Ventura County: Community Continues Strengthening Connections Through CYBHI Initiatives

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

Background and methods for the CYBHI Evaluation and case study

Mathematica is evaluating the CYBHI on behalf of the California Health and Human Services Agency in partnership with Health Management Associates, James Bell Associates, and the Prevention Center of Excellence at the University of California, Los Angeles. The evaluation began in November 2022 and will continue through June 2026. As part of the evaluation, the research team completed case studies of the CYBHI implementation in nine counties, including Ventura 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 Ventura County and California as a whole (see Appendix A for more detail). In addition, between April and July 2024, the research team conducted the Network and Ecosystem Experiences Survey (NEES) and key informant interviews with local leaders in Ventura County. The NEES explored the connections between organizations in Ventura County to better understand how they work together to support children and youth behavioral health. Using results from the NEES, we conducted a social network analysis and developed a network map showing the average strength of the connections between organizations in Ventura County's behavioral health ecosystem (see Appendix B for more detail on the network analysis methodology and measures).

Between summer and late fall 2024, researchers also conducted 11 interviews with individuals in Ventura County to understand the CYBHI workstream implementation and multisector collaboration. Respondents across the survey and interviews varied and included purposively selected leaders from the county behavioral health department; county offices of education; school districts; Medi-Cal managed care plan (MCP); community-based organizations (CBOs); public health department; and other local behavioral health, early childhood, juvenile probation, and child welfare leaders. Six individuals participated in both the survey and an interview.

I. Summary of Findings

Behavioral health ecosystem multisector collaboration

In Ventura County, agencies and organizations in the children and youth behavioral health ecosystem have well-established relationships with each other, often coordinating and collaborating to support children and youth behavioral health initiatives, including the CYBHI. The county's AB 2083 Interagency Leadership Team (ILT) established a foundation for multisector collaboration and serves as a governing structure for an array of offshoot collaboratives and work groups that aim to improve the well-being of children, youth, and families. However, the county is still working to overcome some barriers to multisector collaboration, such as the need for a more comprehensive and efficient communication system to support work across child- and family-serving agencies and community-based organizations. Some participants also identified workforce shortages that limit the capacity of agencies and organizations to work on multiple initiatives.

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

Implementing the CYBHI in Ventura County is progressing across several workstreams. Although many workstreams are still in the initial stages, implementation is benefitting from the county's strong system of multisector collaboration. The county is seeing expansion of behavioral health services and increased awareness of mental health needs.

Workstreams designed to facilitate the delivery of behavioral health services in and near schools, including the Student Behavioral Health Incentive Program (SBHIP), the CYBHI Statewide Multi-Payer School-Linked Fee Schedule, and School-Linked Partnership and Capacity Grants, have been effective in building on the momentum of work connected with implementing the Mental Health Services Act (MHSA) and Mental Health Student Services Act (MHSSA) and initiating a productive relationship across the education and managed care plan sectors. Additional education sector workstreams, including CalHOPE Student Supports and Schools Initiative and the Mindfulness, Resilience, and Well-Being Supports for Children, Youth and Parents grants, are being used in the county to provide social and emotional learning resources and curricula, including culturally responsive programming. The thoughtful implementation of these education sector workstreams is a source of pride and optimism for some county leaders, particularly when they discuss the efforts to help expand school-based behavioral health services for youth and families in ways that are culturally responsive. Preparations for billing the CYBHI Fee Schedule are still in progress, and the county is establishing a set of shared goals and processes and making final determinations on a path forward. Some preliminary challenges include constraints in staff bandwidth in county offices and local education agencies (LEAs) to implement multiple initiatives at once. Some respondents also noted shortages in the behavioral health workforce available to provide the entire range of specialized services, particularly staff who are able to provide support in the range of languages needed and with respect to cultural practices represented in Ventura's school communities.

Implementation of home- and community-based workstreams, including Scaling Evidence-Based and Community-Defined Evidence Practices and Never a Bother Youth Suicide Prevention Media and Outreach Campaign, has begun. These grant-funded efforts include incorporating youth input to inform evidence-based and trauma-informed services and to shape culturally relevant suicide prevention strategies.

Key progress with the CYBHI implementation

- **Student Behavioral Health Incentive Program (SBHIP):** CYBHI funds made available through SBHIP have allowed Ventura to build on the existing momentum of ILT's work and expand on supported initiatives already underway at the Ventura County Office of Education (VCOE) and LEAs, such as establishing and staffing wellness centers. VCOE has prioritized the development of additional wellness centers to increase infrastructure for and access to behavioral health supports and services in school settings.

- **The CYBHI Fee Schedule:** VCOE has been working in partnership with Gold Coast Medi-Cal managed care plan to understand implementation options and how to best develop the infrastructure needed to implement the CYBHI Fee Schedule. As of late fall 2024, two Ventura County LEAs are participating in Cohort 2 of the CYBHI Fee Schedule, and 14 LEAs are participating in Cohort 3.
- **CalHOPE Student Supports and Mindfulness, Resilience, and Well-Being Supports:** CalHOPE has supported Social Emotional Learning (SEL) Communities of Practice, along with a range of training that focus on SEL, Positive Behavior Intervention and Supports (PBIS), Multi-Tier System of Supports (MTSS) and restorative practices. Respondents also highlighted that the county has taken advantage of the funding's flexibility to offer supports that meet the specific needs of individual school communities. These supports range from Second Step to programs such as the Curando la Comunidad, which uses Indigenous healing practices that reflect the cultural practices of some school communities.
- **Scaling Evidence-Based and Community-Defined Evidence Practices (EBPs and CDEPs):** Child- and youth-serving organizations across Ventura County have applied for grant funding and are implementing efforts to scale access to EBPs and CDEPs, including projects focused on expanding trauma-informed practices such as trauma-focused cognitive behavioral therapy (TF-CBT) for youth in recovery from substance use disorders. One respondent from a CBO noted that with this funding, youth would now be able to access a high-quality EBP in the same space where they access an array of other services important to their substance use disorder recovery.
- **Never a Bother (Youth Suicide Prevention and Media Outreach Campaign):** To supplement the statewide campaign, the Never a Bother Campaign uses targeted, community-based strategies to reach youth at increased risk of suicide. In Ventura County, the CBO grantee interviewed for this case study is focused on suicide prevention activities for Native American and Alaskan Native youth. Funding is being used to provide culturally adapted information and youth-focused trainings. The CBO also distributes materials across a range of health care and dental sites and during in-person events. They also host traditional Tribal events, incorporating suicide prevention messaging within cultural wellness practices.

II. County Background

County characteristics

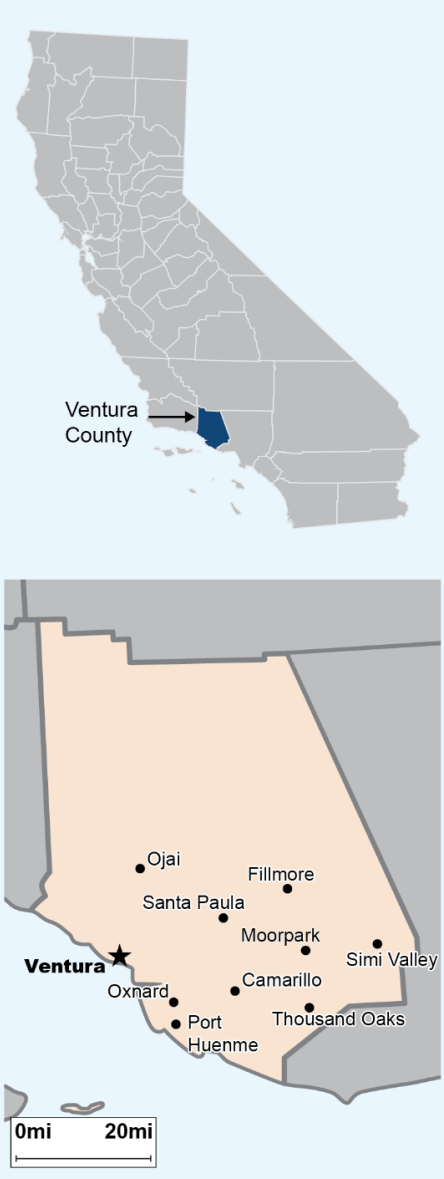
Ventura is in the Central Coast region of the state (Exhibit 1). Covering 1,841 square miles, it is also considered the southernmost county along the California Central Coast.[1] The county is more population dense than the state, with an average of 458 residents per square mile versus 254 statewide (Exhibit 2). Sections of the county have rural designations and include farming communities.

