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Mental Health Services
Oversight & Accountability Commission

# Meeting Materials Packet

## Commission Teleconference Meeting
## April 27, 2023
## 9:00 AM – 3:00 PM

MHSOAC
Mental Health Services
Oversight & Accountability Commission

# COMMISSION MEETING NOTICE & AGENDA

APRIL 27, 2023

**NOTICE IS HEREBY GIVEN** that the Commission will conduct a Regular Meeting on **April 27, 2023, at 9:00 a.m.** This meeting will be conducted via teleconference pursuant to the Bagley-Keene Open Meeting Act according to Government Code sections 11123 and 11133. The location(s) from which the public may participate are listed below. All members of the public shall have the right to offer comment at this public meeting as described in this Notice.

**Date:** April 27, 2023

**Time:** 9:00 AM

**Location:** MHSOAC
1812 9th Street
Sacramento, CA 95811



**ZOOM ACCESS:**

**FOR COMPUTER/APP USE**
Link: https://mhsoac-ca-gov.zoom.us/j/84648403923
Meeting ID: 846 4840 3923

**FOR PHONE DIAL IN**
Dial-in Number: (408) 638-0968
Meeting ID: 846 4840 3923

Public participation is critical to the success of our work and deeply valued by the Commission. Please see the information contained after the Commission Meeting Agenda for a detailed explanation of how to participate in public comment and for additional meeting locations.

## Our Commitment to Excellence

The Commission's 2020-2023 Strategic Plan articulates three strategic goals:

- Advance a shared vision for reducing the consequences of mental health needs and improving wellbeing.
- Advance data and analysis that will better describe desired outcomes; how resources and programs are attempting to improve those outcomes.

Catalyze improvement in state policy and community practice for continuous improvement and transformational change.

MHSOAC
Mental Health Services
Oversight & Accountability Commission

## Commission Meeting Agenda

It is anticipated that all items listed as "Action" on this agenda will be acted upon, although the Commission may decline or postpone action at its discretion. In addition, the Commission reserves the right to take action on any agenda item as it deems necessary based on discussion at the meeting. Items may be considered in any order at the discretion of the Chair. Unlisted items may not be considered.

**9:00 AM**

**1. Call to Order & Roll Call**

Chair Mara Madrigal-Weiss will convene the Commission meeting and a roll call of Commissioners will be taken.

**9:05 AM**

**2. Announcements & Updates**

Chair Mara Madrigal-Weiss, Commissioners and Staff will make announcements.

**9:20 AM**

**3. General Public Comment** *Information*

General Public Comment is reserved for items not listed on the. agenda. No discussion or action by the Commission will take place.

**9:50 AM**

**4. March 23, 2023 Meeting Minutes** *Action*

The Commission will consider approval of the minutes from the March 23, 2023 Commission Meeting.

- Public Comment
- Vote

**10:00 AM**

**5. Consent Calendar** *Action*

All matters listed on the Consent Calendar are routine or noncontroversial and can be acted upon in one motion. There will be no separate discussion of these items prior to the time that the Commission votes on the motion unless a Commissioner requests a specific item to be removed from the Consent Calendar for individual action.

- Fresno County Innovation Project (Extension): Approval of an $3,160,000 in Innovation funding over an additional two years for *The Lodge: Researching Targeted Engagement Approach* innovation project.

- Fresno County Innovation Project: Approval of $3,000,000 in Innovation funding over five years for the *Participatory Action Research with Justice-Involved Youth using an Adverse Childhood Experiences (ACEs) Framework* innovation project.

- Stanislaus County Innovation Project: Approval of $5,185,000 in Innovation funding over five *years for the Embedded Neighborhood Mental Health Team innovation project*.

  - Public Comment
  - Vote

**10:10 AM**

**6. Full Service Partnerships** *Information*

The Commission will hear two panel presentations on Full Service Partnerships (FSPs); *facilitated by Melissa Martin-Mollard, Ph.D., Chief Research and Evaluation.*

- The first panel will describe the history and promise of FSPs, include a consumer perspective, and provide an overview of current efforts to establish best practices for the model.
  - *Dave Pilon, former CEO at Mental Health America of Los Angeles*
  - *Nicole Kristy, MBA, Third Sector Capital Partners*
  - *Michael Robinson, Former FSP Partner*

- The second panel will include representatives from county behavioral health agencies and FSP providers to share perspectives on systemic challenges and opportunities for improvement statewide.
  - *Phebe Bell, Director of Behavioral Health, Nevada County*
  - *Lisa Zepeda, LMFT, Kings View Behavioral Health Systems, Kings County*

  - Public Comment

**12:10 PM**

**7. Lunch**

The Commission Meeting will recess for a lunch break.

**12:40 PM**

**8. Governor's Proposal to Modernize California's Behavioral Health System** *Information*

The Commission will hear a presentation on Governor Newsom's proposal to modernize and expand California's behavioral health system; *presented by Stephanie Welch, Deputy Secretary of Behavioral Health, California Health and Human Services Agency and Tyler Sadwith, Deputy Director of Behavioral Health, California Department of Health Care Services.*

  - Public Comment

**3:00 PM** **9. Adjournment**

| Our Commitment to Transparency | Our Commitment to Those with Disabilities |
|---|---|
| In accordance with the Bagley-Keene Open Meeting Act, public meeting notices and agenda are available on the internet at www.mhsoac.ca.gov at least 10 days prior to the meeting. Further information regarding this meeting may be obtained by calling (916) 500-0577 or by emailing mhsoac@mhsoac.ca.gov | Pursuant to the American with Disabilities Act, individuals who, because of a disability, need special assistance to participate in any Commission meeting or activities, may request assistance by calling (916) 500-0577 or by emailing mhsoac@mhsoac.ca.gov. Requests should be made one (1) week in advance whenever possible. |

**Public Participation:** The telephone lines of members of the public who dial into the meeting will initially be muted to prevent background noise from inadvertently disrupting the meeting. Phone lines will be unmuted during all portions of the meeting that are appropriate for public comment to allow members of the public to comment. Please see additional instructions below regarding Public Participation Procedures.

**The Commission is not responsible for unforeseen technical difficulties that may occur.** The Commission will endeavor to provide reliable means for members of the public to participate remotely; however, in the unlikely event that the remote means fails, the meeting may continue in person. For this reason, members of the public are advised to consider attending the meeting in person to ensure their participation during the meeting.

**Public participation procedures:** All members of the public shall have the right to offer comment at this public meeting. The Commission Chair will indicate when a portion of the meeting is to be open for public comment. **Any member of the public wishing to comment during public comment periods must do the following:**

**If joining by call-in, press *9 on the phone.** Pressing *9 will notify the meeting host that you wish to comment. You will be placed in line to comment in the order in which requests are received by the host. When it is your turn to comment, the meeting host will unmute your line and announce the last three digits of your telephone number. The Chair reserves the right to limit the time for comment. Members of the public should be prepared to complete their comments within 3 minutes or less time if a different time allotment is needed and announced by the Chair.

**If joining by computer, press the raise hand icon on the control bar.** Pressing the *raise hand* will notify the meeting host that you wish to comment. You will be placed in line to comment in the order in which requests are received by the host. When it is your turn to comment, the meeting host will unmute

your line and announce your name and ask if you'd like your video on. The Chair reserves the right to limit the time for comment. Members of the public should be prepared to complete their comments within 3 minutes or less time if a different time allotment is needed and announced by the Chair.

**Under newly signed AB 1261,** by amendment to the Bagley-Keene Open Meeting Act, members of the public who use translating technology will be given additional time to speak during a Public Comment period. Upon request to the Chair, they will be given at least twice the amount of time normally allotted.

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# AGENDA ITEM 4

**Action**

**April 27, 2023 Commission Meeting**

**Approve March 23, 2023 MHSOAC Teleconference Meeting Minutes**

**Summary:** The Mental Health Services Oversight and Accountability Commission will review the minutes from the March 23, 2023 Commission teleconference meeting. Any edits to the minutes will be made and the minutes will be amended to reflect the changes and posted to the Commission Web site after the meeting. If an amendment is not necessary, the Commission will approve the minutes as presented.

**Enclosures (2):** (1) March 23, 2023 Meeting Minutes; (2) March 23, 2023 Motions Summary

**Handouts:** None.

**Proposed Motion**: The Commission approves the March 23, 2023 Meeting Minutes

# State of California

## MENTAL HEALTH SERVICES
## OVERSIGHT AND ACCOUNTABILITY COMMISSION

### Commission Meeting Minutes

**Date** March 23, 2023

**Time** 9:00 a.m.

**Location** San Diego County Office of Education
6401 Linda Vista Road, Comms. Lab 1-4
San Diego, California

**Members Participating:**

Mara Madrigal-Weiss, Chair
Mayra Alvarez, Vice Chair
Mark Bontrager*
Sheriff Bill Brown
Keyondria Bunch, Ph.D.*
Steve Carnevale
Rayshell Chambers
Itai Danovitch, M.D.*
David Gordon*
Gladys Mitchell
Alfred Rowlett
Khatera Tamplen

*Participated remotely.

**Members Absent:**

John Boyd, Psy.D.
Shuo Chen
Senator Dave Cortese

**MHSOAC Meeting Staff Present:**

Toby Ewing, Ph.D., Executive Director
Geoff Margolis, Chief Counsel
Norma Pate, Deputy Director, Administration and Performance Management
Melissa Martin-Mollard, Ph.D., Chief, Research and Evaluation
Tom Orrock, Chief, Community Engagement and Grants
Sharmil Shah, Psy.D., Chief, Program Operations
Kali Patterson, M.A., Research Scientist
Amariani Martinez, Administrative Support
Cody Scott, Meeting Logistics Technician

## 1: Call to Order and Roll Call

Chair Mara Madrigal-Weiss called the meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at approximately 9:07 a.m. and welcomed everyone.

Chair Madrigal-Weiss reviewed a slide about how today's agenda supports the Commission's Strategic Plan Goals and Objectives, and noted that the meeting agenda items are connected to those goals to help explain the work of the Commission and to provide transparency for the projects underway.

Geoff Margolis, Chief Counsel, called the roll and confirmed the presence of a quorum.

## 2: Announcements and Updates

Chair Madrigal-Weiss thanked the San Diego County Office of Education (SDOE)and the Superintendent of Schools, Dr. Paul Gothold, for making the facility available for the Commission meeting and for being in attendance and asked him to say a few words.

Dr. Gothold welcomed the Commission to the SDOE and thanked the Commission for its work and helping children have every resource in front of them. He provided an overview of the SDOE's vision of education, including the whole child approach, community design, and belonging. He stated that the county will soon be putting a universal screening process into place and mental health standards for adults on campus.

Chair Madrigal-Weiss then thanked Dr. Luke Bergmann, the Director of the San Diego County Behavioral Health (SDCBH), for being in attendance. She asked him to say a few words.

Dr. Bergmann provided an overview of the work of the SDCBH, including transforming the behavioral health system of care from being driven by an orientation to crisis to an orientation to continuous care and working further and further upstream in sensible ways. How behavioral health is thought about and discussed needs to culturally change in order to change how it is addressed. He stated that screening for behavioral health and substance use should be done in every primary care and school setting, irrespective of payer. County behavioral health has historically been anchored to Medi-Cal and devotes funding annually to Medi-Cal-anchored programs. Behavioral health care needs to adjust the way it works with schools so that parameters are not being created that are unusual from the perspective of school systems. San Diego County has completed an independent analytic work around workforce needs and found that the workforce needs to increase over 100 percent by 2027 in order to accomplish the goals of the behavioral health department.

Chair Madrigal-Weiss gave the announcements as follows:

Transformational Change Fellowship Update

A Request for Qualifications (RFQ) was released earlier this year and has awarded funding to a partnership led by McGeorge School of Law at the University of the Pacific, with Third Sector Capital Partners, the California Institute for Behavioral Health

Solutions, and the Stanford University Center for Youth Mental Health and Wellbeing. The Fellowship is expected to launch later this year.

EmPATH RFA Announcement

Staff has completed a competitive grant program to support hospital-based crisis support programs. Grants will be awarded in three categories to support the development of Emergency Psychiatric Assessment, Treatment, and Healing (EmPATH) units:

Category 1 – serving adults

- Community Regional Medical Center
- Henry Mayo Newhall Hospital
- Twin Cities Community Hospital
- Loma Linda University Medical Center

Category 2 – serving children and youth

- Loma Linda University Children's Hospital

Category 3 – supporting a rural community

- Sutter Coast Hospital

Modernization of MHSA

The Governor announced a proposed ballot measure for 2024 to modernize the Mental Health Services Act (MHSA). The proposal intends to change the Commission's operations but it is unclear on what is being proposed. Staff is reaching out to the Governor's team for a briefing on the proposal.

Committees

The Commission has relied on a range of committees to ensure the work is informed by community members and is relevant. Due to the expansion of the Commission's portfolio, it has been difficult to staff these committees.

The Chair has asked staff to present on best practices in community engagement at the next Commission meeting.

The Chair asked each Committee Chair to stay on as Chair for another year and to work with staff to engage each committee to support the priorities the Commission discussed at the January meeting by informing the work on Full-Service Partnerships (FSPs), firearm violence, data transparency and accountability, and the development of the Commission's next four-year strategic plan.

The exception is the Children's Committee. Staff capacity cannot support that effort at this time.

Site Visit Report Out

Chair Madrigal-Weiss stated that the Commission participated in a site visit in Imperial County yesterday, hosted by the Imperial County Office of Education (ICOE) and the Imperial County Behavioral Health Services (ICBHS). Chair Madrigal-Weiss, Vice Chair Alvarez, and Commissioners Brown and Carnevale met with the leadership teams, heard from students, and visited two high schools benefiting from Mental Health Student

Services Act (MHSSA) grants. MHSSA grant funding was used to provide five mental health specialists to support eight high school districts. These specialists take referrals, meet with students, provide assessments, and link services for students and their families. This worked out so well that the school districts hired six more specialists to serve all high schools in the county. These 11 specialists streamlined referral processes, strengthened collaboration, and increased access to prevention and intervention services immediately. Students shared about stigma and future careers, and were shocked and awed by the fact that the Commission came to see their program and to hear their stories. The visit was impressive, inspiring, and heartfelt.

Commissioner Carnevale reinforced the thought that the Commission spends much time thinking and trying to act systemically to put programs in place to deliver action, but spending the day with students – and, in one case, a parent – who talked about how these programs changed and improved their lives in dramatic ways was a reminder that every action the Commission takes has a huge impact on individuals in the state and it reinforces the great motivating aspiration for the work.

Commissioner Brown stated that Imperial County is impressive in their collaborative approach to this issue. It is obvious that the different interested parties work well together and the level of enthusiasm that they have for their jobs was great. It shows what the Commission has been advocating in its *Together We Can* report, for example – that the power of collaborating in this age of limited staff and limited budgets is an important component in being successful in the community. Also, the testimonies from the young people with lived experience who were using the services were incredibly impressive.

Vice Chair Alvarez stated that it was inspiring to see the intentional effort made between the ICOE and the ICBHS to work collaboratively and to learn each other's language. They exemplified culture shifting in approaches to what mental health is. It was impressive and inspiring and the personal stories made the work the Commission does more real. She thanked Chair Madrigal-Weiss for her leadership and staff for setting up the site visit.

Chair Madrigal-Weiss stated that the ICOE's Migrant Education Program was also brought in to speak. She noted that the fact that the Migrant Education Program is working with the ICBHS within the ICOE is also a culture shift.

Chair Madrigal-Weiss encouraged including site visits wherever possible in the future.

Commissioner Gordon thanked Executive Director Ewing for coming before several statewide meetings of all county superintendents several years ago to emphasize the importance of collaboration between county offices of education and behavioral health departments. What is being seen today is a result of his efforts to promote those partnerships. It is wonderful to hear of the work going on in other counties.

January Meeting Report Out

Chair Madrigal-Weiss asked Executive Director Ewing to give a brief overview of the January Commission meeting.

Executive Director Ewing gave a progress report on some of the decisions made at the January meeting:

- The Commission identified four priorities for the calendar year: FSPs, impact of firearm violence, data/metrics, and strategic planning.
- A draft scorecard of the progress made for each goal of the Strategic Plan and a calendar of tentative Commission meeting dates for 2023 were included in the meeting materials.
    - Commission meetings will be planned around the four priorities.
- The Commission requested including a discussion on hot topics at each Commission meeting, identifying emerging issues or items that may not be on the traditional agenda.
    - A current hot topic is the Governor's recent proposal. Staff will work with the chair to incorporate this hot topic into a future agenda.
    - Staff has invited a representative from the Governor's Office to present as early as the April meeting.
- Staff has provided a draft outline of the strategic planning process to Commissioner Carnevale for review.
    - Staff plans to meet with the chair and Commissioner Carnevale to structure a strategic planning process.
    - Two Commission meetings have been set aside for strategic planning, including robust community engagement and other strategic planning discussion activities.

**3: <u>General Public Comment</u>**

Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), stated that the Governor's proposal was concerning to mental health communities. She asked on behalf of REMHDCO and many other organizations for the Commission to help preserve the good things of the MHSA. It appears that the plan, particularly around the MHSA, will take away some of the most important things of the MHSA that consumer communities care about, including prevention and community collaboration, and that the Commission will be placed under a department or agency. Commissioners are the guardians of the MHSA. She urged the Commission to not allow it to be decimated.

Stacie Hiramoto suggested that the Commission invite Dr. Cheryl Grills and others to present on the California Reducing Disparities Project (CRDP) Statewide Report at a future meeting. She asked why additional time was given on today's agenda for the Prevention and Early Intervention Report when it was discussed thoroughly at the last Commission meeting.

Reginald Green spoke in support of The Veterans Art Project (VETART) and their pop-up cafes.

Ivan Sam, Cultural Ambassador, VETART, stated that he provides workshops to help veterans engage in art as an alternative healing modality. The speaker shared about the

generational trauma and new traumas experienced being a part of a Native American family in the military.

Richard Gallo, consumer and advocate and Volunteer State Ambassador, Cal Voices ACCESS California, stated that they attended a meeting about the proposed MHSA modernization act and were shocked to learn that the Commission will be moved under a state agency or department. Another concern is the changes to how projects will be funded into three separate categories, some with housing and some without.

Richard Gallo stated concern about the community planning process. The community planning process cannot be removed or altered because it was the intent of the MHSA to include consumers and their families in decisions about the needs and gaps of mental health communities throughout the state. The speaker urged the Commission to advocate against the proposed changes to the MHSA and the Commission.

Gigi Crowder, Executive Director, National Alliance on Mental Illness (NAMI) Contra Costa, thanked the Commissioners for the work they do and reminded them that large groups of individuals from a variety of cultural and ethnic backgrounds first turn to their faith and spiritual leaders when they are in crisis, especially for mental health. The speaker stated concern about the direction that is being taken around prevention and early intervention and the bulk of the funding going to tools, because there are many examples of great opportunities through working with trusted cultural brokers, who are the faith leaders.

Gigi Crowder asked for consideration for the fact that many times smaller nonprofits are doing great work and any funding that they get can greatly enhance the desire to reduce health disparities and promote a sense of belonging for residents so that they are building the trust back up through a warm handoff or exchange with another trusted partner. The speaker encouraged state and county entities to not ignore the strength received from natural trusted resources.

Gigi Crowder stated that the right direction is being moved into on many levels with reducing disparities in the CRDP Statewide Report. The speaker noted that evidence-based practices do not always align with what is important to communities of color, which are community-defined strategies and promising practices. The speaker stated the need to recognize that school settings are not always a safe environment for some communities as progress is being made with breaking down the school-to-prison pipeline, especially for the African American community.

Dannie Casena, Director, California LGBTQ Health and Human Services (HHS) Network, stated that the HHS Network has 15 projects across California that engage in mental health advocacy thanks to the Commission; however, the projects are experiencing extreme cases of homophobia, biphobia, and transphobia. County health departments are telling LGBTQ leaders and organizations that they will never work with the LGBTQ community. As these leaders continue to attend county board meetings, department of mental health meetings, and others, LGBTQ leaders are leaving these meetings with individuals calling them names, threatening their lives, and crashing LGBTQ events to attack the community. Several projects have canceled all March events, due to safety concerns.

Dannie Casena stated that the HHS Network is working with the projects to pivot on how they engage in mental health advocacy. The HHS Network has been supporting LGBTQ leaders by providing social and emotional support; however, it is getting more difficult to not carry the weight of their worries and fears as these local leaders look to Dannie Casena as the Executive Director of the HHS Network. To best support the LGBTQ leaders who are doing this work, the HHS Network is bringing in professional mental health experts, security experts, and a lawyer to assist them in navigating the trauma they are experiencing and identifying ways to ensure their staff remains safe and to learn about the legalities of experiencing hate incidences and hate crimes.

Dannie Casena asked that, as this Commission moves forward with creating Requests for Applications (RFAs) that engage in mental health advocacy, the scope of work is not created as a one-size-fits-all style, that projects have an opportunity to adapt the scope of work that best fits the needs of their particular community, and that there is local community buy-in on what the RFA should look like, such as a community town hall. The speaker has seen the Office of Health Equity (OHE) host online town halls with local community members so they may ensure the RFA is created in a way that best supports the community. The OHE town hall model works. The current model is not effective and is putting the LGBTQ community's life at risk.

Dannie Casena asked the Commission to assist in protecting the LGBTQ community and its advocacy in trying to create access-affirming LGBTQ mental health services.

Chair Madrigal-Weiss asked Dannie Casena to email staff so staff can follow up on these issues.

Steve Dilley, Executive Director, VETART, invited the Commission to visit VETART, an art studio strategically located within the largest military community and veteran population in the state and in the nation that is dedicated to veteran wellness that works upstream to build a foundation of wellness that becomes a bridge that keeps individuals out of the rapids. It is a foundational means of building the continuum in the continuum of care. Art making allows individuals an opportunity to not require anyone to respond to their crisis.

Steve Dilley highlighted portions of a concept paper that VETART did in collaboration with the Prep Institute in San Diego.

Chair Madrigal-Weiss asked staff to organize a visit to VETART. She asked Steve Dilley to send an email to staff so they can get more details.

Astin Williams, Program Coordinator, California LGBTQ HHS Network, echoed Dannie Casena's comments. She spoke on behalf of the LGBTQ lead partners working to make a change. The current unsafe conditions being experienced by partners include acts of violence, discrimination, and harassment from county mental health departments. This can lead to heightened mental health concerns.

Andrea Crook, Director of Advocacy, ACCESS California, stated appreciation that Executive Director Ewing will prioritize ensuring time on the agenda to discuss the new potential ballot measure to modernize the MHSA. She stated concern that the meetings made it sound like the community planning process will be dismantled, the Commission has not been privy to these conversations, and that services will be integrated with other

sectors. She stated appreciation for the Commission setting the standard and modeling transparency and collaboration.

John Drebinger, Senior Advocate, California Council of Community Behavioral Health Agencies (CBHA), stated that the CBHA shares some of the concerns mentioned today, especially those pertaining to the future of programs currently funded by the MHSA through prevention and early intervention innovation funding. CBHA members provide services that are vital components of the behavioral health safety net. He stated the hope that the proposed modernization of the MHSA will not threaten the future of those community-based supports.

John Drebinger stated that the CBHA appreciates the long overdue focus on substance use services in this modernization plan. He stated the hope that the CBHA will work with the administration, the Commission, and the advocacy community to preserve the MHSA while finding solutions for some of California's most vulnerable residents.

Meghan O'Keefe, Chief Executive Officer, Amador County Arts Council, a part of the #Out4MentalHealth grant program, thanked the Commission for its role in the #Out4MentalHealth grant program. This program has bolstered the Amador County Arts Council's long-term commitment to mental health and suicide prevention and is making measurable impacts on the mental health landscape for the community.

Meghan O'Keefe noted that the work sometimes includes hate and isolation. It is far from easy to engage in mental health advocacy of any type in a rural space, but when adding LGBTQ into that initiative, safety becomes an immediate and ongoing issue. They asked the Commission to consider the safety and mental health of the regional leadership while building mental health grant programs. LGBTQ leaders in Amador County and within other rural California spaces are experiencing a wide array of hate and social isolation, especially when engaging in advocating for the mental health of communities. They asked the Commission to see the rural spaces as thought partners in developing even more efficient and effective grant programs that do not put safety and livelihoods at risk.

Concepcion James, Chair, United Latino Voices of Contra Costa County, echoed Gigi Crowder's comments. The speaker stated the need to bring in more professional individuals into school sites and communities; however, there is a benefit of having community-driven strategies. They provided the example of non-profit organizations in Contra Costa County that have support groups for youth in the schools. These kinds of programs should continue and they should work together with professionals. It is not an either/or situation. It is important that funding continues to support community-driven strategies and solutions as bridge-building programs in the community.

Concepcion James stated that there is a serious need to address mental health in California and across the nation, but it is important that it comes from the community. They agreed with the state outlining goals, priorities, and important data to collect, but stated the need to give the bulk of the responsibility in how county programs are designed to the community.

Denise Coleman, Member, Solano County Advisory Board, and Member, Returning Citizens Association, advocated for funding for the Returning Citizens Association to go

into schools as peer support specialists to educate students on how to keep from ending up in the same situation as the Members have.

### 4: February 23, 2023, Meeting Minutes

Chair Madrigal-Weiss stated that the Commission will consider approval of the minutes from the February 23, 2023, Commission meeting. She stated that meeting minutes and recordings are posted on the Commission's website.

**Public Comment.** There was no public comment.

Action: Chair Madrigal-Weiss asked for a motion to approve the minutes. Commissioner Rowlett moved, seconded by Vice Chair Alvarez, that:

- *The Commission approves the February 23, 2023, Meeting Minutes.*

The Motion passed 8 yes, 0 no, and 3 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Bontrager, Carnevale, Chambers, Danovitch, Rowlett, and Tamplen, Vice Chair Alvarez, and Chair Madrigal-Weiss.

The following Commissioners abstained: Commissioners Brown, Gordon, and Mitchell.

### 5: Consent Calendar

Chair Madrigal-Weiss stated that all matters listed on the Consent Calendar are routine or noncontroversial and can be acted upon in one motion. There will be no separate discussion of these items prior to the time that the Commission votes on the motion unless a Commissioner requests a specific item to be removed from the Consent Calendar for individual action.

- Contra Costa County Innovation Project: Approval of $6,119,182 in Innovation funding over four years for their Supporting Equity Through Community-Defined Practices innovation project

**Public Comment.** There was no public comment.

Action: Chair Madrigal-Weiss asked for a motion to approve the Consent Calendar. Commissioner Mitchell moved, seconded by Commissioner Tamplen, that:

- *The Commission approves funding for Contra Costa County's Innovation Plan for up to $6,119,182 over four years.*

The Motion passed 11 yes, 0 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Bontrager, Brown, Bunch, Carnevale, Danovitch, Gordon, Mitchell, Rowlett, and Tamplen, Vice Chair Alvarez, and Chair Madrigal-Weiss.

### 6: MHSSA Update and Technical Assistance Plan

Chair Madrigal-Weiss stated that the Commission will hear a presentation on the implementation of the Mental Health Student Services Act (MHSSA) Grant Program, key learnings from the MHSSA Learning Collaboration, and Phase 1 evaluation

approach and will consider approval of $8.2 million to support a statewide technical assistance strategy. She asked staff to present this agenda item.

Tom Orrock, Chief, Community Engagement and Grants, provided an overview, with a slide presentation, of the background and challenges of the MHSSA collaborative. He reminded everyone that partnerships between county behavioral health departments, county offices of education, and schools that may extend out to probation departments, child welfare departments, and migrant communities are the cornerstone of the MHSSA. The stronger the partnerships, the stronger the program.

Melissa Martin-Mollard, Ph.D., Chief, Research and Evaluation Division, continued the slide presentation and discussed the data that represents the initial impacts of the programs across the state. She stated that grant funding can be used to find solutions tailored to the needs of students and parents and to hire and train staff to provide services. The evaluation will look at whether these dollars are meeting the most vulnerable students. She clarified that the technical assistance piece is separate from the evaluation. WestEd is the lead evaluation partner. Their efforts will inform the technical assistance component.

Heather Nemour, Coordinator, Student Support Services and Programs Division, SDOE, provided an overview, with a slide presentation, of the background, goals and objectives, comprehensive needs assessments, year one successes, and technical assistance priority areas of the MHSSA grant in San Diego County, Creating Opportunities in Preventing and Eliminating Suicide (COPES). She stated that COPES is different from other grantees across the state because it is doing this work to build capacity of the county's local educational agencies (LEAs) as opposed to providing direct services.

**Commissioner Comments & Questions**

Commissioner Carnevale asked for more detail on the efforts to collect impact data.

Ms. Nemour stated that all LEAs send out the California Healthy Kids Survey annually. Through research, the county has identified specific indicators such as school climate and mental health issues that will be tracked through this survey. The LEAs also do an annual Comprehensive Needs Assessment to track growth indicators. She stated that the county also reviews the suicide risk screening data annually.

Commissioner Tamplen stated that the MHSSA grants have demonstrated how the MHSA and the Commission have put efforts into helping to reduce stigma and discrimination. Youth are more open to talking about their mental health issues than prior generations. It is inspiring to see the data and reports on the work the county is doing. She thanked San Diego County for the impact they are having in reducing mental health stigma. She recommended including Dr. Patrick Corrigan's TLC3 (targeted, local, credible, continuous, contact) stigma reduction model.

Ms. Nemour thanked the Commission for the MHSSA grant. It has made it possible for the county to lift up student mental health. She stated that peer programming will be brought in this year at the school level for suicide prevention and mental health. LEAs are becoming mental health champions in their school communities.

Commissioner Mitchell asked about opportunities in data collection to single out the most vulnerable students, such as foster youth and students exposed to trauma, in order to identify prevention efforts.

Ms. Nemour stated that the SDOE supports school districts and charter organizations but does not directly work in the schools. Data is being used to anonymously identify students through check indicators.

Commissioner Bontrager stated that there is $300 million MHSSA funding going to schools and $400 million from the state that flows through the Managed Care Plans to schools through the Student Behavioral Health Incentive Program (SBHIP) and another $550 million coming out in June for school-linked behavioral health capacity-building grants. He asked if there are efforts being made to bring these efforts together to leverage all these sources of funds to build a more sustainable delivery system in schools going forward. There is this one-time infusion of historic monies. The question is how to ensure something sustainable is built for a longer term.

