average, used the funding to help create calm spaces in classrooms. Alameda also provided mini-grants to support mindfulness and well-being efforts in several LEAs, including the county's Court and Community Schools.

Student Behavioral Health Incentive Program (SBHIP)

Implementation progress

Lead state department: Department of Health Care Services (DHCS)

Who we interviewed: Leaders and staff from COEs, LEAs, Medi-Cal managed care plans, and behavioral health departments in all nine counties.

Implementation progress: The SBHIP workstream focuses on developing the behavioral health infrastructure by helping Medi-Cal managed care plans (MCPs) and local education agencies (LEAs partner to address identified gaps in school-based behavioral health infrastructure through a set of targeted interventions. Using SBHIP funds, managed care plans and their partners began implementing 147 selected targeted interventions in January 2023. Plans on an accelerated timeline began implementation in July 2022. Across the nine counties, many counties leveraged funding to establish or expand behavioral health wellness programs, and several counties discussed hiring or training social workers to serve in schools, developing IT enhancements for behavioral services, or adding telehealth. With SBHIP funding concluding in December 2024, some counties were actively implementing interventions, while others were wrapping up their project activities and preparing to transition into CYBHI Fee Schedule implementation in January 2025.

Implementation highlights

Working on SBHIP activities strengthened relationships and collaboration between Medi-Cal managed care plans, COEs, and other organizations in many counties, providing an important foundation for CYBHI Fee Schedule implementation and other initiatives. For example, respondents in Humboldt County reported that working on SBHIP helped establish a new collaborative relationship between the Humboldt COE and the Medi-Cal managed care plan, increasing communication and information sharing across sectors.

Counties used workstream funding to select and implement interventions tailored to local priorities, including efforts focused on underserved populations. For example, in Monterey County, one LEA with a sizable Indigenous student population trained social workers, school counselors, and parent education specialists to facilitate Tier 2 support groups for students from grades 5 and 6, with a focus on Indigenous populations. Other examples of how counties used funding to meet the needs of local communities include the following:

- **Ventura County.** SBHIP funding supported trainings for COE staff on how to meet the needs of students in the county's Indigenous communities and incorporate culturally relevant Indigenous wellness practices into service delivery.
- **Los Angeles County.** The telehealth project expanded access to mental health services for students who lacked reliable broadband at home or faced barriers to obtaining in-person services. During the 2023–2024 school year, the program delivered about 30,000 clinical hours to roughly 3,000 students, with a majority from Latino and Black communities, which are two groups that make up a significant proportion of county's youth population.

School-Linked Partnership and Capacity Grants (SLPC)

Implementation progress

Lead state department: Department of Health Care Services (DHCS)

Who we interviewed: Leaders and staff from COEs, LEAs, Medi-Cal managed care plans, and behavioral health departments in seven counties: Alameda, Fresno, Humboldt, Los Angeles, Shasta, Ventura, and Yolo.

Implementation progress: Through the School-Linked Partnership and Capacity Grants workstream, $400 million in grant funding was available for distribution to LEAs to build the capacity, infrastructure, and partnerships needed to utilize the Fee Schedule. LEAs and their partners are responsible for drafting implementation plans that reflect and address locally defined infrastructure development needs. The School-Linked Partnership and Capacity Grants program began March 2024. At the time of the interviews, COEs were beginning county-level implementation planning and conducting outreach to LEAs in preparation for development and submission of LEA implementation plans in fall 2024.

Implementation highlights

Counties were using grants to strengthen electronic health record (EHR) infrastructure, a foundational step toward implementing the Fee Schedule. For example, a respondent in Fresno County said 10 percent of their funding was being used to purchase an EHR application that all county LEAs could use. In Alameda County, a respondent reported that they will use their funds to work with a vendor to develop a new EHR system that integrates with other student information and county data systems.