Ventura County also has a relatively large population, with 833,000 residents. The population of children and youth is proportionally similar to the state as a whole, though it has declined by 8.9 percent over the past five years, substantially more than the 5.4 percent decrease statewide. Ventura County's residents are predominantly White and non-Hispanic (41.7 percent) and Hispanic or Latino (44.5 percent). Compared with the state as a whole, there are smaller populations of Black or African American, non-Hispanic (1.7 percent versus 5.2 percent statewide) and Asian, non-Hispanic (7.1 percent versus 15.3 percent statewide).

Ventura County's economic conditions are similar to those throughout the state. Relative to the state as a whole, a smaller proportion of the population is below 200 percent of the federal poverty line (22.6 percent in the county versus 27.6 percent statewide); however, the county has a similar median income ($52,373 versus $52,520), a slightly lower unemployment rate (4.0 percent versus 5.3 percent), and lower food insecurity overall and for the population ages 0–18 years (10 percent versus 13.5 percent). In addition, Ventura is ranked 15th (out of 57[2]) in the Healthy Places Index within California, signifying that it has above-average access to health care, housing, education, and other characteristics that support a healthy population.

These statistics may not fully represent the experiences of approximately 20,000 Indigenous people of the Mixteco/Indigena community of farmworkers in Ventura County or the unique barriers they face accessing services. Many speak a native pre-Hispanic Indigenous language, such as Mixteco, Zapoteco, Triqui, or Purépecha. Additionally, the population often faces other barriers because their cultural practices and central beliefs are unique and different from other Latino populations. Finally, this community

Exhibit 1. Ventura County's geography



"Although they [the Mixteco/Indigena community of farmworkers] have been a vital part of the agricultural and economic success of Ventura County, most live in extreme poverty and lack basic provisions such as adequate housing, food, clothing, and other necessities of life."

—California Complete Count – Census 2020 Mixteco/Indigena Community Organizing Project FARMWORKERS

[1] U.S. Census. Ventura County, California. n.d. https://www.census.gov/quickfacts/fact/table/venturacountycalifornia/BZA115221. Accessed on November 11, 2024.

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

often faces challenges such as underpayment and labor abuse, leading to these families being among the poorest in the county.[3]

Exhibit 2. Ventura County's population characteristics

Metric	Ventura	California	Year(s)
Population			
Total population (N)	832,605	39,029,342	2022
Population, 0–4 years (N; %)	43,018; 5.2%	2,118,386; 5.4%	
Population, 5–19 years (N; %)	157,824; 19.0%	7,404,396; 19.0%	
Population, 20–24 years (N; %)	54,126; 6.5%	2,639,787; 6.8%	
Five-year population change (%)	-2.5%	-1.3%	2017–2022
Five-year population change, 0–24 years (%)	-8.9%	-5.4%	
Density (population per square mile)	458	254	2020
Race and ethnicity			
White, non-Hispanic (%)	41.7%	33.7%	2022
Black or African American, non-Hispanic (%)	1.7%	5.2%	
American Indian and Alaska Native, non-Hispanic (%)	0.1%	0.3%	
Asian, non-Hispanic (%)	7.1%	15.3%	
Native Hawaiian and other Pacific Island American, non-Hispanic (%)	0.1%	0.4%	
Some other race, non-Hispanic (%)	0.8%	0.6%	
Two or more races, non-Hispanic (%)	4.0%	4.3%	
Hispanic or Latino (%)	44.5%	40.3%	
Birthplace and language			
Foreign-born, 0–24 years (%)	6.1%	7.2%	2022
English-proficient, 5–17 years (%)	92.5%	91.6%	
Education (18+ years)			
High school or higher (including college) (%)	79.2%	78.8%	2022
College degree or higher (%)	35.3%	34.1%	
Economic indicators, socioeconomic, neighborhood characteristics			
Population within urban blocks (%)	96.6%	94.2%	2022
Population within rural blocks (%)	3.4%	5.8%	
Population below 200% of the federal poverty line (%)	22.6%	27.6%	
Median income (USD)	52,373	52,520	
Unemployment (%)	4.0%	5.3%	
Households with high housing cost burden (%)	40.1%	40.3%	2019
Food insecurity, overall (%)	8.0%	10.5%	2021
Food insecurity, 0–18 years (%)	10.0%	13.5%	
Healthy Places Index (rank)	15	N/A	2015–2019
Diversity Index (rank)	30	N/A	
Health status			
Population with a disability (%)	12.0%	11.7%	2022

[3] Maxwell, Annette E., Sandra Young, Catherine M. Crespi, Roena Rabelo Vega, Reggie T. Cayetano, and Roshan Bastani. "Social Determinants of Health in the Mixtec and Zapotec Community in Ventura County, California." *International Journal for Equity in Health*, vol. 14, no. 16, February 2015. https://pmc.ncbi.nlm.nih.gov/articles/PMC4320817/.

Metric	Ventura	California	Year(s)
Population with a disability, 0–17 years (%)	4.5%	4.0%	2022
Health insurance status (population 0–25 years)			
Medi-Cal or other means-tested public coverage (%)	35.6%	39.3%	2022
Private coverage (%)	63.8%	60.2%	
Uninsured (%)	5.1%	4.9%	
TRICARE/military coverage (%)	2.8%	1.7%	
Medicare coverage (%)	0.8%	1.0%	

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

The overall well-being of children and youth in the Central Coast region where Ventura County is located is similar to that of California as a whole (Exhibit 3). Youth in the Central Coast region have comparable rates of feeling supported by their family, nonparent adults, and friends.

Ventura County children and youth have similar rates of behavioral health challenges compared with children and youth statewide (Exhibit 3). For example, 20 percent of children and youth insured through Medi-Cal have a mental health diagnosis or emotional symptoms (compared with 18 percent statewide). The rate of students who seriously considered attempting suicide in the past 12 months in grade 9 was somewhat higher (18 percent versus 15 percent statewide), whereas a similar proportion did so in grade 11 (15 percent versus 16 percent statewide). Both inpatient hospitalizations and emergency department visits for behavioral health diagnoses for children and youth in Ventura are comparable to the statewide frequency. In addition, Ventura students in grades K–12 have somewhat lower rates of chronic absenteeism (22 percent versus 25 percent statewide).

Exhibit 3. Prevalence of behavioral health outcomes

Metric	Ventura	California	Year(s)
Region-level overall mental well-being for children and youth[a]			
Youth ages 12 to 17 years old who felt their family stood by them during difficult times (%)	77%	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 (%)	72%	72%	
Behavioral health challenges			
Children and youth insured through Medi-Cal with a mental health diagnosis or emotional symptoms (%)	20%	18%	2022
Children and youth insured through Medi-Cal with a substance use disorder diagnosis (%)	2%	3%	
Rates of suicidal ideation			
Students in grade 9 who reported seriously considering attempting suicide in the past 12 months (%)	18%	15%	2019–21
Students in grade 11 who reported seriously considering attempting suicide in the past 12 months (%)	15%	16%	
Emergency department visits and hospitalizations for children and youth with behavioral health-related conditions			
Inpatient hospitalization stays per 1,000 children and youth for any behavioral health diagnosis	11	12	2022

Metric	Ventura	California	Year(s)
Emergency department visits per 1,000 children and youth for any behavioral health diagnosis	29	32	2022
School engagement, as measured through absenteeism and suspension			
Students in grades K–12 who were chronically absent (%)	22%	25%	2022–23
Students in grade 9 reporting school absences due to mental health issues (%)	9%	9%	2019–21
Students in grade 9 reporting school absences due to alcohol or drug use (%)	0%	1%	

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

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

Resource availability and infrastructure

Similar to many counties across California, Ventura County faces a full shortage designation for both primary care and mental health care professionals (Exhibit 4). Additionally, the number of child and adolescent psychiatrists per 100,000 children and youth is approximately half of the statewide average (9 versus 17), although the county has a similar number of non-psychiatrist behavioral health providers licensed with county Medi-Cal Specialty Mental Health Services plans per 100,000 (37 versus 37 statewide). Ventura is also comparable to the rest of the state in the ratio of outpatient treatment programs for young adults (5 per 100,000 children and youth versus 4 statewide). However, the county stands out in the school-based ecosystem and has substantially more school-based health programs with mental health services (12 per 100,000 children and youth versus 4 statewide).