Commissioner Bontrager stated that one thing seen with the MHSSA and SBHIP is that county offices of education have been elevated when it comes to student wellness and wellbeing through both processes. He asked if anything has been happening at the local county office of education level so funds from both the MHSSA and SBHIP are flowing through that office, if the funding is braided or leveraged, and if there is anecdotal information about any of that.

Chair Madrigal-Weiss stated that it looks different in each county, depending on the relationships. In San Diego County, anything that has to do with behavioral health runs through her department. Her department ensures that efforts are braided and resources are leveraged at the local level. She stated that her department leverages SBHIP participants with COPES. San Diego County's 33 LEAs identified with COPES are aligned with SBHIP districts and then leveraged to model and replicate for those districts that were not with SBHIP but were with COPES.

Chair Madrigal-Weiss stated that the MHSSA has, by design, brought together county behavioral health departments and LEAs or COEs. The MHSSA was a critical first step in dovetailing SBHIP.

Dr. Martin-Mollard stated that, from an evaluation standpoint, staff has asked WestEd to help identify core metrics for student mental health that looks across initiatives to what can be achieved. The evaluation effort will not be limited to the impacts of the MHSSA on student and school mental health but it will look at how all initiatives together and all funding braided together can have an impact.

Mr. Orrock stated that it sounds like what is needed is a statewide coordinated effort around sustainability and evaluation.

Commissioner Gordon elaborated on the Chair's comments. He stated that it is true that every county is approaching this in the way that best meets their individual needs. Sacramento County has chosen to begin the push for sustainability by creating a funding stream, which allows billing back through Medi-Cal to help fund clinicians at each school in the county. Approximately 40 clinicians are deployed.

Commissioner Gordon stated that, as far as the evaluation part of it goes, a discussion of years past must be revisited. One of the main goals was to try to bring the health systems and school systems closer together for a couple of reasons: (1) because the schools are a point of collaboration and access for families and young people, particularly underserved families and young people, and (2) more must be done with prevention down the road. As effective as current treatment is, many things are being treated after the fact. Prevention work in preschools and so on is difficult to do, but the sustainability is the major challenge. If there is a reliable source to bring schools and the medical system together, they can work on collaboration and prevention for the future.

Commissioner Rowlett stated that there are not enough individuals today to do the work that the need requires. He stated that sustainability in the workforce must also be considered along with sustainability in funding.

Commissioner Carnevale stated that prevention programs save money in the long run; however, this is often missed. Programs disappear when the funding runs out due to short-sightedness. He suggested increasing the understanding of the economics of these programs so they are seen as investments.

Chair Madrigal-Weiss asked staff to include this as part of technical assistance. She asked Mr. Orrock to continue his presentation.

**Presentation, continued**

Mr. Orrock provided an overview of the work done to date, learnings, technical assistance plan, Technical Coaching Team (TCT) responsibilities, minimum qualifications, and timeline of the proposed $8.2 million statewide technical assistance strategy. He stated that, in response to what was heard from current MHSSA grantees, two RFQs are being proposed as a hybrid approach to MHSSA grantee capacity development: (1) at least five contracts with current MHSSA grantees to make up the TCT, and (2) one statewide coordinator and additional subject matter experts.

**Commissioner Comments & Questions**

Vice Chair Alvarez asked about the difference between an RFQ and an RFA.

Mr. Orrock stated that the RFQ helps to identify experts to help design the statewide strategy. These experts can begin providing technical assistance to other grantees immediately on sustainability, program implementation, workforce, etc.

Commissioner Mitchell asked how to find technical coaching experts.

Executive Director Ewing stated that, recognizing the comments made earlier around one-time funding and sustainability, this is designed to support a peer-to-peer model that has the potential to be sustained after the funding is gone. Except for the statewide coordinator, it is not designed to secure an outside consultant who will teach and leave. Rather, it is designed to draw from the MHSSA partnerships to help partners learn from each other so that, when the funding is gone, the potential for peer-to-peer learning will remain.

**Public Comment**

Stacie Hiramoto stated concern that there is no mention about reducing disparities or cultural competence. Schools are not safe havens for some students and families. It is important to consider this when designing these plans to ensure that individuals who are unserved or underserved are included. She encouraged partnering with community-based organizations.

Richard Gallo stated the need for grantees to provide better data reporting as part of the requirement of the grant due to utilizing MHSA dollars. It needs to be inclusive of students in special education.

Laurel Benhamida, Ph.D., Muslim American Society – Social Services Foundation and REMHDCO Steering Committee, stated that her doctorate is in Second Language Acquisition and she was involved in education before mental health. She asked what is going on in Imperial County with refugee, immigrant, and migrant children from war and other conflict regions, such as Afghans, Ukrainians, and Central and South Americans. She asked about MHSSA programs that include prevention and early intervention programs for post-traumatic stress disorder (PTSD). She asked if the survey questions were fill-in style or if there was a menu to choose from. She asked, if it was a menu style, if the menu choices included technical assistance, culturally and linguistically appropriate services, and community-defined evidence practices (CDEPs). She asked if it appeared that these were priorities.

Mark Karmatz, consumer and advocate, stated that Jason Garcia, Director of Workforce and Development, Project Return Peer Support Network, will be presenting next Tuesday at 11:00 a.m. The speaker stated concern that the Mental Health Commission in Los Angeles meeting is that the same time.

**Commissioner Discussion**

Chair Madrigal-Weiss asked for a motion to approve the Proposed RFQ Outline, direct staff to issue two RFQs, one for technical coaching and one for statewide coordination, and authorize staff to initiate a competitive bid process and enter into contracts with the highest scoring applicants.

Commissioner Mitchell so moved.

Commissioner Gordon seconded.

Commissioner Rowlett stated concern that he has seen, when technical assistance is solicited for Black and indigenous students of color, their achievement markers are not reached even though the applicants for the RFA meet the minimum qualifications. He stated the hope that this RFQ would ask applicants what they plan to do better to address the needs of unserved, underserved, and inappropriately served students, and what different community-based strategies they will incorporate as part of the minimum qualifications. Asking better questions and requesting better information from the applicants will help identify innovative applicants who are best qualified to provide technical assistance to marginalized students.

Chair Madrigal-Weiss asked staff to work with Commission Rowlett to include his requests in the RFQs for technical assistance and evaluation.

Action: Commissioner Mitchell moved, seconded by Commissioner Gordon, that:

- *The Commission approves the Proposed RFQ Outline, directs staff to issue two Requests for Qualifications, one for technical coaching and one for statewide coordination, and authorizes staff to initiate a competitive bid process and enter into contracts with the highest scoring applicants.*

The Motion passed 11 yes, 0 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Bontrager, Brown, Carnevale, Chambers, Danovitch, Gordon, Mitchell, Rowlett, and Tamplen, Vice Chair Alvarez, and Chair Madrigal-Weiss.

## 7: Children and Youth Behavioral Health Initiative

Chair Madrigal-Weiss stated that the Commission will hear a presentation and consider directing staff to move forward with a proposal to provide approximately $150 million in grants to organizations seeking to scale evidence-based and community-defined evidence practices (CDEPs), including funding for technical assistance and program monitoring, for Round 4: youth-driven programs and Round 5: early intervention programs and practices of the Children and Youth Behavioral Health Initiative (CYBHI). Chair Madrigal-Weiss asked staff to present this agenda item.

Tom Orrock, Chief, Community Engagement and Grants, stated that the CYBHI is a $4.7 billion initiative to improve access to behavioral health services for children and youth regardless of their insurance coverage. Of the $4.7 billion, $429 million has been set aside to expand evidence-based practices and CDEPs that improve youth behavioral health based on robust evidence for effectiveness, impact on racial equity, and sustainability. He provided an overview, with a slide presentation, of the background, expanding evidence-based practices, the six rounds of grants, and minimum qualifications for the grants.

Mr. Orrock stated that Commission staff has been in discussion with the Department of Health Care Services (DHCS) about the Commission's role in administering the grants for Rounds 4 and 5. Initially, the plan was for the DHCS to disburse 10 percent of the $429 million ($43 million) to the Commission to scale specified prevention and early intervention practices; however, more recent conversations with the DHCS have resulted in a new approach, where the Commission would administer the grant process in collaboration with the DHCS for Rounds 4 and 5 with approximately $150 million in grants. The funding levels and types of programs have not yet been determined.

Mr. Orrock stated that Allcove Youth Drop-in Centers has been identified by the community through public engagement and is held up as an example of a Round 4 program. Coordinated specialty care clinic programs that address the needs of individuals experiencing a first-episode psychosis have been identified as an example of an evidence-based early intervention model for Round 5 programs. These two programs, along with other youth-driven and early intervention programs, could be expanded with these funds. He stated that $15 million is available for technical assistance to support awardees and is folded into the larger plan.

Mr. Orrock noted there is a tight timeline to distribute these funds, since the funding expires in June of 2025. If approved, staff hopes to release a RFAs in April or early May so awarded programs will have a full two years of funding available. The hope is to move forward with continued discussion and collaboration with the DHCS and to begin the grant program, once the funding levels and eligible program types are more clearly identified.

**Commissioner Comments & Questions**

Commissioner Chambers asked about the definition of youth.

Executive Director Ewing stated that these grants are limited to services for the 0-25 population; however, it is recognized that, in specific instances, there are opportunities to serve their families, as well. The DHCS has done a year-long process of defining programs that would be eligible for Rounds 4 and 5 and are making that determination, and they are also making the determination of the amount of funding that will be available in each round.

Vice Chair Alvarez stated that this is an incredible one-time opportunity that will go to support youth-driven community-based programs. She asked about sustainability.

Executive Director Ewing stated that the process the DHCS initiated and pursued included a requirement that the programs must be programs that could be billed for. These are incentive dollars to launch or scale evidence-based or community-defined practices that can be funded with ongoing revenues.

Executive Director Ewing stated that part of the technical assistance includes working with providers to maximize California Advancing and Innovating Medi-Cal (CalAIM) and other recent modifications to Medi-Cal, but also the new rules around commercial insurance funding for individuals with mental health needs. This has been a limiting factor in terms of what is eligible. There are certain evidence-based practices that are eligible for these funds but the language that the DHCS is putting forward is that applicants can identify community-defined practices that are comparable, and can demonstrate that there is a robust evidence base from the community to support that and that there is a perception of sustainable financing strategies.

**Public Comment**

Stacie Hiramoto stated that REMHDCO and the CRDP have been following the CYBHI process, but this came out of the blue. She stated that she hoped for transparency and working with the community because the community is puzzled. For example, there is no stated role for the Commissioners in approving the proposed funding package. The Commission is being asked to authorize staff to administer the plans, but there is no information in the outline regarding how the RFAs or grantees will be managed and the plan for the administrator of the RFAs and grantees is not presented. Many things are missing.

Stacie Hiramoto stated that Allcove Youth Drop-in Centers was mentioned, but Allcove has primarily been put in upper middle-class neighborhoods, not in average or low-income neighborhoods. She stated concern about expanding a program that is not serving underserved communities.

Stacie Hiramoto stated that the presentation slides were not made available to the public until today. This makes it difficult for the public to provide comment.

Chair Madrigal-Weiss asked Executive Director Ewing to respond to Stacie Hiramoto's concerns.

Executive Director Ewing stated that the legislation specified that 10 percent of the funds would come to the Commission, but over the course of the DHCS's over-18-month process, the DHCS asked the Commission to administer Rounds 4 and 5 using the process the DHCS had already pursued with community engagement, rather than simply administering the 10 percent. He stated that he was unable to comment on how robust that community engagement was from the communities' perspective, but he understood that they had significant community engagement in terms of programs that would be eligible.

Executive Director Ewing stated that Allcove is one program that is eligible but it is not the only one. Two Allcove sites are open: one in the San Jose area in Santa Clara County and one in Los Angeles County. Sacramento County is also opening a site in the Oak Park area. The Commission is aggressively working with partners to ensure that the Allcove model is available in communities with the greatest needs. The CYBHI has a specific emphasis on highlighting programs that target the most disadvantaged communities. He noted that funding is not limited to Allcove, but it is a program where applicants can develop youth-driven models with an evidence base.

Diego Bravo, Resource Development and Policy Manager, Safe Passages, part of the CRDP, stated that CDEPs were mentioned in today's presentation, but the outline of the proposed process in the meeting materials does not list CDEPs under the descriptions of Rounds 4 or 5, although CDEPs are specifically referenced dozens of times in the official CYBHI funding strategy document, which is the guiding document of all CYBHI grants. He stated the hope that CDEPs will be included in all RFA releases.

Diego Bravo stated that Safe Passages believes that more information and transparency is needed regarding how the Commission will manage RFA processes or grantees once funds are awarded.

Diego Bravo asked for clarification on detail provided in the meeting materials on how the Commission was authorized to administer CYBHI Round 4 of the grant program, as Safe Passages was under the assumption that the initial plan was for the Commission to just administer Round 5. The meeting materials simply state that the Commission is authorized to do so, but it seems, based on the outline, that, if this action is approved, the power of authorization and management would then be shifted to staff.

Diego Bravo stated the need for more transparency and oversight on these processes. He stated appreciation for the Commission's continued work and advocacy in this space for communities.

Josefina Alvarado Mena, CEO, Safe Passages, and Chair, CRDP Sustainability Committee, stated that they participated in the think tank that advised the DHCS on evidence-based practice and CDEPs workstreams for the CYBHI. The speaker stated that they feel blindsided about the movement of Rounds 4 and 5 to the Commission because this was never part of the discussion. Also, the context of the guidance and

discussions about the strategic funding plan for this workstream were not presented in any of the public forums for public comment.

Josefina Alvarado Mena stated that this investment is important to the state of California and particularly to organizations and communities that will be serving children and youth. Transparency is critical. The speaker stated concern about the lack of transparency in the meeting materials about the process that is being asked to be approved. The outline of the process does not include detail about the selection process, it does not include CDEPs under Rounds 4 and 5, and no role is articulated for the Commission in approving the final funding packages, which does not seem appropriate, given the public nature of this funding.

Josefina Alvarado Mena stated that, because there are currently no details about the RFA process or about the way the grant will be managed after grants are awarded, there is no opportunity for the public to provide comment or guidance about this process. The speaker stated the need to provide the opportunity for public comment and guidance about the RFAs as well as the grant management process after the fact.

Concepcion James stated that most of the youth across California are Latino. The speaker stated concern about a bias in the programming, technical assistance, and models being chosen to implement across California. There needs to be more cultural sensitivity and community engagement. Allcove may be a good program, but there are other successful programs in Contra Costa County that are in the schools and led by community non-profit groups. There needs to be an openness to hear more from community non-profits across the state in terms of their reaction to the proposed plan.

Sonya Young Aadam, CEO, California Black Women's Health Project, part of the CRDP, supported comments made by REMHDCO, Safe Passages, and others particularly around the issue of transparency. The speaker stated concern about the administration of this process and asked for more information on what that means from the selection of applicants to all decisions made about how the grants are handled.

Sonya Young Aadam stated that Commissioners have commented about what is seen with grants, programs, or contracts where there is no deliberate or intentional language to address disparities reduction and marginalized populations. The speaker stated that they are a part of the Governor’s Behavioral Health Task Force that spent a great deal of time on this $4.7 billion initiative. At no point was there any discussion about the Commission potentially administering Rounds 4 and 5. The speaker asked that there be strong consideration for the continued inclusion of CDEPs. It is a cause for worry when that is not listed in the materials.

Sonya Young Aadam asked if the Commission has a role in the selection process. The speaker stated that their organization runs three CDEPs but they wondered if they would ever qualify for the Commission’s standards.

Sonya Young Aadam thanked the Commission and stated appreciation for all it is doing. The speaker stated the hope to work much more closely together so that, when it comes out, it is something that will serve Black, indigenous, and people of color (BIPOC), particularly those who are dealing with public school systems, where children and youth are not being well cared for and in many cases are being harmed.

Laurel Benhamida stated that it is good to hear CDEPs being talked about and funded. She spoke in support of the comments made by the previous speakers. Communities want things to be done in a way that works the best for the people being served. She stated that, if the Commission will be funding CDEPs, it will be funding small community-based organizations. She suggested looking at the model of the Office of Health Equity's CRDP, where they had a lot of community input from small community-based organizations about how to craft the RFPs so small organizations can succeed in filling them out. That is a role model to look at.

Dr. Benhamida asked who will be hired to work with the small community-based organizations that do have CDEPs to help them be billable. That is the road to sustainability.

Eba Laye, Executive Director, Whole Systems Learning, part of the CRDP, was discouraged by today's discussion. Most of the population in California is people of color, yet disparities are not really spoken about. Disparities also relate to disparate treatment. The public has now learned that some rounds will be administered by the DHCS and others by the Commission. The speaker questioned if the same standards will be used in evaluating grant applications.

Eba Laye stated that the requirement for CDEPs to be billable defeats the purpose because the Medi-Cal billing system is based on the clinical model that does not allow the implementation of community-based services. The clinical model has been demonstrated to not serve most of the people in the state of California. Also, pointing out one service pushes community-defined practices into the background. This is not just a disservice to California, but it serves to increase the disparities that already exist.

Eba Laye stated that the disparities and disparate treatment against most of the people and the children of California continue, particularly the groups that are unserved, underserved, and inappropriately served. These are the populations that CDEPs represent. To increase that ill-treatment of these populations is very discouraging. It is discouraging to learn that, unless a service provider has a clinical billing model that none of the children will ever be interested in, they may not qualify. The clinical model takes the front seat while the CDEPs are in the back or not even in the car at all.

Steve McNally, family member and Member, Orange County Behavioral Health Advisory Board, speaking as an individual, agreed with comments made by Commissioners to ensure capacity building in the RFA where it requires people to work in collaboratives across areas and to look to leveraged funds that exist that are not being spent in this area.

Steve McNally stated that they attended many of the community engagement meetings with the DHCS. What the speaker found was that the DHCS's idea of presenting and breaking silos was to present the same information in silos. The speaker suggested bringing all the players together in one presentation when rolling this out. Once everyone knows each other, they tend to like each other. One thing missing in California regardless of the amount of funding is that there is no trust outside of the silos. This makes it difficult to implement programs. Also, very few state agencies empower communities after their presentation and they do not discuss implementation. The

speaker noted that it is very far along in this process of spending this money while people remain confused about how to spend it.

Steve McNally stated that Allcove is beautiful but it is expensive. Many communities will be unable to fund it. There are other entities who are funding the same model for services without the expense that Stanford put on it. There is so much money in so many places that is lost to economies of scale. Someone needs to lead the leadership to ensure that all the money is connected to each other and that there are shared outcomes so that they are building upon each other. Everyone must be in the room to discuss alternative models.

**Commissioner Discussion**

Commissioner Chambers asked if an applicant needs to be eligible to bill Medi-Cal in order to receive the funding.

Executive Director Ewing stated that he did not know but stated that Medi-Cal is not the only funding stream available to fund these services. The Commission would need to clarify the standards and expectations that the DHCS put forward. The Commission is not being asked to establish the standards for what the funds can be used for; it has been asked to implement the standards through a competitive procurement process.

Executive Director Ewing stated that the question is whether the DHCS should implement this whole thing including programs, such as Allcove, or whether the Commission is willing to do this work. The criteria have been established by the DHCS. The eligibility standards are the same throughout all six rounds. The DHCS recognizes that the Commission has some expertise in the areas addressed in Rounds 4 and 5. The DHCS has asked the Commission to not just administer the $42 million as originally negotiated with the Legislature, but to expand that to an amount not to exceed $150 million.

Executive Director Ewing suggested identifying a Commissioner who will sit with staff, review the rules, and sign off on the specifics of the proposal. Because it is a competitive procurement, this cannot be done publicly.

Commissioner Mitchell stated that the issue is more about the transparency process. She asked if the Commission can develop a transparency statement or policy so the public can feel like the Commission is not operating in secrecy.

Executive Director Ewing stated that the DHCS has been responsible for the public process up to this point. He stated that he cannot comment on whether that process has been sufficiently transparent. It is the Commission’s practice to not only have this conversation in public and provide materials, but to post a list of the selected winners on the website. A future goal is to list the full contracts online. That is a level of transparency that is above and beyond standard practice in government.

Commissioner Mitchell stated concern for issues like today’s presentation that the public did not know was happening, which caused them to feel left out of the process. She suggested putting out a statement or flyer informing the public of the Commission transparency process when introducing new topics, subjects, or issues as a matter of procedure.

Vice Chair Alvarez stated that, to Commissioner Mitchell's point, there are two parties involved here but only the Commission is represented at this meeting. She noted that it would have gone a long way to have invited the DHCS to this meeting to demonstrate this move and that it was not the DHCS on the Commission or the Commission taking it on, but that it was a result of the discussion that the two entities came together in order to leverage the capacity of the Commission. The DHCS is trusting the Commission to distribute these two important rounds of funding. That is an amazing credit to the Commission team, but it would have been an important symbol to the public to have them in attendance at this meeting. She suggested that joint efforts include representatives from all teams present at future meetings so everyone can engage in a discussion together.

Commissioner Mitchell agreed that joint efforts should include all parties and stated that it would help keep Executive Director Ewing from being put in the awkward position of being asked difficult questions that only the other party would know.

Executive Director Ewing agreed that it would have been more productive to have representatives from the DHCS present to explain the issue and answer questions. Many questions from the public were about the process prior to this point, which the Commission was not responsible for. He stated that the Legislature has been pushing the DHCS and the Commission about the status of the interagency agreement. It was over the last two weeks that the DHCS asked the Commission to do Rounds 4 and 5.

Vice Chair Alvarez stated the need to be mindful that a lot was put on the DHCS with the $4.7 billion CYBHI. The fact that the DHCS is leveraging their partners is logical.

Commissioner Rowlett agreed with Vice Chair Alvarez's comments and stated appreciation for the transparent nature of this conversation. He stated that this is an operational consideration. He asked the Commission to consider organizations that are invested in CDEPs or working with underserved communities, BIPOC, or LGBTQ communities to be involved in the RFA evaluation process when appropriate and within parameters.

Commissioner Carnevale stated that the Governor has just recommended that the Commission potentially become part of the DHCS. The fact that the DHCS reached out to ask the Commission to partner indicates that they see the Commission as a valuable partner that provides exactly the services that the original structure intended.

Chair Madrigal-Weiss stated that, to Commissioner Rowlett's point, different pieces are known from the different lenses and groups Commissioners represent. Commissioners need more conversation around this. She suggested including this issue in strategic planning discussions.

Chair Madrigal-Weiss stated that the Commission is being asked important questions but did not get to inform how the process went. To honor these questions and transparency, she asked Vice Chair Alvarez to work with staff to ensure that all concerns heard today are addressed.

Commissioner Mitchell asked, in that process, if a policy or practice statement can be developed whereby the public can be assured that the Commission does operate in transparency so that the Commission's integrity is not questioned.

Chair Madrigal-Weiss asked what a process would look like versus a statement.

Commissioner Mitchell stated that one may not be better than the other but the recognition of building that trust is important.

Executive Director Ewing stated that, when the Commission makes a decision about an award, all of those materials automatically are made public to support the appeal process so everyone can see everything that was submitted, what the rubric was, and what the scoring was. All that information is available to an applicant who did not prevail to use to challenge the determination of who did win. In this way, transparency is built into the process.

Commissioner Mitchell stated that honesty, integrity, and transparency are valued. It is important to let the public know in a statement that that is how the Commission operates and, by way of what it does and the way it communicates with interested parties, that the Commission upholds it. It is important to say what the Commission is, what it does, and how it does it.

Executive Director Ewing asked if this might be done through the strategic planning process.

Chair Madrigal-Weiss agreed and added that it could be part of the Commission's mission.

Commissioner Mitchell agreed.

Commissioner Rowlett stated that, in the development of an RFA, to solicit the input of the community, there are unique challenges there, but in the way of promoting transparency, there are unique opportunities. He endorsed, even in the development of an RFA, that the Commission talks about the inclusion of interested parties and how the Commission can be better than the DHCS at doing that to prove why the DHCS should choose the Commission for more of their work. The Commission includes community input at the front end – at the development of an RFA. Therein lies one of the issues that the Commission can address that also helps the Executive Director.

Executive Director Ewing stated that the Chair has asked staff to put together a presentation on world class community engagement.

Action: Chair Madrigal-Weiss asked for a motion. Commissioner Mitchell moved, seconded by Commissioner Carnevale, that:

- *The Commission directs staff to administer the grants for Rounds 4 and 5 of the CYBHI consistent with the Interagency Agreement between the Commission and the Department of Health Care Services, including approximately $15 million in Technical Assistance Grants along with Vice Chair Alvarez working alongside the staff to ensure that the Commission addresses community comments.*

The Motion passed 10 yes, 0 no, and 1 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Bunch, Carnevale, Chambers, Danovitch, Gordon, Mitchell, Rowlett, and Tamplen, Vice Chair Alvarez, and Chair Madrigal-Weiss.

The following Commissioner abstained: Commissioner Bontrager.

**8: Lunch**

**9: Prevention and Early Intervention Report and Establishing Additional PEI Priorities**

Chair Madrigal-Weiss noted that there are two parts to this agenda item. They will be discussed separately.

Prevention and Early Intervention Report

Chair Madrigal-Weiss stated that the Commission will first hear a presentation on the Prevention and Early Intervention Report, *Well and Thriving*, and will consider adopting the report. She asked staff to present this agenda item.

Kali Patterson, M.A., Research Scientist, provided an overview, with a slide presentation, of the background of Senate Bill (SB) 1004, the Commission's Prevention and Early Intervention Project, and findings and recommendations included in the Prevention and Early Intervention Report, *Well and Thriving.*

**Commissioner Comments & Questions**. No Commissioner comments or questions.

**Public Comment**

Stacie Hiramoto stated that she had issues with the characterization of SB 1004. The community did not view the introduction of SB 1004 as presented. There was a framework for PEI, which arose from this Commission. Approximately one year after the formation of the Commission, the Commission developed a Committee made up of two Commissioners, counties, and community members who represented many types of communities. Passionate children's, older adult, and consumer groups came together with the Commission and worked out an agreement on the PEI Guidelines. They were not perfect but everyone agreed to them.

Stacie Hiramoto stated that there is only so much PEI money. That is why it is important for the community and counties to work together. She stated that she heard that SB 1004 was introduced because individuals were frustrated that there were so many different things that they could not measure because counties were spending PEI money on different things, as they should. With no consultation with counties, SB 1004 first started out with only the first three priorities. It was only through vigorous lobbying that the older adults were able to add that priority in and culturally and linguistically competent language was added, although it is so broad that it is meaningless.

Chair Madrigal-Weiss asked Stacie Hiramoto to submit her full written comment to staff.

Alison M. spoke on behalf of Mary Ann Bernard, retired lawyer, family member, and advocate for the severely mentally ill, who was unable to be in attendance. The speaker stated that the Commission needs to remedy an embarrassing oversight in the *Well and Thriving* report: while it defines relapse prevention as "tertiary prevention" at page 3, it otherwise ignores both the concept and a legal mandate in the MHSA for relapse prevention and early intervention programs for individuals who already have severe mental illness. The legal requirement is in the last clause of Section 5840(c), the heart of the PEI provisions, which says PEI shall also include components similar to programs

that have been successful in reducing the duration of untreated severe mental illnesses and assisting people in quickly regaining productive lives.

Alison M. stated that Ms. Bernard suggests listing the legal requirement for relapse prevention programs as an opportunity spotlight under the report's Finding Four, perhaps after the discussion of limited services at page 57. The Commission should include examples of successful relapse prevention programs, such those similar to the Mentally Ill Offender Crime Reduction Grant Program mandated by the voters in Section 5813.5(f) but ignored by most counties despite successes documented by the California Department of Corrections and Rehabilitation (CDCR); good supportive housing programs that help the most severely ill stay stable; stepdown facilities for those spilling out of 24-hour crisis sites, jails, or hospitals without being fully stabilized – please note that locked facilities are specifically authorized to receive MHSA funding by Section 5847(b)(5) – and AOT/Laura's Law, which is a proven and cost-effective early intervention for individuals with serious mental illnesses with recent histories of violence or dangerousness shown by repeated involuntary hospitalizations, before they become dangerous again.

Chair Madrigal-Weiss thanked Alison M. and noted that the Commission received Mary Ann Bernard's written comment.

Action: Chair Madrigal-Weiss asked for a motion to adopt the PEI draft report, *Well and Thriving*. Commissioner Carnevale moved, seconded by Commissioner Tamplen, that:

- *The Commission adopts the PEI draft report, Well and Thriving.*

The Motion passed 10 yes, 0 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Bontrager, Bunch, Carnevale, Chambers, Gordon, Mitchell, Rowlett, and Tamplen, Vice Chair Alvarez, and Chair Madrigal-Weiss.

Establishing Additional PEI Priorities

Chair Madrigal-Weiss stated that the Commission will now discuss the process for establishing additional PEI Priorities and will consider adopting additional priorities under SB 1004.

Chair Madrigal-Weiss stated that many in the community are asking the Commission to establish new priorities for PEI to emphasize support for transition age youth (TAY) who are not in college and to highlight community-defined evidence practices (CDEPs) as programs that should be funded under PEI. To aid the discussion, she asked Chief Council Margolis to review what adopting new priorities means within the statutes of the law and what that process looks like.

Chief Counsel Margolis stated that Welfare and Institutions Code (WIC) section 5840.7(a) pursuant to SB 1004 says that the Legislature has established five specific priorities and has allowed the Commission to adopt additional priorities. Typically, adopting additional priorities or other rules under the law requires that they be promulgated as regulations, which is a robust process involving community participation. A regulation such as this will take two to three years to accomplish;

however, the law provides an exemption in this case by stating in lieu of regulations, the Commission can use an Informational Notice to indicate that it has adopted additional priorities. In January of 2020, the Commission did such Informational Notice and notified the entire community about the five priorities already established in statute and indicated at that time that the Commission had not adopted any additional priorities.

Chief Counsel Margolis stated that, if the Commission were to adopt additional priorities, it would have to engage in a process of putting those out in some way, which means it could choose to go through the regulatory process, even though it does not have to, or it could use an Informational Notice to communicate the adoption. From a procedural perspective, this means that, depending upon what happens here today, one of the options is to direct staff to issue such an Informational Notice. Part of the discussion then should include thoughts about how the process will unfold: regulations, Informational Notice, have staff to have discretion in developing that Informational Notice, or craft the Information Notice here today amongst the group.