COEs and LEAs were pooling grant resources to build shared infrastructure to support Fee Schedule implementation, an approach particularly valuable for smaller or under-resourced districts. For example, in Yolo County, four LEAs will use grant funding to hire and share staff to support billing and service provision. The Los Angeles COE is leveraging grant resources to reduce barriers for LEAs to participating in the Fee Schedule, including funding an EHR system for smaller districts and charter schools as well as expanding technical assistance and mental health-related staff training.

Statewide Multi-Payer Fee Schedule for School-Linked Behavioral Health Services

Implementation progress

Lead state department: Department of Health Care Services (DHCS)

Who we interviewed: Leaders and staff from COEs, LEAs, Medi-Cal managed care plans, and behavioral health departments in eight counties: Alameda, Fresno, Humboldt, Imperial, Los Angeles, Monterey, Shasta, and Yolo. Of these counties, six (Alameda, Fresno, Humboldt, Imperial, Los Angeles, Shasta) had LEAs participating in Cohort 1 of the Fee Schedule.

Implementation progress: 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. Fee Schedule (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 practitioners may bill for behavioral health services. In addition, behavioral health services provided under the Fee Schedule may not require co-payments, co-insurance, deductibles, or any other form of cost sharing. Cohort 1 of the Fee Schedule, comprising 47 LEAs across 25 counties, launched in January 2024. At the time of data collection, LEAs and COEs participating in Cohort 1 were working to develop the technical infrastructure needed to implement the Fee Schedule (such as electronic health record systems, data-sharing agreements, and medical billing systems) and preparing staff and credential practitioners to participate in the Fee Schedule.

Addressing county challenges

Some COEs and LEAs desired more guidance on how to operationalize the CYBHI Fee Schedule, including clarity on processes related to billing and claims, obtaining data sharing agreements, and exchanging data. In response, DHCS released detailed process guidance for COEs and LEAs and resources to support claims submission and processing and expanded their technical assistance offerings, including tailored support through weekly office hours and regionally based technical assistance.

Implementation highlights

While counties were still in the early stages of Fee Schedule implementation at the time of interviews, respondents expressed optimism about its potential to expand access and fill longstanding service gaps. In several counties, respondents highlighted the new practitioner types included in the Fee Schedule, such as Certified Wellness Coaches, as a promising strategy to help address the needs of children and youth who may benefit from support but do not require clinical services. Respondents saw the Fee Schedule as a tool to build out the middle of the behavioral health continuum by funding additional school-based positions and reaching students with mild to moderate needs. For example, in Alameda, respondents expect the Fee Schedule to help schools provide more services to children with mild to moderate behavioral health needs, a gap in the current behavioral health system. Others emphasized its potential to reach students underserved by existing systems, such as Latinx students, LGBTQ+ students, and students with substance use challenges, particularly when they have limited access because of insurance constraints or provider shortages.

Cross-Cutting Local Strategies

Across counties, respondents shared the strategies they used to overcome implementation barriers in education settings.

Implementation Barrier	*What Worked*
Counties faced workforce shortages, high staff turnover, and limited administrative capacity, particularly in rural areas. Competing demands from other school-based initiatives and limited professional development time constrained educator participation in workstream activities.	• **COEs and LEAs used workstream funding to expand capacity.** Counties used CYBHI funding, including the CWC Employer Support and SBHIP grants, to hire new staff to support implementation and expand school-based capacity. • **Counties met educators and school staff where they were.** In one county, the COE used CalHOPE workstream funding to provide stipends to encourage attendance at Community of Practice sessions. The county also held trainings during more accessible times, such as after school hours and on the weekends, and in convenient locations for educators, including virtually and on-site in remote areas to encourage participation. • **State departments provided resources to expand capacity for implementation.** These resources included workstream-specific technical assistance support and opportunities for peer learning and collective problem solving through a range of formats, including community of practice sessions and weekly office hours.
Counties navigated how to strengthen awareness and build trust among LEAs and families regarding education-setting workstreams. Some COEs reported that LEAs needed additional information to understand opportunities such as the School-Linked Partnership and Capacity Grants and the CYBHI Fee Schedule. Respondents also noted that families expressed concerns about data sharing, which created hesitation around participation.	• **Counties held informational sessions to build awareness.** In several counties, COEs met with superintendents and school staff to raise awareness of workstreams and provide information about available supports for implementing them. • **Counties provided spaces to identify and discuss LEA needs.** In one county, the COE provided a forum for LEA staff to discuss implementation ideas such as using a consortium model for smaller LEAs that need administrative support for billing. • **State departments promoted awareness of workstreams by expanding engagement efforts and supporting communication to parents and caregivers**. Activities included presenting at conferences, participating in local meetings, and developing multilingual caregiver-facing materials to promote understanding of the Fee Schedule and address data-sharing concerns.