Exhibit 4. Availability of behavioral health care resources

Metric	Ventura	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 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 old	9	17	2022, 2024
Number of non-psychiatrist behavioral health care providers licensed with county Specialty Mental Health Services plan per 100,000 residents	37	37	2021
Number of outpatient treatment programs for young adults per 100,000 children and youth ages 0–24 years[a]	5	4	
School-based health programs with mental health services per 100,000 children and youth ages <18 years	12	4	2024

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

[a] The numerator for this measure is based on the number of outpatient treatment programs for *young adults*, while the denominator is inclusive of all children and youth 0–24 years because documentation suggests that many of these programs may pertain to children as well as young adults. (Manatt Health and Anton Nigusse Bland. *Assessing the Continuum of Care for Behavioral Health Services in California: Data, Stakeholder Perspectives, and Implications.* Report prepared for California Department of Health Care Services. January 2022. https://www.dhcs.ca.gov/Documents/Assessing-the-Continuum-of-Care-for-BH-Services-in-California.pdf).

Respondents perceived a general shortage of behavioral health providers in Ventura County, with access to services hindered by a number of barriers for children, youth, and families. Respondents considered shortages particularly pronounced in the Oxnard area, which has a majority Hispanic/Latino population and lacks access to culturally representative providers. Throughout the county, families face transportation challenges and insufficient availability of services outside of typical school or working hours. In addition, assessments are difficult to

obtain due to a lack of psychologists. Respondents across sectors also cited a need to better support families and parents in addition to children through wraparound services, parent education, and enhanced engagement efforts. For example, an early childhood respondent noted a gap in behavior supports for parents of very young children. Respondents cited CYBHI efforts such as SBHIP-funded wellness centers as a promising pathway for enhancing the broader wellness system and embedding behavioral health services within a broader system of family services.

Respondents across sectors cited critical gaps in inpatient care and substance use disorder treatment, with additional challenges fully meeting youth needs for crisis services. In particular, respondents noted a lack of inpatient psychiatric beds for youth. Those who need to be hospitalized for treatment, especially younger youth, are frequently held at the emergency department, sometimes for up to three days, or sent out of the county to locations such as Bakersfield or Tarzana. The county's crisis facilities include seven short-term residential therapeutic programs that serve youth from Ventura as well as other counties, a crisis stabilization unit (CSU), and a short-term residential program for youth transferring from the CSU. However, CSU capacity is reportedly limited and challenging to access for justice-involved youth, which can hinder the provision of needed services. Respondents also described the difficulty of treating youth for substance use disorders and the shortage of providers for those treatment services.

Equity concerns: groups facing disproportionate access challenges

Youth from the Mixteco/Indigena community of farmworkers reportedly encounter the most severe barriers, hindering access to behavioral health services in Ventura due to limitations in the behavioral health workforce. Service providers reported difficulty engaging individuals from migrant Indigenous backgrounds due to language and culture differences; the Western understanding of behavioral health differs from the community's traditional practices and wellness frameworks. Respondents also reported that stigma surrounding the receipt of behavioral health services prevents this population of youth and families from obtaining needed services. The limited availability of services outside of typical business hours becomes a magnified barrier for families during harvest season, when there is limited flexibility in long working days to access supports and services.

Juvenile justice-involved youth and transition-age youth also face unique challenges accessing services. A juvenile justice respondent explained that justice-involved youth are often unable to access intensive care or crisis services when needed, in part due to difficulties with care coordination between systems, and would benefit from embedded clinicians in the juvenile facility. Respondents also cited barriers for foster youth and those transitioning out of services who are under 18 years. Transition-age youth in particular often experience homelessness as they enter young adulthood, which further hinders access to care. In addition, although the county's department of behavioral health has a long-standing subsystem designed to address the needs of the child welfare-involved population, one respondent indicated that meeting the needs of child welfare-involved children and youth with highly complex needs is a challenge; the acuity of their needs has become even higher.

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 the context for understanding the CYBHI implementation in Ventura County, we 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 12 organizations in Ventura County based on the ratings provided by the 11 organizations that completed the survey. The map depicts the average strength of the connections between organizations (Exhibit 5).

Understanding connections across the behavioral health ecosystem in Ventura County

In Ventura County, we invited 12 child- and youth-serving organizations to complete the NEES via email and received responses from 11. Invited organizations included government agencies and departments; a managed care plan; and CBOs, including organizations that serve diverse communities. We asked survey respondents, such as directors and executive directors, how their organizations currently work with the other organizations invited to complete the survey to support children and youth behavioral health. Respondents rated their organizations' working relationships with these other organizations invited to complete the survey on a 5-point scale: (1) co-exist, (2), cooperate, (3) coordinate, (4) collaborate, and (5) integrated.[4]

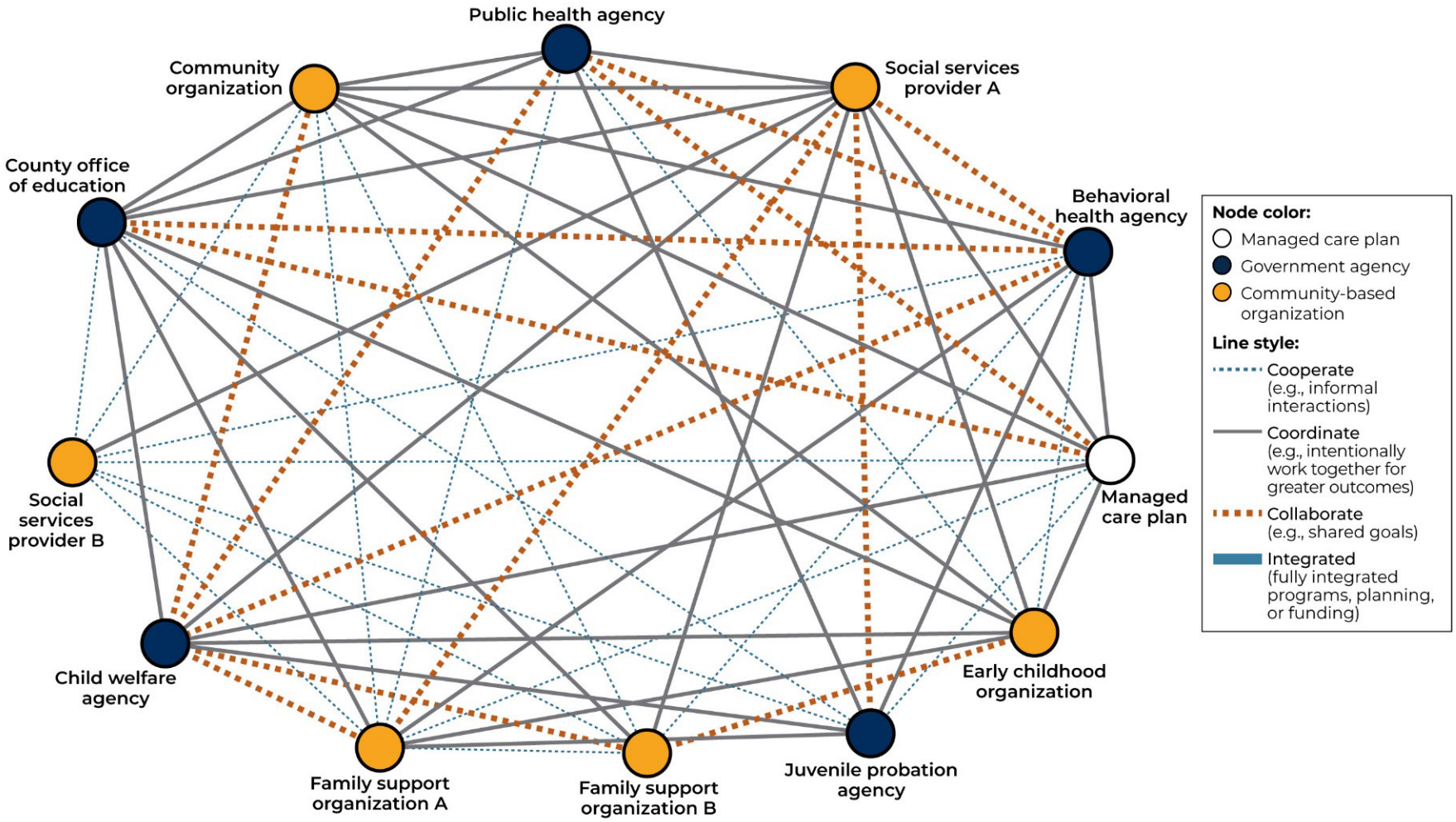
These ratings were used to conduct a network analysis and develop a network map showing the average strength of the connections between organizations, based on each organization's rating of the other.[5,6] A line between two organizations shows that a connection exists. No line indicates that the organizations 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.