**Commissioner Comments & Questions**

Commissioner Mitchell asked about the timeline on an Informational Notice.

Chief Counsel Margolis stated that there is no timeline. The question of timing is whether it can be issued based on what happens today or if it needs to come back to the Commission at a future meeting.

Commissioner Mitchell stated her understanding that it will not require approval from the Office of Administrative Law (OAL) or other departments.

Chief Counsel Margolis stated that is correct. There is an express exemption from the Governor and Legislature that the Commission can use Informational Notices in this case until the Commission adopts the regulations.

Commissioner Mitchell stated that this is a great opportunity to expedite the process.

Vice Chair Alvarez stated that the Commissioners present at the February Commission meeting engaged in productive conversation and agreed to add language that prioritizes all TAY, not just those in college, and to add language that prioritizes CDEPs. She asked if it is appropriate to move now for the Commission to use an Informational Notice augmenting existing priorities with language supporting all TAY and CDEPs.

Chief Counsel Margolis stated that the Commission can add new priorities, not augment existing ones.

Chair Madrigal-Weiss asked what would happen if additional priorities were proposed during strategic planning. She asked about the number of times the Commission can create Informational Notices to identify new priorities.

Commissioner Carnevale stated that the Commission determined to have a strategic planning process to look at all priorities. He stated his recollection of the last meeting was that Commissioners were not discussing it as a new priority but as clarifying language that the Commission represents all citizens of California and not just a subgroup. He stated that he did not think of it as changing the Commission's priorities. The conversation has been reframed coming out of legal deliberations. He stated that

he now needs to rethink everything in the sense that, if the Commission is establishing new priorities, it should go into the strategic plan.

Vice Chair Alvarez stated that it is semantics here. The two recommendations are clarifications of existing priorities already outlined in SB 1004: the priority of cultural and linguistic appropriateness refines the language to include CDEPs, and the priority of TAY refines the language to include all TAY, not just those in college.

Commissioner Carnevale asked for clarification that it does not establish a new priority.

Vice Chair Alvarez agreed but stated that legally the Commission must create new priorities. It is not establishing new priorities but, by listing them out as Numbers 7 and 8, it is.

Chief Counsel Margolis agreed. He stated appreciation that Commissioners are trying to thread that needle but, from a legal perspective, the law specifically states that these are the five priorities. The Commission has the discretion to add additional priorities. In trying to reshape existing priorities, the way the Commission must do it is to establish new priorities.

Executive Director Ewing clarified that during the legislative process the Commission pointed out that it is not necessarily a robust idea to establish priorities in statute recognizing that priorities may shift, particularly around behavioral health. The language around adding additional priorities was to recognize that over time the learning and understanding of impacts would change. It was designed to create a living body of priorities as the world evolves and knowledge evolves. Commissioners are in a conundrum because the Commission is not authorized to modify or reject the Legislature's priorities. The Commission is only allowed to establish new ones.

Vice Chair Alvarez stated her assumption that there is nothing that says the Commission can only do an Informational Notice once.

Executive Director Ewing agreed.

Vice Chair Alvarez stated that, if new priorities are identified during the strategic planning process, the Commission can put out a new Informational Notice.

Executive Director Ewing agreed that the Commission can continue to add priorities over time, but what is left unclarified is, in identifying new priorities, if the Commission can remove priorities that were established by the Commission at an earlier date. He asked Commissioners to state their priorities and noted that SB 1004 also requires the Commission to develop a technical assistance strategy and a monitoring strategy for those priorities. These priorities are optional for counties but a monitoring system has yet to be put in place for the seven existing mandatory county priorities, one of which is to reduce school failure. He asked for clarity on expectations around priorities and what it means in terms of the operational work that staff does on the Commission's behalf.

Commissioner Rowlett stated that he views the strategic planning process as separate and distinct from this and that various components of the strategic planning process may include another Informational Notice as part of the process. He stated that the priority today is to adopt the two additional priorities and the need to have an

Informational Notice that would allow the Commission to advance those two additional priorities.

Chair Madrigal-Weiss stated that she needs to see where it all comes together.

Commissioner Carnevale stated that Commissioners seem to be in general agreement. Commissioners thought they were cleaning up language but now are realizing that legally new priorities need to be established. He asked how that reads and what that means.

Chair Madrigal-Weiss stated that the only way to clean it up is to create two new priorities.

Commissioner Carnevale asked why two.

Commissioner Bunch stated that Commissioners were ready to vote at the February meeting; Commissioners should vote today on that language. It sounds more confusing today than at the February meeting.

Chair Madrigal-Weiss stated that the language of the vote had yet to be formulated at the last meeting. Also, Commissioners were going in the wrong direction at the February meeting.

Chief Counsel Margolis stated that Commissioners were drafting a motion on the fly at the last meeting to try to accomplish what appeared to be the will of the group but the process was not finalized. It does not take anything away from the conversation that the Commissioners have had and the understanding in terms of a desire last month, but a motion was not quite put on the table that encapsulated the two additional priorities.

Vice Chair Alvarez made a motion to add two new PEI priorities through use of an Informational Notice to read as follows: (1) youth outreach and engagement strategies for TAY not in college, and (2) CDEPs.

Executive Director Ewing asked for clarification on if the Commissioners would like to see that and have that publicly reviewed and voted on in writing at the next meeting. It is the Informational Notice that establishes the priorities. Vice Chair Alvarez has forwarded a motion with specific language. Part of the challenge staff saw in working through the process and engaging the community is about emphasizing strategies to reduce disparities. If the Commission has the specific language and is ready to vote, this makes it easy – Commissioners tell staff the language, and staff puts it in an Informational Notice and sends it out.

Executive Director Ewing stated that, if the Commissioners wanted to have a conversation about the goals of that and having broader language around reducing disparities and prioritizing certain things, this would be more complicated. Commissioner Rowlett had asked how to advance those two priorities. Executive Director Ewing asked what that means in this context. Issuing an Informational Notice signals to the counties that they should pursue these additional priorities. Advancing those things is an operational question that staff would need to know what the intention is. He stated that he heard Vice Chair Alvarez present language for staff to then work with. That is a simple vote.

Commissioner Rowlett agreed that that is the first step.

Commissioner Carnevale stated that what he heard was, once these are set as priorities, they cannot be changed but only added to. He asked how to ensure that the additional priorities are vetted to a point where the Commission can be confident that it makes sense and will not be sorry that it did that later.

Chair Madrigal-Weiss stated that a lot of it has to do with listening to what the community has said – these words will make game-changers in the counties. It is the first step. Following up, the Commission will continue to work with communities to see that that is actually making it. This is a way of showing that the Commission intends and wants to work collaboratively with communities. This is a way to do that. Things are not written that are not prepared to measure, look at, and create the systems for. This is timely, this is right, and this is what is being said over and over. She recommended getting this done and working out the process along the way.

Commissioner Carnevale asked if Commissioners are confident that the language of the proposed motion is good language to accomplish that.

Chair Madrigal-Weiss stated that everyone must work together to make it strong. This is a good faith action to do it.

Commissioner Carnevale seconded the motion.

Chair Madrigal-Weiss asked Chief Counsel Margolis to read the motion.

Chief Counsel Margolis stated that the motion is that the Commission directs staff to prepare an Informational Notice pursuant to Welfare and Institutions Code section 5840.8 indicating that the Commission has adopted additional priorities regarding transitional age youth not in college and community-defined evidence practices (CDEPs), pursuant to Welfare and Institutions Code Section 5840.7(a)(6).

**Public Comment**

Stacie Hiramoto reminded everyone that over 25 individuals provided public comment on this issue at the last meeting. She stated that the language of the motion is fine but hoped that there is good faith and that this simple Informational Notice does not take months to put out. She noted that the public and many counties were not made aware that the last Informational Notice was sent out. She stated that there is no opposition to this motion including the counties, providers, and consumers. She assured the Commission that the public is not trying to leave anyone out but is trying to get services that will help reduce disparities.

Josefina Alvarado Mena thanked the Commission for their support for these two recommendations. There is an opportunity for the language to clearly establish why this is being done. She suggested including “towards California’s shared goal of reducing behavioral health disparities, the Commission establishes CDEPs and TAY as PEI priorities.” The language is important. The Informational Notice should confirm why the Commission and the community wanted to take this important action while moving the state forward to adding the needs of all Californians.

Josefina Alvarado Mena urged the Commission to include a timeline in the motion, such as a two-week timeline or before the April Commission meeting, that this Informational Notice be issued to the counties. This is the time where funding and grant decisions are

being made. This additional guidance could be helpful to local counites and can get to the implementation part of this conversation.

Danny Thirakul, Public Policy Coordinator, California Youth Empowerment Network (CAYEN), thanked the Commission for listening to community input and for considering incorporating the community input changes to the PEI priorities. CAYEN strongly endorses access to behavioral health services for all TAY.

Laurel Benhamida suggested a slight change to the motion to add strength and clarity.

Action: Vice Chair Alvarez moved, seconded by Commissioner Carnevale, that:

- *The Commission directs staff to prepare an Informational Notice pursuant to Welfare and Institutions Code section 5840.8 indicating that the Commission has adopted additional priorities regarding transitional age youth not in college and community-defined evidence practices (CDEPs), pursuant to Welfare and Institutions Code section 5840.7(a)(6).*

The Motion passed 10 yes, 0 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted “Yes”: Commissioners Bontrager, Bunch, Carnevale, Chambers, Gordon, Mitchell, Rowlett, and Tamplen, Vice Chair Alvarez, and Chair Madrigal-Weiss.

## 9: Adjournment

Chair Madrigal-Weiss stated that the next Commission meeting will take place on April 27th. There being no further business, the meeting was adjourned at 2:24 p.m.

Mental Health Services
Oversight & Accountability Commission

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**Motions Summary**
**Commission Meeting**
**March 23, 2023**

**Motion #:** 1

**Date:** March 23, 2023

**Proposed Motion:**
That the Commission approves the February 23, 2023 Commission Meeting Minutes

**Commissioner making motion:** Commissioner Rowlett

**Commissioner seconding motion:** Vice Chair Alvarez

Motion carried 8 yes, 0 no, and 3 abstain, per roll call vote as follows:

| Name | Yes | No | Abstain | Absent | No Response |
|---|---|---|---|---|---|
| 1. Commissioner Bontrager | ☒ | ☐ | ☐ | ☐ | ☐ |
| 2. Commissioner Boyd | ☐ | ☐ | ☐ | ☒ | ☐ |
| 3. Commissioner Brown | ☐ | ☐ | ☒ | ☐ | ☐ |
| 4. Commissioner Bunch | ☐ | ☐ | ☐ | ☐ | ☒ |
| 5. Commissioner Carnevale | ☒ | ☐ | ☐ | ☐ | ☐ |
| 6. Commissioner Carrillo | ☐ | ☐ | ☐ | ☒ | ☐ |
| 7. Commissioner Chambers | ☒ | ☐ | ☐ | ☐ | ☐ |
| 8. Commissioner Chen | ☐ | ☐ | ☐ | ☒ | ☐ |
| 9. Commissioner Cortese | ☐ | ☐ | ☐ | ☒ | ☐ |
| 10. Commissioner Danovitch | ☒ | ☐ | ☐ | ☐ | ☐ |
| 11. Commissioner Gordon | ☐ | ☐ | ☒ | ☐ | ☐ |
| 12. Commissioner Mitchell | ☐ | ☐ | ☒ | ☐ | ☐ |
| 13. Commissioner Rowlett | ☒ | ☐ | ☐ | ☐ | ☐ |
| 14. Commissioner Tamplen | ☒ | ☐ | ☐ | ☐ | ☐ |
| 15. Vice-Chair Alvarez | ☒ | ☐ | ☐ | ☐ | ☐ |
| 16. Chair Madrigal-Weiss | ☒ | ☐ | ☐ | ☐ | ☐ |

**Motions Summary**
**Commission Meeting**
**March 23, 2023**

**Motion #:** 2

**Date:** March 23, 2023

**Proposed Motion:**
That the Commission approves funding for Contra Costa County's Innovation Plan for up to $6,119,182 over four years

**Commissioner making motion:** Commissioner Mitchell

**Commissioner seconding motion:** Commissioner Tamplen

Motion carried 11 yes, 0 no, and 0 abstain, per roll call vote as follows:

| Name | Yes | No | Abstain | Absent | No Response |
|---|---|---|---|---|---|
| 1. Commissioner Bontrager | ☒ | ☐ | ☐ | ☐ | ☐ |
| 2. Commissioner Boyd | ☐ | ☐ | ☐ | ☒ | ☐ |
| 3. Commissioner Brown | ☒ | ☐ | ☐ | ☐ | ☐ |
| 4. Commissioner Bunch | ☒ | ☐ | ☐ | ☐ | ☐ |
| 5. Commissioner Carnevale | ☒ | ☐ | ☐ | ☐ | ☐ |
| 6. Commissioner Carrillo | ☐ | ☐ | ☐ | ☒ | ☐ |
| 7. Commissioner Chambers | ☐ | ☐ | ☐ | ☐ | ☒ |
| 8. Commissioner Chen | ☐ | ☐ | ☐ | ☒ | ☐ |
| 9. Commissioner Cortese | ☐ | ☐ | ☐ | ☒ | ☐ |
| 10. Commissioner Danovitch | ☒ | ☐ | ☐ | ☐ | ☐ |
| 11. Commissioner Gordon | ☒ | ☐ | ☐ | ☐ | ☐ |
| 12. Commissioner Mitchell | ☒ | ☐ | ☐ | ☐ | ☐ |
| 13. Commissioner Rowlett | ☒ | ☐ | ☐ | ☐ | ☐ |
| 14. Commissioner Tamplen | ☒ | ☐ | ☐ | ☐ | ☐ |
| 15. Vice-Chair Alvarez | ☒ | ☐ | ☐ | ☐ | ☐ |
| 16. Chair Madrigal-Weiss | ☒ | ☐ | ☐ | ☐ | ☐ |

Mental Health Services
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**Motions Summary**
**Commission Meeting**
**March 23, 2023**

**Motion #:** 3

**Date:** March 23, 2023

**Proposed Motion:**
That the Commission approves the Proposed RFQ Outline, directs Staff to issue two Requests for Qualifications, one for technical coaching and one for statewide coordination, and authorizes Staff to initiate a competitive bid process and enter into contracts with the highest scoring applicants.

**Commissioner making motion:** Commissioner Mitchell

**Commissioner seconding motion:** Commissioner Gordon

Motion carried 11 yes, no, and 0 abstain, per roll call vote as follows:

| Name | Yes | No | Abstain | Absent | No Response |
|---|---|---|---|---|---|
| 1. Commissioner Bontrager | ☒ | ☐ | ☐ | ☐ | ☐ |
| 2. Commissioner Boyd | ☐ | ☐ | ☐ | ☒ | ☐ |
| 3. Commissioner Brown | ☒ | ☐ | ☐ | ☐ | ☐ |
| 4. Commissioner Bunch | ☐ | ☐ | ☐ | ☐ | ☒ |
| 5. Commissioner Carnevale | ☒ | ☐ | ☐ | ☐ | ☐ |
| 6. Commissioner Carrillo | ☐ | ☐ | ☐ | ☒ | ☐ |
| 7. Commissioner Chambers | ☒ | ☐ | ☐ | ☐ | ☐ |
| 8. Commissioner Chen | ☐ | ☐ | ☐ | ☒ | ☐ |
| 9. Commissioner Cortese | ☐ | ☐ | ☐ | ☒ | ☐ |
| 10. Commissioner Danovitch | ☒ | ☐ | ☐ | ☐ | ☐ |
| 11. Commissioner Gordon | ☒ | ☐ | ☐ | ☐ | ☐ |
| 12. Commissioner Mitchell | ☒ | ☐ | ☐ | ☐ | ☐ |
| 13. Commissioner Rowlett | ☒ | ☐ | ☐ | ☐ | ☐ |
| 14. Commissioner Tamplen | ☒ | ☐ | ☐ | ☐ | ☐ |
| 15. Vice-Chair Alvarez | ☒ | ☐ | ☐ | ☐ | ☐ |
| 16. Chair Madrigal-Weiss | ☒ | ☐ | ☐ | ☐ | ☐ |

**Motions Summary**
**Commission Meeting**
**March 23, 2023**

**Motion #:** 4

**Date:** March 23, 2023

**Proposed Motion:**
That The Commission directs staff to administer the grants for Rounds 4 and 5 of the CYBHI consistent with the Interagency Agreement between the Commission and the Department of Health Care Services, including approximately $15 million in Technical Assistance Grants along with Vice Chair Alvarez working alongside the staff to ensure that the Commission addresses community comments.

**Commissioner making motion:** Commissioner Mitchell

**Commissioner seconding motion:** Commissioner Carnevale

Motion carried 10 yes, 0 no, and 1 abstain, per roll call vote as follows:

| Name | Yes | No | Abstain | Absent | No Response |
|---|---|---|---|---|---|
| 1. Commissioner Bontrager | ☐ | ☐ | ☒ | ☐ | ☐ |
| 2. Commissioner Boyd | ☐ | ☐ | ☐ | ☒ | ☐ |
| 3. Commissioner Brown | ☐ | ☐ | ☐ | ☐ | ☒ |
| 4. Commissioner Bunch | ☒ | ☐ | ☐ | ☐ | ☐ |
| 5. Commissioner Carnevale | ☒ | ☐ | ☐ | ☐ | ☐ |
| 6. Commissioner Carrillo | ☐ | ☐ | ☐ | ☒ | ☐ |
| 7. Commissioner Chambers | ☒ | ☐ | ☐ | ☐ | ☐ |
| 8. Commissioner Chen | ☐ | ☐ | ☐ | ☒ | ☐ |
| 9. Commissioner Cortese | ☐ | ☐ | ☐ | ☒ | ☐ |
| 10. Commissioner Danovitch | ☒ | ☐ | ☐ | ☐ | ☐ |
| 11. Commissioner Gordon | ☒ | ☐ | ☐ | ☐ | ☐ |
| 12. Commissioner Mitchell | ☒ | ☐ | ☐ | ☐ | ☐ |
| 13. Commissioner Rowlett | ☒ | ☐ | ☐ | ☐ | ☐ |
| 14. Commissioner Tamplen | ☒ | ☐ | ☐ | ☐ | ☐ |
| 15. Vice-Chair Alvarez | ☒ | ☐ | ☐ | ☐ | ☐ |
| 16. Chair Madrigal-Weiss | ☒ | ☐ | ☐ | ☐ | ☐ |

**Motions Summary**
**Commission Meeting**
**March 23, 2023**

**Motion #:** 5

**Date:** March 23, 2023

**Proposed Motion:**
That the Commission adopts the PEI draft report, Well and Thriving.

**Commissioner making motion:** Commissioner Carnevale

**Commissioner seconding motion:** Commissioner Tamplen

Motion carried 10 yes, 0 no, and 0 abstain, per roll call vote as follows:

| Name | Yes | No | Abstain | Absent | No Response |
|---|---|---|---|---|---|
| 1. Commissioner Bontrager | ☒ | ☐ | ☐ | ☐ | ☐ |
| 2. Commissioner Boyd | ☐ | ☐ | ☐ | ☒ | ☐ |
| 3. Commissioner Brown | ☐ | ☐ | ☐ | ☐ | ☒ |
| 4. Commissioner Bunch | ☒ | ☐ | ☐ | ☐ | ☐ |
| 5. Commissioner Carnevale | ☒ | ☐ | ☐ | ☐ | ☐ |
| 6. Commissioner Carrillo | ☐ | ☐ | ☐ | ☒ | ☐ |
| 7. Commissioner Chambers | ☒ | ☐ | ☐ | ☐ | ☐ |
| 8. Commissioner Chen | ☐ | ☐ | ☐ | ☒ | ☐ |
| 9. Commissioner Cortese | ☐ | ☐ | ☐ | ☒ | ☐ |
| 10. Commissioner Danovitch | ☐ | ☐ | ☐ | ☐ | ☒ |
| 11. Commissioner Gordon | ☒ | ☐ | ☐ | ☐ | ☐ |
| 12. Commissioner Mitchell | ☒ | ☐ | ☐ | ☐ | ☐ |
| 13. Commissioner Rowlett | ☒ | ☐ | ☐ | ☐ | ☐ |
| 14. Commissioner Tamplen | ☒ | ☐ | ☐ | ☐ | ☐ |
| 15. Vice-Chair Alvarez | ☒ | ☐ | ☐ | ☐ | ☐ |
| 16. Chair Madrigal-Weiss | ☒ | ☐ | ☐ | ☐ | ☐ |

**Motions Summary**
**Commission Meeting**
**March 23, 2023**

**Motion #:** 6

**Date:** March 23, 2023

**Proposed Motion:**
The Commission directs staff to prepare an Informational Notice pursuant to Welfare and Institutions Code section 5840.8 indicating that the Commission has adopted additional priorities regarding transitional age youth not in college and community-defined evidence practices (CDEPs), pursuant to Welfare and Institutions Code section 5840.7(a)(6).

**Commissioner making motion:** Commissioner Alvarez

**Commissioner seconding motion:** Commissioner Carnevale

Motion carried 10 yes, 0 no, and 0 abstain, per roll call vote as follows:

| Name | Yes | No | Abstain | Absent | No Response |
|---|---|---|---|---|---|
| 17. Commissioner Bontrager | ☒ | ☐ | ☐ | ☐ | ☐ |
| 18. Commissioner Boyd | ☐ | ☐ | ☐ | ☒ | ☐ |
| 19. Commissioner Brown | ☐ | ☐ | ☐ | ☐ | ☒ |
| 20. Commissioner Bunch | ☒ | ☐ | ☐ | ☐ | ☐ |
| 21. Commissioner Carnevale | ☒ | ☐ | ☐ | ☐ | ☐ |
| 22. Commissioner Carrillo | ☐ | ☐ | ☐ | ☒ | ☐ |
| 23. Commissioner Chambers | ☒ | ☐ | ☐ | ☐ | ☐ |
| 24. Commissioner Chen | ☐ | ☐ | ☐ | ☒ | ☐ |
| 25. Commissioner Cortese | ☐ | ☐ | ☐ | ☒ | ☐ |
| 26. Commissioner Danovitch | ☐ | ☐ | ☐ | ☐ | ☒ |
| 27. Commissioner Gordon | ☒ | ☐ | ☐ | ☐ | ☐ |
| 28. Commissioner Mitchell | ☒ | ☐ | ☐ | ☐ | ☐ |
| 29. Commissioner Rowlett | ☒ | ☐ | ☐ | ☐ | ☐ |
| 30. Commissioner Tamplen | ☒ | ☐ | ☐ | ☐ | ☐ |
| 31. Vice-Chair Alvarez | ☒ | ☐ | ☐ | ☐ | ☐ |
| 32. Chair Madrigal-Weiss | ☒ | ☐ | ☐ | ☐ | ☐ |

# AGENDA ITEM 5

**Action**

**April 27, 2023 Commission Meeting**

**Consent Calendar**

**Summary:** The Mental Health Services Oversight and Accountability Commission will consider approval of the Consent Calendar which contains three Innovation Funding Requests.

Items are placed on the Consent Calendar with the approval of the Chair and are deemed non-controversial. Consent Calendar items shall be considered after public comment, without presentation or discussion. Any item may be pulled from the Consent Calendar at the request of any Commissioner. Items removed from the Consent Calendar may be held over for consideration at a future meeting at the discretion of the Chair.

**Fresno and Stanislaus Counties are requesting that the Commission authorize up to $11,345,000 in Mental Health Services Act Innovation funds for the following three projects:**

| Project Name | Total INN Funding Requested | Duration of INN Project (years) |
|---|---|---|
| Participatory Action Research with Justice-Involved Youth using an Adverse Childhood Experiences (ACEs) Framework (Fresno County) | $3,000,000 | 5 |
| The Lodge – Extension (Fresno County) | $3,160,000 | 5 |
| Embedded Neighborhood Mental Health Team (Stanislaus County) | $5,185,000 | 5 |
| **Total:** | **$11,345,000** | |

**PARTICIPATORY ACTION RESEARCH WITH JUSTICE-INVOLVED YOUTH USING AN ADVERSE CHILDHOOD EXEPRIENCES (ACEs) FRAMENWORK (FRESNO COUNTY):**

Utilizing the Adverse Childhood Experience (ACE) Framework and recognizing that ACE scores are positively correlated with justice involvement, Fresno County would like to partner with community agencies, institutions of higher learning, and justice-involved youth to conduct a research-based innovation project that is designed to collect data that will support the development of appropriate interventions for youth and prevent the future involvement of youth in the justice system.

The County would like to conduct research that is two-fold:

1. Work collaboratively with partnering agencies to identify needs of justice-involved youth to prevent future youth from becoming justice-involved; and
2. Utilize insight from subject matter experts and justice-involved youth to engage the target population in the facilitation and training of ACEs in focus groups. It is the County's goal that insight received directly from the target population may help identify prevention strategies and interventions that may be utilized by the County to prevent youth from becoming justice involved.

*NOTE: Fresno County has observed that most diversion programs do not include the local youth perspective, which may contribute to these programs not being culturally responsive.*

The Mental Health Services Act (Section 5830(c)(7)) allows for an innovation project to affect any aspect of the mental health system including research. Fresno County would like to identify best practices through this research innovation project by collaborating with partnering agencies as well as working **directly with current and former justice-involved youth** to develop strategies and programs to prevent youth justice involvement. Research and feedback received from the target population (youth between the ages of 15-17 who are currently involved in the County's juvenile justice system) will inform how to best serve this population by developing programs and services that are intended to reduce future justice involvement while contributing to statewide learning.

Due to the large amount of research involved, the County will be contracting out for the research, data, evaluation, and peer components of this project. Additionally, the County will work with California Mental Health Services Authority (CalMHSA) to assist in the procurement and contracting of this project.

The County has referenced the Commission's *Together We Can* report on improving behavioral health services for justice-involved individuals, with particular emphasis on the fourth and fifth recommendation in the report:

> ***Fourth Recommendation:*** *Justice and Behavioral Health agencies and providers to work collaboratively to support local prevention and diversion of mental health consumers from the system; and*
> ***Fifth Recommendation:*** *Identify issues related to data and information used to address service gaps and encourage efforts to improve outcomes and reduce the number of persons using the justice system for behavioral health needs.*

The County is focusing on both recommendations for this project with emphasis on the collaborative component to yield results that identify best practices that can be used to prevent future youth justice involvement.

**The Community Program Planning Process:**

The idea and development of this project came from Fresno County's community that identified services for justice-involved youth as a priority during the MHSA 2017-2020 three-year planning process. Both agency justice partners as well as current and former justice-involved youth provided input informing the direction of this project, including that services for this population were typically not informed or influenced by those with lived experience and were lacking in variables such as culture and socioeconomic status.

The County has held several focus groups and administered surveys to gain insight and input from organizations who provide services to justice-involved youth, including individuals between the ages of 13-24 with current or previous justice involvement.

**THE LODGE – EXTENSION (FRESNO COUNTY):**

Fresno County is requesting an extension of spending authority as well as an additional two years for this project. The Commission initially approved this Innovation project on May 28, 2020, for innovation spending authority up to the amount of $4,200,000 spread over three years.

The Lodge is a zero barrier, evidenced-based shelter that provides people who are considered in the precontemplation stage, not engaged in services, serving up to thirty people at a time, with peer-led supportive engagement and linkages to services. This project is not proposed as an avenue to address those at risk or who are experiencing homelessness, SUD, and co-occurring disorders. Instead, it is intended to provide for all basic needs for those without previous treatment and providing linkages for them to engage in care and continued services, while utilizing peers to implement and engage in evidenced-based practices to assist in moving through the stages of change.

The project was implemented on March 1, 2021, six months after Commission approval, and is currently scheduled to end on June 30, 2023. The County was successful in operationalizing the project (during the pandemic) within the first six months including:

- Hiring of staff
- Training staff
- Meeting with project evaluators
    - Development of the data collection tool
    - Coordinate communication
- Served unduplicated individuals in pre-contemplation stage of change
    - First year: 211
    - Second year 377
- Provided successful linkages to lodgers
    - Mental Health Services

- Substance Use Services
- Housing

Although the County was able to accomplish the above, maintaining only two years of data is insufficient to thoroughly evaluate the project and answer the learning questions with supportive statistics. The additional request for time will also allow the County the opportunity to accurately assess the efficacy of this project and inform its decisions about programmatic successes regarding continuation, sustainability, planning, or adaptation of the project.

Ultimately, this project extension will provide the County with the opportunity to gather an additional two years of programmatic data, while increasing the stay for residents of *The Lodge* from 45 days to up to 90 days, and continue to provide care, using a peer-driven approach in conjunction with low barrier lodging that meets an individual's basic needs first, for the those in the pre-contemplative stage (people who are not thinking seriously about changing and are not interested in any kind of help) of change who are homeless, at risk of being homeless, and suffer from serious or the on-set of serious mental illness.

**The Community Program Planning Process:**

The local community planning process for this extension engaged community members, community partners, peers, community-based organizations, and providers. The extension was fully supported by participants of the community planning process. The Department engaged in numerous conversations regarding *The Lodge project* with the County's Chief Administrative Officer about the challenges of working with the unhoused population in addressing serious and severe mental illness for those who have not engaged in care previously.

**EMBEDDED NEIGHBORHOOD MENTAL HEALTH TEAM (STANISLAUS COUNTY):**

Stanislaus County seeks to learn if embedding three mobile teams of paraprofessionals within trusted community-based organizations will increase awareness of, and access to, needed mental health and substance use resources for underserved populations in neighborhoods that have high rates of mental health crisis calls.

Stanislaus County MHSA Advisory Committee members identified that families and community members observe behaviors and want to seek support or mental health services for their loved ones prior to a crisis occurring but that they report not knowing where or how to access non-crisis services. Family members also report supporting their loved ones through multiple behavioral health crisis episodes and without knowing who to call, often being forced to access crisis support lines or 911. This problem is prevalent statewide, and all California counties could benefit from the outcomes of this project.