Findings in Homes and Communities

Workstreams that strengthen the workforce and services across the continuum of care

Homes and communities are foundational in shaping children's behavioral health: they are where youth form trusting relationships, develop coping skills, and experience the cultural and social supports that buffer against stress. Historically, stigma around behavioral health and uneven access to community-based services have limited families' and neighborhoods' ability to prevent and address emerging needs. To fill these upstream gaps, the CYBHI has invested in a comprehensive continuum of supports, including efforts to increase public awareness, scale evidence-based practices, develop and expand workforce capacity, and strengthen crisis response.

The **Never a Bother** youth suicide prevention campaign reduces stigma and increases help-seeking through targeted media, school and community partnerships, and direct engagement with youth. Complementing these efforts are broader campaigns such as Live Beyond, the Public Education and Change Campaign, and the Positive Parenting, Thriving Kids video series, which provide families with tools to recognize and respond to early behavioral health concerns. The **Scaling Evidence-Based and Community-Defined Evidence Practices (EBPs/CDEPs)** workstream has awarded more than $250 million in grants to fund parent–child programs, trauma-informed care trainings, youth drop-in centers, and safe-space initiatives. The **Youth Suicide Reporting and Crisis Response Pilot Program** allocated about $35 million to 10 counties to facilitate real-time suicide data reporting, coordinated crisis teams, and culturally responsive postvention protocols. The **CBO Behavioral Health Workforce Grant Program** awarded $116 million in four-year grants supporting recruitment, training, loan repayments, and stipends for peer support specialists, substance use disorder counselors, and other culturally concordant practitioners, supporting CBOs in hiring and retaining these providers where they're most needed. Together, these coordinated investments support a robust continuum of behavioral health supports in home and community settings. By increasing behavioral health awareness, supports, and services through these workstreams, CYBHI is strengthening communities' ability to deliver timely and culturally responsive care.

In the section that follows, we detail county findings from four of these workstreams, showcasing overarching takeaways, detailed workstream findings, and promising strategies to address different implementation contexts.

Top Takeaways

Key Opportunity	*CYBHI Impact*
California faces widespread shortages of behavioral health providers, with particularly acute gaps in rural areas where geographic barriers compound accessing challenges. County respondents reported ongoing challenges recruiting and retaining a sufficient behavioral health workforce to meet the needs of children, youth, and families. All nine counties had full or partial shortages of mental health professionals, and most fell below the state average for child and adolescent psychiatrists or non-psychiatrist clinicians. In rural counties such as Humboldt, Imperial, and Shasta, limited local services often required families to seek care out of county, further straining access and continuity of care.	**Counties leveraged CYBHI funding to expand service capacity for children, youth, and families, particularly in remote and rural areas.** For example, CBOs used the CBO Behavioral workforce grant to increase hiring and retention of clinical staff, allowing them to serve more children, youth, and families in their communities. Organizations also used Scaling EBPs and CDEPs grants to address geographic barriers to behavioral health services (for example, by delivering a parenting program on-site in a remote tribal community and employing a case manager to conduct outreach in rural areas).
Youth in California want a behavioral health system that reflects their identities and experiences, meets their needs, and gives them a voice in shaping their cares (Youth at the Center). The counties in our sample include some of the most diverse counties in the state, with large communities of Latino or Hispanic families, Indigenous families, and Asian American or Pacific Islander families. These communities may face a range of cultural or linguistic barriers that affect their ability to access behavioral health services.	**Local organizations used CYBHI resources to deploy providers and deliver services that resonate with youth and families in their communities.** For example, organizations leveraged CBO Behavioral Health Workforce grant funding to expand and retain a pool of providers with lived experience aligned to the communities they serve. Local organizations also use Scaling EBPs and CDEPs grant funding to implement culturally responsive care co-designed with youth and family voices.