[4] 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.

[5] In Ventura County, there were instances where only one organization rated a connection between two organizations. Using data where we had responses from both sides of a connection, we conducted an agreement analysis to understand whether survey respondents tended to rate the strength of their relationship in similar ways. Based on this analysis, we 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.

[6] 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 Ventura 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 or work together for greater outcomes; Collaborate = shared mission, goals, decision makers, or resources; Integrated = fully integrated programs, planning, or funding.

Perceptions of multisector collaboration to support children and youth behavioral health

Multisector relationships and collaboration

The behavioral health ecosystem in Ventura County comprises a network of highly connected agencies and organizations that work together to varying degrees to support children and youth behavioral health (Exhibit 5). Of the 12 organizations in the network, each has at least eight connections, and three government entities—the behavioral health department, county office of education, and public health department—are connected to every other organization in the network. The average strength of the network in Ventura County is 2.87, largely reflecting cooperation and coordination to support children and youth behavioral health. More than one-third of connections (42.4 percent) have an average strength of "coordinate," indicating that organizations intentionally work together for greater outcomes, and one-fifth of connections (19.7 percent) have an average strength of "collaborate," reflecting that organizations have shared goals and resources related to children and youth behavioral health. One-quarter of the connections in the network map (25.8 percent) have an average strength of "cooperate," indicating that organizations interact informally on specific projects.

In Ventura County, agencies and organizations from across sectors work well together, and most have strong relationships across the network. Interview respondents identified strong relationships between organizations and government agencies in the ecosystem, noting that these relationships facilitate collaboration and coordination on various programs and initiatives, including the CYBHI workstreams and coordinated approaches to efficiently using limited county funding and resources. Respondents explained that these relationships are built from years of working together on the ILT, which provided a foundation for collaboration on other initiatives. Respondents across sectors acknowledged that it would be useful to establish more formal partner agreements, such as memorandums of understanding, to continue strengthening these relationships.

> "We have a pretty robust and enthusiastic ILT and wellness system collaborative and that has really seeped through. I know for us, our County Office of Ed folks are there, our HSA folks, our probation folks, even our managed care plan as part of our interagency leadership team. I feel when we get the right folks in the room, when we have County Office of Ed and ourselves, we've been able to move things forward."
>
> —Ventura County Behavioral Health respondent

Nearly all agencies and organizations in Ventura County (91.6 percent) have at least one collaborative relationship within the network (Exhibit 5). Among government entities, there are collaborative relationships between the behavioral health department, public health department, and child welfare services, as well as the behavioral health department and county office of education. CBOs and managed care plans also have strong relationships, including with government entities. For example, the managed care plan has collaborative relationships with the county office of education and the public health department, and family support organization B has collaborative relationships with the child welfare and the early childhood organization.

Barriers to multisector collaboration

Across sectors, respondents cited staff capacity as a barrier to multisector collaboration. Ventura County respondents noted that although they often do well aligning initiatives, supports, and services, staffing turnover and limited bandwidth are reasons for unintended silos. As one respondent noted, successful collaboration stems from successful relationships, and it can be challenging to establish and maintain these relationships when faced with frequent staff turnover within a particular department or agency. One CBO respondent added that having multiple initiatives and grants requires significant administrative attention that can take away from time spent on multisector collaboration. A child welfare respondent added that there is a constant tension between balancing the need for people, funding, and time, and making a concerted effort to collaborate across sectors.

Data-sharing restrictions also hinder collaboration across organizations serving children, youth, and families. Respondents across sectors indicated that system-specific regulations related to data sharing, such as the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act (HIPAA), led to restrictive sharing practices among entities. To counter this effect and increase collaboration across systems to support access to necessary supports and services, respondents indicated that the Community Information Exchange and the ILT are actively working toward improving cross-sector data sharing. Several respondents discussed a work group's efforts related to developing a universal release that would allow information to be shared across sectors more easily. For example, a child welfare respondent detailed how they used court processes and had counsel conduct legal analysis to understand what information can be shared, when, and with whom. The respondent also discussed the work going into understanding broader information sharing across systems from the perspective of people with lived experience to gain their insights on this level. A behavioral health respondent added that there is a will among the ILT and the work group to maneuver the nuances of the law to overcome data-sharing barriers related to regulations such as FERPA and HIPAA, acknowledging that a larger act of legislation may be necessary to overcome cross-sector barriers and support the final implementation of this data sharing.

> "And then the other part is a recognition that there's what you're allowed to share legally, but it's just as important to understand the why of what you're sharing and that those with lived expertise are comfortable with what you're sharing and understand the why. And so, what we're trying to do now is spend some time unpacking what kinds of information are being shared, for what purposes, and what we're comfortable with sharing."
>
> —Ventura County Child Welfare respondent

Facilitators of multisector collaboration

Multisector collaboration in Ventura County benefits from connections that grew out of a range of prior collective initiatives. Respondents across sectors discussed how the ILT serves as a foundation for children's cross-sector work in the county. Respondents described how relationships were cultivated through the ILT, and work associated with the MHSA of 2004 and the MHSSA of 2019, among other efforts. The respondent went on to detail how CYBHI workstreams, including SBHIP, the CYBHI Fee Schedule, CalHOPE Student Supports, and Mindfulness, Resilience, and Well-Being Supports, maximized the momentum of these established platforms for collaboration in the county to meet the specific needs of children and families.

> "Of course, we have our own worlds to live in, funding sources, rules and regulations, what have you, so sometimes that does go a little sideways. I want to say, in the past five years or so, our attitude even morphed into something better of, let's figure out a way to do it rather than just saying, we can't."
>
> —Ventura County Probation Office respondent

Spotlight on multisector collaboratives in Ventura County

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

AB 2083 Interagency Leadership Team

The AB 2083 ILT brings together county public systems, CBOs, health care providers, law enforcement, the education sector, and family and youth advocates to improve outcomes for children, youth, and families, and build a supportive environment where families can thrive. Stakeholders said that AB 2083 legislatively prompted counties to develop and implement an integrated core practice model (ICPM). The ICPM is a research-based framework developed by the California Department of Health Care Services (DHCS) and the California Department of Social Services with guidelines for effective collaborative service delivery for children, youth, and families within the Children and Youth System of Care (CYSOC).[7] Ventura County established the ICPM for Children and Youth System of Care (CYSOC). Based on this fundamental agreement that all children and families should benefit from the systems work, most interview respondents praised AB 2083 and the ILT for becoming the foundation upon which many of the county's work groups and collaborative projects spring. They discussed how many of the CYBHI initiatives act as fuel to maintain the momentum of countywide projects already started by the ILT. According to one survey respondent, the ILT has "great representation across sectors, including AB 2083 mandated partners and beyond." Another survey respondent explained that the ILT serves as the governing body for the Wellness System Collaborative, noting that it is "an integral part of the Wellness System Collaborative and at the top of its infrastructure."

> "The CHHS website states: 'The legislation [AB 2083] is focused on the child welfare system but can and must expand to look at children and youth served by various other systems.' So, rather than thinking we have 'surpassed' the mandate, I prefer to think that we have fully embraced the intent of the law."
>
> —COE respondent

Most NEES respondents whose organizations participate in the ILT reported that the ILT is collaborating with youth and families to identify solutions that will build trust and improve the use of services. They also reported that the ILT is establishing relationships with organizations across sectors to ensure the delivery of a comprehensive array of supports and services, from prevention to intensive levels. Key areas of progress reported by most NEES respondents include (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.

Wellness System Collaborative

In Ventura County, the ILT serves as the governing body for the Wellness System Collaborative (WSC), which is working to align government systems, community partners, and family partners to create an integrated Child, Youth, and Family Wellness System where there is no wrong door for families to seek the supports they need.[8] The WSC aims to maximize the quality of life and wellness of all children, youth, and families in Ventura County by increasing access to services, supports, and wellness; strengthening protective factors; addressing social determinants of health; and decreasing formal system involvement.

Most NEES respondents whose organizations participate in the WSC reported that, consistent with its mission, the WSC (1) implements a shared vision and goals for aligning services and systems with the needs and desires of the people being served and (2) collaborates with parents and caregivers of children with lived experience on decision making. Recently, the WSC has made some progress aligning resources and activities across child- and youth-serving organizations in the county and improving care coordination so that children, youth, and families can access the supports and services they need where they need them; it has also made moderate progress strengthening the capacity of organizations in the county to work together toward shared goals for children and youth behavioral health.

Other multisector collaboratives

One child welfare interview respondent detailed how multisector collaboratives roll into the ILT and WSC, which act as the infrastructure for work in Ventura County. They described the ILT as the executive body as defined by AB 2083; within this body, there is a public-level system that helps fund others, and a community-level body of work that represents those using the elements of cross-system work. The respondent explained that there are several cross-system bodies within the county, but they are all grounded in the vision of the ILT and WSC. One example of a multisector collaborative in this structure is the Juvenile Justice Coordinating Committee, which, as respondents noted, implements "cross-sector approaches to support justice-involved youth across multiple domains, including behavioral health."

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 active to varying degrees across California counties.

Overview of workstreams in Ventura County

> "SBHIP has really allowed us to get into a deeper level of reaching what is a community need."
>
> —COE respondent

Overall, Ventura County is locally implementing 10 workstreams that involve the distribution of funding to county or community entities, including 44 grants as of September 2024.[9] This case study discusses Ventura's implementation experiences with **education sector workstreams**, including the SBHIP, the CYBHI Fee Schedule, CalHOPE Student Support and Schools Initiative, and Mindfulness, Resilience, and Well-Being Supports. It also discusses workstreams occurring in **home and community settings**, including Scaling EBPs and CDEPs and Never a Bother (Youth Suicide Prevention and Media Outreach Campaign). Other workstreams active in the county include programs under the Broad Behavioral Health Workforce Capacity workstream and Behavioral Health Continuum Infrastructure Program (BHCIP) grants. For example, Ventura County has two BHCIP Round 4 grants intended to fill in gaps in infrastructure by adding a short-term residential therapeutic program and a community wellness/youth prevention center. Broad Behavioral Health Workforce Capacity programs active in the county include the Health Careers Exploration Program, Peer Personnel Training and Placement Program, Psychiatric Education Capacity Expansion Grants, and Social Work Education Capacity Expansion Grants.

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

In Ventura County, there is a strong existing foundation for CYBHI workstreams, such as SBHIP, to advance efforts to expand behavioral health services and access to care in schools.

The implementation of CYBHI education-setting workstreams builds on the ILT's work. Guided by the integrated core practice model, the ILT comprises representatives from public health, behavioral health, children and family services, and VCOE. Respondents spoke to the collaborative mindset these partners bring to their work, emphasizing that prior efforts to collectively strengthen behavioral health care in schools provided a platform for CYBHI implementation. As such, early implementation of education-setting workstreams in Ventura County has largely allowed the county to continue, advance, or scale work that began before the CYBHI implementation.

For example, before the CYBHI, VCOE partnered with the Human Services Agency (HSA) to implement the Healthy Start program, integrating clinical social work into school settings to assess and address children's needs while providing preventive services. This initiative was initially launched in Oxnard, a region identified by HSA as one of the top five areas with the highest proportion of child welfare referrals. Recognizing the program's success, other LEAs expressed interest in replicating the model to introduce social workers into their schools. With the availability of

[7] California Department of Social Services. "California Integrated Core Practice Model Resource Guide." August 2024. https://www.cdss.ca.gov/Portals/9/CCR/ICPM/integrated-core-practice-model-resource-guide.pdf.

[8] San Diego State University Social Policy Institute. "Ventura County Child, Youth, and Wellness System: All Children and Families in Ventura County Will Live and Thrive in Safe, Healthy Communities." https://first5ventura.org/wp-content/uploads/2023/09/Wellness-System-packet-number-5-on-Agenda.pdf.

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

funding from SBHIP, VCOE and HSA adopted a creative approach to integrating social workers into schools and agencies, and used SBHIP dollars to recruit and train social workers. This strategic effort not only expanded the Healthy Start program but also extended its reach and impact across the region.

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

The **CYBHI Fee Schedule** provides a consistent and predictable funding mechanism for school-linked services by establishing a specific set of behavioral health services and rates at which Medi-Cal and commercial plans must reimburse school-linked providers. The Fee Schedule provides guidance for LEAs to receive reimbursement for school-linked behavioral health services using a fee-for-service model. Specifically, it (1) defines the scope of services for outpatient mental health and substance use disorder treatment, (2) identifies applicable billing codes and rates for behavioral health services, and (3) specifies which providers may bill for behavioral health services. The Fee Schedule requires commercial and public payers to pay school-linked providers. In addition, behavioral health services provided under the Fee Schedule may not require co-payments, co-insurance, deductibles, or any other form of cost sharing. Unlike the certified public expenditure approach of the LEA Medi-Cal Billing Option Program (LEA BOP), LEAs receive reimbursement for the entire service rate, which frees up local funds for further investment in schools and prevents the administrative burden of cost settlement reconciliation.

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

School-Linked Partnership and Capacity Grants are one-time investments intended to enhance school-linked behavioral health services and support operational readiness for the Fee Schedule. The Santa Clara County Office of Education, in partnership with the Sacramento County Office of Education, oversees fund distribution to all 58 COEs and provides training and technical assistance 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 effort can include work in the following four areas: Medi-Cal enrollment, service delivery infrastructure and capacity building, data collection and documentation, and billing infrastructure.

In another example, the Oxnard Unified High School District (OUHSD) is expanding student wellness centers, an initiative already underway in Ventura County schools. About seven years ago, they established the student intervention specialist position to offer mental health support on campus and later evolved that position into a student wellness specialist. Using Local Control and Accountability Plan (LCAP) funding, they opened wellness centers on five high school campuses. Following the establishment of these initial wellness centers, the LEA implemented a braided funding strategy to support the rollout to additional districts, drawing on funding sources such as MHSA, MHSSA, and SBHIP. Currently, each OUHSD wellness center is staffed by two student wellness specialists and one wellness guidance tech who conducts intake at the center.

Across the county, with the infusion of SBHIP funding, VCOE supported school districts in developing five additional wellness centers in four high-poverty junior high and elementary schools. The nine wellness centers span seven large comprehensive high schools, one smaller school, and one continuation school.

The school-based workstreams are credited with supporting the existing multisector collaboration and increasing infrastructure and capacity to expand school-linked behavioral health services that reflect the specific needs of individual school communities and the types of services and supports desired by youth and families. Ventura County stands out in its objective to tailor programs to the specific needs of each school ecosystem. This objective was demonstrated during the implementation planning for school-based workstreams such as SBHIP, where VCOE identified and prioritized addressing the unique mental health and behavioral health needs of two student

populations: students of color and those who speak languages other than English. This effort is evidenced by support of the work of the five LEAs that are also recipients of SBHIP funding where these student populations are most prevalent. These LEAs are committed to using SBHIP to offer wellness support to families and working to make accessing such supports as convenient as possible for historically underserved students and their families.

For youth ages 0–25, service gaps often relate to the cultural background and employment status of families. Among first-generation families, there is a notable stigma around seeking behavioral health services, compounded by uncertainty about how to access available resources. To bridge these cultural and informational gaps, the VCOE collaborates with community organizations, including the Mixteco Indigena Community Organization Project (MICOP). MICOP provides culturally relevant training to staff to improve services for the local Indigenous community, which includes a significant population of farmworkers and Indigenous families. An education respondent noted that although bringing together community members can sometimes pose challenges, VCOE has adopted a responsive approach by working directly with school staff in their local districts. This strategy allows VCOE to engage with educators and meet school needs effectively, with the goal of ensuring that culturally competent support is available where it is needed most.

The Ventura County Behavioral Health (VCBH) Department has also taken intentional steps to incorporate traditional Indigenous wellness practices within local wellness centers, some of which have been expanded or launched via SBHIP. This approach fosters trust with Indigenous families and aligns services more closely with their cultural needs.

A different way SBHIP implementation is being supported across sectors is evidenced by VCBH and VCOE sharing financial resources to allow staff time to engage in meetings that bring participating SBHIP districts together, facilitating opportunities to work across district and county offices as they plan and implement their programs.

Establishing the infrastructure for the long-term sustainability of school-based programs is yet another area of cross-sector collaboration that has evolved related to the interplay between SBHIP and the CYBHI Fee Schedule. The county is exploring two primary pathways to sustainability: adopting the Fee Schedule or pursuing direct contracts with MCPs. To inform these plans, the managed care plan has sought additional guidance from VCOE on issues such as how to handle direct contracting, processes for provider credentialing, and approaches to data sharing and care coordination. MCPs have maintained transparency with LEAs, emphasizing that significant work is needed before full implementation can proceed.

Implementation of workstreams facilitating classroom and campus behavioral health supports for youth and their families

Ventura County has engaged school staff and educators in SEL activities, using funding to promote wellness school communities and provide prevention services aligned with MTSS. VCOE offers independence across schools to determine how SEL is implemented. Recognizing that there is no "one-size-fits-all" approach to implementation, the county offers training and resources, but each school can implement the programs, such as the evidence-based SEL curriculum Second Step, that work best for their community. An education respondent also highlighted that the CYBHI Safe Spaces training has been beneficial in building the capacity of classroom teachers to create positive opportunities for SEL.

Through CalHOPE and Mindfulness grants, as well as SBHIP, some Ventura County schools and their CBO partners have been able to expand SEL services and activities, including culturally relevant programming in partnership with the Curando la Communidad initiative of the Mixteco Indigena Community Organization (MICOP).

Ventura County's vision for school-based services is that they be easily accessible and include ways to support the needs of the whole family.

In addition to classroom-based behavioral health supports, Ventura County schools hope to make behavioral health promotion and prevention services broadly available to caregivers and families via wellness centers. An education respondent said they see a gap in treatment services and programs for families with complex needs, such as insecure housing and exposure to trauma. They also recognize that many individuals with complex needs include caregivers of students. The education respondent said that the wellness centers established both before and through the CYBHI have been key in making services available to families and, through coordination with community partners, making sure families can access necessary services.

> "It is a mindset, it is a shift in. We are here to serve. We serve the community. We are here when kids need us."
>
> —Interview respondent

> It's one thing to have services available. It's another thing to actually have families engaged in services. It is not enough to simply say that services are available without giving regards to whatever barriers there might be for children and families within our county to be able to access those services."
>
> —VCOE respondent

The education respondent also highlighted that these supports and services must not only be available but also be both accessible and relevant to realize their intended impact on youth and families. Wellness centers, as expanded by the CYBHI, may help reduce historical barriers to access.

Implementation of home- and community-based sector workstreams

In Ventura County, funding for Scaling EBPs and CDEPs has strengthened the capacity of home- and community-based services providers to meet community needs. In Ventura County, CYBHI home- and community-based workstreams have supported a range of programs; in particular, Scaling EBPs/CDEPs grantees in Ventura County are supporting transition-age youth, enabling scaling of evidence-based early childhood interventions and creating evidence-based programming for youth recovering from substance use, with a particular emphasis on supporting programs that youth and families desire.

One CBO, recognizing that one of the major contributing factors to the region's rising unhoused population has been youth aging out of the foster care system, is using a Scaling EBPs/CDEPs Round 4 grant to develop a program to support these youth, complementing an existing housing assistance program. This funding has also enabled the CBO to provide consistent trauma-focused cognitive behavioral therapy (TF-CBT) training for clinicians across the agency, increasing the capacity to offer this service. The CBO also sees these types of trainings as a piece of its overall program investment in workforce development, which also includes offering career pathways and leadership training, and establishing an overall positive work environment. These efforts have resulted in reducing staff turnover from 42 percent to 21 percent, thus retaining these highly trained staff. To sustain these collective efforts, the CBO plans to pursue additional grant funding.

An early childhood sector respondent discussed the implementation of HealthySteps via Round 1 of Scaling EBPs/CDEPs as a means by which pediatric primary care providers can increase the depth of dyadic services to young children and their caregivers. This organization detailed grant-funded processes and activities related to piloting HealthySteps in two clinics, using early childhood staff to provide supports. Through this pilot, the clinics learned that additional efforts were required for optimal implementation, including strengthened collaboration between clinics and managed care plans related to reimbursement. Additionally, clinics required clarification from the HealthySteps National Office related to contract and reporting requirements to implement the model. Despite concerns about maintaining program fidelity within the limited implementation timeline, clinics remain committed to finding ways to make HealthySteps sustainable and have made efforts to deepen collaboration with the managed care plan.

Another CBO is using grant funds to support youth in substance use recovery through evidence-based group therapies integrating peer support and recreational activities. Following the assessment of individual needs at intake, each peer support specialist attends weekly group sessions with coaches to discuss client challenges and identify shared themes, such as addiction recovery, AA/NA support, and coping skills for self-harm. By maximizing peer support strategies and seeking youth feedback, the CBO has tailored the program to reflect youth preferences, integrating well-received activities such as meditation. To ensure future program sustainability, the CBO is working with consultants on a Medi-Cal credentialing application with the California Department of Health Care Services (DHCS) to seek Medi-Cal reimbursement for peer support coaching and group activities.

To complement the statewide Never a Bother Campaign, a Ventura County CBO is building the capacity for youth suicide prevention among American Indian and Alaska Native youth through the integration of traditional practices and youth feedback.

A CBO in Ventura County is using grant funding provided in conjunction with the Never a Bother Campaign to educate and train Native American youth on suicide prevention with tailored messaging and attention to the thoughtful integration of traditional cultural wellness practices. The CBO provides youth-focused programming that is culturally tailored and specific to the population it serves, such as youth-talking circles, beading circles, and sweat lodge ceremonies, using multiple funding sources, including revenue from direct clinical services. Working with partner agencies to implement Never a Bother in alignment with its overall approach, the CBO has launched social media campaigns on Instagram and Facebook, hosted in-person events, and tabled at pre-existing events to reach youth with limited access to technology. At clinical offices at the CBO site and partner organizations, the CBO displays materials on digital screens and in waiting rooms to share the Never a Bother messaging.

The CBO also hosted youth-focused and culturally adapted Question Persuade and Refer trainings to develop youth capacity to support peers experiencing suicidal ideation. The CBO said that following this training, youth reported feeling more confident and competent in initiating conversations about suicide. Despite higher comfort with and knowledge about suicidality, youth reported that they are not necessarily more likely to intervene with a peer than before the training; the CBO hopes that modifications to programming will increase youth capacity and confidence to take action.

The main implementation challenge the CBO has faced has been attendance, particularly in the face of local environmental stressors such as wildfires. It has solicited feedback from the youth who have asked for more activities and a greater variety of ways to connect with others.

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

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

The **Scaling EBPs and CDEPs** workstream provides grants to enhance the accessibility and quality of prevention services and clinical care offered in their communities through evidence-based practices (EBPs) or community-defined evidence practices (CDEPs). Each round of grant funding focuses on a specific area: Round 1: parent and caregiver support; Round 2: trauma-informed programs and practices; Round 3: early childhood wraparound services; Round 4: youth-driven programs; and Round 5: early intervention. To date, the Scaling EBPs and CDEPs workstream has awarded $248 million in CYBHI funding to 424 organizations across all 58 counties in California, with additional awards pending for early childhood wraparound services. The current grant awards support the delivery of more than 30 different evidence-based and community-defined evidence practices across the state. Note that the Scaling EBPs Round 3 grants, which focus on early childhood wraparound services, were announced in September 2024 and are not covered in this report.

Never a Bother (Youth Suicide Prevention Media and Outreach Campaign)

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

V. Conclusion

Ventura County is a diverse and populous county. Although children and youth in Ventura County experience similar rates of behavioral health challenges compared with those statewide, respondents perceived that some populations, including youth from the local Mixteco/Indigena communities, juvenile justice-involved youth, and youth in foster care transitioning into adulthood, experience significant barriers accessing services that meet their needs. In our key informant interviews, respondents also cited substantial gaps in the availability of high-acuity behavioral health services—including inpatient psychiatric beds; substance use disorder services; and supports for caregivers and families through wraparound services, parent education, and enhanced engagement efforts.

Although initial implementation is still underway, our analysis—drawing from available data, early implementation findings, and interviews with leaders—indicates that Ventura County is leveraging CYBHI resources and an already strong foundation of multisector collaboration in ways that are addressing the county's needs. CYBHI funding has been used to expand the footprint of wellness centers in the county, increasing access to supports in the school community. Behavioral health staff at some wellness centers have been trained on trauma-informed practice and culturally appropriate services specifically for the Mixteco/Indigena communities. Local CBOs are also using CYBHI funding to support the provision of TF-CBT as part of a program providing connections to housing and behavioral health supports for foster care youth transitioning to adulthood, and the delivery of evidence-based group therapies integrating peer support and recreational activities to support youth in substance use recovery.

Continuing to build on the strong collaborative efforts across sectors and integrate CYBHI work into established systems of care will help the county bridge remaining service gaps in the behavioral health ecosystem. Ventura is positioned to establish a shared vision and plan for implementation of the CYBHI Fee Schedule and then leverage reimbursement as a piece of long-term financial sustainability for new and expanded school-based programs. Such prevention and early intervention supports may divert youth from requiring higher-acuity and long-term services and supports. For those youth who could benefit from more acute levels of care, such as inpatient hospitalization or crisis services—in particular, youth with complex needs such as those with foster care or juvenile justice involvement—establishing more localized services may be beneficial. In the meantime, the ILT's ongoing focus to decrease barriers to multisector collaboration via a more comprehensive and efficient communication system will only enhance the interconnectedness of the organizations and agencies that support the youth and families of Ventura County.

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

Variable	Source	Years
Population		
Total population (N)	American Community Survey at https://data.census.gov/table	2022
Population, 0–4 years (N; %)		
Population, 5–19 years (N; %)		
Population, 20–24 years (N; %)		
Five-year population growth (%)	American Community Survey at https://data.census.gov/table	2017–2022
Five-year population growth, 0–24 years (%)		
Density (population per square mile)	U.S. Census at https://maps.geo.census.gov/ddmv/map.html	2020
Race and ethnicity		
White, non-Hispanic (%)	American Community Survey at https://data.census.gov/table	2022
Black or African American, non-Hispanic (%)		
American Indian and Alaska Native, non-Hispanic (%)		
Asian, non-Hispanic (%)		
Native Hawaiian and other Pacific Island American, non-Hispanic (%)		
Some other race, non-Hispanic (%)		
Two or more races, non-Hispanic (%)		
Hispanic or Latino (%)		
Birthplace and language		
Foreign-born, 0–24 years (%)	American Community Survey at https://data.census.gov/table	2022
English-proficient, 5–17 years (%)		
Education (18+ years)		
High school or higher (including college) (%)	American Community Survey at https://data.census.gov/table	2022
College degree or higher (%)		
Economic indicators, socioeconomic, neighborhood characteristics		
Population within urban blocks (%)	U.S. Census at https://www2.census.gov/geo/docs/reference/ua/2020_UA_COUNTY.xlsx	2020
Population within rural blocks (%)		
Population below 200% of the federal poverty line (%)	American Community Survey at https://data.census.gov/table	2022
Median income (USD)		
Unemployment (%)		
Households with high housing cost burden (%)	KidsData.org analysis of the American Community Survey	2019
Food insecurity, overall (%)	Feeding America's Map the Meal Gap data at https://map.feedingamerica.org/	2021
Food insecurity, 0–18 years (%)		
Healthy Places Index (rank)	Healthy Places Index at https://map.healthyplacesindex.org/	2015–2019
Diversity Index (rank)		

Variable	Source	Years
Health status		
Population with a disability (%)	American Community Survey at https://data.census.gov/table	2022
Population with a disability, 0–17 years (%)		
Health insurance status (population 0–25 years)		
Medi-Cal or other means-tested public coverage (%)	American Community Survey at https://data.census.gov/table	2022
Private coverage (%)		
Uninsured (%)		
TRICARE/military coverage (%)		
Medicare coverage (%)		
Prevalence of behavioral health outcomes		
Children and youth insured through Medi-Cal with a mental health diagnosis or emotional symptoms (%)	Transformed Medicaid Statistical Information System Analytic Files at https://resdac.org/cms-virtual-research-data-center-vrdc and Mathematica's analysis	2022
Children and youth insured through Medi-Cal with a substance use disorder diagnosis (%)		
Youth ages 12 to 17 years old who felt their family stood by them during difficult times (%)	California Health Interview Survey (Center for Health Policy Research at the University of California, Los Angeles) and Mathematica's analyses; applied for data at https://healthpolicy.ucla.edu/our-work/california-health-interview-survey-chis/access-chis-data	2022
Youth ages 12 to 17 years old who felt at least two non-parent adults took genuine interest (%)		
Youth ages 12 to 17 years old who felt supported by friends (%)		
Students in grade 9 who 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 0–25	Health Resources and Services Administration FQHC and look-alike locator at https://data.hrsa.gov/data/reports/datagrid?gridName=FQHCs	2024

Appendix B. Network Analysis Methodology and Measures

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

Methodology

We invited 12 organizations in Ventura County to complete the NEES via email and received responses from 11 organizations (for a 91.7 percent response rate). Invited organizations included government agencies and departments; an MCP; and CBOs, including organizations that serve diverse communities. Administrators of child- and youth-serving organizations, such as directors and executive directors, rated the strength of their organizations' connections with other organizations on a 5-point scale, ranging from (1) coexist to (5) integrated.[10,11] After using R software to conduct a network analysis based on these ratings, we then produced and developed the network map using Kumu software. We also used ratings across all organizations to 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, description, and average strength

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 and work together for greater outcomes
4	Collaborate	Shared mission, goals, decision makers, or resources
5	Integrated	Fully integrated programs, planning, or funding

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

In Ventura County, there were instances where only one organization of two rated a connection between the two. 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 1 point apart. For example, if one organization rated the connection "cooperate" (2) and the other organization rated it "coordinate" (3), we considered them to be in agreement. Using this standard, we then calculated how often organizations agreed with each other about the strength of their relationships.

Across all nine counties included in the case studies, a high rate of agreement (70.0 percent or greater) suggests that connection ratings are generally in agreement with each other; thus, a single organization's assessment of the strength of the relationship can be used as a representation of the actual strength reported by both ends of the connection. In Ventura County, the agreement score was 73.6 percent. Due to this high rate of agreement, we concluded that a connection rated by a single respondent was a reliable representation of the strength of the connection between

[10] 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.

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

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 Ventura County.

Exhibit B.2. Ventura County network analysis summary statistics

Network measure	Statistic	Description
Possible network size	12	Number of organizations invited to take the survey.
Number of possible connections	132	The total number of possible connections between all 12 organizations invited to complete the survey. 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	12	The number of organizations included in the network map. This count includes organizations that did and did not respond to the survey.
Number of observed connections	119	The total number of connections reported by organizations that completed the survey. This total excludes missing data and "not applicable" responses.
Number of unidirectional connections	13	A unidirectional connection is observed when only one of the two organizations rates the strength of the connection.
Reciprocated connections	106	The number of connections that were bidirectional (that is, both organizations reported the strength of the connection with each other).
Reciprocity rate	0.89	The number of bidirectional ties out of the total number of observed ties.
Average strength of the network	2.87	The average strength rating for the network, where the denominator is the number of observed ties.

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

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

Average strength range	Rating strength	Number of connections	Percentage of connections
1.0–1.99	Coexist	8	12.1
2.0–2.99	Cooperate	17	25.8
3.0–3.99	Coordinate	28	42.4
4.0–4.99	Collaborate	13	19.7
5.0	Integrated	0	0
	Total	**66**	**100.0%**

Appendix C. Details on the Implementation of Selected Workstreams

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

Exhibit C.1. Workstream: SBHIP

Workstream: Student Behavioral Health Incentive Program	
Short overview	• Ventura County has used SBHIP funds to scale wellness centers, adding four centers to the existing five across the county. • Additionally, SBHIP funds supported a partnership between VCOE and MICOP to include culturally relevant Indigenous wellness practices into all facets of service delivery. To date, MICOP has delivered two full-day trainings to staff to discuss how to meet the needs of students in Indigenous communities.
Key implementation findings	**The wellness centers are fully implemented and addressing the needs of youth and their families.** SBHIP supported the addition of seven wellness centers in four districts. The wellness centers were located at either elementary or middle schools. Each district developed its own staffing model. **The county has worked intentionally to address cultural and knowledge gaps within the community.** • MICOP has provided training programs for behavioral health staff on trauma-informed practice specifically for the Indigenous community and built awareness of common challenges for Indigenous families. **The county has encountered some barriers to SBHIP implementation, including behavioral health workforce and staffing shortages.** • Demand for behavioral health providers in Ventura County outstrips supply, creating conditions for salary competition between schools and CBOs; this situation sometimes leads to staff turnover.
Sustainability and what is next	• After SBHIP funds expire, school districts are looking to braid funding to sustain efforts, including the use of LCAP dollars. • Some districts are exploring extending wellness center services to evenings and weekends to better accommodate children and caregivers who are part of the farmworker community and are not afforded flexibility in their schedules to participate in programs during the school day.

Exhibit C.2. Workstream: CYBHI Fee Schedule

Workstream: CYBHI Statewide Multi-Payer School-Linked Fee Schedule	
Short overview	• After seeking to learn from the implementation efforts of the pilot Fee Schedule cohort, Ventura County LEAs are participating in Cohorts 2 and 3 of the Fee Schedule.
Key implementation findings	**Awareness about the CYBHI Fee Schedule is growing in Ventura.** • Ventura County LEAs and the MCP attended meetings and sought out conversations with districts participating in Cohort 1 of the CYBHI Fee Schedule to supplement and clarify information received directly from the state. • To inform implementation plans, the MCP seeks additional guidance and works alongside VCOE on issues related to direct contracting, processes for provider credentialing, and approaches to data sharing and care coordination.
Sustainability and what is next	In Ventura County, 16 LEAs are participating in Cohorts 2 and 3 of the CYBHI Fee Schedule. The VCOE is supporting districts to use the CYBHI Fee Schedule to sustain mental health services for students and build an interconnected system and framework that joins school districts with county agencies and CBOs.

Exhibit C.3. Workstream: CalHOPE and Mindfulness, Resilience, and Well-Being Supports

Workstream: CalHOPE and Mindfulness, Resilience, and Well-Being Supports	
Short overview	• Similar to other workstreams, the grants under CalHOPE allowed VCOE flexibility to independently implement programs that worked for grant recipients. • VCOE was intentional in implementing activities that fit the local landscape with culturally relevant and meaningful programming that increased the opportunity for SEL.
Key implementation findings	**CalHOPE and Mindfulness, Resilience, and Well-Being Supports activities have been implemented to benefit students and families.** • VCOE has offered good training, workshops, and professional development over time, which has helped build the capacity of classroom teachers to create safe spaces. • Indigenous wellness practices are evidence-based practices that offer healing. They have been appreciated by the local community and have garnered interest from some to receive training. **Staff trainings are available, but there are challenges with getting the teachers out of the classroom to attend training.** • VCOE has been unable to bring in substitute teachers to allow teachers or other interested district employees to receive training.
Sustainability and what is next	Education sector respondents suggested that ongoing state funding for SEL efforts would be valuable for supporting ongoing programming, which they see as of high value for supporting teachers and students.

Exhibit C.4. Workstream: Scaling Evidence-Based and Community-Defined Evidence Practices

Workstream: Scaling Evidence-Based and Community-Defined Evidence Practices	
Short overview	• Organizations in Ventura County are implementing multiple efforts funded through Scaling EBPs and CDEPs. • The funded projects discussed in interviews include incorporating evidence-based trauma-informed services in a program to support youth transitioning out of foster care, implementing the HealthySteps model, and implementing evidence-based group therapies to support substance use recovery.
Key implementation findings	**Although implementation is in the early stages for many of the grant projects in Ventura, one grantee has started providing services.** • Two of the grantees are in the early stages of implementation and are preparing to administer training; another grantee is awaiting execution of the contract so it can move forward with conducting a pilot. • Another grantee has fully implemented evidence-based group therapies for substance use. Program activities have been met with positive feedback from youth, with a particular appreciation for the decision to staff the program with coaches and specialists with relatable lived experiences and race and ethnicity reflective of program participants.
Sustainability and what is next	**Grantees mentioned mixed approaches to establish sustainability for funded services after the end of the grant period.** • One CBO expressed concern that funding will be available after the grant ends but plans to apply for another grant opportunity to sustain programming. • Another grantee said there is motivation to keep the program going, indicating that if it is structured to include memorialized processes, there is a possibility it will be sustainable.

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

Exhibit C.5. Workstream: Never a Bother (Youth Suicide Prevention and Media Outreach Campaign)

Workstream: Never a Bother (Youth Suicide Prevention and Media Outreach Campaign)	
Short overview	• Ventura County grantees have used workstream funding on suicide prevention activities focused on the Native and Indigenous youth populations. • One grantee has used funding to distribute materials across a range of health care and dental sites, and during in-person events. It also hosts traditional Tribal events where it incorporates suicide prevention messaging within cultural wellness practices. • In addition, the grantee has offered culturally adapted suicide prevention training to youth.
Key implementation findings	• One grantee highlighted that it incorporated suicide prevention activities across natural public settings, such as clinical offices and during in-person events. It also infused the suicide prevention activities within the context of traditional ceremonies and cultural wellness events, such as beading circles. It also offered suicide prevention training to youth with culturally responsive adaptations to increase resonance and comfort with the content.
Sustainability and what is next	**Both grantees believed that more funding and a longer grant duration would help sustain and scale the work they are doing.** • One grantee uses multiple funding streams to support its suicide prevention programming, thus increasing the likelihood that it will be able to sustain similar work in the future.

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

Let's Progress Together.

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