The Embedded Neighborhood Mental Health Team project will consist of three teams of paraprofessionals, including peer-support specialists, who will:

- perform outreach and engagement through foot and bike patrol and regular communication with community members
- serve as community liaisons to support families and individuals in need to learn about and connect to available services

- recommend appropriate referrals and warm handoffs to additional services
- provide facilitation for a variety of client-focused specialty groups
- establish and implement treatment plans as appropriate
- provide paraprofessional level counseling services to clients

**The Community Program Planning Process:**
The idea for this project came from Stanislaus County's 2022 strategic planning process and its MHSA Advisory Committee planning process where an alternative response to mental health crisis and the need for help in access and navigation of the mental health services system were identified as high priority issues.

The strategic planning process included three innovation work group sessions in January 2022, where attendees focused on exploring innovative ways to plan for, prevent, and respond to mental health crisis needs in the community.

**Enclosures (5):** (1) Commission Community Engagement Process; (2) Participatory Action Research with Justice-Involved Youth using Adverse Childhood Experiences (ACEs) Framework Staff Analysis; (3) The Lodge Extension Staff Analysis; (4) Embedded Neighborhood Mental Health Team Staff Analysis; and (5) Letter of Support for Embedded Neighborhood Mental Health Team

**Additional Materials (3):** Links to the three final Innovation project plans are available on the Commission website at the following URLs:

**Participatory Action Research with Justice-Involved Youth using an Adverse Childhood Experiences (ACEs) Framework:**
https://mhsoac.ca.gov/wp-content/uploads/Fresno_INN-Plan_ACEs-and-Justice-Involved-Youth-Research.pdf

**The Lodge Extension:**
https://mhsoac.ca.gov/wp-content/uploads/Fresno_INN-Plan_The-Lodge_-Extension.pdf

**Embedded Neighborhood Mental Health Team:**
https://mhsoac.ca.gov/wp-content/uploads/Stanislaus_INN-Plan_Embedded-Neighborhood-Mental-Health-Team.pdf

**Proposed Motion:** That the Commission approves funding for two Fresno County Plans and one Stanislaus County Innovation Plan for a total of up to $11,345,000.

Mental Health Services
Oversight & Accountability Commission

**Commission Process for Community Engagement on Innovation Plans**

To ensure transparency and that every community member both locally and statewide has an opportunity to review and comment on County submitted innovation projects, Commission staff follow the process below:

## Sharing of Innovation Projects with Community Partners

- **Procedure – Initial Sharing of INN Projects**
  i. Innovation project is initially shared while County is in their public comment period
  ii. County will submit a link to their plan to Commission staff
  **iii. Commission staff will then share the link for innovation projects with the following recipients:**
    - **Listserv recipients**
    - **Commission contracted community partners**
    - **The Client and Family Leadership Committee (CFLC)**
    - **The Cultural and Linguistic Competency Committee (CLCC)**
  iv. Comments received while County is in public comment period will go directly to the County
  v. Any substantive comments must be addressed by the County during public comment period
- **Procedure – Final Sharing of INN Projects**
  **i. When a final project has been received and County has met all regulatory requirements and is ready to present finalized project (via either Delegated Authority or Full Commission Presentation), this final project will be shared again with community partners:**
    - **Listserv recipients**
    - **Commission contracted community partners**
    - **The Client and Family Leadership Committee (CFLC)**
    - **The Cultural and Linguistic Competency Committee (CLCC)**
  ii. The length of time the final sharing of the plan can vary; however, Commission tries to allow community partner feedback for a minimum of two weeks
- **Incorporating Received Comments**
  i. Comments received during the final sharing of the INN project will be incorporated into the Community Planning Process section of the Staff Analysis.
  ii. Staff will contact community partners to determine if comments received wish to remain anonymous
  iii. Received comments during the final sharing of INN project will be included in Commissioner packets
  iv. Any comments received after final sharing cut-off date will be included as handouts

# STAFF ANALYSIS – FRESNO COUNTY

| | |
|---|---|
| **Innovation (INN) Project Name:** | **Participatory Action Research with Justice-Involved Youth Using an Adverse Childhood Experience (ACEs) Framework** |
| **Total INN Funding Requested:** | **$3,000,000** |
| **Duration of INN Project:** | **5 Years** |
| **MHSOAC consideration of INN Project:** | **April 27, 2023** |

**Review History:**

| | |
|---|---|
| Approved by the County Board of Supervisors: | Pending Commission Approval |
| Mental Health Board Hearing: | March 15, 2023 |
| Public Comment Period: | February 1, 2023 through March 2, 2023 |
| County submitted INN Project: | March 17, 2023 |
| Date Project Shared with Stakeholders: | February 2, 2023 and March 28, 2023 |

**Statutory Requirements (WIC 5830(a)(1)-(4) and 5830(b)(2)(A)-(D)):**

**The primary purpose of this project** *is to promote interagency and community collaboration related to mental health services, supports or outcomes.*

**This Proposed Project meets INN criteria** *by introducing a new practice or approach to mental health systems, including, but not limited to, prevention and early intervention; and makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population.*

**Project Introduction:**

Utilizing the Adverse Childhood Experience (ACE) Framework and recognizing that ACE scores are positively correlated with justice involvement, Fresno County would like to partner with community agencies, institutions of higher learning, and justice-involved youth to conduct a research-based innovation project that is designed to collect data that will support the development of appropriate interventions for youth and prevent the future involvement of youth in the justice system.

**What is the Problem:**

Adverse Childhood Experiences (ACEs) are "potentially traumatic events that occur in childhood and can change brain development and affect how the body responds to stress" (www.cdc.ca.gov). Fresno County provides statistics reflecting 61.7% of Californians have experienced at least one ACE score and 16.7% have a score of four or more ACEs. Specific to the County, 60.4% have a score of one or more ACEs (n=563).

The County cites studies linking ACEs scores with justice involvement – a one-point score increase reflected greater likelihood of justice involvement. The County would like to conduct research that is two-fold:

1. Work collaboratively with partnering agencies to identify needs of justice-involved youth to prevent future youth from becoming justice-involved; and
2. Utilize insight from subject matter experts and justice-involved youth to engage the target population in the facilitation and training of ACEs in focus groups. It is the County's goal that insight received directly from the target population may help identify prevention strategies and interventions that may be utilized by the County to prevent youth from becoming justice involved.

*NOTE: Fresno County has observed that most diversion programs do not include the local youth perspective, which may contribute to these programs not being culturally responsive.*

**How this Innovation project addresses this problem (see pgs 3-12):**

Research Component

The Mental Health Services Act (Section 5830(c)(7)) allows for an innovation project to affect any aspect of the mental health system including research. Fresno County would like to identify best practices through this research innovation project by collaborating with partnering agencies as well as working **directly with current and former justice-involved youth** to develop strategies and programs to prevent youth justice involvement. Research and feedback received from the target population (youth between the ages of 15-17 who are currently involved in the County's juvenile justice system) will inform how to best serve this population by developing programs and services that are intended to reduce future justice involvement while contributing to statewide learning.

Due to the large amount of research involved, the County will be contracting out for the research, data, evaluation, and peer components of this project. Additionally, the County will work with California Mental Health Services Authority (CalMHSA) to assist in the procurement and contracting of this project.

The following partners will be leveraged to gain an understanding of ACEs and identify, based on research, the types of interventions that may have yielded recidivism for youth involvement in the juvenile justice system:

- Criminology Departments from local colleges and universities (Fresno City College, CSU, Fresno, Fresno Pacific University, and UC Merced)
- Local school of Public Health
- Statisticians
- Epidemiologists
- Local researchers
- Community behavioral health providers
- Probation Department
- County's Trauma and Resilience Network
- Current and Former incarcerated or justice-involved youth

The County has referenced the Commission's *Together We Can* report on improving behavioral health services for justice-involved individuals, with particular emphasis on the fourth and fifth recommendation in the report:

> ***Fourth Recommendation:*** *Justice and Behavioral Health agencies and providers to work collaboratively to support local prevention and diversion of mental health consumers from the system; and*
> ***Fifth Recommendation:*** *Identify issues related to data and information used to address service gaps and encourage efforts to improve outcomes and reduce the number of persons using the justice system for behavioral health needs.*

The County is focusing on both recommendations for this project with emphasis on the collaborative component to yield results that identify best practices that can be used to prevent future youth justice involvement.

<u>ACEs Component</u>

Justice-involved youth participants in this project will be trained, voluntarily, on understanding the ACEs framework (ACEs screening and scoring of participants are not the objective in this project).

The County's local Court Appointed Special Advocate (CASA) non-profit organization will utilize their existing ACEs training designed for youth and tailor it for this project with emphasis on understanding ACEs and how the justice-involved youth can transcend their own ACEs and apply it towards wellness and resiliency.

Both current and former justice-involved youth may voluntarily choose to become trainers in ACEs, and/or can provide training and education to current justice-involved youth in the County's juvenile justice system in the understanding of the ACEs framework. **Both trainers**

**will receive a stipend as well as project participants** for their efforts and input in this project (see pg 11 for stipend information).

Justice-involved youth are a critical component of this project. Along with their new understanding of the ACEs framework, these individuals with lived experience are positioned to inform this project by identifying challenges and barriers that could have possibly diverted them from the juvenile justice system in the first place. In the development of this project, the County states there is a high interest from justice-involved youth to share their experiences, thoughts, and willingness to receive training for this project. The Probation Department will be key in recruiting and referring participants and will assist in coordinating ongoing trainings.

**The Community Program Planning Process (see pgs 15-22 of project plan):**

Local Level

The idea and development of this project came from Fresno County's community identifying services for justice-involved youth as a priority during the MHSA 2017-2020 three-year planning process. Both agency justice partners as well as current and former justice-involved youth provided input informing the direction of this project. During the community's feedback, it was voiced that services for this population were typically not informed or influenced by those with lived experience and were lacking in variables such as culture and socioeconomic status.

In addition to input from the community, Fresno County also worked collaboratively with agencies that included: Fresno County Health Improvement Project, Department of Social Services/Child Welfare Services, County Department of Public Health, County Probation Department, and the County's Trauma and Resiliency Network.

**The County has held several focus groups and administered surveys to gain insight and input from organizations who provide services to justice-involved youth and was also inclusive of individuals between the ages of 13-24 with current or previous justice involvement.**

Fresno County's community planning process included the following:

- 30-day public comment period: February 1, 2023 through March 2, 2023
- Local Mental Health Board Hearing: March 15, 2023
- Board of Supervisor Approval: Pending Commission Approval

A final plan, incorporating community partner and stakeholder input as well as technical assistance provided by Commission staff, was submitted on March 17, 2023.

Commission Level

This project was initially shared with Community Partners on February 2, 2023, and the final version was again shared on March 28, 2023. Additionally, this project was shared with

previous members of both the Client and Family Leadership and Cultural and Linguistic Competence Committees.

**No comments were received by the Commission in response to the sharing of this project.**

**Learning Objectives and Evaluation (see pgs 14-15 of project plan):**

Fresno County has proposed to partner with institutions of higher learning to research how ACEs and various other factors affect justice-involved youth with the overarching goal of utilizing findings to better serve this population and reduce recidivism rates. Additionally, ACEs training will be provided to a group of incarcerated peer-youth who will then become trainers and co-facilitators to provide an understanding of ACEs and how justice-involved youth can be resilient despite their ACEs scores.

This project proposes to gather research from individuals between the ages of 15-17 who are currently involved in the juvenile justice system, and **provide training to over 400 justice-involved youth during the life of this project.**

To guide their project, three learning questions have been identified:

1. What are the best practices for prevention of justice involvement among youth from youth for youth?
2. What are best strategies for engaging with justice-involved youth – both generally and for research purposes?
3. What are the best strategies for the County to reduce future involvement in the justice system?

The County has indicated this project is to conduct and gather research from youth with justice involvement as well as provide training on ACEs. This project will not provide services or programs and the overarching goal is to gather feedback from justice-involved youth to determine the best ways the County can engage this community to prevent recidivism and interactions with the criminal justice system in general.

Contracted providers, researchers, and higher learning institutions will be utilized for this project to analyze gathered data and determine findings that will allow the County to strengthen partnerships amongst agencies to provide better services for this target population.

While exact *methods* may not be known at this time, the County will work with an external consultant to conduct the evaluation to gather research directly tied to the identified learning questions. The evaluator will be responsible for collecting data (quantitative and/or qualitative), data analysis and the completion of the final evaluation report.

Outcomes and lessons learned will be disseminated through MHSA Annual Updates, ongoing community partner meetings, the County's Mental Health Board, as well as through final innovative project report.

## **The Budget (*see pgs 25-30 of project plan*):**

| **5 Year Budget** | **FY 23/24** | **FY 24/25** | **FY 25/26** | **FY 26/27** | **FY 27/28** | **TOTAL** |
|---|---|---|---|---|---|---|
| Operating Costs | $ 83,000.00 | $ 83,000.00 | $ 83,000.00 | $ 83,000.00 | $ 83,000.00 | $ 415,000.00 |
| Consultant Costs | $ 78,000.00 | $ 75,000.00 | $ 68,500.00 | $ 68,500.00 | $ 60,000.00 | $ 350,000.00 |
| Contractor / Evaluation / Research | | $ 645,000.00 | $ 670,000.00 | $ 670,000.00 | $ 250,000.00 | $ 2,235,000.00 |
| | | | | | | $ - |
| Total | $ 161,000.00 | $ 803,000.00 | $ 821,500.00 | $ 821,500.00 | $ 393,000.00 | $ 3,000,000.00 |
| | | | | | | |
| **Funding Source** | FY 22/23 | FY 23/24 | FY 24/25 | | FY 25/26 | **TOTAL** |
| Innovation Funds | $ 161,000.00 | $ 803,000.00 | $ 821,500.00 | $ 821,500.00 | $ 393,000.00 | $ 3,000,000.00 |
| | | | | | | |
| | | | | | | |
| **Total** | **$ 161,000.00** | **$ 803,000.00** | **$ 821,500.00** | | **$ 393,000.00** | **$ 3,000,000.00** |

Fresno County is seeking authorization to use up to **$3,000,000** in innovation funding over a five-year period.

- Operating costs total $415,000 (13.9% of total project) to cover County costs for personnel to oversee this project, ensure innovation compliance, and completion of innovation annual reports.
- Consultant costs total $350,000 (11.7% of total project) to cover project management supported by CalMHSA as well as training curriculum to train peers and peer co-facilitators to conduct ACEs training
- A total of $2,235,000 (74.5% of total project) has been allocated towards the following:
    - Research and evaluation of this project that will be conducted by higher institutions, statisticians, partners and peers ($1,939,000)
    - Stipends to encourage participation in training sessions ($200,000)
    - Costs for community-based organizations to host events (i.e event promotion, space rental, food during events, $60,000)
    - Transportation costs to allow participants and their families to attend events ($15,000)
    - Childcare costs to allow participants to attend events while ensuring adequate childcare needs ($21,000)

Although this is not a service-based innovation project, the County has considered the results of this work to support sustaining appropriate and effective treatment options for justice involved youth.

*If the Innovation Project is approved, the County must receive and inform the MHSOAC of this certification of approval from the Fresno County Board of Supervisors before any Innovation Funds can be spent.*

# FRESNO COUNTY
# STAFF ANALYSIS – EXTENSION

| | |
|---|---|
| **Innovative (INN) Project Name:** | **The Lodge: Researching Targeted Engagement Approach** |
| **Extension Funding Requested for Project:** | **$3,160,000** |
| **Extension of Time Requested for Project:** | **Two (2) Years** |
| **MHSOAC Consideration of INN Project:** | **April 27, 2023** |

**Original Approval History:**

| | |
|---|---|
| Original Commission Approval Date: | May 28, 2020 |
| Original Commission Approved Funding: | $4,200,000 |
| Original Approved Duration of INN Project: | Three Years |
| Project Start Date: | March 1, 2021 |

**Review History:**

| | |
|---|---|
| County Submitted Innovation Extension: | December 1, 2022 |
| Mental Health Board Hearing: | January 18, 2023 |
| Approved by the County Board of Supervisors: | Pending Commission Approval |
| Public Comment Period: | Dec 1, 2022 – Jan 3, 2023 |
| County Submitted Final INN Extension Request: | January 25, 2023 |
| Project Shared with Community Partners: | Dec 25, 2022, & Feb 2, 2023 |

## Project Introduction:

Fresno County is requesting an extension of up to $3,160,000 in spending authority, as well as an additional two years for their Innovation project: ***The Lodge: Researching Targeted Engagement Approach.*** The Commission initially approved this Innovation project on May 28, 2020, for innovation spending authority up to the amount of $4,200,000 spread over three years. This project was intended to utilize evidenced-based approaches to engage the following populations:

- Individuals in the pre-contemplation stage of change;
- Individuals not engaged in treatment;

- Individuals experiencing homelessness or at risk of homelessness; and
- Who suffer from chronic or severe mental illness (SMI), Substance Use Disorder (SUD) and/or co-occurring disorders.

The Lodge is a zero barrier, evidenced-based shelter that provides people who are considered in the precontemplation stage, not engaged in services, serving up to thirty people at a time, with peer-led supportive engagement and linkages to services. This project is not proposed as an avenue to address those at risk or who are experiencing homelessness, SUD, and co-occurring disorders. Instead, it is intended to provide for all basic needs for those without previous treatment and providing linkages for them to engage in care and continued services, while utilizing peers to implement and engage in evidenced-based practices to assist in moving through the stages of change.

This two-year project extension request will provide the opportunity to gather additional programmatic data, while increasing the stay for residents of *The Lodge* from 45 days up to 90 days, while continuing to provide care for these individuals using a peer driven approach in conjunction with low barrier lodging intended to meet an individual's basic needs first. The option for extended stays will provide time, additional peer support and resources, to assist participants in completing linkages to needed services, and permanent housing placements.

**The Extension:**

The County is requesting an extension of Innovation spending authority up to $3,160,000, as well as a request for two additional years. Additional funding request will be utilized to continue service provision, annual expenses, as well as the selected evaluators and contractors.

The request for an extension of time will provide an opportunity to procure additional data collection to accurately assess the efficacy of this project that will inform decisions about successes regarding continuation, sustainability, planning, or adaptation of the project. The project was implemented on March 1, 2021, six months after Commission approval, and is currently scheduled to end on June 30, 2023. Although the County has gathered data since implementing this project, additional time is needed to gather, analyze, and evaluate the data in response to the learning questions the County has posed.

The additional funding will also provide an opportunity to serve more participants by providing basic needs as well as temporary housing. while still allowing for data collected to be evaluated for the efficacy of peer-driven engagement that utilizes motivational interviewing to best inform the evaluation, continuity, adaptation, and sustainability of this project

**The Community Program Planning (CPPP)**

The local community planning process for this extension engaged community members, community partners, peers, community-based organizations, and providers. The extension was fully supported by participants of the community planning process. The Department

engaged in numerous conversations regarding The Lodge project with the County's Chief Administrative Officer about the challenges of working with the unhoused population in addressing serious and severe mental illness for those who have not engaged in care previously.

> *The following comment was submitted to the County in support of the project:*
>
> *"We work very closely with The Lodge. I can say that if it was not for The Lodge many of these clients would not get connected to mental health services. The* Lodge offers an alternative path to engagement than traditional mental health programs."
>
> *Jessica Padilla, Kings View Behavioral Health PATH Program Manager*

Commission Level

This extension request was initially shared with Community Partners on December 5, 2022, and the final version was again shared on February 2, 2023. Additionally, this project was shared with both members of the Client and Family Leadership and Cultural and Linguistic Competence Committees.

> *The following comment of support has been summarized and was submitted to the county on January 2, 2023, via email:*
>
> *"Without an extension, additional information and assessment would not be available to determine outcomes of statewide learning. More data is needed to understand the Outcomes, and which Elements of the Program model are contributing to successful linkages. The Deep Learning should be explored and is allowable under Innovation regulations. I wholeheartedly support this Innovation Plan."*
>
> *Member of the MHSOAC Client Family Leadership Committee Member*

The county held their 30-day public comment from December 1, 2022 through January 3, 2023. No letters of support or opposition were received by Commission staff.

## Learning Objectives and Evaluation

The County's previously established learning goals will remain the same. The County seeks to increase the length of stay at The Lodge from 45 days to a maximum of 90 days. The programmatic data collected and analyzed to date indicates that a 45-day stay is insufficient to link consumers to services, leaving consumers at risk of being unhoused.

The County was successful in operationalizing the project (during the pandemic) within the first six months after receiving Commission approval including:

- Hiring of staff
- Training staff

- Meet with project evaluators
    - Development of the data collection tool
    - Coordinate communication
- Served unduplicated individuals in pre-contemplation stage of change
    - First year: 211
    - Second year 377
- Provided successful linkages to lodgers
    - Mental Health Services
    - Substance Use Services
    - Housing

Social Research Institute at California State University, Fresno Foundation, will continue as the evaluators for the additional two-year extension.

**Budget**

The County is requesting authorization to spend up to an additional $3,160,000 in MHSA Innovation spending authority and an additional two years for a total of five years to complete this project. If approved, the new project amount will be $7,360,000. ***The County has funds subject to reversion***.

- The Evaluation Budget will be increased at the current budget rate of $50,000 per year, for a total of $100,000 with this two-year program extension.
- $1,500,000 per year for a total of $3,000,000 for two additional years of ***The Lodge*** programmatic components.
- $30,000 for the Department of Health Administrative costs per year for the additional two years for a total of $60,000.

| | |
|---|---|
| Originally Approved Innovation Funding | $4,200,000 |
| **Innovation Extension Funding Request** | **$3,160,000** |
| Project Total | $7,360,000 |

# STAFF ANALYSIS –Stanislaus County

| | |
|---|---|
| **Innovation (INN) Project Name:** | **Embedded Neighborhood Mental Health Team** |
| **Total INN Funding Requested:** | **$5,185,000** |
| **Duration of INN Project:** | **5 Years** |
| **MHSOAC consideration of INN Project:** | **April 27, 2023** |

**Review History:**

| | |
|---|---|
| Approved by the County Board of Supervisors: | Scheduled for May 2, 2023 |
| Mental Health Board Hearing: | March 23, 2023 |
| Public Comment Period: | February 22, 2023-March 23, 2023 |
| County submitted INN Project: | April 4, 2023 |
| Date Project Shared with Stakeholders: | March 1, 2023 and April 4, 2023 |

**Statutory Requirements (WIC 5830(a)(1)-(4) and 5830(b)(2)(A)-(D)):**

**The primary purpose of this project is to** *increase access to mental health services to underserved groups.*

**This Proposed Project meets INN criteria** *by introducing a mental health practice or approach that is new to the overall mental health system, including, but not limited to, prevention and early intervention.*

**Project Introduction:**

Stanislaus County seeks to learn if embedding three mobile teams of paraprofessionals (consisting of (1) paraprofessional counselor, equivalent to a Stanislaus County Behavioral Health Specialist, and one (1) peer support level staff, equivalent to a Stanislaus County Clinical Services Technician) within a trusted community-based organization will increase awareness of, and access to, needed mental health and substance use resources for underserved populations in neighborhoods that have high rates of mental health crisis calls.

**What is the Problem:**

Alternative response to mental health crisis and the need for help in access and navigation of the mental health services system were identified as high priority issues through the County's

strategic planning process. This problem is prevalent statewide, and all California counties could benefit from the outcomes of this project.

Stanislaus County's MHSA Advisory Committee members identified that families and community members observe behaviors and want to seek support or mental health services for their loved ones prior to a crisis occurring but that they report not knowing where or how to access non-crisis services. Family members also report supporting their loved ones through multiple behavioral health crisis episodes and without knowing who to call, often being forced to access crisis support lines or 911. The County further identified that a lack of trust in county services is a barrier that may prevent family members from accessing available county services before crises occur. The County identified an additional barrier of workforce shortages adding further need for innovative solutions.

An analysis of available crisis call data identified several neighborhoods within the County with both high rates of mental health crisis calls and higher rates of underserved populations. The County proposes to utilize this innovation proposal to increase access to care for those in need by collaborating with a trusted, local community- based organization.

In 2018, Stanislaus County applied for and received Triage grant funding. The grant funded three clinical positions and three peer navigator positions to prevent crisis recidivism by co-locating within the Community Emergency Response Team to provide follow-up support to individuals who were assessed for 5150 holds but not hospitalized. As part of the multi-year effort in Stanislaus County to strengthen the crisis system of care, Triage funds allowed the County to provide needed clinical follow-up but did not address the community-identified need to increase awareness of, and trust in, available services prior to a crisis occurring. Less than 10% of the Triage-funded services occurred in the community. This innovation proposal seeks to test a solution to this missing component of the County's system of care.

**How this Innovation project addresses this problem**

This Innovation project will develop, pilot and evaluate the effectiveness of embedding mobile, mental health supportive services and resources into a community-based organization working with underserved populations within three neighborhoods identified as having high rates of mental health crisis calls in Stanislaus County.

The County will contract with a community-based organization and through the contracting process, will ensure that building trust and rapport within the identified communities will be the cornerstone of the project. Efforts to embed services in historically safe spaces within the neighborhoods will be prioritized. Examples of safe spaces include churches, neighborhood stores and barbershops.

The Embedded Neighborhood Mental Health Team project will consist of three teams of paraprofessional counselors and peer-support specialists, who will:

- perform outreach and engagement through foot and bike patrol and regular communication with community members

- serve as community liaisons to support families and individuals in need to learn about and connect to available services
- recommend appropriate referrals and warm handoffs to additional services
- provide facilitation for a variety of client-focused specialty groups
- establish and implement treatment plans as appropriate
- provide paraprofessional level counseling services to clients

The Embedded Neighborhood Mental health Teams will receive referrals through the street outreach done as part of the project, through the existing Community Emergency Response Team when individuals do not meet 5150 criteria and through the Access, Crisis and Support line when calls are received from the targeted neighborhoods and do not require a crisis response. The teams will start out operating 8 hours a day, 5 days a week and will be adjusted based on community input, data and availability of staff.

Proactive interventions designed to prevent behavioral health crisis and intensive clinical and community support as part of a post-crisis response will be offered through this project either through the paraprofessional component or through the supported referrals for higher levels of services.

**The Community Program Planning Process (see pages 23-29 of plan)**

Local Level

The idea for this project came from Stanislaus County's 2022 strategic planning and its MHSA Advisory Committee (made up of 40 individuals representing a diverse spectrum of community interests) planning processes where an alternative response to mental health crisis and the need for help in access and navigation of the mental health services system were identified as high priority issues.

Included in the strategic planning were three innovation planning work group sessions in January 2022 where attendees focused on exploring innovative ways to plan for, prevent, and respond to mental health crisis needs in the community.

Stanislaus County's community planning process included the following:

- 30-day public comment period: February 22, 2023 through March 23, 2023
- Local Mental Health Board Hearing: March 23, 2023
- Board of Supervisor Approval: Following Commission Approval

A final plan, incorporating community partner and stakeholder input as well as technical assistance provided by Commission staff, was submitted on April 4, 2023.

Commission Level

This project was initially shared with Community Partners on March 1, 2023, and the final version was again shared on April 4, 2023.

**One letter of support was received by the Commission in response to the sharing of this project and is included as a handout.**

**Learning Objectives and Evaluation (please see pages 21-22 of full plan)**

The County estimates that each neighborhood team will connect with approximately 240 community members for a total of 720 community members served over the course of five years. The program will prioritize serving individuals with a history of being unserved or underserved including people of color and those who identify as LGBTQ.

The County will utilize the Request for Proposal contracting process, to hire a contractor who will develop a full evaluation plan built around the following learning questions:

- How might embedded clinical services within a neighborhood or a targeted diverse community increase access to mental health services and increase awareness of Mental Health Services.
- How might embedded clinical services within a neighborhood or a targeted diverse community increase access to treatment services post crisis contact.
- How might embedding clinical services within a neighborhood or a targeted diverse community increase access for family members to support family members or loved ones in access to treatment.
- How might embedding clinical services within a neighborhood or a targeted diverse community increase access for family members and individuals to tangible peer and community supports.
- How might embedding clinical services within a neighborhood or a targeted diverse community increase trusting relationships amongst mental health treatment service providers, neighborhood residents, family members and individuals seeking help for mental illness and/or substance use disorders.
- How might embedding a community mental health support center, with peer support within a neighborhood or a targeted diverse community increase community-based culturally responsive support for individuals in a mental health crisis and treatment.
- How might embedded mental health services increase the number of individuals receiving mental health services in the targeted neighborhoods.
- How might embedded mental health services increase access to treatment for those within the targeted neighborhoods.
- How might embedded mental health services decrease crisis calls within the targeted neighborhoods.
- Whether embedded mental health services will have a positive effect in reducing the time from first contact to assessment and first appointment, resulting in a higher level of engagement.

The County will connect the contracted evaluator and services provider to identify qualitative approaches and additional quantitative approaches and to ensure that the evaluation reflects cultural competence and community relevance.

## The Budget

| **Funding Source** | Year-1 | Year-2 | Year-3 | Year-4 | Year-5 | **TOTAL** |
|---|---|---|---|---|---|---|
| Innovation Funds | $ 1,085,000 | $ 1,025,000 | $ 1,025,000 | $ 1,025,000 | $ 1,025,000 | $ 5,185,000 |
| **5 Year Budget** | Year-1 | Year-2 | Year-3 | Year-4 | Year-5 | **TOTAL** |
| Program Operations-Contracted | $ 846,300 | $ 780,000 | $ 780,000 | $ 780,000 | $ 780,000 | $ 3,966,300 |
| Administrative Overhead | $ 238,700 | $ 245,000 | $ 245,000 | $ 245,000 | $ 245,000 | $ 1,218,700 |
| Total Innovation Funds | $ 1,085,000 | $ 1,025,000 | $ 1,025,000 | $ 1,025,000 | $ 1,025,000 | $ 5,185,000 |

Stanislaus County is seeking authorization to use up to $5,185,000 in Innovation funding over a five-year period:

- Direct Costs total $3,966,300 (76.5% of the total project) and include all contractor expenses for service delivery (salaries and benefits, supplies, rent, translation, subcontracts). Contacted personnel will include:
  - 1 FTE supervisory level staff equivalent to a Stanislaus County Behavioral Health Coordinator.
  - 3 FTE para-professional counselor equivalent to a Stanislaus County Behavioral Health Specialist.
  - 3 FTE peer support level staff equivalent to a Stanislaus County Clinical Services Technician.
- Administrative Overhead in the amount of $1,218,700 consisting of:
  - Independent evaluation contract costs $225,000 (4% of the total project) associated with developing the evaluation plan, supporting data collection, analysis and preparing reports.
  - Administration costs of $993,700 (19% of the total project) for county oversight of the project including procurement, contract monitoring, and fiscal tracking.

## Sustainability

If the project is determined to be a successful new approach, the County will incorporate this model into its Prevention and Early Intervention programming.

*The proposed project appears to meet the minimum requirements listed under MHSA Innovation regulations; however, if the Innovation Project is approved, the County must receive and inform the MHSOAC of the certification of approval from the Stanislaus County Board of Supervisors before any Innovation funds can be spent.*

April 7, 2023

Mental Health Oversight & Accountability Commission
c/o Shannon Tarter
Submitted via electronic mail

**RE: Proposed Innovation Plan for Stanislaus County**

Dear Ms. Tarter:

We are pleased to write this letter in support of the Innovations Plan Update and proposal to launch an Embedded Neighborhood Mental Health Team by the Behavioral Health and Recovery Services Agency in our neighboring county, Stanislaus. We agree that the strategy that BHRS has developed is one that will best serve the residents of Stanislaus County and encourage MHSOAC to approve the Plan Update.

The Reinvent South Stockton Coalition (RSSC) is a collective impact initiative founded in 2014 to empower residents of South Stockton to transform their community through improvements in health, housing, education, employment, safety, and parks. RSSC also convenes the San Joaquin County Transforming Communities for Healing, a coalition of community stakeholders, community-based organizations, and non-profits brought together to address the systems that have contributed to the collective trauma faced by many San Joaquin County residents. SJCTCH promotes community healing by advancing policy and systems change, including community education, advocacy, and training service providers to implement trauma-informed care.

As in South Stockton, LGBTQ and residents of cultural and ethnically diverse community neighborhoods in Stanislaus County have comparatively higher rates of mental health need and also require enhanced, culturally competent outreach services to overcome barriers such as mistrust, language, and disconnection from community networks of care. By targeting specific neighborhoods for community-embedded services and bringing in teams of paraprofessional outreach workers and navigators, BHRS is more likely to reach these populations and provide them with the care that they need. We look forward to assessing the outcomes of this innovative project, with an eye to deploying a similar approach in San Joaquin County.

In community,

RC Thompson, LCSW
Executive Director

cc: Tony Vartan

# AGENDA ITEM 6

**Information**

**April 27, 2023 Commission Meeting**

**Public Hearing on Full Service Partnerships**

**Summary**: The Mental Health Services Oversight and Accountability Commission will hear a panel presentation on the challenges and opportunities related to Full Service Partnerships (FSP), a critical investment of the Mental Health Services Act.

**Background**: The Mental Health Services Act (MHSA) was designed to drive transformational change in California's mental health system. Full Service Partnerships are a core component of the MHSA and of the care continuum for adults with severe mental illness and children with severe emotional and/or behavioral challenges who meet criteria for FSP services.

This first public hearing on FSPs will focus on the history and promise of the original FSPs, the provider and county behavioral health perspective on delivering FSP services locally, and a statewide perspective on efforts from a multi-county collaborative to align practices, processes, and outcome measures.

**Enclosure (4):** (1) Briefing Memo; (2) Report to the Legislature on Full Service Partnerships; (3) Panelist Bios; (4) Panelist Invitation Letters

**Handouts (1):** The presentation will be supported by PowerPoint slides.

**Proposed Motion:** None

Mental Health Services
Oversight & Accountability Commission

# Full Service Partnerships

April 27th, 2023 Public Hearing Brief

## Purpose

The purpose of this document is to provide background for the Commission's April 27th hearing on Full Service Partnerships (FSPs). The Commission will hear from a panel of experts to support the Commission's understanding of FSP programs across the state.

## Introduction

Full Service Partnerships are a core investment of the Mental Health Service Act (MHSA), and counties are required to dedicate a "majority" of MHSA Community Services and Supports funding to support these programs.

As part of the Commission's broad mission to support transformational change, the Commission has taken on this project to strengthen these essential investments.

## Background

California's Full Service Partnership (FSP) programs are recovery-oriented, comprehensive services targeted to individuals who have a severe mental illness and are cycling through hospitalizations, the criminal justice system, and homelessness. FSP programs were designed to serve people in the community rather than in locked state hospitals. Advocates and mental health professionals who implemented the first iterations of FSP programs were able to demonstrate that by engaging mental health consumers in their care and providing services tailored to individual needs, FSPs can reduce costs, improve the quality and consistency of care, enhance outcomes, and, most importantly, save lives. The name—Full Service Partnership—reflects the goal of developing a partnership between the person being served and the service provider, and offering a full array of services, through a "whatever it takes" approach to meeting needs. By providing recovery and support for individuals who otherwise would be caught in a lifelong cycle of hospitalizations and incarcerations, FSPs help clients develop and advance toward their goals by offering tailored, integrated, goal-driven care. Today, FSPs are core investments of the Mental Health Services Act (MHSA) and a key element of California's continuum of care, intended to be the bulwark against the most devastating impacts of untreated mental illness. There are now FSPs which serve children, transitional aged youth, adults, and older adults.

FSP programs under the MHSA are team-based and recovery-focused, typically based on intensive case management or assertive community treatment (ACT)[1] for adults and wraparound models for FSPs serving children. There are no clearly defined fidelity or quality metrics for FSPs because the approach is not manualized or standardized. Each FSP participant is intended to receive services and supports that are tailored to their needs and integrated through the "whatever it takes" approach. Recognizing that FSP clients often have

[1] ACT is an evidence-based practice that uses a multidisciplinary team approach with assertive outreach in the community.

a long history of unmet mental health needs, and considerable involvement with hospitals and the criminal justice system, access to care is intended to be available around the clock. FSPs utilize a team approach with high staff-to-client ratios.

Clients may be referred from child welfare agencies, psychiatric hospitals, emergency departments, other mental health programs, homeless shelters, jails, and other community-based organizations. Each county behavioral health program establishes eligibility criteria for participation in an FSP program, but adult clients typically must meet the following criteria: be homeless or at risk of homelessness; involved or at risk of involvement with the criminal justice system; frequently hospitalized for mental health challenges or frequent users of emergency department services.[2] The criteria for children is typically a child age 0-15 with a Serious Emotional Disturbance (SED) who has been or is at risk of being removed from the home by child protective services or has been in out-of-home placement or probation-involved and is transitioning back to into a home/community setting.

Despite these programs, California is facing multiple challenges to reduce the number of individuals who are unhoused and justice-involved and facing hospitalization because of unmet mental health needs. Research suggests the number of people who are homeless in 2022 increased by 22,500 from 2019, to reach 173,800.[3] While housing affordability is a primary driver of homelessness, individuals with mental health needs are particularly vulnerable and at risk. Current data on the numbers of the unhoused Californians with mental health needs are limited; however, research done prior to the pandemic found that rates are typically greater than 75 percent.[4]

Similarly, the state faces an increase in the number of Californians who are determined by the courts to be incompetent to stand trial and committed to programs administered by the California Department of State Hospitals. The state has invested more than $1 billion to address the increased need for services over the last two years with annual expenditure increases expected through 2025-26. Research from the Department of State Hospitals indicates that individuals coming into the state hospital system are cycling through the local criminal justice system – with nearly half having 15 or more arrests prior to being sent to a state institution, with many of those failing to receive community mental health services in the six months prior to the latest charge that resulted in a state hospital commitment. The California Department of State Hospitals also reports that some 71 percent of clients return following discharge with new felony charges and an Incompetent to Stand Trial designation.[5]

Community hospitals also report high numbers of mental health clients cycling through hospital emergency departments, and confusion over the role of contracted Full Service

[2] https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201100384
[3] https://calmatters.org/housing/2022/10/california-homeless-crisis-latinos/
[4] https://siepr.stanford.edu/publications/policy-brief/homelessness-california-causes-and-policy-considerations#:~:text=The%20prevalence%20is%20particularly%20high,Culhane%201998%3B%20Poulin%20et%20al
[5] https://www.dsh.ca.gov/About_Us/docs/IST_SolutionsBudgetOverview_08-01-22.pdf

Partnership providers when clients land in emergency departments needing crises mental health services.[6]

Finally, in its deliberations on the Community Assistance, Recovery and Empowerment (CARE) Act, the Legislature cited the growing numbers of Californians with serious and persistent mental health needs that are going unmet.[7] This raises the question of whether California's investment in FSPs is adequate, effective, and achieves the desired outcomes.

## Process

In January 2023, the Commission submitted a report to the legislature that outlines the steps the Commission has underway to strengthen the use of these programs in response to high numbers of mental health consumers who are struggling with housing, justice involvement, and hospitalization.

This initial report highlighted three key concerns:

1. The State faces data quality challenges that impede its capacity to fully understand how effective FSPs are in preventing homelessness, justice involvement, and hospitalization.
2. Despite regulatory requirements, county behavioral health programs do not appear to be allocating mandatory minimum funding levels to support Full Service Partnership programs.
3. California has not established sufficient technical assistance and support to guide the development and operation of FSP programs to enhance their effectiveness and improve outcomes.

The report outlined immediate opportunities and next steps, including: formation of an advisory group or Commission Subcommittee to engage in a community process; identify opportunities for capacity building and technical assistance; a landscape analysis of FSP programs and upstream prevention and early intervention strategies that could reduce the number of individuals in need of FSP services; data quality improvement efforts; analysis with existing data, and; exploring investment strategies that would meet the need for FSP services statewide.

As part of initial work to strengthen FSPs, in 2020, the Commission invested in a Multi-County FSP Innovation project, with 9 counties and others to create a common, more consistent FSP framework across counties, increase clarity and consistency of enrollment criteria, referral and transition processes, and improve data collection and outcomes reporting across programs.
Building upon that work, the Commission is undertaking the following steps to improve our understanding of the effectiveness of FSPs today, opportunities for reform, and strategies for

[6] Personal communication with Sheree Lowe, Vice President, California Hospital Association
[7] https://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill_id=202120220SB1338

quality improvement toward the goal of reducing homelessness, hospitalization, and criminal justice involvement.

### April 26th Site Visit

Commissioners will have the opportunity to visit two FSP programs in Sacramento, both run by Turning Point Community Programs—Integrated Services Agency and Pathways to Success after Homelessness. The Commission will hear from staff about services and supports that are part of the FSP model and challenges and opportunities they see in meeting the needs of individuals referred to FSP programs.

### April 27th Public Hearing on Full Service Partnerships

The first public hearing on FSPs will focus on the history and promise of programs and include a panel presentation designed to support the Commission's understanding of the program model, the systemic challenges in meeting the need across the state, and opportunities to strengthen programs through capacity building, technical assistance, and evaluation.

Panelists have been invited to present before the Commission to share their perspective on these challenges and opportunities.

The first panel will include one of the original designers of FSPs and a peer with lived experience with an FSP.

The second panel includes a county behavioral health director, a clinician from a FSP, and a representative from Third Sector who will share findings from the multi-county collaborative.

The panelist bios are included in the meeting packet enclosures.

*Some considerations:*

- What current policy and practice barriers exist that impede the state's ability to meet the needs of those who could benefit from a FSP?
- What are opportunities for capacity building and technical assistance that could support counties and providers in delivering effective FSP programs?
- Are there opportunities to strengthen the care continuum, specifically prevention and early intervention strategies, that would reduce the demand for FSP services?
- What are current challenges in the financing and funding streams available for FSP programs?

Mental Health Services
Oversight & Accountability Commission

# Report to the Legislature on Full Service Partnerships

Approved by the Mental Health Services Oversight and Accountability Commission

January 25, 2023

For submission to the Fiscal and Policy Committees of the Legislature

Mental Health Services
Oversight & Accountability Commission

# Table of Contents

## Executive Summary

Biennial reporting on Full Service Partnership (FSP) programs is required under Welfare and Institutions Code Section 5845.8, as established with the passage of Senate Bill 465 (Eggman, Chapter 544, Statutes of 2021). This first report provides an overview of California's deployment of FSP programs established under the Mental Health Services Act and outlines the steps the Mental Health Services Oversight and Accountability Commission has underway to strengthen the use of these programs in response to high numbers of mental health consumers who are struggling with housing, justice involvement, and hospitalization.

Early evidence on the effectiveness of FSPs suggests that these programs, when implemented with fidelity, can reduce hospitalizations, criminal justice contacts, and improve housing stability for consumers with severe and persistent mental illness. However, California is experiencing an increase in the number of individuals with unmet mental health needs who are unhoused, revolving in and out of hospital emergency departments and the criminal justice system, and often deemed incompetent to stand trial and committed to state hospitals.

In its deliberations on the Community Assistance, Recovery and Empowerment (CARE) Act, the Legislature cited the growing number of Californians with serious and persistent mental health needs that are going unmet.[1]

Recognizing the potential of FSPs to be a critical component of the State's response to those unmet needs, the Commission gathered information on the history and purpose of FSPs, reviewed the evidence base of their effectiveness, conducted an initial analysis of available statewide FSP data, and mapped the alignment of the reporting requirements outlined in SB 465 with existing quality improvement efforts across the state, particularly through innovation efforts supported by county behavioral health leaders.

This initial exploration and analysis revealed three primary concerns:

1. The State faces data quality challenges that impede its capacity to fully understand the effectiveness of FSPs in preventing homelessness, justice involvement, and

[1] https://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill_id=202120220SB1338

hospitalization.

2. Despite regulatory requirements, counties do not appear to be allocating mandatory minimum funding levels to support FSP programs.
3. California has not established sufficient technical assistance and support to ensure the effectiveness of FSP programs and support improved outcomes.

Given these challenges and the importance of FSPs in the continuum of treatment services within California for some of the most vulnerable individuals with mental health needs, the Commission submits this initial report to the Legislature, including a set of recommendations for next steps.

## Background and Purpose

California's Full Service Partnership (FSP) programs are recovery-oriented, comprehensive services targeted to individuals who are unhoused, or at risk of becoming unhoused, and who have a severe mental illness often with a history of criminal justice involvement, and repeat hospitalizations. FSP programs were designed to serve people in the community rather than in locked state hospitals. Advocates and mental health professionals who implemented the first iterations of FSP programs were able to demonstrate that by engaging mental health consumers in their care and providing services tailored to individual needs, FSPs can reduce costs, improve the quality and consistency of care, enhance outcomes, and, most importantly, save lives. The name – Full Service Partnership – reflects the goal of developing a partnership between the person being served and the service provider, and offering a full array of services, through a "whatever it takes" approach to meeting needs – or Full Service. By supporting recovery with individuals who otherwise would be caught in a cycle of hospitalizations and incarcerations, FSPs help people develop and advance toward personal mental health goals by offering tailored, integrated, goal-driven care. Today, FSPs are core investments of the Mental Health Services Act and a key element of California's continuum of care, intended to be the bulwark against the most devastating impacts of untreated mental illness.

Several converging factors have prompted policy makers to raise concerns that California's investments in FSPs may not be adequate to meet the growing need. These include:

- State and communities struggling with an increasing number of residents living unhoused, many with unmet mental health needs.
- Waiting lists to enter State hospitals for mental health care under felony Incompetent to Stand Trial designations.
- Ongoing reliance on local law enforcement and community hospital care as mental health consumers cycle in and out of mental health crises.

### Relevant Legislation

In October 2021, Governor Newsom signed legislation directing California's Mental Health Services Oversight and Accountability Commission to provide biennial reports to the Legislature on the operations of FSPs and recommendations on fortifying state and community response to the needs of Californians who can benefit from these programs (SB 465, Eggman, Chapter 544, Statutes of 2021). Welfare and Institutions Code Section 5845.8 states that the Commission's reports shall include:

- Information regarding individuals eligible for FSPs, including information on incarceration or criminal justice involvement; housing status or homelessness; hospitalization, emergency room utilization, and crisis service utilization.
- Analyses of separation from a FSP and the housing, criminal justice, and hospitalization outcomes for the 12-months following separation.
- An assessment of whether those individuals most in need are accessing and maintaining participation in a FSP or similar programs.
- Identification of barriers to receiving the data relevant to the report requirements and recommendations to strengthen California's use of FSPs to reduce incarceration, hospitalization, and homelessness.

In September 2022, the Legislature passed, and Governor Newsom signed, the Community Assistance, Recovery and Empowerment (CARE) Act (SB 1338, Umberg, Chapter 319, Statutes of 2022), establishing a framework to improve access to mental health services for persons who

are untreated, undertreated, or unstably housed and experiencing schizophrenia spectrum and other psychotic disorders. The framework begins with establishing a mechanism for mental health consumers and counties to negotiate individualized service plans – called CARE plans - with the courts serving as an oversight entity and authorized to compel county participation in those plans. While mental health peers and their allies have raised concerns that the CARE Act could be implemented in a coercive manner, the intent is for the Act to lead to improved access to and engagement in care. Recognizing that FSPs are intended to serve individuals who are at risk of homelessness, criminal justice involvement, and with a history of hospitalizations, the CARE Act is expected to increase demand for FSP services. For example, the development of Individual Service and Support Plans – comparable to the newly required CARE Plans – are a required component of Full Service Partnerships.

In response to SB 465 and the likelihood that the CARE Act will increase the need for effective FSP services, the Commission's goals are to improve understanding of how FSPs operate, how they can best serve mental health consumers, and highlight strategies to reduce unnecessary participation in the CARE Act process because there is more access to quality FSPs. These efforts are intended to improve the effective use of limited public sector mental health funding, reduce costs, and improve outcomes for mental health consumers and their families.

## History

In November 2004, California voters passed Proposition 63 and enacted the Mental Health Services Act (MHSA). The MHSA established new requirements for county mental health systems, including improved focus on persons with serious and persistent mental health needs, new requirements for prevention and early intervention, and a mandate for investments in innovation to drive transformational change in public mental health systems. The prevention and early intervention language of the MHSA includes an expansive focus on interrupting homelessness, criminal justice and child welfare involvement, school failure, unemployment, suicide, and prolonged suffering.

The MHSA also established a new revenue stream to support community mental health.

The Act levies a 1 percent annual tax on personal income over $1 million. More than $3 billion is generated each year to fund public mental health systems and services in California.

California's investment in Full Service Partnerships (FSPs) evolved from advocacy efforts in the 1990s to reduce the number of people who were sent to locked state mental hospitals when they could be served in the community at lower cost with better outcomes. In 1999, the state passed legislation to establish four pilot projects across California to fund comprehensive and integrated care for persons with high risk for homelessness, justice involvement, and hospitalization. Early results found that program participants decreased the number of days in a hospital by 66 percent, jail days were reduced by 82 percent, and days living unhoused by 80 percent.[2] One of the funded demonstration projects, a community program called The Village, was administered by the Mental Health Association of Los Angeles and incorporated a range of recovery principles into its work. In addition to success in reducing hospitalization, criminal justice involvement, and days unhoused, The Village was able to support employment for the clients they served.[3]

In response to these results, California expanded funding for the pilot program to include more sites around the state. Follow-up evaluations confirmed early findings: housing is a critical component of recovery; people with serious mental illness can achieve housing stability with adequate support, and consumers with the most challenges (e.g. struggling with a substance use disorder, recently incarcerated, living on the streets at enrollment, etc.) were not harder to support or keep in housing compared to mental health consumers with fewer challenges.[4]

Building off these early successes, the subsequent passage of the MHSA – and the funding it generated – created optimism that California would be able to address the needs

[2] https://www.csh.org/wp-content/uploads/2011/12/Report_AB20341.pdf
[3] http://static1.1.sqspcdn.com/static/f/1084149/15474792/1323450497457/49AnOverviewoftheVillage.pdf?token=yLvMwOUGOEYES7lmmLBuALqeTCU%3D#:~:text=The%20Village%20Integrated%20Service%20Agency%20in%20Long%20Beach%2C,system%20change.%20At%20the%20Village%2C%20we%20have%20had
[4] https://www.csh.org/wp-content/uploads/2011/12/Report_AB20341.pdf

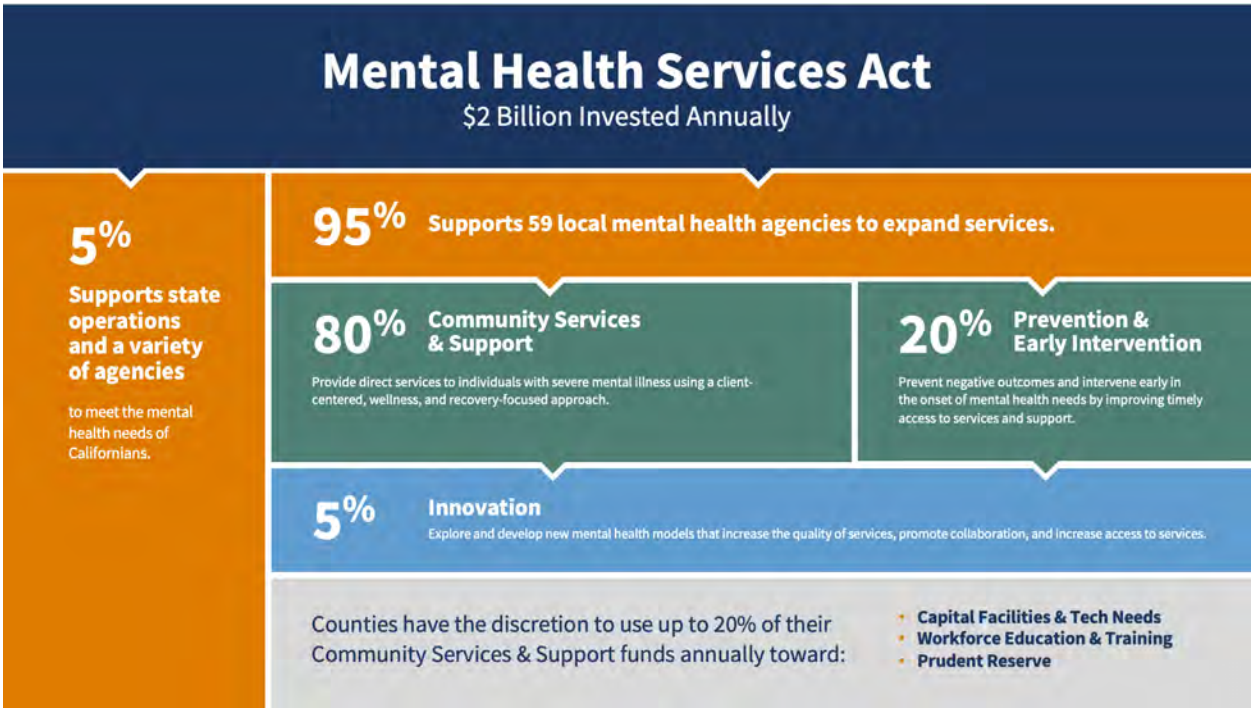
of mental health consumers with the most complex needs without relying on long-term hospitalization, criminal justice involvement, or seeing large numbers of Californians living on the streets because of unmet mental health needs.

Under the MHSA, the revenues generated each year are shared between the State and California's 59 local behavioral health agencies.[5] The State receives 5 percent of MHSA revenues to fund state operations, provide grants to county behavioral health departments, and to support other needs. The bulk of MHSA revenues – 95 percent – are allocated to local behavioral health agencies through a distribution formula that is largely based on the population of each local agency and the mental health needs in their communities.

Under the MHSA, local behavioral health agencies – which are typically counties – are required to distribute those funds into a minimum of three MHSA components. The largest share of the funding – 76 percent – must be dedicated to Community Services and Supports (CSS) or core mental health services for persons with more severe or serious mental health conditions. Counties are required to dedicate 19 percent of the funds they receive for prevention and early intervention activities. The balance, 5 percent of the funds, are required to support innovative efforts to improve services and outcomes. County behavioral health leaders have the option to set aside up to 20 percent of the CSS funding each year to fund a Prudent Reserve, support workforce education and training, or address capital facility and technology needs.

[5] While there are 58 counties in California, there are 59 local mental health authorities. Sutter and Yuba Counties are one entity, and the City of Berkeley and Tri-Cities are carved out from their respective counties.

Figure 1: MHSA Distribution Summary

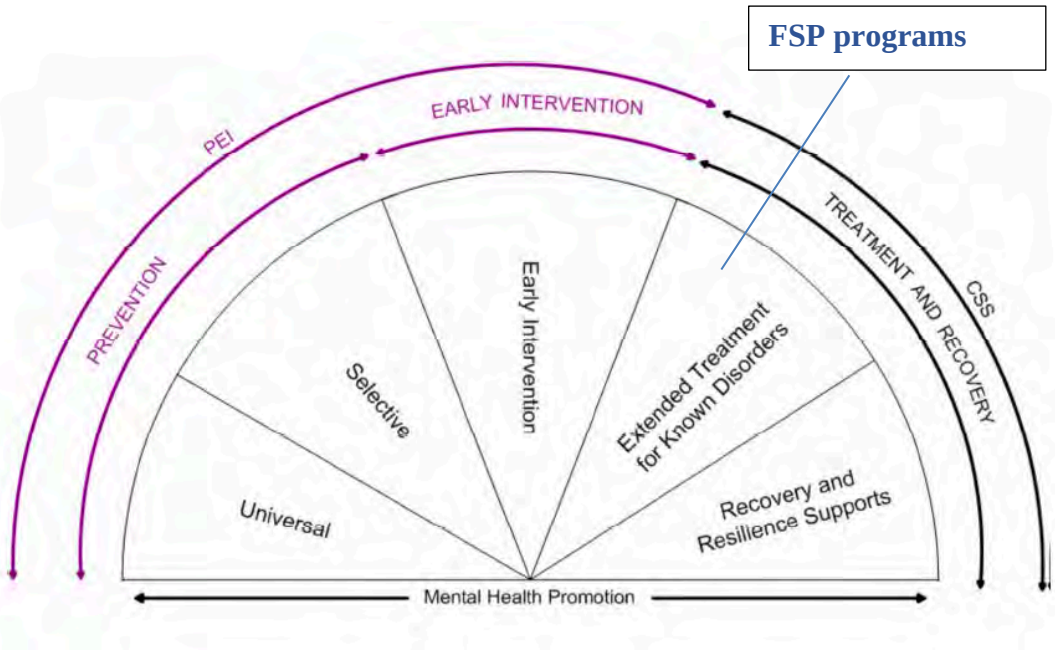



Recognizing the significance of FSPs in supporting mental health consumers with serious and persistent needs, and the focus of the MHSA on recovery, housing, and reducing criminal justice involvement, Section 3620, subdivision (c) of the MHSA regulations requires counties to dedicate a "majority" of MHSA CSS funding for FSPs. Counties also are allowed – subject to consultation with local mental health partners and community members – to use prevention and early intervention funds, with some limitations, to support children and youth who may need FSP services.

## Full Service Partnership Programs

A unique quality of Full Service Partnerships (FSPs) is that the approach to treatment planning and service delivery emerges from a negotiation between the client and the provider. The question that launches the treatment planning process is often, "What do you need as a partner in your recovery journey?"

Figure 2: Mental Health Continuum




FSP programs under the MHSA are team-based and recovery-focused, typically based on intensive case management or assertive community treatment (ACT).[6] The approach to FSPs is not manualized or standardized. Each FSP participant is intended to receive services and supports that are tailored to their needs and integrated through the "whatever it takes" approach. Recognizing that FSP clients often have a long history of unmet mental health needs and considerable involvement with hospitals and the criminal justice system, access to care is available around the clock. A Personal Services Coordinator/Case Manager is required to respond to the client or family 24 hours a day, 7 days a week to provide after-hours support when necessary.[7]

[6] ACT is an evidence-based practice that uses a multidisciplinary team approach with assertive outreach in the community.
[7] California Code Reg. Tit.9 § 3620

Clients can be referred into an FSP from psychiatric hospitals, emergency departments, and other mental health programs, as well as outreach workers, homeless shelters, jails, and community-based organizations.

Each California county behavioral health department establishes eligibility criteria for participation in an FSP program and many FSPs are run by contracted providers which results in additional variation in program design and eligibility within a given county. Despite that variation, clients typically must meet the following criteria: be homeless or at risk of homelessness; involved or at risk of involvement with the criminal justice system; frequently hospitalized for mental health challenges or frequent users of emergency department services.[8]

### Types of FSPs

FSPs are designed and tailored to address the needs of various age groups and subpopulations:

- Child FSPs: intensive in-home mental health service program for children ages 0-15 and their families. Using a wraparound approach, these FSPs work with children and families on goals that support safety, wellbeing, health, and stability of the family.
- Transition Aged Youth (TAY) FSPs: comprehensive and higher-level outpatient mental health services that use a team approach to meeting the behavioral health needs of youth ages 16-25 experiencing social, behavioral, and emotional distress.
- Adult FSPs: Adult FSPs are designed for adults ages 26-59 who have been diagnosed with a severe mental illness. Adult FSPs assist with housing, employment, and education, as well as mental health and substance use services when needed.
- Older adult FSPs: for adults 60 and older with histories of homelessness and/or incarceration, these FSP programs often use the Assertive Community Treatment (ACT) model.

[8] https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201100384

- Forensic FSPs: These programs have a focus on justice-involved adults with serious mental health needs and co-occurring substance abuse disorders.

## Evidence of Success

Earlier iterations of FSPs had demonstrated measures of success, such as fewer hospitalizations, increased housing stability, and less involvement with the criminal justice system. Since the passage of the MHSA in 2004, there have been several evaluations to determine statewide impact, along with numerous local efforts to quantify the success of FSPs. These evaluations show that FSPs can be highly effective at achieving the goals of lower criminal justice involvement, reductions in homelessness, fewer hospitalizations and emergency department visits, and cost savings.

### *Local Evaluations*

- Cost savings: A 2018 report by RAND found that Los Angeles' FSP investment has resulted in $82 million in cost savings over five years.[9]
- Improved housing and less criminal justice involvement: San Francisco's FSP evaluation found a reduction in arrests and time in other restrictive settings along with improvements in the quality and stability of housing.[10]
- Improved access to services and less homelessness: San Diego County found that participation in an FSP was associated with improved access to care and better housing outcomes.[11]

### *Statewide Evaluations*

- Fewer emergency department visits: One study found that FSPs were highly effective in reducing emergency department visits – compared to usual care, the odds of FSP

[9] https://www.rand.org/pubs/research_briefs/RB10041.html
[10] https://www.sfdph.org/dph/files/CBHSdocs/MHSAdocs/SFMHSA5YearReport-2010.pdf
[11] https://jamanetwork.com/journals/jamapsychiatry/article-abstract/210805

clients visiting the emergency department were 54 percent less after 12 months of treatment and 68 percent less after 18 months.[12]

- Decline in emergency mental health services: In a study looking at children ages 11-18, researchers found that before FSP enrollment, participating children had high and increasing rates of mental health emergency services, and after enrollment, had rapid reductions in emergency services use compared to children who did not receive FSP services.[13]

- Less criminal justice involvement: An internal analysis conducted by the Commission draws upon data from FSP providers and criminal justice data from the California Department of Justice. That work found a strong association between FSP participation and reductions in arrests. Participants had a 47 percent reduction in arrests in the 12 months following participation in an FSP compared to 12 months before participation.

These and other evaluations indicate that FSP programs can and do reduce criminal justice involvement, emergency department and psychiatric inpatients stays, and improve housing stability.

## Guiding Questions

The history and initial evaluations of FSP programs suggests they represent opportunities to drive down the numbers of Californians who are unhoused, justice involved and facing hospitalization because of unmet mental health needs, yet California has seen increases in each of those challenges.

Cities and towns across the state are struggling to meet the needs of people living in encampments throughout the state. Research suggests the number of people who are homeless in

[12] https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201100384
[13] https://www.ingentaconnect.com/content/wk/mcar/2017/00000055/00000003/art00015

2022 increased by 22,500 from 2019 to reach 173,800.[14] While housing affordability is a primary driver of homelessness, individuals with mental health needs are particularly vulnerable and at risk. Current data on the numbers of the unhoused Californians with mental health needs are limited; however, research done prior to the pandemic found that rates can be as high as 75 percent for the chronically homeless, and between 30 and 50 percent for the population of unhoused.[15]

Similarly, the state faces an increase in the number of Californians who are determined by the courts to be incompetent to stand trial and committed to programs administered by the California Department of State Hospitals. The state is investing more than $1 billion in a multi-year plan to address the increased need for services through 2025-26. Research from the Department of State Hospitals indicates that individuals coming into the state hospital system are cycling through the local criminal justice system – with nearly half having 15 or more arrests prior to being sent to a state institution, with many of those failing to receive community mental health services in the six months prior to the latest charge that resulted in a state hospital commitment. The California Department of State Hospitals also reports that some 71 percent of clients return following discharge from a state hospital with new felony charges and an Incompetent to Stand Trial designation by the courts.[16]

State officials suggest the increase in demand for state hospital beds is directly tied to the number of Californians with Schizophrenia Spectrum disorders who are not receiving community-based care and, as a result, are becoming involved with the criminal justice system.

[14] https://calmatters.org/housing/2022/10/california-homeless-crisis-latinos/
[15] https://siepr.stanford.edu/publications/policy-brief/homelessness-california-causes-and-policy-considerations#:~:text=The%20prevalence%20is%20particularly%20high,Culhane%201998%3B%20Poulin%20et%20al
[16] https://www.dsh.ca.gov/About_Us/docs/IST_SolutionsBudgetOverview_08-01-22.pdf

Community hospitals also report high numbers of mental health clients cycling through hospital emergency departments, and confusion over the role of contracted FSP providers when clients land in emergency departments needing crises mental health services.

Finally, in its deliberations on the Community Assistance, Recovery and Empowerment (CARE) Act, the Legislature cited the growing numbers of Californians with serious and persistent mental health needs that are going unmet.[17]

The Commission's initial review of data relating to FSP identifies three primary concerns:

1) The State faces data quality challenges that impede its capacity to fully understand how effective FSPs are in preventing homelessness, justice involvement, and hospitalization.
2) Despite regulatory requirements, county behavioral health departments do not appear to be allocating mandatory minimum funding levels to support FSP programs.
3) California has not established sufficient technical assistance and support to ensure that FSP programs are meeting to goals of reducing homelessness, hospitalizations and justice involvement.

Despite the initial success of FSPs, significant numbers of Californians with mental health challenges lack stable housing, are involved in the criminal justice system, and are cycling through state and community hospitals. These concerns suggests that California's investment in FSPs is not meeting the current need and raises the following questions:

1) How effective are FSPs – as presently designed and operated – at reducing homelessness, incarceration, and hospitalization?
2) What lessons can be learned from exemplary programs to improve the efficacy of the overall FSP initiative?

[17] https://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill_id=202120220SB1338

3) Is California making adequate investments in FSPs, and if not, what strategies should the state explore to improve the alignment of revenues with programmatic needs and intended outcomes?

4) What strategies should the state explore or pursue to improve prevention and early intervention strategies, to reduce reliance on FSPs where possible?

These questions, along with the descriptive questions outlined in Welfare and Institutions Code 5845.8 are addressed below.

*How effective are FSPs – as presently designed and operated – at reducing homelessness, incarceration, and hospitalization?*

To address this question, the Commission explored existing state data systems that contain information on persons served by Full Service Partnerships. Unfortunately, the data in the state's primary FSP reporting system is inadequate to provide clear and reliable information on the effectiveness of individual FSPs and the broader FSP initiative.

The Department of Health Care Services maintains a Data Collection Reporting (DCR) tool that was designed to receive information on FSP programs across the state. The DCR was intended to gather information on FSP enrollments, key events in the life of participants, and quarterly updates on progress toward goals and services received. Preliminary review of data from the DCR indicates significant gaps in required reporting. For instance, the DCR is intended to gather demographic data on persons served. Demographic data are important to enable the tracking of disparities in access to care across racial, ethnic, age and gender subsets of California's population. A review of data from the 2020-21 fiscal year revealed more than a third of persons listed as receiving FSP services had no racial, ethnic or gender data linked to their FSP enrollment through the DCR.

The DCR also includes a reporting requirement for "Key Events," defined as any significant change related to housing, education, employment, emergency services, arrests, health issues,

transfer to a new FSP provider, or disenrollment from the program. These events are reported through a Key Event Tracker, which is intended to provide a snapshot of changes in key quality of life areas that are tracked on a continuous basis throughout the course of participation in the FSP. There is no limit to the number of key events that can be submitted into the data system and monitored over the course of FSP enrollment.

Recognizing that Key Event data can reflect incidents of arrests, housing instability, hospitalizations, and changes in FSP enrollment, these data are of high value in demonstrating outcomes associated with FSP involvement. To meet the goals of FSP involvement, key events should trend toward stability in care, housing, and avoidance of criminal justice involvement and hospital use. Currently key event data are unavailable for a significant subset of FSP clients. Given the considerable risks that FSP clients face for criminal justice involvement, housing instability and hospitalization, the Commission would anticipate robust data on key events for enrollees. It is unclear if key event data are not being submitted by providers, if the data are not finding their way into the Key Event Tracker, or if there a high percentage of FSP enrollees who fail to experience "key events," which would seem unlikely.

Through the DCR the state has the potential to track relevant information about key events of a consumer as they move through an FSP; however, the DCR does not track other critical information such as services provided and progress toward goals. This information is more likely to be captured in provider/county electronic health records, and there is currently no data reporting mechanism by which that information is reported to the state.

In the absence of more complete data sets on FSP participants, the Commission has explored opportunities to link FSP enrollment data with other data sets on justice involvement, hospitalization, employment, and housing status. As reference above, the Commission pursued an exploratory link between data held in the DCR with data gathered by the California Department of Justice (DOJ). Those data were reflected justice involvement prior to 2018. We

are currently working to receive updated data from the DOJ that can be linked to current FSP enrollment data.

Similarly, the Commission is working to identify potential datasets that can be linked to DCR client data to explore hospital use, employment, homelessness and housing status.

To improve the ability to monitor the outcomes and impacts of FSPs on key priorities, the Commission is exploring the strengths and limitations of the existing data systems and strategies to improve access to existing data, pathways to improved state-level reporting and the need to streamline reporting requirements. It is unclear if existing data reporting requirements are cost-effective and how they could be modified for improve cost-effectiveness. To pursue these questions and develop potential recommendations, the Commission will work with the Department of Health Care Services, mental health clients supported by FSPs, county behavioral health leaders, FSP providers, and other subject matter experts.

*What lessons can be learned from exemplary programs to improve the efficacy of California's overall FSP initiative*?

In 2019 the Commission partnered with ten local behavioral health departments and a non-profit consultant to explore strategies to strengthen emphasis on outcomes through the design and delivery of FSP services. This project, the Multi-County FSP Innovation built upon a project launched by the Los Angeles County Department of Mental Health with support from Third Sector, a non-profit technical assistance provider. Following Los Angeles County's initial work, the Commission provided financial support to extend participation to nine additional counties. The project was designed to strengthen how counties contract for FSP services with an emphasis on creating incentives for FSP providers to focus on outcomes. In addition to Los Angeles, Fresno, Sacramento, San Bernardino, San Mateo, Siskiyou, Ventura, Stanislaus, Napa, and Lake counties participated in the Multi-County FSP Innovation Project, in partnership with Third Sector. The project was designed with the following goals:

- Develop a shared understanding and more consistent interpretation of FSP's core components across counties, creating a common FSP framework.
- Increase the clarity and consistency of enrollment criteria, referral, and transition processes through developing and disseminating readily understandable tools and guidelines across stakeholders.
- Improve how counties define, and pursue priority outcomes across FSP programs.
- Develop a clear strategy for tracking outcomes and performance measures through various state-level and county-specific reporting tools.
- Develop new and/or strengthen existing processes that leverage data to foster learning, accountability, and meaningful performance feedback in order to drive continuous improvement in program operations and outcomes.

To allow for flexibility, FSP programming can vary greatly from county to county, with different operational definitions and data processes; however, this diversity of approaches presents challenges in understanding and telling a statewide impact story. The Multi-County FSP Innovation Project is intended to implement a more uniform data-driven approach that provides counties with an increased ability to use data to improve FSP services and outcomes. Counties are leveraging the collective power and shared learnings of a cohort to collaborate on how to provide the most impactful FSP programs and ultimately drive transformational change in the delivery of mental health services.[18]

Participating counties worked together to identify standardized measures for tracking what services individuals receive and how successful those services are. Guided by more than 200 interviews with FSP consumers, family members, and peers, 50 provider focus groups, and recommendations around evidence-based practices, the counties selected and defined five measures to compare across counties for adult FSP participants:

- Frequency and location of services

[18] https://tscp.wpenginepowered.com/wp-content/uploads/2022/03/Multi-County-FSP_Year-2-Summary-Report-2-10-FINAL-1.pdf

- Increased stable housing, including stable, temporary, and unstable housing arrangements
- Reduced justice involvement; including incarcerations and arrests
- Reduced utilization of psychiatric services; including reduced psychiatric and crisis stabilization unit (CSU) admissions
- Increased social connectedness

While some of these outcome measures were historically collected, none were tracked with consistent definitions or metrics across counties. These new, standardized measures should allow participating counties to share and discuss their data collaboratively, identify best practices, and engage in continuous improvement activities collectively. In addition, these counties now collect and track social connectedness data – a recommendation elevated by service recipients – as a key outcome for individuals with serious mental illness.

As part of the Multi-County Full Service Partnership Innovation Project, counties came up with a set of recommendations to the Department of Health Care Services (DHCS) to improve the DCR system. These recommendations were drafted into a memorandum and submitted to DHCS, acknowledging the department's Comprehensive Behavioral Health Data Systems Project to modernize and streamline data reporting across California's multiple behavioral health data systems, including the DCR. The Commission endorses these recommendations which include concrete feedback on improving communication support, technical system enhancements, and pre-procurement process suggestions.

The Multi-County Full Service Partnership Innovation Project is currently in its evaluation phase and involved a limited subset of county behavioral health departments. Consistent with the comments above, the Commission will continue its work with the Multi-County Innovation project, explore opportunities following the evaluation to engage additional counties and partner with the Department of Health Care Services to improve the utility of existing data reporting requirements and data systems.

*Is California making adequate investments in FSPs, and if not, what strategies should the state explore to improve the alignment of revenues with programmatic needs?*

In 2021, the MHSA generated an estimated $2.8 billion in funding to support community mental health services. Of those funds, $2.3 billion were distributed to county behavioral health departments, which resulted in the following allocations:

- Community Services and Supports (CSS): $1.6 billion
- Prevention and Early Intervention (PEI): $423 million
- Innovation: $99 million

State regulations require "a majority" of CSS funds to support FSP programs. However, in 2010, likely in response to fiscal uncertainties the state was facing at the time, the former Department of Mental Health issued an Information Notice clarifying that for the 2011-12 fiscal year only, the state would calculate the minimum FSP investment to reflect all FSP expenditures, including any federal funding used to support FSP programs. The Information Notice changed the rules for county FSP spending from requiring counties to meet their "majority" expenditure requirement with MHSA revenues, with federal and other funds being in addition to the MHSA investment, to a new formula that would lower MHSA and thus overall expenditure requirements for FSPs. County behavioral health officials state that despite Information Notice 10-21 communicating that this change in fiscal rules applied only for the 2011-12 fiscal year, in the absence of subsequent information, the counties have continued to operate under the temporary direction.

The Mental Health Services Act was passed with clear and compelling goals to reduce justice involvement, homelessness and support community-based care, which is often interpreted as meaning also reducing reliance on hospitalization. The subsequent regulatory requirement to dedicate the "majority" of Community Services and Support funding for FSPs signals the opportunity that FSPs represent to avoid these negative outcomes. Yet uncertainly on the state's

fiscal rules has hampered opportunities to ensure an adequate investment in FSPs across California's 59 local behavioral health agencies.

As part of its work under the terms of SB 465, the Commission will work with the Department of Health Care Services and county behavioral health leaders to clarify the fiscal requirements relating to FSPs and strengthen utilization of existing resources to support improved FSP outcomes.

*What strategies should the state explore or pursue to improve prevention and early intervention strategies, to reduce reliance on FSPs where possible?*

As depicted in Figure 2 above, FSPs exist within a continuum of services and are at the higher end of treatment services. While existing state databases do not allow a clear understanding of who is presently served by FSP providers, discussions with state and county behavioral health leaders indicate that FSPs are best suited to support persons with schizophrenia and related disorders that involve psychosis. As such, the Commission is working to explore opportunities to best engage individuals at the initial stage of psychosis and to prevent the escalation of needs that would result in new demands on FSP programs. In other words, the State of California needs to build out a robust FSP service delivery system that is responsive to the needs of people with serious and persistent mental health care needs, and the state also must work to reduce the escalation of mental health needs and the demand for FSP services.

Research on early psychosis intervention indicates that there are clinically beneficial and cost-effective approaches to care delivery that can prevent the escalation of needs.[19] The Governor and Legislature have supported several initiatives to increase upstream interventions that can lower demand for high-cost FSP services, particularly the expansion of access to early psychosis interventions.

[19] https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-015-0650-3

As the Commission's work on Full Service Partnerships progresses, we want to explore the impact that expanded access to early psychosis services can have as an FSP prevention strategy.

## Immediate Opportunities and Next Steps

### *Developing a Strategic Reporting and Capacity Building Plan*

Given the requirements of the Welfare and Institutions Code Section 5845.8, as established with the passage of Senate Bill 465 (Eggman, Chapter 544, Statutes of 2021) and the learning from the four key questions established in this initial report, there is significant groundwork to cover before the next report is due in November 2024.

The Commission's strategic reporting and capacity building plan for FSPs will incorporate clear and concise goals and objectives for data collection, monitoring, and reporting. It will incorporate a plan and process for community engagement and outline a process for capacity building, program improvement, and community feedback.

The plan also will reflect principles of diversity, equity, and inclusion, to ensure that the state's investment in Full Service Partnerships supports efforts to reduce disparities, particularly as they relate to criminal justice involvement, homelessness, and hospitalization.

As mentioned above, the process for developing a strategic data reporting and capacity building plan will incorporate the following:

1. Formation of an Advisory Group. The Commission will convene a group of subject matter experts to inform the work moving forward, including FSP providers, state and local agencies representatives, consumers, family members, and others. The Advisory Group will be tasked with informing all aspects of the Commission's work on FSPs.
2. Identify Opportunities for Capacity Building. As the Commission has learned through the Multi-County FSP Innovation Project, there is diversity in FSP programs in terms of eligibility criteria, services provided, step-down criteria, other program

elements and measures of success. The project also has revealed opportunities to engage county behavioral health leaders, FSP providers and others to support capacity building and technical assistance to improve the design and delivery of FSP services and supports. The Commission is exploring opportunities to build off of the Multi-County FSP Innovation Project, involve more counties and improve access to technical assistance and support for all counties.

3. Conducta landscape analysis to understand FSPs within the continuum of prevention, early intervention, and treatment. With the passage of the CARE Act, greater attention to individuals who are deemed Incompetent to Stand Trial, and efforts across California to enhance early psychosis programs, there is a tremendous opportunity to critically examine where FSPs fit into California's larger continuum of care. For example, investing in upstream prevention and early intervention approaches should, over time, reduce the number of individuals who need FSP services. In other words, if the system of care can identify, treat, and stabilize an individual at the point of their first psychotic break, evidence suggests that their trajectory changes and they are less likely to become homeless, develop substance use disorders, and become involved in the criminal justice system. The Commission will work with and support related efforts underway at the Department of Health Care Services.

4. Data quality improvement efforts. As discussed, there are numerous data issues with the DCR related to accuracy, completeness, and quality. For example, without complete data on race/ethnicity, it is difficult to disaggregate results to explore potential disparities in outcomes by race/ethnicity. The DCR also lacks service/treatment information making it impossible to map specific services to positive outcomes. The Commission will explore opportunities to collaborate with DHCS and county partners (e.g. the Multi-County Innovation project on FSPs) on existing efforts to improve these data systems so that they accurately tell the FSP story and help document success and challenges across the state.

5. Data linkage and population-based analyses. The Commission will explore opportunities with the Department of Health Care Services to link individual-level data from the DCR with other state-based datasets, such as data from the California Department of Health Care Access and Information and the DOJ, to better understand population-level outcomes associated with FSP services.
6. Provide recommendations for investment strategy for FSPs. Given the confusion over expenditure rules and uncertainty over whether individuals who meet the criteria for FSP services are getting enrolled and served, the Commission is exploring opportunities to analyze current FSP expenditures, develop an estimate of unmet need in the state, and potential recommendations for reforming expenditure rules, establishing expectations for expanding FSP treatment capacity, and related strategies.

## Appendices

### *Data Sources for FSP Analysis*

The State of California has four primary data sources available to understand the operations of Full Service Partnerships (FSPs) and the outcomes they achieve for mental health clients and the communities where they live. The Department of Health Care Services maintains two of those data systems: the Data Collection and Reporting (DCR) system, which was designed specifically to receive information on clients involved with FSP, and; the Client Information System (CSI), which has data on all mental health clients served by county mental health departments. Additional data systems include those maintained by the California Department of Health Care Access and Information (HCAI), which includes data on hospitalizations and discharges, and data held by the California Department of Justice relating to criminal justice involvement.

To support this initial effort and future work, the Commission will primarily rely on these data systems and access additional data, or data collection methods, as needed.

Under existing state regulations, each county behavioral health department is required to submit to the state detailed data on clients served through Full Service Partnerships. Those requirements are outlined in Title 9 of the California Code of Regulations. At the time an individual enters into a FSP, the county is required to collect the following information and submit it to the Department of Health Care Services (DHCS) within 90 days:

- Residential status, including hospitalization or incarceration
- Educational status
- Employment status
- Legal issues/designation
- Sources of financial support
- Health status
- Substance abuse issues
- Assessment of daily living functions, when appropriate
- Emergency interventions

Additionally, at any time during the course of participation in an FSP, counties also are required to report any emergency interventions, or changes in living situation, educational or employment status and criminal justice involvement. The reports are known as Key Event reports. Counties also are required to provide quarterly assessments for each FSP participant that provide data on the following:

- Educational status
- Sources of financial support
- Legal issues/designation
- Health status
- Substance abuse issues

As with the initial assessment data, Key Event data and quarterly assessment date are required to be submitted to the DHCS within 90 days of collection.

In addition to the DCR system, which holds data only on FSP clients, DHCS maintains the CSI data system, through which counties are required to report information to the state on all persons receiving mental health services from a county. Those receiving services through Medi-Cal and those who are not enrolled in Medi-Cal are required to report into the state's CSI data system. Counties are required to report on client demographics and descriptions of the services provided within 90 days of providing services (CCR Title 9, 3530.10, Information Notice 19-051).

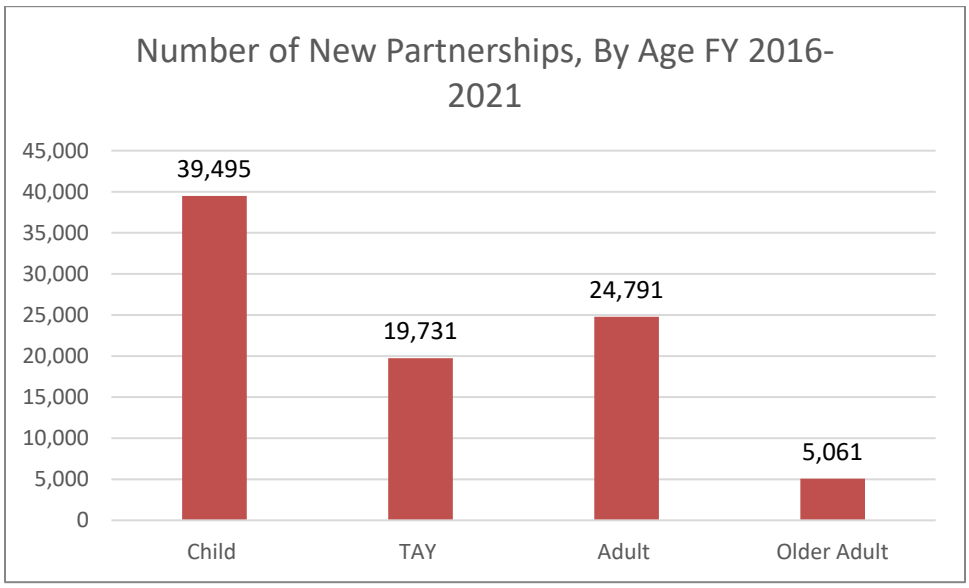
The Commission receives data regularly from the DHCS to support existing efforts to monitor FSP programs. These data sources include: FSP DCR database and the MHSA CSI. Additional data use agreements with the HCAI provide the Commission with patient discharge data (PDD) for hospitalizations.

***Initial Data Analysis***

Partnerships by Age

Figure 2 shows the number of new partnerships (e.g. clients) who enrolled in an FSP over the last five years (between FY 2016-2021), by age group. Child FSPs are an important service, with 44% of all new partners falling into the 0-15 age group. The percentage of clients by age group has remained stable over the last five years, with children constituting approximately 45% of new enrollments; transition age youth were 22%; adults were 28%; and older adults were 6%.

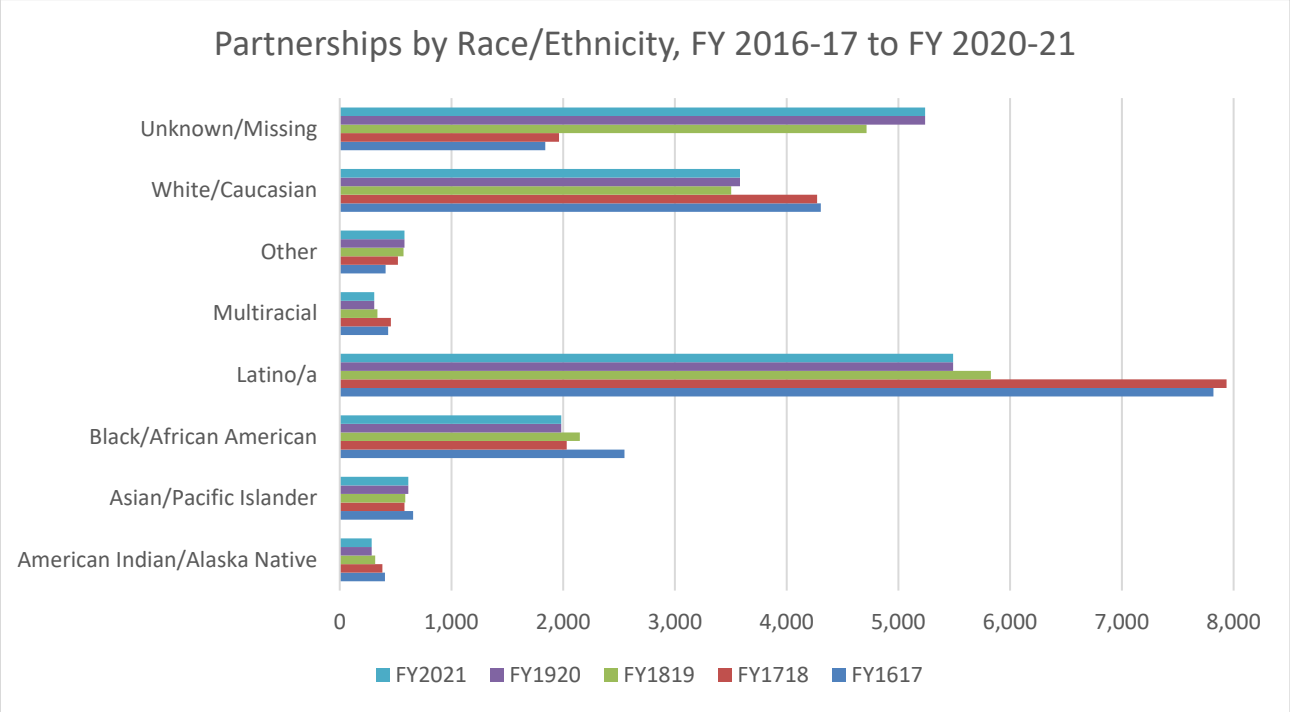
Figure 3: Number of New Partnerships, By Age, FY 2016-2021




## Partnerships by Race/Ethnicity

Comparing trends by year for partners served by race/ethnicity is challenging because the number of partners with no race/ethnicity reported in the DCR has increased.

Figure 4: Number and Percentage of Partners by Race/Ethnicity, FY 2016-17 to 2020-21




## Partnerships by Gender

Comparing trends by year for partners served by gender is also challenging because the number of partners with no gender identified increased between FY 2016-17 and FY 2020-21. In FY 2016-17, 53% of those served identified as male; 43% as female; 5% as Other; and less than 1% were Unknown. In contrast, in FY 2020-21, gender was designated Unknown for 27% of partners. The challenges of the COVID pandemic may have impacted data quality.

## Discharges from FSPs

One of the triggers for a Key Event Tracker (KET) is a discharge of a client from the FSP. There are multiple reasons why a partnership might be discontinued, including:

- Target population criteria not met
- Partner decided to discontinue FSP participation
- Partner moved to another county/service area
- After repeated attempts to contact partner, they cannot be located
- Community services/program interrupted (e.g. partner moves to a higher level of care,

will be serving a jail sentence, placed in juvenile hall, serving prison)

- Partner has successfully met their goals such that discontinuation of FSP services is appropriate

Of the 215,404 partners in the DCR system, 164,902 had a KET with a discharge reason (76.6%). Over the last five years, there were 58,482 discharges. Table 1 summarizes the reasons for discharge.

Table 1: Reasons for Discharge from FSP, 2016-2020

| **Reason for Discharge** | **Percentage** |
|---|---|
| Met Goals | 41% |
| Partner discontinued FSP partnerships | 19% |
| Partner could not be located | 18% |
| Partner moved to a different service area or county | 10% |
| Service interruption (e.g. jail, prison, juvenile hall, residential treatment | 7% |
| Target population criteria not met | 5% |
| **TOTAL** | **100%** |

An initial analysis of inpatient hospitalizations was conducted. Inpatient admissions were identified between one year before each FSP began, during the FSP, and for one year after the FSP ended. Table 1 shows that inpatient admissions one year after FSPs between FY 14/15 and FY18/19 were less than half the number of admissions in the year before each FSP began (46 per 100 FSPs before and 20 after). For each year examined, inpatient admissions reduced significantly during the FSPs and even more after the FSP as compared to the year before.

Table 2: Psychiatric Inpatient Admissions Before, During, and After FSP, FY 2015-FY 2018

| | | Psych Inpatient Admissions | | | Annualized Admissions per 100 FSP Years | | | Change After/Before | | |
|---|---|---|---|---|---|---|---|---|---|---|
| FY | Nbr. FSPs* | Before | During | After | Before | During | After | Ratio | t-value | Prob t |
| FY14/15 | 12,674 | 7,098 | 5,580 | 2,972 | 56 | 38 | 23 | 0.42 | -25.0 | <.0001 |
| FY15/16 | 13,149 | 6,996 | 4,727 | 3,122 | 53 | 36 | 24 | 0.45 | -21.8 | <.0001 |
| FY16/17 | 15,640 | 6,742 | 3,957 | 2,748 | 43 | 32 | 18 | 0.41 | -23.1 | <.0001 |
| FY17/18 | 13,541 | 5,029 | 2,463 | 2,318 | 37 | 28 | 17 | 0.46 | -19.9 | <.0001 |
| FY18/19 | 5,048 | 1,720 | 542 | 841 | 34 | 27 | 17 | 0.49 | -9.2 | <.0001 |
| Total | 60,052 | 27,585 | 17,269 | 12,001 | 46 | 34 | 20 | 0.44 | -45.6 | <.0001 |

Mental Health Services
Oversight & Accountability Commission

**Full Service Partnerships**
**Biographies**

**Dave Pilon, PhD,** established one of the first FSP programs during his time with Mental Health America of Los Angeles, where he worked from 1989 until his retirement in 2017. His last eight years there were as its President and CEO. Since his retirement, he has consulted with numerous mental health programs and systems – the most significant as the writer of the TRIESTE Innovation Grant on behalf of Los Angeles County – which was approved by the Mental Health Services Oversight and Accountability Commission in May 2019. Over his career he has consulted in the design and transformation of mental health programs and systems throughout the United States, New Zealand, and Japan.

**Michael Charles Robinson** was a 53-year-old Chemical Plant Manager in 2008. After losing his beloved wife to an illness, he subsequently became homeless. In 2009, after a bout of mental health crises, Michael began utilizing Turning Point Community Programs, most notably the Pathways to Success after Homelessness program. Through Pathways, Michael was supported in finding housing, and has been living in his current home since 2011. This, in addition to the mental health services provided by Pathways have, in Robinson's words, "saved his life." Now, a 69-year-old retiree, Michael enjoys fishing, going to the movies, basketball, and helping those who find themselves in the same situation he was in.

**Lisa Zepeda, LMFT,** is a Licensed Marriage & Family Therapist who has worked at Kings View in Kings County for the past 12 years where she also completed her student training and internship. Prior to that, Ms. Zepeda worked as an instructor in the public community college system for 7 years. She is passionate about the work she does in meeting the needs of consumers, especially in the community where she was raised, and reducing the stigma when it comes to mental health.

**Phebe Bell, MSW**, is the Director of Behavioral Health for Nevada County. In this role she oversees specialty mental health services for children and adults, a comprehensive crisis system, and substance use disorder services. The department also recently added homeless services to its array of programs and manages numerous supportive housing facilities. Other important areas of focus for the department include supporting the justice involved population, partnering to increase school-based services, and working with community partners to maximize accessibility to behavioral health services for vulnerable or underserved populations. Phebe is the Past President of the California Behavioral Health Director's Association.

**Nicole Kristy, MBA**, is a Director at Third Sector, a national nonprofit technical assistance organization that advises government agencies and their partners on effective ways to reshape policies, systems, and services toward better outcomes. She is currently leading the Multi-County Full Service Partnership (FSP) Innovation Project, a collaborative of nine California counties seeking to identify and

implement changes to data collection and reporting, service guidelines, eligibility and graduation requirements, and other program elements to improve mental health outcomes across the state. Prior to joining Third Sector, Nicole worked at a large healthcare consulting firm where she led providers across the country through the transition from traditional reimbursement models to value-based care.

Mental Health Services
Oversight & Accountability Commission

STATE OF CALIFORNIA
GAVIN NEWSOM, Governor



April 14, 2023

Dave Pilon, PhD
Former CEO, Mental Health America
100 W. Broadway
Long Beach, CA 90802

*Letter sent via email*

Dear Dr. Pilon,

Thank you for agreeing to present at the public hearing on Full Service Partnerships (FSPs) during the Commission's April 27th, 2023 meeting. Experts and community partners have been invited to outline the history and promise of Full Service Partnerships, their current service delivery model, the fiscal realities impacting FSPs, and systemic challenges that hinder California's ability to serve those eligible for services.

The meeting begins at 9:00 PST, and presentations are scheduled to begin at approximately 10:00 a.m. PST following brief announcements, general public comment, and any other agenda items. If you are attending via Zoom, please log into the meeting by 9:00 a.m. PST if possible, or by 9:30 am PST at the latest. We request that your presentation be approximately 20 minutes. Please consider the following topics as part of your presentation:

- The history of Full Service Partnerships as a demonstration project of Mental Health America (The Village)
- The original promise of FSPs as community-based, recovery-oriented approaches that take a "whatever it takes" approach to working with partners
- Current challenges associated with FSPs, including fiscal issues, staffing, and program design, e.g. psychosocial rehabilitation

- FSPs as a component of the larger continuum of care within a behavioral health system and strategies to support individuals earlier in their life trajectory that would negate the need for an adult FSP.

Please send a brief biography and written response or any relevant background materials related to the items above by April 17th, 2023 to Melissa Martin-Mollard at melissa.mmollard@mhsoac.ca.gov. Please note that written responses and biographies will be shared as public documents. As a speaker, you will receive Zoom log-in information from Commission staff.

Should you have any questions, I can be reached at toby.ewing@mhsoac.ca.gov. Thank you again for your willingness to participate in this important meeting.

Respectfully,

Toby Ewing, Ph.D.

Executive Director

Mental Health Services
Oversight & Accountability Commission

STATE OF CALIFORNIA
GAVIN NEWSOM, Governor



April 14, 2023

Nicole Kristy
Director
Third Section Capital Partners
6 Liberty Square, #2319
Boston, MA 02109

*Letter sent via email*

Dear Ms. Kristy,

Thank you for agreeing to present at the public hearing on Full Service Partnerships (FSPs) during the Commission's April 27th, 2023 meeting. Experts and community partners have been invited to outline the history and promise of Full Service Partnerships, their current service delivery model, the fiscal realities impacting FSPs, and systemic challenges that hinder California's ability to serve those eligible for services.

The meeting begins at 9:00 PST, and presentations are scheduled to begin at approximately 10:00 a.m. PST following brief announcements, general public comment, and any other agenda items. If you are attending via Zoom, please log into the meeting by 9:00 a.m. PST if possible, or by 9:30 am PST at the latest. We request that your presentation be approximately 20 minutes. Please consider the following topics as part of your presentation:

- Brief overview of the Multi-County Full Service Partnership Innovation Project
- Differences in program elements across counties, including definitions of target populations, graduation and transition processes, and metrics of success
- Key takeaways from the innovation project around capacity building and technical assistance opportunities for counties and FSP providers

Please send a brief biography and written response or any relevant background materials related to the items above by April 17th, 2023 to Melissa Martin-Mollard at melissa.mmollard@mhsoac.ca.gov. Please note that written responses and biographies will be shared as public documents. As a speaker, you will receive Zoom log-in information from Commission staff.

Should you have any questions, I can be reached at toby.ewing@mhsoac.ca.gov. Thank you again for your willingness to participate in this important meeting.

Respectfully,

Toby Ewing, Ph.D.

Executive Director

Mental Health Services
Oversight & Accountability Commission

STATE OF CALIFORNIA
GAVIN NEWSOM, Governor



April 14, 2023

Phebe Bell
Director Behavioral Health, Nevada County
500 Crown Point Cir
Grass Valley, CA 95945

*Letter sent via email*

Dear Ms. Bell,

Thank you for agreeing to present at the public hearing on Full Service Partnerships (FSPs) during the Commission's April 27th, 2023 meeting. Experts and community partners have been invited to outline the history and promise of Full Service Partnerships, their current service delivery model, the fiscal realities impacting FSPs, and systemic challenges that hinder California's ability to serve those eligible for services.

The meeting begins at 9:00 PST, and presentations are scheduled to begin at approximately 10:00 a.m. PST following brief announcements, general public comment, and any other agenda items. If you are attending via Zoom, please log into the meeting by 9:00 a.m. PST if possible, or by 9:30 am PST at the latest. We request that your presentation be approximately 20 minutes. Please consider the following topics as part of your presentation:

- How effective are FSPs, as currently designed and operated, at reducing hospitalization, incarceration, and homelessness, and what are the key systemic barriers that impede these outcomes

- FSP model fidelity and quality metrics in the context of a "whatever it takes" approach that is individualized

- What opportunities and challenges exist to ensure California is making adequate investments in FSPs and how might the state explore alignment of revenues with programmatic needs?

Please send a brief biography and written response or any relevant background materials related to the items above by April 17th, 2023 to Melissa Martin-Mollard at melissa.mmollard@mhsoac.ca.gov. Please note that written responses and biographies will be shared as public documents. As a speaker, you will receive Zoom log-in information from Commission staff.

Should you have any questions, I can be reached at toby.ewing@mhsoac.ca.gov. Thank you again for your willingness to participate in this important meeting.

Respectfully,

Toby Ewing, Ph.D.

Executive Director

Mental Health Services
Oversight & Accountability Commission

STATE OF CALIFORNIA
GAVIN NEWSOM, Governor



April 14, 2023

Lisa Zepeda, LMFT
Program Manager
Kings View Behavioral Health Systems, Kings County
1393 Bailey Drive
Hanford, CA 93230

*Letter sent via email*

Dear Ms. Zepeda,

Thank you for agreeing to present at the public hearing on Full Service Partnerships (FSPs) during the Commission's April 27th, 2023 meeting. Experts and community partners have been invited to outline the history and promise of Full Service Partnerships, their current service delivery model, the fiscal realities impacting FSPs, and systemic challenges that hinder California's ability to serve those eligible for services.

The meeting begins at 9:00 PST, and presentations are scheduled to begin at approximately 10:00 a.m. PST following brief announcements, general public comment, and any other agenda items. If you are attending via Zoom, please log into the meeting by 9:00 a.m. PST if possible, or by 9:30 am PST at the latest. We request that your presentation be approximately 20 minutes. Please consider the following topics as part of your presentation:

- From a provider perspective, describe the FSP model and the clients in your county who are eligible to receive FSP services (referral sources, eligibility criteria, staffing structure)

- Describe the "whatever it takes" approach and provide how the team works to engage and partner with clients

- What are the challenges and opportunities from a provider perspective in terms of strengthening the care continuum to address the needs of clients

Please send a brief biography and written response or any relevant background materials related to the items above by April 17th, 2023 to Melissa Martin-Mollard at melissa.mmollard@mhsoac.ca.gov. Please note that written responses and biographies will be shared as public documents. As a speaker, you will receive Zoom log-in information from Commission staff.

Should you have any questions, I can be reached at toby.ewing@mhsoac.ca.gov. Thank you again for your willingness to participate in this important meeting.

Respectfully,

Toby Ewing, Ph.D.

Executive Director

# AGENDA ITEM 8

**Information**

**April 27, 2023 Commission Meeting**

**Governor Newsom's Proposal to Modernize California's Behavioral Health System**

**Summary:**
The Commission will hear a presentation on Governor Newsom's proposal to modernize and expand California's behavioral health system by the California Health and Human Services Agency and the California Department of Health Care Services. This presentation will provide the Commission with a contextual understanding of the proposal's key elements, the impact on the Commission's operations, and the Commission's role going forward.

**Background:**
On March 19, 2023, as part of Governor Newsom's "State of the State Tour," the Governor announced a 2024 ballot initiative to improve how California responds to mental health needs, substance use disorders, and homelessness. According to the Governor, "this is the next step in our transformation of how California addresses mental illness, substance use disorders, and homelessness – creating thousands of new beds, building more housing, expanding services, and more. People who are struggling with these issues, especially those who are on the streets or in other vulnerable conditions, will have more resources to get the help they need." Although proposal language has not been released, the Governor's background materials detail that the initiative would:

1. Authorize a $3-$5 million general obligation bond to fund unlocked community behavioral health residential settings and provide housing for homeless veterans.

2. Modernize the Mental Health Services Act (MHSA):

    - Revise MHSA funding allocations to 30 percent for housing and enhanced care in residential settings for individuals with serious mental illness/serious emotional disturbance and/or substance use disorder (SUD); 35 percent for Full Service Partnerships (FSP); and 35 percent for other services including Community Services and Supports (non FSP), Prevention and Early Intervention, Capital Facilities and Technological Needs, Workforce Education and Training, and prudent reserve.

    - Authorize MHSA funding to provide treatment and services to individuals with SUD but do not have a co-occurring mental health disorder.

    - Require counties to bill Medi-Cal for all reimbursable services.

- Reduce allowable prudent reserve amounts from 33 percent to 20 percent for large counties and 25 percent for small counties and reassess prudent reserve balances more frequently from every 5 years to every 3 years.

- Authorize up to 2 percent of local MHSA revenue to fund administrative needs.

- Pare back the requirements for three-year program and expenditure plans.

- Require that the Commission become advisory under the California Health and Human Services Agency and its Executive Director to be a gubernatorial appointee.

3. Improve statewide accountability and access to behavioral health services:

    - Require counties to report more detailed fiscal information including allocations and unspent funds.

    - Develop outcome measures, not just process measures.

    - Require the Department of Managed Health Care and the Department of Health Care Services to develop a plan for achieving parity between commercial and Medi-Cal mental health and substance use disorder benefits.

**Implementation:**
The last day for the Secretary of State to determine that a measure is eligible and qualified for the 2024 ballot is June 27, 2024. To meet this deadline, the portions of the Governor's proposal which require a ballot initiative will have to pass the Legislature before that date. Because the MHSA is an initiative statute, any legislation amending the Act requires a supermajority vote by the Legislature and voter approval.

The Governor's materials also state that changes to the MHSA will require multi-year implementation starting in 2025.

SB 326 (Eggman) currently includes language for a portion of the proposal which requires counties to bill Medi-Cal for all reimbursable services.

It is unknown if other components of the proposal will be pursued through legislation or the budget process.

**Moving Forward:**
The California Health and Human Services Agency has stated they look forward to working with the legislature, system and implementation partners, and a broad set of community partners, including those impacted by behavioral health conditions, to set these reforms into motion to deliver equitable, accessible, and affordable community-based behavioral health care for All Californians.

**Presenters:**
Stephanie Welch, Deputy Secretary of Behavioral Health, California Health and Human Services Agency (CalHHS)
Tyler Sadwith, Deputy Director of Behavioral Health, California Department of Health Care Services (DHCS)

**Enclosures (10):**

(1) Governor Newsom's Press Release
(2) Governor Newsom's Fact Sheet
(3) CalHHS Press Release
(4) CalHHS/DHCS PowerPoint
(5) CalHHS Organizational Chart
(6) SB 326 (Eggman)
(7) Stephanie Welch Biography
(8) Stephanie Welch Invitation
(9) Tyler Sadwith Biography
(10) Tyler Sadwith Invitation

**Handouts:** A PowerPoint from CalHHS and DHCS will be provided during the presentation.

# Governor Newsom Proposes Modernization of California's Behavioral Health System and More Mental Health Housing

Published: Mar 19, 2023

***WHAT TO KNOW:*** *Governor Newsom proposed a 2024 ballot initiative to improve how California treats mental illness, substance abuse, and homelessness: A bond to build state-of-the-art mental health treatment residential settings in the community to house Californians with mental illness and substance use disorders and to create housing for homeless veterans, and modernize the Mental Health Services Act to require at least $1 billion every year for behavioral health housing and care*

SAN DIEGO – Governor Gavin Newsom, in partnership with Senator Susan Talamantes Eggman (D-Stockton), has proposed the next step to modernize how California treats mental illness, substance use disorders, and homelessness.

An initiative would go on the 2024 ballot that would:

1. Authorize a general obligation bond to:
    1. Build **thousands of new community behavioral health beds in state-of-the-art residential settings to house Californians with mental illness and substance use disorders**, which could serve over 10,000 people every year in residential-style settings that have on-site services – not in institutions of the past, but locations where people can truly heal.
    2. Provide more funding specifically for **housing for homeless veterans**.
2. Amend the Mental Health Services Act (MHSA), leading to at least $1 billion every year in local assistance for **housing and residential services for people experiencing mental illness and substance use disorders**, and allowing MHSA funds to serve people with substance use disorders.
3. Include new accountability and oversight measures for counties to improve performance.

The **MHSA was originally passed 20 years ago; it is now time to refresh it** so it can better meet the challenges we face. Key changes that the Governor is proposing include: Creating a permanent source of housing funding of $1 billion a year in local assistance funds to serve people with acute behavioral health issues, focusing on Full Service Partnerships for the most seriously ill; and allowing MHSA to be used for people with substance use disorders alone.

**WHAT GOVERNOR NEWSOM SAID:** “This is the next step in our transformation of how California addresses mental illness, substance use disorders, and homelessness – creating thousands of new beds, building more housing, expanding services, and more. People who are struggling with these issues, especially those who are on the streets or in other vulnerable conditions, will have more resources to get the help they need.”

**WHAT COMES NEXT:** The Administration plans to work in close partnership with legislative leaders in this space including Senator Eggman and Assemblymember Jacqui Irwin (D-Thousand Oaks), as well as with the California State Association of Counties, other critical local government stakeholders, community-based service organizations, advocates, and people with lived experience as bill language is developed.


## FACT SHEET

**WHAT ELSE GOV. NEWSOM HAS DONE:**

- $2.2 billion for the Behavioral Health Continuum Infrastructure Program.
- $1.5 billion for Behavioral Health Bridge Housing.
- $1.4 billion to expand and diversify the behavioral health workforce.
- $4.7 billion Master Plan for Kids' Mental Health, of which the Children and Youth Behavioral Health Initiative is the central component.
- $1.4 billion to build out a Medi-Cal benefit for mobile crisis response, as well as $38 million to expand 9-8-8 and CalHOPE crisis call center.
- Over $600 million to support community-based alternatives to state hospitalization for those who commit felonies who are incompetent to stand trial.
- Over $1 billion to address the opioid epidemic.
- $7 billion to reform CalAIM – enhanced care management for people with serious mental illness, a no wrong door approach to care, and more.

- $1.6 billion proposed to implement the California Behavioral Health Community-Based Continuum Demonstration to strengthen services and supports for those who are at risk of homelessness, incarceration and foster care placements.
- $50 million for the California Veterans Health Initiative (CVHI) for veteran suicide prevention and mental health.

# Modernizing Our Behavioral Health System & Building More Mental Health Housing

Gov. Newsom is proposing a 2024 ballot initiative to improve how California treats mental illness, substance abuse, and homelessness: **a bond to build state of the art mental health treatment campuses to house Californians with mental illness and substance use disorders and to create housing for homeless veterans, and modernize the Mental Health Services Act to require at least $1 billion every year for behavioral health housing and care**

**MORE HOUSING AND TREATMENT FOR THOUSANDS:** The shortage of 6,000 behavioral health beds contributes to the crisis of homelessness. A general obligation bond would provide billions of dollars for thousands of new beds to treat mental illness and substance abuse, serving over **10,000 more people every year** – not in institutions of the past, but locations where people can really heal:

1. **Multi-Property Settings:** Residential campus-style settings where multiple individuals can live, attend groups, recover, and further stabilize with a number of onsite supportive services.
2. **Cottage Settings:** Smaller residential settings, where many services will be available but will also allow individuals to access existing services in the community.
3. **Home Settings:** Permanent Supportive Housing and Scattered Site Housing offer even smaller settings to integrate individuals into the community and provide long-term housing stability.

**ADDITIONAL FUNDS TO PROVIDE HOUSING FOR HOMELESS VETERANS:** California has 10,395 homeless veterans – the bond would provide **funding to build new housing for those who need it**.

**MODERNIZING THE MENTAL HEALTH SERVICES ACT:** The MHSA funds 30% of the mental health system, but it's never undergone reform in the 20 years since voters passed it. Current MHSA rules don't allow funds to be used to meet the housing needs for people with serious behavioral issues. Modernizing it will lead to $1 billion every year for housing, treating substance abuse disorders, and more:

1. **$1 billion annually required for behavioral health housing** and other community-based residential solutions to provide an ongoing source of funding for new settings.
2. **Include those with substance use disorders**, broadening the target population of MHSA funding to include more people who need support.
3. **Focus funding on Full-Service Partnerships and services for the most seriously ill**, prioritizing community services and supports, prevention, early intervention, and infrastructure.
4. **Require counties to bill Medi-Cal for all reimbursable services** in accordance with Medicaid State Plan and applicable waivers, to further stretch scarce dollars and leverage MHSA to maximize federal funding for services.
5. **Improve local accountability and increase transparency** by updating counties' behavioral health plans and moving the MHSA Commission under CalHHS to increase coordination.

# Joint Statement from California Health & Human Services Agency Leaders on Governor Newsom's Proposal to Modernize and Expand Behavioral Health Services

Following Governor Gavin Newsom's announcement of a proposal to improve how California treats mental health, substance use disorders, and homelessness, leaders of the California Health & Human Services Agency (CalHHS), Department of Health Care Services (DHCS), and Department of Managed Health Care (DMHC) underscore their shared commitment with the governor.

"The Governor's proposals to modernize California's behavioral health system look to pull every lever that government has at its disposal and builds on the reforms and investments we have already put into motion over the last few years, all intended to push California to do more for those suffering the most significant and most debilitating behavioral health conditions," said **Dr. Mark Ghaly, Secretary of CalHHS**. "Together we are developing a thoughtful set of connected efforts that provide tools to help anybody, anywhere, anytime with their unique behavioral health challenges. This is another step to push us to do more and do better by Californians who need these services, often living in the shadows, and their families and communities that expect all of us to link arms and support them to thrive."

**WHAT TO KNOW:** Governor Newsom is proposing a general obligation bond for the 2024 ballot designed to create thousands of new community behavioral health beds in state-of-the-art residential settings to support and house Californians with mental illness and substance use disorders. The ballot would also include an amendment to the Mental Health Services Act (MHSA), leading to at least $1 billion every year in local assistance for housing and residential services for people experiencing mental illness and substance use disorders, and allowing MHSA funds to serve people with substance use disorders.

"By refocusing on how these dollars are used, we will address one of the most important social drivers of health for people with serious behavioral health conditions: housing," said **Dr. Ghaly**. "The Governor has put forward another bold idea to ensure we have the resources to build those community beds. On top of that, this transformation is going to allow us to treat people with not only mental health issues but with substance use disorders in ways we never have been able to do before."

"I am proud to be working with the Governor and leaders throughout the state focused on modernizing and improving California's Behavioral Health System," said **DMHC Director Mary Watanabe**. "At the DMHC, we are committed to ensuring Californians have access to quality behavioral health care services through their health plans. We are working with our state partners and the health plans we regulate to improve the delivery of care including access to quality mental health and substance use disorder services."

"The Department of Health Care Services is working to ensure that Californians have access to behavioral health care so they can thrive in their communities," said **DHCS Director Michelle Baass.** "The Administration's plan takes significant steps to make this vision a reality through the modernization of the Mental Health Services Act."

**WHAT COMES NEXT:** The Administration plans to work in close partnership with the California State Legislature, as well as with the California State Association of Counties, other critical local government stakeholders, community-based service organizations, advocates, and people with lived experience as bill language is developed.

# Modernizing California's Behavioral Health System

March 2023

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

CalHHS
California Health & Human Services Agency

# Context

- Since 2019, California has embarked on massive investments and policy reforms to re-envision the state's mental health and substance use system.

- We have invested more than $10 billion in a range of efforts that begin to build up the community-based care the sickest Californians desperately need. This includes investments in prevention and early intervention programs for kids, to investments in programs like the CARE Act and system improvements in Medi-Cal through CalAIM.

- But more can and must be done. Now it's time to take the next step and build upon what we have already put in place – continuing the transformation of how California treats mental illness and substance abuse.

# Key Elements

1. Authorize a general obligation bond to fund unlocked community behavioral health residential settings
    - The bond would also provide housing for homeless veterans
2. Modernize the Mental Health Services Act (MHSA)
3. Improve statewide accountability and access to behavioral health services

# Authorize General Obligation Bond

# Authorize a General Obligation Bond

- Build thousands of new unlocked community behavioral health beds in residential settings to house Californians with mental illness and substance use disorders
- Provide more funding for housing of homeless veterans
- $3-5 billion bond on 2024 ballot

# Adding New Behavioral Health Settings

**Multi-Property Settings**

Residential campus-style settings where multiple individuals can live, attend groups, recover, and further stabilize with a number of onsite supportive services.

**Cottage Settings**

Smaller residential settings, where many services will be available but will also allow individuals to access existing services in the community.

**Home Settings**

Permanent Supportive Housing and Scattered Site Housing offer even smaller settings to integrate individuals into the community and provide long-term housing stability.

# Modernize the Mental Health Services Act

# Modernize the Mental Health Services Act

- Update local categorical funding buckets – lifting up housing interventions and workforce
- Broaden the target population to include those with debilitating substance use disorders
- Focus on the most vulnerable
- Fiscal accountability, updates to county spending and revise county processes
- Restructure role of the Mental Health Services Oversight Accountability Commission
- Many components will require 2024 Ballot initiative
- Multi-year implementation starting in July 2025

# Update Local Categorical Funding Buckets

- 30% for housing and enhanced care in residential settings for individuals with serious mental illness/serious emotional disturbance and/or substance use disorder.
  - Counties will manage the funds and direct the funds toward local priorities that meet designated purposes described above
- A services bucket with two sub-categories:
  - 35% of the local assistance for Full Service Partnership (FSP) which should be optimized to leverage Medicaid as much as is allowable
  - 35% for other services including Community Services and Supports (non FSP), Prevention and Early Intervention, Capital Facilities and Technological Needs, Workforce Education and Training, and prudent reserve
- To reduce overlap with the Children and Youth Behavioral Health Initiative and close the gap in preventive services, Prevention and Early Intervention (PEI) dollars for schools should be focused on schoolwide behavioral health supports and programs and not services and supports for individuals.

# Housing Interventions and Supports

- Dedicate 30% in local MHSA funding for housing interventions for people living with serious mental illness/serious emotional disturbance and/or substance use disorder who are experiencing homelessness. 30% is approximately $1 billion but will vary year to year.

- Funding could be used for full spectrum of housing services and supports, rental subsidies, operating subsidies, and non-federal share for Medi-Cal covered services, including clinically enriched housing. It also could be used to further the California Behavioral Health Community-Based Continuum Demonstration.

- Funding may also be used for capital development projects, subject to DHCS limits established through bulletin authority.

# Workforce

- Expand the use of local MHSA funds under the Workforce Education and Training (WET) component to include activities for workforce recruitment, development, and retention.

- The use of these funds could include professional licensing and/or certification testing and fees, loan repayment, stipends, internship programs, retention incentives, and continuing education and that increase the racial/ ethnic and geographic diversity of the workforce.

- In addition to expanding the local MHSA funds under WET, allocate MHSA funds to create a new Behavioral Health Workforce Initiative, while drawing down additional federal funds for a five-year period.

# Broaden Target Population

- Authorize MHSA funding to provide treatment and services to individuals who have a debilitating substance use disorder (SUD) but do not have a co-occurring mental health disorder.

- Increase access to SUD services for individuals with moderate and severe SUD.

- Require counties to incorporate SUD prevalence and local unmet need data into spending plans. Use data to inform and develop accountability to improve the balance of funding for SUD.

# Focus on Most Vulnerable

## Adults

- Adults with serious mental illness (SMI) or substance use disorder (SUD) who are or at risk of experiencing homelessness or are or are at risk of being justice-involved, and/or meet the criteria for behavioral health linkages under the CalAIM Justice-Involved Initiative
- Adults with SMI at-risk of conservatorship

## Children and Youth

- Children and youth with serious emotional disturbance or SUD, who are experiencing homelessness, are involved or at risk of being justice-involved, meet the criteria for behavioral health linkages under the CalAIM Justice-Involved Initiative or are in or transitioning out of the child welfare system

# Fiscal Accountability and County Spending

- Require counties to bill Medi-Cal for all reimbursable services in accordance with Medicaid State Plan and applicable waivers, to further stretch scarce dollars and leverage MHSA to maximize federal funding for services.
- Reduce allowable prudent reserve amounts from 33% to 20% for large counties and 25% for small counties.
- Reassess prudent reserve more frequently from every 5 years to every 3 years.
- Authorize up to 2 percent of local MHSA revenue to be used for administrative resources to assist counties in improving plan operations, quality outcomes, reporting fiscal and programmatic data and monitoring subcontractor compliance for all county behavioral health funding.

# Revise County Process

- Pare back the requirements for Three-Year Program and Expenditure Plans, standardize the level of detail and submission process, and provide additional flexibilities for transparent amendment process.

- Provide county behavioral health agencies with more flexibility to adjust spending.

- Transform the MHSA planning process into a broader county/region behavioral health planning process. Require counties to work with Medi-Cal Managed Care Plans in the development of their Population Needs Assessments and with Local Health Jurisdictions in the development of their Community Health Improvement Plans and for these reports to inform the MHSA planning process to ensure strategic alignment of funding and local cross-system collaboration.

- Require plans be approved by boards of supervisors by June 30.

# Mental Health Services Oversight Accountability Commission

- Move the Mental Health Services Oversight Accountability Commission (MHSOAC) under the California Health and Human Services Agency so that it is connected with the rest of the behavioral health system.

- Require that the Commission would become advisory, and its Executive Director would be a gubernatorial appointee.

# Improve Statewide Accountability and Access to Behavioral Health Services

# Fiscal Transparency

Require counties to report:

- Annual allocation of MHSA, Realignment, and all federal block grants;
- Annual spend on non-federal match payments including MHSA, Realignment or other county sources;
- MHSA, Realignment and Block Grant only spend;
- Any other behavioral health investments  using local General Fund or other funds;
- Any unspent MHSA, Realignment or block grant funds for that fiscal year;
- Cumulative unspent MHSA, Realignment or block grant funds, inclusive of reserves;
- Admin costs, and
- Information on services provided to persons not covered by Medi-Cal, including commercial insurance, Medicare, and uninsured.

# County Accountability and Infrastructure

- Develop outcome measures, not just process measures, to drive toward meaningful and measurable system change.

- Align county Behavioral Health (BH) plans (including MHPs and DMC-ODS) and Medi-Cal Managed Care Plan contract requirements when the same requirements exist across programs. This includes, but is not limited to:
  - Require key administrative positions (e.g., quality director, chief financial officer, operations director, compliance officer)
  - Compliance oversight and monitoring of subcontractors
  - Post on their website network adequacy filings, annual number of utilizers and utilization by service type
  - Establish a robust set of quality metrics for county BH plans and establish quality thresholds/goals
  - Require county BH plans annually report utilization and quality to Board of Supervisors (BOS) and require the BOS to attest that they are meeting their obligation under Realignment
  - Require county BH plans to form member advisory council to inform policy and programs
  - Implement closed loop referrals

# Alignment between Medi-Cal and Commercial Coverage of Behavioral Health Services

- Over the next year, DMHC and DHCS will develop a plan for achieving parity between commercial and Medi-Cal mental health and substance use disorder benefits. This may include, but is not limited to, phasing in alignment of utilization management, benefit standardization, and coverage of county-provided services.

- DMHC and DHCS will establish a stakeholder process that will include health plans and other system partners to develop framework.

# Next Steps

# Next Steps

- We look forward to working with the Legislature, system and implementation partners, and a broad set of stakeholders, including those impacted by behavioral health conditions, to set these reforms into motion to deliver equitable, accessible, and affordable community-based behavioral health care for All Californians.

# Questions?

For questions and inquiries, contact
BehavioralHealthTaskForce@chhs.ca.gov

DHCS

CalHHS
California Health & Human Services Agency

Mark Ghaly, MD, MPH
Secretary

Virginia Franco
Special Assistant

Marko Mijic
Undersecretary

Tran Duong
Program Analyst

Brendan McCarthy
Deputy Secretary
Program & Fiscal Affairs

Samantha Lui
Deputy Secretary
Legislative Affairs

Sami Gallegos
Deputy Secretary
External Affairs

Jared Goldman
Deputy Secretary
Legal Affairs

Sonia Herrera
Deputy Secretary
Administrative Affairs

Corrin Buchanan
Deputy Secretary
Policy & Strategic Planning

Kimberly Chen
Assistant Secretary
DHCS & DMHC

Debra Cooper, PhD
Assistant Secretary
DDS, DOR, & CSD

Darci Delgado, PsyD
Assistant Secretary
CDA, DSH, HCAI, & OYCR

Nick Picinich
Assistant Secretary
DCSS & CDSS

Julie Souliere
Assistant Secretary
CDPH, EMSA, & OSG

Katherine Lucero
Director
Office of Youth and
Community Restoration

Diana Ramos, MD
Surgeon General

Geoff Britton
Chief
Office of Law
Enforcement Support

Nathaniel Mitchell
Assistant Secretary
Special Projects

Melissa Stafford Jones
Director
Children and Youth
Behavioral Health
Initiative

Stephanie Welch
Deputy Secretary
Behavioral Health

Adam Dondro
Chief Information Officer
&
Director
Office of Systems
Integration

Elizabeth Basnett
Chief Emergency Officer
&
Interim Director
Office of Resilience and
Response

Daniel Torres
Chief Equity Officer

John Ohanian
Chief Data Officer
&
Director
Center for Data Insights
and Innovation

## CalHHS Departments

Susan DeMarois
Director
Department of Aging

Kim Johnson
Director
Department of Social
Services

Tomás Aragón, MD, DrPH
Director
Department of Public
Health

Michelle Baass
Director
Department of Health
Care Services

Mary Watanabe
Director
Department of Managed
Health Care

Joe Xavier
Director
Department of
Rehabilitation

Nancy Bargmann
Director
Department of
Developmental Services

Elizabeth Landsberg
Director
Department of Health
Care Access and
Information

Stephanie Clendenin
Director
Department of State
Hospitals

Elizabeth Basnett
Interim Director
Emergency Medical
Services Authority

David Scribner
Director
Department of
Community Services and
Development

David Kilgore
Director
Department of Child
Support Services

*February 23, 2023*
Date

AMENDED IN SENATE MARCH 21, 2023

# SENATE BILL No. 326

**Introduced by Senator Eggman**

February 7, 2023

An act *to amend Section 5891 of the Welfare and Institutions Code,* relating to mental health.

LEGISLATIVE COUNSEL'S DIGEST

SB 326, as amended, Eggman. Mental Health Services Act.

*Existing law, the Mental Health Services Act, an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, funds a system of county mental health plans for the provision of mental health services, as specified. The act establishes the Mental Health Services Fund, which is continuously appropriated to, and administered by, the State Department of Health Care Services to fund specified county mental health programs. The act may be amended by the Legislature only by a ⅔ vote of both houses and only so long as the amendment is consistent with and furthers the intent of the act. The Legislature may clarify procedures and terms of the act by majority vote.*

*This bill would require a county, for a behavioral health service eligible for reimbursement pursuant to the federal Social Security Act, to submit the claims for reimbursement to the State Department of Health Care Services under specific circumstances. By imposing a new duty on local officials, this bill would create a state-mandated local program.*

*The bill would make findings that it clarifies procedures and terms of the Mental Health Services Act.*

*The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.*

*This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.*

~~Existing law, the Mental Health Services Act, an initiative statute enacted by the voters as Proposition 63 in the November 2, 2004, statewide general election, establishes the continuously appropriated Mental Health Services Fund to fund various county mental health programs. The act also establishes the Mental Health Services Oversight and Accountability Commission to oversee the administration of the act.~~

~~The act may be amended by the Legislature only by a ⅔ vote of both houses and only so long as the amendment is consistent with and furthers the intent of the act. The Legislature may clarify procedures and terms of the act by majority vote.~~

~~This bill would state the intent of the Legislature to enact legislation to modernize the Mental Health Services Act.~~

Vote: majority. Appropriation: no. Fiscal committee: ~~no~~ *yes*. State-mandated local program: ~~no~~ *yes*.

*The people of the State of California do enact as follows:*

*SECTION 1. Section 5891 of the Welfare and Institutions Code is amended to read:*

5891. (a) *(1)* The funding established pursuant to this act shall be utilized to expand mental health services. ~~Except as provided in subdivision (j) of Section 5892 due to the state's fiscal crisis, these~~ *These* funds shall not be used to supplant existing state or county funds utilized to provide mental health services. The state shall continue to provide financial support for mental health programs with not less than the same entitlements, amounts of allocations from the General Fund or from the Local Revenue Fund 2011 in the State Treasury, and formula distributions of dedicated funds as provided in the ~~last fiscal year which ended prior to the effective date of this act.~~ *2003–04 fiscal year.* The state shall not make any change to the structure of financing mental

health ~~services, which increases~~ *services that increase* a county's share of costs or financial risk for mental health services unless the state includes adequate funding to fully compensate for ~~such~~ *the* increased costs or financial risk. These funds shall only be used to pay for the programs authorized in Sections 5890 and 5892. These funds may not be used to pay for any other program. These funds may not be loaned to the General Fund or any other fund of the state, or a county general fund or any other county fund for any purpose other than those authorized by Sections 5890 and 5892.

*(2) In order to maximize federal financial participation in furtherance of subdivision (d) of Section 5890, a county shall submit claims for reimbursement to the State Department of Health Care Services in accordance with applicable Medi-Cal rules and procedures for a behavioral health service eligible for reimbursement pursuant to Title XIX or XXI of the federal Social Security Act (42 U.S.C. Secs. 1396 et seq. and 1397aa et seq.) when that service is paid, in whole or in part, using the funding established pursuant to this section.*

(b) (1) Notwithstanding subdivision (a), and except as provided in paragraph (2), the Controller may use the funds created pursuant to this part for loans to the General Fund as provided in Sections 16310 and 16381 of the Government Code. Any ~~such~~ loan shall be repaid from the General Fund with interest computed at 110 percent of the Pooled Money Investment Account rate, with interest commencing to accrue on the date the loan is made from the fund. This subdivision does not authorize any transfer that would interfere with the carrying out of the object for which these funds were created.

(2) This subdivision does not apply to the Supportive Housing Program Subaccount created by subdivision (f) of Section 5890 or any moneys paid by the California Health Facilities Financing Authority to the Department of Housing and Community Development as a service fee pursuant to a service contract authorized by Section 5849.35.

(c) Commencing July 1, 2012, on or before the 15th day of each month, pursuant to a methodology provided by the State Department of Health Care Services, the Controller shall distribute to each Local Mental Health Service Fund established by counties pursuant to subdivision (f) of Section 5892, all unexpended and

unreserved funds on deposit as of the last day of the prior month in the Mental Health Services Fund, established pursuant to Section 5890, for the provision of programs and other related activities set forth in Part 3 (commencing with Section 5800), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), Part 3.9 (commencing with Section 5849.1), and Part 4 (commencing with Section 5850).

(d) Counties shall base their expenditures on the county mental health program's three-year program and expenditure plan or annual update, as required by Section 5847. ~~Nothing in this subdivision shall~~ *This section does not* affect subdivision (a) or (b).

*SEC. 2. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.*

*SEC. 3. The Legislature finds and declares that this act adds provisions to clarify procedures and terms of the Mental Health Services Act, enacted by Proposition 63 at the November 2, 2004, statewide general election.*

~~SECTION 1. It is the intent of the Legislature to enact legislation to modernize the Mental Health Services Act.~~

O

Mental Health Services
Oversight & Accountability Commission

**Governor Newsom's Proposal to Modernize and Expand California's Behavioral Health System**

**Stephanie Welch,** Deputy Secretary of Behavioral Health, California Health and Human Services Agency (CalHHS)

Stephanie Welch is the Deputy Secretary of Behavioral Health for the California Health and Human Services (CalHHS) Agency. In this role she acts as a senior advisor to the Secretary of CalHHS and other state departments on behavioral health policy. In addition, the Deputy Secretary builds bridges across various government sectors and with stakeholders from diverse perspectives. Prior to this role, Stephanie was the Executive Officer of the Council on Criminal Justice and Behavioral Health (CCJBH) based in the Office of the Secretary at the California Department of Corrections and Rehabilitation (CDCR). Stephanie has over two decades of experience in mental health policy, program administration, evaluation and advocacy at both the state and county level, working at organizations such as the California Mental Health Services Authority (CalMHSA), the County Behavioral Health Directors Association (CBHDA) and the California Council of Community Behavioral Health Agencies (CBHA). Stephanie approaches her work improving systems by examining the impact to individuals and communities, always striving for better-quality experiences and outcomes. Stephanie holds an MSW from the University of Southern California and a BA in Sociology from the University of California, Davis.

Mental Health Services
Oversight & Accountability Commission

STATE OF CALIFORNIA
GAVIN NEWSOM, Governor

MARA MADRIGAL-WEISS
Chair

MAYRA E. ALVAREZ
Vice Chair

TOBY EWING
Executive Director

April 11, 2023

**VIA EMAIL**

Stephanie Welch
Deputy Secretary, Behavioral Health
California Health & Human Services Agency (CalHHS)
1215 O Street
Sacramento, California 95814

*Re: April 2023 Commission Meeting*

Dear Ms. Welch:

Thank you for agreeing to attend the Commission's public meeting on Thursday, April 27, 2023, at the Commission's office – 1812 9th Street, Sacramento, California. Your presentation on Governor Newsom's proposal to modernize and expand California's behavioral health system will assist the Commission in developing guidance and recommendations for the Governor, Legislature, and other community partners on setting these reforms in motion to deliver equitable, accessible, and affordable community-based behavioral health for all Californians.

Your comments will also provide a context for understanding the key elements of the Governor's Proposal, the impact on the Commission's operations, and the Commission's role going forward. Your presentation is scheduled to begin at approximately 12:40 p.m. and will be followed by a discussion with Commissioners and an opportunity for public comment. It would be most helpful to the Commissioners if you could include the following in your remarks:

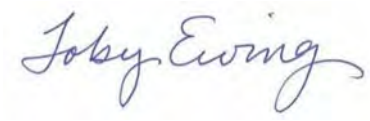
- An overview of the three key elements of the Governor's proposal to: 1) authorize a general obligation bond to fund behavioral health expansion and housing for homeless veterans; 2) modernize the Mental Health Services Act (MHSA); and 3) improve statewide accountability and access to behavioral health services.
- The vision and goals for the reorganization and restructuring of the Commission.
- The timeline and plans for implementation.
- The opportunities for Commission engagement moving forward.

Please send a brief biography and a copy of any documents or other background or presentation materials to Kendra Zoller at Kendra.Zoller@mhsoac.ca.gov by Monday, April 17, 2023, so that we may include them in the meeting materials. Please note that your biography and other written materials related to the items above will be shared as public documents.

Should you have any questions or concerns, please contact me at Toby.Ewing@mhsaoc.ca.gov or 916-216-9089.

Thank you again for your willingness to participate in this important meeting.

Respectfully,



Toby Ewing
Executive Director

**Governor Newsom's Proposal to Modernize and Expand California's Behavioral Health System**
**Biography for Department of Health Care Services Representative**

**Tyler Sadwith**, Deputy Director of Behavioral Health, California Department of Health Care Services.

Tyler Sadwith was appointed Deputy Director of Behavioral Health at the California Department of Health Care Services (DHCS) by Governor Newsom in June 2022. Tyler is responsible for leading DHCS' ambitious agenda to ensure high-quality and accessible specialty mental health and substance use disorder services in Medi-Cal and other public programs. He leads the development and implementation of policy and initiatives designed to strengthen behavioral health care access, quality, service delivery, and achieve equitable health care outcomes for 14 million Medi-Cal members and Californians served through other programs. He provides direct management to four divisions: Community Services, Licensing and Certification, Medi-Cal Behavioral Health Oversight and Monitoring, and Medi-Cal Behavioral Health Policy. Prior to his appointment, Tyler served as the Assistant Deputy Director of Behavioral Health at DHCS where he assisted in overseeing the planning, implementation, coordination, evaluation, and management of the Department's behavioral health services. Tyler was a Senior Consultant at Technical Assistance Collaborative, Inc., where he provided strategic advice and technical support to state health leaders on behavioral health policy and delivery system reforms. Additionally, he served as the Technical Director at the Centers for Medicare & Medicaid Services (CMS), where he spearheaded efforts in supporting states to introduce comprehensive benefit, program, and delivery system reforms through Medicaid Section 1115 substance use disorder (SUD) demonstration waivers. He also implemented the agency's opioid strategy and oversaw the SUD portfolio of CMS' Medicaid Innovation Accelerator Program, a cross-agency strategic support and technical assistance platform designed to support service delivery and payment innovation in Medicaid. Tyler earned a Bachelor of Arts degree in History from Reed College.

Mental Health Services
Oversight & Accountability Commission

STATE OF CALIFORNIA
GAVIN NEWSOM, Governor

MARA MADRIGAL-WEISS
Chair

MAYRA E. ALVAREZ
Vice Chair

TOBY EWING
Executive Director

April 11, 2023

**VIA EMAIL**

Tyler Sadwith
Deputy Secretary, Behavioral Health
California Department of Health Care Services (DHCS)
1501 Capitol Avenue
Sacramento, California 95814

*Re: April 2023 Commission Meeting*

Dear Mr. Sadwith:

Thank you for agreeing to attend the Commission's public meeting on Thursday, April 27, 2023, at the Commission's office – 1812 9th Street, Sacramento, California. Your presentation on Governor Newsom's proposal to modernize and expand California's behavioral health system will assist the Commission in developing guidance and recommendations for the Governor, Legislature, and other community partners on setting these reforms in motion to deliver equitable, accessible, and affordable community-based behavioral health for all Californians.

Your comments will also provide a context for understanding the key elements of the Governor's Proposal, the impact on the Commission's operations, and the Commission's role going forward. Your presentation is scheduled to begin at approximately 12:40 p.m. and will be followed by a discussion with Commissioners and an opportunity for public comment. It would be most helpful to the Commissioners if you could include the following in your remarks:

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- The vision and goals for the reorganization and restructuring of the Commission.
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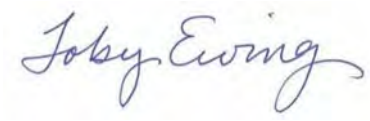
Should you have any questions or concerns, please contact me at Toby.Ewing@mhsaoc.ca.gov or 916-216-9089.

Thank you again for your willingness to participate in this important meeting.

Respectfully,



Toby Ewing
Executive Director

# MISCELLANEOUS ENCLOSURES

**April 27, 2023, 2023 Commission Meeting**

**Enclosures (4):**

(1) Evaluation Dashboard
(2) Innovation Dashboard
(3) Department of Health Care Services Revenue and Expenditure Reports Status Update
(4) 2023 Commission Meeting Dates (Tentative)

Mental Health Services
Oversight & Accountability Commission

# Summary of Updates

## Contracts

New Contract: None

Total Contracts: 3

## Funds Spent Since the March Commission Meeting

| Contract Number | Amount |
|---|---|
| 17MHSOAC073 | $ 0.00 |
| 17MHSOAC074 | $ 0.00 |
| 21MHSOAC023 | $ 0.00 |
| **Total** | **$ 0.00** |

## Contracts with Deliverable Changes

17MHSOAC073
17MHSOAC074
21MHSOAC023

Mental Health Services
Oversight & Accountability Commission

# Regents of the University of California, Davis: Triage Evaluation (17MHSOAC073)

**MHSOAC Staff:** Kai LeMasson

**Active Dates:** 01/16/19 - 12/31/23

**Total Contract Amount:** $2,453,736.50

**Total Spent:** $**1,882,236.32**

This project will result in an evaluation of both the processes and strategies county triage grant program projects have employed in those projects, funded separately to serve Adult, Transition Age Youth and child clients under the Investment in Mental Health Wellness Act in contracts issued by the Mental Health Services Oversight and Accountability Commission. This evaluation is intended to assess the feasibility, effectiveness and generalizability of pilot approaches for local responses to mental health crises in order to promote the implementation of best practices across the State.

| Deliverable | Status | Due Date | Change |
|---|---|---|---|
| Workplan | Complete | 4/15/19 | No |
| Background Review | Complete | 7/15/19 | No |
| Draft Summative Evaluation Plan | Complete | 2/12/20 | No |
| Formative/Process Evaluation Plan<br>Updated Formative/Process Evaluation Plan | Complete<br>Complete | 1/24/20<br>1/15/21 | No<br>No |
| Data Collection and Management Report | Complete | 6/15/20 | No |

Mental Health Services
Oversight & Accountability Commission

| Deliverable | Status | Due Date | Change |
|---|---|---|---|
| Final Summative Evaluation Plan | Complete | 7/15/20 | No |
| Data Collection for Formative/Process Evaluation Plan Progress Reports (10 quarterly reports) | In Progress | 1/15/21- 3/15/23 | No |
| Formative/Process Evaluation Plan Implementation and Preliminary Findings (11 quarterly reports) | In Progress | 1/15/21-<br>6/15/23 | No |
| Co-host Statewide Conference and Workplan (a and b) | In Progress | 9/15/21<br>Fall 2022 | No |
| Midpoint Progress Report for Formative/Process Evaluation Plan | Complete | 7/15/21 | No |
| Drafts Formative/Process Evaluation Final Report (a and b) | In Progress | 3/30/23<br>7/15/23 | No |
| Final Report and Recommendations | Not Started | 11/30/23 | No |

Mental Health Services
Oversight & Accountability Commission

# The Regents of the University of California, Los Angeles: Triage Evaluation (17MHSOAC074)

**MHSOAC Staff:** Kai LeMasson

**Active Dates:** 01/16/19 - 12/31/23

**Total Contract Amount:** $2,453,736.50

**Total Spent:** **1,882,236.32**

This project will result in an evaluation of both the processes and strategies county triage grant program projects have employed in those projects, funded separately to serve Adult, Transition Age Youth and child clients under the Investment in Mental Health Wellness Act in contracts issued by the Mental Health Services Oversight and Accountability Commission. This evaluation is intended to assess the feasibility, effectiveness and generalizability of pilot approaches for local responses to mental health crises in order to promote the implementation of best practices across the State.

| Deliverable | Status | Due Date | Change |
|---|---|---|---|
| Workplan | Complete | 4/15/19 | No |
| Background Review | Complete | 7/15/19 | No |
| Draft Summative Evaluation Plan | Complete | 2/12/20 | No |
| Formative/Process Evaluation Plan<br>Updated Formative/Process Evaluation Plan | Complete<br>Complete | 1/24/20<br>1/15/21 | No<br>No |
| Data Collection and Management Report | Complete | 6/15/20 | No |
| Final Summative Evaluation Plan | Complete | 7/15/20 | No |
| Data Collection for Formative/Process Evaluation Plan<br>Progress Reports (10 quarterly reports) | In Progress | 1/15/21- 3/15/23 | No |

Mental Health Services
Oversight & Accountability Commission

| Deliverable | Status | Due Date | Change |
|---|---|---|---|
| Formative/Process Evaluation Plan Implementation and Preliminary Findings (11 quarterly reports) | In Progress | 1/15/21-<br>6/15/23 | No |
| Co-host Statewide Conference and Workplan (a and b) | In Progress | 9/15/21<br>TBD | No |
| Midpoint Progress Report for Formative/Process Evaluation Plan | Complete | 7/15/21 | No |
| Drafts Formative/Process Evaluation Final Report (a and b) | In progress | 3/30/23<br>7/15/23 | No |
| Final Report and Recommendations | Not Started | 11/30/23 | No |

Mental Health Services
Oversight & Accountability Commission

# The Regents of the University of California, San Francisco: Partnering to Build Success in Mental Health Research and Policy (21MHSOAC023)

**MHSOAC Staff:** Rachel Heffley

**Active Dates:** 07/01/21 - 06/30/24

**Total Contract Amount:** $5,414,545.00

**Total Spent:** **$1,061,087.52**

UCSF is providing onsite staff and technical assistance to the MHSOAC to support project planning, data linkages, and policy analysis activities including a summative evaluation of Triage grant programs.

| Deliverable | Status | Due Date | Change |
|---|---|---|---|
| Quarterly Progress Reports | Complete | 09/30/21 | No |
| Quarterly Progress Reports | Complete | 12/31/21 | No |
| Quarterly Progress Reports | Complete | 03/31/2022 | No |
| Quarterly Progress Reports | Complete | 06/30/2022 | No |
| Quarterly Progress Reports | Complete | 09/30/2022 | No |
| Quarterly Progress Reports | Complete | 12/31/2022 | Yes |
| Quarterly Progress Reports | Not Started | 03/31/2023 | No |
| Quarterly Progress Reports | Not Started | 06/30/2023 | No |

Mental Health Services
Oversight & Accountability Commission

| Deliverable | Status | Due Date | Change |
|---|---|---|---|
| Quarterly Progress Reports | Not Started | 09/30/2023 | No |
| Quarterly Progress Reports | Not Started | 12/31/2023 | No |
| Quarterly Progress Reports | Not Started | 03/31/2024 | No |
| Quarterly Progress Reports | Not Started | 06/30/2024 | No |

Mental Health Services
Oversight & Accountability Commission

# INNOVATION DASHBOARD

APRIL 2023

| UNDER REVIEW | Final Proposals Received | Draft Proposals Received | TOTALS |
|---|---|---|---|
| Number of Projects | 5 | 7 | **12** |
| Participating Counties (unduplicated) | 4 | 7 | **11** |
| Dollars Requested | $12,831,192 | $259,937,653.86 | **$272,768,845.86** |

| PREVIOUS PROJECTS | Reviewed | Approved | Total INN Dollars Approved | Participating Counties |
|---|---|---|---|---|
| FY 2017-2018 | 34 | 33 | $149,548,570 | 19 (32%) |
| FY 2018-2019 | 54 | 54 | $303,143,420 | 32 (54%) |
| FY 2019-2020 | 28 | 28 | $62,258,683 | 19 (32%) |
| FY 2020-2021 | 35 | 33 | $84,935,894 | 22 (37%) |
| FY 2021-2022 | 21 | 21 | $50,997,068 | 19 (32%) |

| TO DATE | Reviewed | Approved | Total INN Dollars Approved | Participating Counties |
|---|---|---|---|---|
| 2022-2023 | 22 | 22 | $86,498,517 | 18 |

## INNOVATION PROJECT DETAILS

### DRAFT PROPOSALS

| Status | County | Project Name | Funding Amount Requested | Project Duration | Draft Proposal Submitted to OAC | Final Project Submitted to OAC |
|---|---|---|---|---|---|---|
| Under Review | Yolo | Crisis Now | $3,584,357 | 3 Years | 6/1/2022 | Pending |
| Under Review | Santa Clara | TGE Center | $17,298,034 | 54 Months | 10/4/2022 | Pending |
| Under Review | Monterey | Rainbow Connection | 1,000,001 | 5 Years | 1/6/2023 | Pending |
| Under Review | Los Angeles | Interim Housing Multidisciplinary Assessment & Treatment Teams | $155,927,580 | 5 Years | 3/7/2023 | Pending |
| Under Review | San Bernardino | Progressive Integrated Care Collaborative | $16,557,576 | 5 Years | 3/24/2023 | Pending |
| Under Review | San Diego | Public Behavioral Health Workforce Development and Retention Program | $75,000,000 | 5 Years | 3/17/2023 | Pending |
| Under Review | San Luis Obispo | Behavioral Health for Residential Care Facilities: Older Adult Mental Health Care & Education Project (BRACE) | $984,578 | 3 Years | 3/24/2023 | Pending |

### FINAL PROPOSALS

| Status | County | Project Name | Funding Amount Requested | Project Duration | Draft Proposal Submitted to OAC | Final Project Submitted to OAC |
|---|---|---|---|---|---|---|
| Under Final Review | Tuolumne | Family Ties: Youth and Family Wellness | $925,892 | 5 Years | 8/22/2022 | 12/7/2022 |
| Under Final Review | Marin | From Housing to Healing, Re-Entry Community for Women (EXTENSION) | $560,300 | 5 Years | 12/5/2022 | 3/8/2023 |
| Under Final Review | Fresno | The Lodge (EXTENSION) | $3,160,000 | 5 Years | 12/2/2022 | 1/25/2023 |

| FINAL PROPOSALS | | | | | | |
|---|---|---|---|---|---|---|
| Status | County | Project Name | Funding Amount Requested | Project Duration | Draft Proposal Submitted to OAC | Final Project Submitted to OAC |
| Under Final Review | Fresno | Participatory Action Research with Justice-Involved Youth using an Adverse Childhood Experiences (ACEs) Framework | $3,000,000 | 5 Years | 8/15/2022 | 3/17/2023 |
| Under Final Review | Stanislaus | Embedded Neighborhood Mental Health Team | $5,125,000 | 5 Years | 3/1/2023 | 4/13/2023 |

| APPROVED PROJECTS (FY 22-23) | | | |
|---|---|---|---|
| County | Project Name | Funding Amount | Approval Date |
| Napa | FSP Multi-County Collaborative | $844,750 | 10/11/2022 |
| Sonoma | Semi-Statewide Enterprise Health Record | $4,420,447.54 | 11/17/2022 |
| Tulare | Semi-Statewide Enterprise Health Record | $6,281,021 | 11/17/2022 |
| Humboldt | Semi-Statewide Enterprise Health Record | $608,678 | 11/17/2022 |
| Colusa | Social Determinants of Rural Mental Health (Extension) | $983,124 | 11/18/2022 |
| Sacramento | Behavioral Health Crisis Services Collaborative | $1,000,000 | 1/4/2023 |
| Alameda | Peer-led Continuum for Forensics and Reentry Services | $8,692,893 | 1/25/2023 |
| Alameda | Alternatives to Confinement | $13,432,651 | 1/25/2023 |
| Santa Barbara | Housing Assistance and Retention Team | $7,552,606 | 1/25/2023 |
| Kings | Semi-Statewide Enterprise Health Record (EHR) Multi-County INN Project | $3,203,101.78 | 1/25/2023 |
| Imperial | Semi-Statewide Enterprise Health Record (EHR) Multi-County INN Project | $2,974,849 | 1/25/2023 |

| APPROVED PROJECTS (FY 22-23) | | | |
|---|---|---|---|
| County | Project Name | Funding Amount | Approval Date |
| Mono | Semi-Statewide Enterprise Health Record (EHR) Multi-County INN Project | $986,403 | 1/25/2023 |
| Placer | Semi-Statewide Enterprise Health Record (EHR) Multi-County INN Project | $4,562,393 | 1/25/2023 |
| San Benito | Semi-Statewide Enterprise Health Record (EHR) Multi-County INN Project | $4,940,202 | 1/25/2023 |
| San Joaquin | Semi-Statewide Enterprise Health Record (EHR) Multi-County INN Project | $8,478,140 | 1/25/2023 |
| Siskiyou | Semi-Statewide Enterprise Health Record (EHR) Multi-County INN Project | $1,073,106 | 1/25/2023 |
| Ventura | Semi-Statewide Enterprise Health Record (EHR) Multi-County INN Project | $3,514,910 | 1/25/2023 |
| San Mateo | Mobile Behavioral Health Services for Farmworkers | $1,815,000 | 2/23/2023 |
| San Mateo | Music Therapy for Asian Americans | $940,000 | 2/23/2023 |
| San Mateo | Recovery Connection Drop-in-Center | $2,840,000 | 2/23/2023 |
| San Mateo | Adult Residential In-Home Support Element (ARISE) | $1,240,000 | 2/23/2023 |
| Contra Costa | Supporting Equity through Community Defined Practices | $6,119,182 | 3/23/2023 |

DHCS Status Chart of County RERs Received
April 27, 2023, Commission Meeting

Below is a Status Report from the Department of Health Care Services regarding County MHSA Annual Revenue and Expenditure Reports received and processed by Department staff, dated April 10, 2023. This Status Report covers FY 2019 -2020 through FY 2021-2022, all RERs prior to these fiscal years have been submitted by all counties.

The Department provides MHSOAC staff with weekly status updates of County RERs received, processed, and forwarded to the MHSOAC. Counties also are required to submit RERs directly to the MHSOAC. The Commission provides access to these for Reporting Years FY 2012-13 through FY 2021-2022 on the data reporting page at: https://mhsoac.ca.gov/county-plans/.

The Department also publishes County RERs on its website. Individual County RERs for reporting years FY 2006-07 through FY 2015-16 can be accessed at: http://www.dhcs.ca.gov/services/MH/Pages/Annual-Revenue-and-Expenditure-Reports-by-County.aspx. Additionally, County RERs for reporting years FY 2016-17 through FY 2021-22 can be accessed at the following webpage: http://www.dhcs.ca.gov/services/MH/Pages/Annual_MHSA_Revenue_and_Expenditure_Reports_by_County_FY_16-17.aspx.

DHCS also publishes yearly reports detailing funds subject to reversion to satisfy Welfare and Institutions Code (W&I), Section 5892.1 (b). These reports can be found at: https://www.dhcs.ca.gov/services/MH/Pages/MHSA-Fiscal-Oversight.aspx.

DHCS Status Chart of County RERs Received
April 27, 2023, Commission Meeting

## DCHS MHSA Annual Revenue and Expenditure Report Status Update

There is one RER not finalized for FY 19-20, Inyo.

| County | FY 20-21 Electronic Copy Submission | FY 20-21 Return to County | FY 20-21 Final Review Completion | FY 21-22 Electronic Copy Submission | FY 21-22 Return to County | FY 21-22 Final Review Completion |
|---|---|---|---|---|---|---|
| Alameda | 1/26/2022 | 2/3/2022 | 2/8/2022 | 1/31/2023 | 2/6/2023 | 2/7/2023 |
| Alpine | 1/26/2022 | 2/3/2022 | 2/15/2022 | | | |
| Amador | 1/27/2022 | 2/3/2022 | 2/10/2022 | 1/31/2023 | 2/7/2023 | 2/17/2023 |
| Berkeley City | 2/1/2022 | 2/3/2022 | 3/1/2022 | 1/31/2023 | 2/2/2023 | 2/7/2023 |
| Butte | 8/11/2022 | 8/12/2022 | 8/15/2022 | | | |
| Calaveras | 1/31/2022 | 2/4/2022 | 2/8/2022 | 1/27/2023 | | 2/7/2023 |
| