

# Schools Can't Do It Alone:

## Envisioning a Statewide System of Support to Advance School-Based Behavioral Health in California



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This brief is a companion to our recent research brief, [\*Schools Can't Do It Alone: Developing Sustainable Systems of Care for School-Based Behavioral Health in California\*](#). That research brief found that local educational agencies (LEAs) focused much of the recent state funding for behavioral health to build their internal capacity to provide behavioral health supports by hiring practitioners internally, such as school counselors and school social workers. However, given current state and local budget constraints, this may not be a sustainable model for school-based behavioral health services. Rather, there is an opportunity to build the capacity of health care

**partners to provide more school-based care. There is also an opportunity to build the capacity of LEAs to develop infrastructure for advancing integrated school-based systems of care and improving student behavioral health outcomes. Consequently, this companion brief envisions how a statewide system of technical assistance (TA) to support school-based behavioral health might be structured to create improved access to TA among LEAs statewide and to improve student behavioral health outcomes.**

California has made historic investments in youth mental and behavioral health since the start of the COVID-19 pandemic, but these funds are not intended merely to enable LEAs to hire more school behavioral health staff—particularly since these funds are short term. Rather, some of the state’s recent initiatives explicitly aim to support sustainable, integrated school-based systems of care. In such a system, cross-sector partners collaborate with LEAs to provide a comprehensive, coordinated set of services that promote whole-child development and advance equity for students and families (Breaking Barriers et al., 2022). By combining the expertise and resources from multiple sectors, including both education and health care, integrated school-based systems of care offer a powerful opportunity to advance both the *effectiveness* and the *sustainability* of school-based behavioral health supports and services.

However, developing integrated school-based systems of care requires that LEAs and local partners invest in infrastructure for ongoing collaboration and service coordination. For example, such infrastructure might include formal partnerships, processes for ongoing communication and coordination with partners, data-sharing systems and protocols, and closed-loop referral systems (i.e., systems in which LEAs refer students to available community resources with follow-up from the community provider to ensure services were rendered).

One recent statewide initiative that explicitly aims to fund such infrastructure is the Student Behavioral Health Incentive Program (SBHIP), launched in 2022 and ending in December 2024. Another is the state’s School-Linked Partnership and Capacity Building grants, a \$400 million initiative launched in early 2024 to support county offices of education (COEs) and school districts

**A note about terminology:**

*School-based* refers to services and programs provided on school campuses, primarily for students, regardless of who is delivering the service, which could include community-based providers colocated in schools and LEA-employed staff. School-based services and programs are one part of a child- and youth-serving integrated system of care; by necessity, students may also need to receive services outside of school campuses (e.g., in residential treatment centers).

*Behavioral health* refers to “mental health and substance use disorders, life stressors and crises, and stress-related physical symptoms. Behavioral health care refers to the prevention, diagnosis, and treatment of those conditions” (American Medical Association, 2022, para. 1).

in developing infrastructure for billing the state’s new Multi-Payer Fee Schedule. Doing so would enable the COEs and districts to receive reimbursement for eligible school-based health services.

But LEAs have expressed the need for much more TA to help them develop the infrastructure for integrated school-based systems of care. Based on WestEd’s recent analysis of LEAs’ SBHIP needs assessments and project plans, as well as interviews with representatives of COEs of managed care plans (MCPs) and with school-based health experts from a variety of organizations and sectors (Caparas et al., 2024), LEAs’ TA needs span a variety of topic areas.

Some of LEAs’ TA requests are specific to certain programs or initiatives (e.g., “How do I ensure that the reimbursement claims I submit through the fee schedule comply with the Family Educational Rights and Privacy Act [FERPA]?”) while other requests are broader (e.g., “How can my LEA establish a system for coordinating services with external partners?”). Table 1 includes many of the major areas of need for TA.

**Table 1. Technical Assistance Needed to Expand School-Based Behavioral Health and Integrated School-Based Systems of Care**

Category	TA on...
Care coordination for students	<ul style="list-style-type: none"> <li>» Sharing data and information about students between staff and partners</li> <li>» Following privacy laws such as FERPA and the Health Insurance Portability and Accountability Act (HIPAA)</li> <li>» Developing referral protocols and systems</li> <li>» Implementing and sustaining coordination teams</li> <li>» Developing relationships and crafting contracts or memoranda of understanding (MOUs) with external partners</li> </ul>
Sustainability	<ul style="list-style-type: none"> <li>» Understanding different Medi-Cal billing programs</li> <li>» Identifying funding other than from health care reimbursement to support services</li> <li>» Budgeting and forecasting for services</li> <li>» Integrating billing systems into current practices and student information systems</li> <li>» Training practitioners on documentation requirements</li> </ul>

Category	TA on...
Infrastructure	<ul style="list-style-type: none"> <li>» Gathering health information and consent for services from parents, guardians, and students</li> <li>» Evaluating vendors, service providers, and software systems</li> <li>» Evaluating impact through shared data, dashboards, and/or outcome measures</li> </ul>
Services for students	<ul style="list-style-type: none"> <li>» Coordinating services across multi-tiered systems of support (MTSS)</li> <li>» Providing professional development for staff (e.g., on social and emotional learning, trauma-informed and restorative practices, mental health first aid)</li> <li>» Implementing evidence-based or community-defined practices and services</li> <li>» Implementing screening, early intervention, and prevention programs</li> <li>» Hiring and staffing considerations (e.g., practitioner qualifications, licensing, supervision requirements)</li> </ul>

TA to address some of these topics already exists from various sources, including nonprofit providers, independent consultants, and state-sponsored initiatives. However, the TA is often siloed; for example, the state offers training on specific behavioral health topics or programs but tends to focus on each in isolation from others. Furthermore, LEAs often do not know what TA currently exists or how to access it, and there is no one location or entity that can direct LEAs toward comprehensive TA on policy and implementation for school-based behavioral health, much less on how to implement integrated school-based systems of care.

Given the difficulty of navigating the state's fractured landscape of school-based behavioral health TA, access to TA often relies on local leaders' individual knowledge and networks. But as one COE leader described,

The kids and families in my county should not be receiving good access to these services and programs just because of someone I know. There should be equitable access across the state. There's something that's not working within our system if I have access to someone who can help me with this, but other counties don't have access.

This brief explores what a statewide TA structure focusing on school-based behavioral health support could look like. The goals of this structure would be to

- » improve LEAs' and community-based partners' awareness of TA to support school-based behavioral health,
- » improve equity of access to available TA,
- » align TA on school-based behavioral health with LEAs' existing improvement efforts, and ultimately
- » advance integrated school-based systems of care and improve outcomes for students and families.

Since 2017, California has embraced the Statewide System of Support (SSOS) as its unified, cohesive structure for deploying TA to local educational systems. Given the state's investment in the SSOS and given the SSOS's positive reception from the field, this brief explores two potential ways for how California could use the existing or a similar model for TA to support school-based behavioral health in LEAs. Model 1 explores integrating TA on school-based behavioral health into the existing SSOS. Model 2 explores creating a separate structure, analogous and connected to the SSOS, that is focused on school-based behavioral health.

## Overview of California's System of Support

A cornerstone of California's public education accountability system, the SSOS connects school districts, COEs, and charter schools to TA, tools, and resources that build these local entities' capacity to participate in continuous improvement, reduce achievement gaps, and improve outreach and collaboration with families, community members, and other educational partners (California Department of Education [CDE], n.d.-b).

State agencies, COEs, and designated Lead Agencies (which are often housed in selected COEs) provide this support using a three-tiered model (CDE, n.d.-b). Tier 1 support (general assistance) is available for all LEAs and schools. Tier 2 support (differentiated assistance) is available to those whose student performance on the California School Dashboard (Dashboard) indicates the need for additional support based on eligibility requirements described in statute (*EC* § 52071, 52071.5, and 47607.3). Tier 3 support (intensive intervention) is reserved for those with persistent performance issues, although the SSOS has primarily focused on Tier 1 and Tier 2 support.

TA provided through the SSOS includes a substantial focus on building local education leaders' capacity to engage in continuous improvement processes, which include systems analyses, identification of potential solutions, implementation, and progress-monitoring. However, TA also includes content-specific resources and knowledge-building, including TA offered by the Lead Agencies, each of which offers support on a topic such as literacy, early math, special education, MTSS, or community engagement (CDE, n.d.-b). Geographic Lead

Agencies also provide a range of capacity-building supports for COEs and LEAs within their respective regions and serve as resource connectors, connecting COEs and LEAs to existing state initiatives or other appropriate resources.

The California *Education Code* tasks COEs and Lead Agencies with directly providing support, while it tasks three state agencies—the California Collaborative for Educational Excellence (CCEE), the CDE, and the State Board of Education (SBE)—with coordinating the SSOS (EC § 52073). For example, the CCEE and the CDE collaborate to select Lead Agencies, convene Lead Agencies to share best practices, and work with Lead Agencies to provide statewide professional learning (CCEE, n.d.-b). The CCEE also hosts an online directory of SSOS Lead Agencies and an online SSOS Resource Hub—a centralized, searchable database of tools and resources from existing state-funded projects, grants, and initiatives (CCEE, n.d.-a).

The SSOS has been widely well received by local education leaders (Humphrey & O'Day, 2019), and independent evaluations of the SSOS and its various components have found evidence of growth in local capacity-building and, in some cases, positive impacts on student outcomes (CCEE, n.d.-c; Krausen et al., 2022). However, the SSOS explicitly focuses on educational systems, and although some TA within the SSOS connects to school-based behavioral health (such as TA connected to MTSS), behavioral health is generally only a focus when LEAs identify it as a critical strategy for improving educational outcomes included on the Dashboard. Behavioral health indicators are not currently included on the Dashboard, and no equivalent statewide system exists for coordinating TA related to school-based behavioral health (or behavioral health more broadly with a focus on children and youth).

## Key Features Recommended for Any Model

Research conducted for this project suggests several important features of any model for capacity-building TA to improve behavioral health outcomes and ensure sustainability of services in school settings.

- 1. Collaboration across agencies.** California's funding and support systems are currently designed to focus on the county as the support provider. COEs already serve as the key support providers in the SSOS, and other county agencies, such as county behavioral health, are pivotal to behavioral health coordination efforts. Special Education Local Plan Areas (SELPAs) also typically operate from COEs. Regardless of which agency is tasked with leading TA at the county level, collaboration between county agencies is critical to ensuring that services are coordinated and funding is maximized to meet the needs of students and families. Counties could, for example, leverage the current county-led (AB 2083) system of care model, which focuses on foster youth and requires collaboration and coordination across multiple county-level agencies. There is already substantial

support for the idea of expanding this model to support all students. However, even if the state does not *fully* expand the AB 2083 system of care to all students (i.e., with case management for eligible students), it could use the existing AB 2083 structure (i.e., the cross-agency, county-level MOUs and relationships that counties were required to establish) to coordinate a new school-based behavioral health TA infrastructure. Even in cases where LEAs are further along in their school-based behavioral health implementation than their COE is, LEAs will need to collaborate with other local agencies and community-based partners to leverage resources most effectively.

- 2. A dual focus on (a) improving student behavioral health outcomes and (b) building the infrastructure to support sustainable access to services.** Regardless of model, research for this project suggests the need for capacity-building TA on both of these areas of focus. For the first focus, TA would support system leaders in finding meaningful outcome measures for understanding impact and for implementing and evaluating strategies to expand access to school-based behavioral health services. For the second focus, most of the TA would center on infrastructure support, including systems for breaking down silos between funding sources, increasing Medi-Cal reimbursements, developing data-sharing MOUs, and more.
- 3. Expanded access to support without making TA a requirement.** The intention of any new TA infrastructure is to expand access to TA, not to require that LEAs use it. As noted earlier, not all LEAs require support from their county, nor do all counties have the capacity to provide behavioral health TA to LEAs. All LEAs would benefit from increased Tier 1 support as defined in the SSOS context as general assistance to all LEAs, while Tier 2 TA could be tailored to support the specific needs of some LEAs. The SSOS uses student performance data on the Dashboard to identify LEAs that would benefit from differentiated assistance, whereas an analogous statewide measure for student behavioral health does not currently exist. Access to Tier 2 support could be prioritized based on data such as LEA demographic data, Dashboard data most closely linked to behavioral health, California Healthy Kids Survey (CHKS) data (though not every LEA administers the CHKS), a future SEL-related statewide measure, or some combination.

## Model 1: Integrating Behavioral Health Technical Assistance Into the Existing Statewide System of Support

### Overview

Model 1 would add an explicit focus on school-based behavioral health as another layer of support within the SSOS.

## Key Entities and Roles

- » **COE:** COEs would continue to serve as LEAs' main TA providers and resource-connectors. In addition to providing the current Level 1 and Level 2 support provided through the SSOS, COEs would now be responsible for providing Level 1 school-based behavioral health TA to all LEAs. In addition, for LEAs eligible for Level 2 support, COEs would have a more explicit charge to assist LEAs in improving student behavioral health, recognizing the link between student behavioral health and current Dashboard outcome measures such as rates of chronic absenteeism, suspensions, and expulsions.
- » **Other county agencies:** No other specific agency would have an assigned role. COEs would be expected to maintain and strengthen relationships with local behavioral health departments and other partners through existing collaborative efforts, such as SBHIP and the AB 2083 system of care, and would connect LEAs to these agencies as needed to address identified gaps in existing programs and services and to build stronger partnership infrastructure to better meet students' behavioral health needs.
- » **State:** The state could designate new funding for the provision of school-based behavioral health TA within the SSOS through a Lead Agency or set expectations for a more intentional and explicit focus on improving student behavioral health outcomes through the existing MTSS lead.

## Potential Benefits of Model 1

Likely the greatest benefit of Model 1 is that it aligns with California's priority of having *one system* for supporting students. For example, the CDE communicates the vision of having "one system serving the whole child," with the state's education accountability system, TA, and other resources aligned under this one system (CDE, n.d.-a). Recognizing the importance of inclusion, California has also been taking steps to break down silos between general education and special education and progress toward "one system" that appropriately serves all learners (WestEd, 2021). Historically, having separate systems has contributed to silos, so integrating school-based behavioral health TA into California's existing SSOS could help avoid this pitfall (and the potential negative optics of establishing a separate system or structure).

Another benefit is that TA through the SSOS is designed to increase the capacity of system leaders to improve student outcomes. Accordingly, integrating a focus on behavioral health into the SSOS would maintain an explicit focus on improving student behavioral health outcomes in addition to having TA focused on infrastructure development to ensure sustainability and increased access to school-based behavioral health services. Integration of TA on behavioral health in the SSOS also would acknowledge the relationship between behavioral health and other Dashboard indicators, such as chronic absenteeism, suspensions, and



academic achievement. One potential downside, however, is that behavioral health outcomes are also a responsibility of health care providers, and accountability for outcomes should be embedded within health care systems.

Furthermore, having COEs serve as the central TA providers and resource connectors for all of LEAs' needs, both education-focused and behavioral health-focused, may provide COEs with a greater opportunity to align all of the TA and improvement efforts occurring within an LEA, including the LEA's Local Control and Accountability Plan (LCAP) development, any existing support received through the SSOS, school-level work such as School Plan for Student Achievement (SPSA) development and Comprehensive Support and Improvement (CSI) efforts, and other statewide grants or initiatives that the LEA is involved with. As LEAs' primary support providers, COEs are already deeply involved with many of these efforts and often aim to align them to the extent possible. COEs' leadership role in Model 1 may provide them with a fuller understanding of all the behavioral health TA that each LEA receives, thereby enhancing the COEs' ability to align and integrate LEAs' various improvement efforts.

Finally, in a similar vein, having COEs continue to serve as LEAs' primary contacts for all TA may improve the likelihood that LEAs will reach out to access school-based behavioral health TA, as LEAs already have relationships with their COEs. LEAs may be less likely to engage with other agencies, such as county behavioral health departments, until these agencies have established positive relationships with them. Even then, it may be easier for LEAs to have COEs as their "one-stop shop" who can either directly provide or connect them to providers to fulfill all their TA requests.

## Model 2: A Separate, Connected Structure Focusing on Behavioral Health

### Overview

Model 2 would replicate the SSOS structure by designating regional- and county-level leads, separate from the SSOS, to provide or connect LEAs and community partners with TA to support school-based behavioral health. Model 2 would maintain close connections to the SSOS via collaboration between COEs and other county agencies. The focus of TA would be on youth behavioral health outcomes and the infrastructure needed to improve those outcomes, with schools as key partners.

### Key Entities and Roles

- » **County behavioral health department:** Within each county, this department would be responsible for providing Tier 1 and Tier 2 TA and partnering with the COE to coordinate TA.

- » **COE:** Each COE would be required to partner with the county behavioral health department and help ensure that each LEA's school-based behavioral health TA aligns with the LEA's existing TA or improvement efforts supported by the SSOS. For example, if an LEA is already receiving support related to behavioral health through the SSOS (e.g., training or systems change initiatives related to PBIS, SEL, special education, and/or trauma-informed and restorative practices), the COE would collaborate with the county behavioral health department's designee to ensure that any new behavioral health TA would complement—and not duplicate—these efforts. In addition, given COEs' existing relationships with LEAs, COEs would take an active role in connecting LEAs to the county behavioral health department's designee and would encourage LEAs to request behavioral health TA based on related needs that arise during LEAs' involvement with the SSOS.
- » **State:** The state would direct funding toward county behavioral health departments for infrastructure development and the provision of behavioral health TA. This could include some of the behavioral health funding that the state has thus far been directing toward a series of short-term initiatives, as Model 2 would achieve the same goals—but with fewer silos.

## Potential Benefits of Model 2

One of the primary benefits of Model 2 is that it would strengthen the collaboration between county behavioral health departments and COEs. Furthermore, it would create shared ownership of school-based behavioral health TA, as it would make health care agencies' responsibility for supporting school-based behavioral health services more concrete. These benefits would likely be much harder to foster under Model 1, which could reinforce the notion that education agencies alone are responsible for student behavioral health outcomes. Additionally, noneducation partners (e.g., community-based mental health agencies, community clinics, hospital-based practitioners) that are key in delivering school-based services and connecting students to an integrated system of care may be much more likely to access and engage in TA provided through county behavioral health departments, whom they work with more regularly, than through COEs.

Compared to Model 1, a separate TA structure would have a clearer focus on school-based behavioral health supports rather than having that role potentially diluted by COEs' existing responsibilities under the SSOS. A separate model would also expand expertise and staffing capacity beyond COEs—an important consideration given that COEs already carry heavy responsibilities as TA providers and can take on only so much. Relatedly, current statewide and regional Lead Agencies within the SSOS are typically concentrated within the same set of high-capacity COEs across the state. Reaching beyond the existing SSOS structure may cultivate valuable TA leads beyond those high-capacity COEs.

The TA needed to expand school-based behavioral health services and programs would be largely distinct from the TA offered through SSOS, and so having a separate TA system may help ensure that this focus does not get lost. That is, while the current SSOS largely focuses on building LEAs' capacity to participate in continuous improvement processes and building educators' capacity to change school or classroom practices, it does not include a major focus on building LEAs' capacity to engage with the health care system to support school-based behavioral health. For example, in their SBHIP project plans, LEAs reported needing assistance to set up for billing Medi-Cal for behavioral health services reimbursement, to structure MOUs and contract language with partners, and to develop data-sharing arrangements that follow federal and state laws. This type of structural-focused TA extends beyond the scope of the existing SSOS, and although COEs would aim to connect LEAs to this type of TA within Model 1, more robust collaboration from health agencies via Model 2 may help ensure that it remains a major focus.

Finally, although LEAs have increasingly embraced TA provided through the SSOS as a positive form of support, the SSOS is inextricably linked with the state's education accountability system; thus, many LEAs still view the SSOS's Level 2 support as an intervention based on LEA underperformance. Given that the new structure for school-based behavioral health TA would *not* be required, keeping it separate from the SSOS may help LEAs see it for what it is—a valuable new resource that LEAs should seek out to improve students' behavioral health outcomes—rather than associating it with required accountability activities.

## Conclusion

As youth mental and behavioral health needs remain elevated statewide, school-based leaders and educators continue to search for opportunities to build internal capacity to address student needs. Some LEA leaders have indicated that they have exhausted internal resources even as they have used state and federal short-term funding to hire more counselors and other support staff. Some student behavioral health needs necessarily require support beyond what schools alone can provide.

Nevertheless, schools are critical access points for youth behavioral health support. Accordingly, research and practice suggest that California's LEAs would benefit from increased access to TA that focuses on both improving youth behavioral health outcomes and building the infrastructure for an integrated and sustainable system of care for students. Although this brief is not intended to suggest the promise of one model over another, it is intended to highlight opportunities for a stronger focus on building capacity across the state—within both education and health care—for improving behavioral health outcomes and support infrastructure and for better aligning behavioral health TA with other major state improvement initiatives. California has an existing structure for deploying TA to LEAs through the SSOS, and there is a clear need for capacity-building support within the school-based

behavioral health space. California currently faces a substantial budget deficit, which makes the need more important than ever to maximize existing TA investments toward long-term system improvements.

As always, the development of any improvement infrastructure should take into account how the design of the system either explicitly or implicitly holds specific entities accountable for improvement. LEAs and health care entities both have important roles to play in supporting improved youth behavioral health outcomes, and more work could be done to define which of those outcomes each of the sectors has the greatest power to impact. School-based behavioral health supports and even the most robust capacity-building efforts for LEAs are, on their own, insufficient to address the myriad and complex student needs. Health care partners must also work to improve their capacity to provide school-based care by expanding access to services and developing their own accountability systems for ensuring student access to care and improved outcomes.

In addition, careful consideration should be given to how capacity-building efforts are funded. SBHIP attempted to incentivize collaboration between MCPs and COEs by funneling funding through MCPs. Other more recent state investments in TA that are aimed at improving billing for the state's new fee schedule provide funding directly to COEs, which then direct most of the funding to LEAs. These different structures for funding behavioral health improvement efforts should continue to be studied to understand which models most effectively promote collaboration between health care and education, as well as between different levels in the system, and which models provide the greatest benefit to students in terms of expanded access to programs and services.

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