Key Opportunity	*CYBHI Impact*
 **California continues to face rising rates of youth suicide and self-injury hospitalization, with disproportionately high impacts on Indigenous youth and LGBTQ+ youth.** In several of the counties examined, rates of suicidal ideation among high school students exceed the statewide average. Yet county respondents reported persistent challenges accessing timely, actionable data to monitor trends and guide response efforts. At the same time, many existing suicide prevention campaigns may not engage or resonate with diverse groups of youth.	**Counties used CYBHI funding to lay the foundation for more responsive and inclusive youth suicide prevention and response strategies.** For example, Never a Bother grantees launched prevention awareness efforts intentionally tailored to reach specific groups of local youth most impacted by suicide, such as Indigenous and LGBTQ+ youth. In parallel, county agencies beginning Youth Suicide Crisis Reporting and Response pilots brought together cross-sector partners to identify gaps in existing activities and begin developing more robust surveillance systems and infrastructure to inform future efforts.

Deep Dive Implementation Progress and Highlights

Community-Based Organization Behavioral Health Workforce

Implementation progress

Lead state department: Department of Health Care Access and Information (HCAI)

Who we interviewed: Leaders and staff from CBOs in six counties: Alameda, Fresno, Monterey, Shasta, Ventura, and Yolo.

Implementation progress: The CBO Behavioral Health Workforce Program, part of the Broad Behavioral Health Workforce Capacity workstream, provides four-year grant funding to eligible CBOs to support the recruitment and retention of behavioral health personnel. In exchange for a 12-month service commitment, the funding can be used for loan repayments, scholarships, and stipends for paid and volunteer CBO behavioral health staff. In March 2023, the program awarded approximately $116 million to 134 CBOs across 48 counties. Interviewed grantees were in various stages of planning and implementation, with some reporting that they used grant funding to support hiring and retention of behavioral health providers while others were still planning and preparing to start implementation.

Implementation highlights

Organizations leveraged CBO Behavioral Health Workforce awards to hire and retain employees with lived experience that reflects the communities they serve. For example, an Alameda County respondent identified the funding as critical for creating a structured career pathway for local youth with lived experience. The funding supported a program coordinator to manage outreach, recruitment, screening, onboarding, and evaluation for their training program, resulting in a fivefold, year-over-year increase in applicants for eight trainee positions, with nearly all recent applicants coming from bilingual and/or bicultural backgrounds. In Fresno County, which faces significant behavioral health workforce shortages and has far fewer child and adolescent psychiatrists per 100,000 children relative to the statewide average, an organization that works with local universities to recruit practicum students who can become clinicians used grant funding to retain practicum students as providers for longer periods of time, allowing them to build trust, develop rapport, and maintain continuity of care for their clients.

Grantees in some counties used awards to expand services and reach more children and youth. In Ventura County, one organization used the funding to provide educational stipends to existing clinical staff, increasing worker satisfaction and reducing turnover from 42 percent in 2020 to 21 percent in 2023. Improved retention enabled the organization to maintain continuity of care and serve more youth with severe behavioral health needs. In Alameda County, the grant supported the hiring of four new staff members who will benefit from the loan forgiveness program. In this highly diverse county, the additional workforce capacity enables the organization to expand its footprint and serve the substantial Asian American and Pacific Islander communities in additional schools.

Never a Bother

Implementation progress

Lead state department: California Department of Public Health (CDPH)

Who we interviewed: Leaders and staff from CBOs in five counties: Alameda, Fresno, Humboldt, Los Angeles, and Ventura.

Implementation progress: 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. The campaign focuses on youth populations disproportionately affected by suicide—youth who identify as American Indian/Alaska Native, Hispanic and Latino, and African American or Black—and aims to reach youth at increased risk because of having identified behavioral health needs or conditions; youth impacted by the foster care system; and two-spirit (2S)/LGBTQ+ youth. California Department of Public Health's Office of Suicide Prevention launched Never a Bother in March 2024 following an eight-month planning phase that incorporated input from more than 400 youth. To complement the campaign, 33 CBOs and tribal partners across 33 counties received grants to help promote and implement the community-level suicide prevention strategies. At the time of data collection, interviewed grantees across counties were actively using funding to implement youth suicide awareness and prevention activities.

Implementation highlights

Grantees across five counties leveraged the CYBHI funding to host events, programs, and services about youth suicide awareness and prevention tailored to the needs of populations experiencing disproportionate rates of youth suicide:

- **Alameda County.** A grantee used the funding to develop campaign materials, such as coping mechanism cards and social media content, and to convene a youth council and advisory board. The funding also supported youth participation at a Native youth conference focused on leadership and career development as well as volunteer events. Driven by the youth council, local events focus on unhoused and LGBTQ+ youth who face disproportionately higher rates of suicide.
- **Fresno County.** A grantee leveraged funding to expand low-barrier opportunities for Black youth and their families to engage with behavioral health offerings, helping address cultural stigma around seeking help for mental health challenges. Activities include a monthly party for youth and families to visit the organization's physical space and Community Health Days offering free therapy sessions by licensed mental health practitioners.
- **Humboldt County.** A grantee employed funding to distribute suicide prevention materials at youth-facing events and host cultural and wellness events that incorporated traditional tribal practices to reach the county's significant Native population. The grantee also plans to train tribal youth using the Gathering of Native Americans curriculum.
- **Los Angeles County.** A grantee applied funding to support social media outreach that elevated youth voice. The grantee also used the grant to build youth capacity for suicide prevention and mental health awareness, particularly among youth of color, by providing training to help young people understand prevention, public health, and risk factors for behavioral health concerns.

Implementation highlights

- **Ventura County.** A grantee used funding to educate and train Native youth in suicide prevention through culturally relevant youth-focused programming, such as youth talking circles, beading circles, and sweat lodge ceremonies. They also offered culturally adapted Question, Persuade, Refer training to develop youth's capacity to support peers experiencing suicidal ideation. Youth who completed the training reported feeling more confident and competent in initiating conversations about suicide.

Scaling Evidence-Based and Community-Defined Evidence Practices

Implementation progress

Lead state department: Department of Health Care Services (DHCS)

Who we interviewed: Leaders and staff from COEs, LEAs, CBOs, early childhood organizations, and behavioral health departments in all nine counties.

Implementation progress: From July 2023 to September 2024, the Scaling EBP and CDEP grant program awarded 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. 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. Interviewed grantees were in various stages of planning and implementation depending on the grant round and track. Most grantees were still in the early planning stages of developing training curriculum and building staff capacity, while some grantees had already begun to use funds to train clinicians and staff in EBPs and CDEPs and to start or scale service delivery.

Addressing county challenges

Delays in award notifications, contract completion, and the receipt of grant funding hindered initial implementation of EBPs and CDEPs in counties. Recognizing this challenge, DHCS offered grantees a no-cost extension and restructured the payment schedule for the most recent grant round to reduce the number of deliverables attached to payment and increase the amount of payment tied to each deliverable so that grantees would receive more upfront funds.

Implementation highlights

In many counties with diverse populations or communities facing cultural or linguistic barriers to care, grantees were using Scaling grant funding to provide culturally appropriate and responsive care that incorporates youth and family voices.

- **Humboldt County.** One grantee worked with Spanish-speaking families to adapt its Triple P program model to be more accessible and welcoming to Spanish speakers.
- **Alameda County.** Another grantee was conducting client satisfaction surveys and soliciting continuous feedback from parents during sessions of the Effective Black Parenting Program, with plans to make adaptations to the curriculum as needed based on parent input.
- **Los Angeles County.** One grantee planned to use funding to focus on Black women college students between the ages of 18 and 25 in predominantly White institutions and integrate Dialectical Behavior Therapy (DBT) into an existing community-defined, evidence-based program. The grantee's plans included adapting DBT tools to be more culturally relevant with the goal of providing young adult Black women with DBT tools and strategies to navigate and reduce mental health stigma and isolation.

Grantees were addressing geographic barriers that limit timely and accessible care in counties with substantial rural areas.

- **Humboldt County.** One grantee was delivering the Triple P model in a remote tribal community with positive early feedback from participants.
- **Yolo County.** A grantee used funding to hire a case manager to conduct outreach to populations underserved by behavioral health services in rural areas and recruit parents to participate in its Attachment and Biobehavioral Catch-Up program.

Grantees were leveraging funding to bring more evidence-based practices to school settings, mitigating access barriers by meeting children and youth where they are.

- **Shasta County.** A grantee organization was using funding to implement a Cognitive Behavioral Interventions for Trauma in Schools program in two schools, offering individual counseling, group counseling, neurofeedback, and mentoring for students in grades six to eight. Readily accessible school-based services are a key mechanism for addressing the needs of the county's children and youth, who experience higher rates of behavioral health challenges relative to the state as a whole.
- **Los Angeles County.** Multiple grantees were using funding to deliver services in school-based settings, which will help address resource gaps and challenges accessing care in some regions of the county. For example, one grantee leveraged funds to expand an existing school support group and train nonclinical school staff to provide services for high school students using an evidence-based cognitive behavior therapy model called the Blues Program.

Youth Suicide Reporting and Crisis Response Pilot Programs

Implementation progress

Lead state department: California Department of Public Health (CDPH)

Who we interviewed: Leaders and staff from public health and behavioral health departments in three counties: Alameda, Humboldt, and Los Angeles.

Implementation progress: Through the Youth Suicide Reporting and Crisis Response workstream, the department established 10 pilot sites in September 2023 to develop and improve local-level planning for rapid suicide reporting. The pilots are intended to develop or enhance equitable, timely, and culturally responsive suicide prevention and postvention strategies at the local level. CDPH allocated approximately $35 million to the pilot counties, seven of which have youth suicide rates exceeding the state average. At the time of interviews, workstream pilot sites had completed their baseline system maps, through which they identified strengths, gaps, and needs in their local suicide reporting and crisis response systems.

Addressing county challenges

Data availability and data sharing, particularly real-time morbidity and mortality data, are ongoing barriers to suicide reporting and crisis response, which the pilot projects aim to address. The workstream technical assistance provider, the Center for Applied Research Solutions (CARS), is working with counties to address data challenges, providing memoranda of understanding (MOU) guidelines for data sharing between county agencies and county-specific technical assistance. CDPH and CARS have facilitated discussions between counties on strategies to overcome challenges related to sharing protected health information.

Implementation highlights

County public health departments and partners were leveraging Youth Suicide Reporting and Crisis Response Pilot Programs funding to evaluate existing youth suicide prevention and crisis response efforts, identify gaps, and strengthen collaboration across sectors:

- **Los Angeles County.** Grant funding served to identify Service Planning Areas with higher rates of suicide to better target services. Funding also supported a new epidemiologist position to expand the syndromic surveillance system, facilitating monthly reviews of suicide attempt trends using hospitalization and emergency department data.
- **Alameda County.** The Department of Public Health convened regular work group meetings on crisis response activities and rapid reporting. Attendees included behavioral health department staff, representatives from school-based initiatives, and service providers. At these meetings, participants mapped service gaps to understand where individuals fall through the system.
- **Humboldt County.** County departments worked with community partners to begin mapping gaps in the suicide reporting and crisis response system. Early findings highlighted staff training needs (for example, engaging youth with autism spectrum disorder in the emergency department) and inconsistent suicide reporting processes across schools.

Cross-Cutting Local Strategies

Across counties, respondents shared the strategies they used to overcome implementation barriers in the home and community settings.

Implementation Barrier	*What Worked*
Counties navigated how to effectively engage youth in workstream activities. Some grant recipients shared that state-level funding restrictions can sometimes limit their ability to offer incentives such as food. External events, such as wildfires, altered youth engagement.	• **Counties leveraged non-CYBHI funding sources.** In some counties, grantees used funding from other sources to provide food and other incentives at youth events. • **Counties uplifted youth leaders and convened youth councils.** In two counties, grantees described how youth leaders and youth councils supported recruitment and buy-in for activities. • **Counties met youth where they are.** One grantee held events during the summer to align with youth availability, and another grantee cross-promoted behavioral health programs at in-person events to reach youth with limited access to technology. • **State departments offered peer learning opportunities to support youth engagement strategizing.** For example, in peer-to-peer discussions, grantees shared how they are braiding and blending funding to provide food and other incentives at events to encourage youth participation.

Conclusion

Counties in this analysis confront deep systemic barriers to meeting the behavioral health needs of children, youth, and families. Widespread and persistent workforce shortages, especially among child and adolescent specialists and bilingual providers, limit capacity and contribute to lengthy waitlists and delays in accessing timely care. Infrastructure gaps across crisis and residential services as well as geographic and transportation barriers further hinder access, particularly in rural and remote areas. Sociocultural and linguistic barriers continue to impact marginalized populations, especially in diverse counties. These challenges are exacerbated in counties where residents face difficult economic conditions and recruiting and retaining staff is especially challenging.

Through targeted CYBHI investments and a strong commitment to youth and families, counties have begun to work to close these gaps. They have leveraged workforce grants to fund Certified Wellness Coach positions and bolster CBO hiring incentives to attract and retain providers. Supported by a range of CYBHI funding sources, including Scaling EBPs and CDEPs and CWC Employer Support Grants, county organizations have hired and trained bilingual and culturally representative providers to deliver evidence-based services and prevention campaigns that reflect youth and family voice and cultures. COEs and LEAs are also expanding access to behavioral health services in education settings, where youth spend much of their time, through school-based workstreams such as SBHIP and the CYBHI Fee Schedule. Using flexible resources through CalHOPE workstreams, they have delivered culturally grounded wellness and SEL supports for Indigenous populations and other marginalized communities. Across workstreams, counties are taking creative approaches to implementation challenges, investing in external partners to bridge knowledge gaps, taking advantage of learning collaboratives to strategize with other counties, and adapting staffing models.

Looking ahead, counties are strategizing to sustain and scale these gains. Early CYBHI Fee Schedule claims mark a shift toward more stable long-term funding. At the same time, counties are exploring how to braid and blend other funding sources, such as Behavioral Health Services Act funding or the California Community Schools Partnership Program, to sustain new positions and services initiated using short-term funding, such as the CWC Employer Support Grants and

Scaling EBPs and CDEPs. Counties are also working to build an evidence base to attract future investments. For example, one Never a Bother grantee documented the program's impact on the community as evidence when applying for other funding opportunities. Additional CYBHI workstreams not covered in this report are also coming to fruition. Counties and CBOs are completing construction projects funded by the Behavioral Health Continuum Infrastructure Program, including residential facilities and wellness centers, that are now delivering services and addressing key gaps along the continuum of care. Youth peer-to-peer support pilots are underway across several counties, building evidence for effective models of behavioral health support. California youth and families are increasingly utilizing Digital service platforms, including Soluna, BrightLife Kids, and Mirror, throughout the state.[3,4] Complementing these efforts are county investments in workforce development, such as the CBO Behavioral Health Workforce grants, and prevention and awareness campaigns such as Never a Bother. Longer-term strategies to address persistent workforce shortages are also in motion. Grant programs like the Social Work Education Capacity Expansion and the Psychiatric Education Capacity Expansion grant programs aim to grow the provider pipeline and address workforce shortages across the state.

Examples highlighted in this report illustrate how counties are beginning to use targeted investment in CYBHI resources to address longstanding needs and implement solutions tailored to local contexts. As counties continue to align these tools to meet the needs of their populations, they will be well positioned to improve behavioral health access, equity, and outcomes for California's children, youth, and families.

Approach

Between summer and late fall 2024, we interviewed 132 respondents in nine counties to understand CYBHI workstream implementation. We selected counties based on their participation in CYBHI workstreams and representativeness of California's geographic, demographic, and economic diversity. Respondents included leaders from county behavioral health departments, COEs, school districts, Medi-Cal managed care plans, CBOs, public health departments, and other behavioral health, early childhood, juvenile probation, and child welfare leaders. We included a subset of workstreams that were actively implemented or planned across the nine counties during our data collection period. We then selected respondents from organizations involved in implementation.

The number of interviews differs across counties and workstreams because of variation in implementation status, presence and extent of workstream implementation efforts in each county, and number of key partners or sectors involved in workstream implementation. For example, the team conducted more interviews for workstreams that were advanced in their implementation, those with broader geographic or organizational footprint, or those that required cross-sector partnership. We conducted interviews to gather insight into the implementation of each focal workstream across a range of implementation contexts, but we did not discuss each workstream in every county in which activities were present. For example, although all counties received funding through CalHOPE Student Support and Schools Initiative; Mindfulness, Resilience, and Well-Being Supports for Children, Youth, and Parents; and School-Linked Partnership & Capacity Grants, we did not prioritize these workstreams for interviews in all counties because of the large number of school-based workstreams and limited availability of education sector respondents.

[3] Department of Health Care Services. "Children and Youth Behavioral Health Initiative (CYBHI) BrightLife Kids and Soluna Impact Updates." 2025. https://www.dhcs.ca.gov/CYBHI/Documents/CYBHI-BrightLife-Kids-and-Soluna-Impact-Updates.pdf. Accessed July 7, 2025.

[4] California State Senate. "California, Senate, Budget and Fiscal Review Subcommittee No. 3 on Health and Human Services." May 1, 2025. https://www.senate.ca.gov/media/senate-budget-and-fiscal-review-subcommittee-no-3-health-and-human-services-20250501.

Interview respondents shared their perspectives on implementation progress, facilitators and barriers, and further support needed for implementation. We analyzed these data to produce cross-county findings.

Table 1. Interviewee Participation by Workstream

Workstream	Number of Counties	Number of Interviews
Scaling Evidence-Based and Community-Defined Evidence Practices	9	40
Student Behavioral Health Incentive Program (SBHIP)	9	26
CYBHI Fee Schedule	8	28
School-Linked Partnership and Capacity Grants	7	15
Community-Based Organization Behavioral Health Workforce	6	10
CalHOPE Student Support and Schools Initiative	6	9
Certified Wellness Coaches	5	11
Never a Bother	5	6
Mindfulness, Resilience, and Well-Being Supports for Children, Youth, and Parents	3	4
Youth Suicide Reporting and Crisis Response Pilot Programs	3	3

Let's Progress Together.

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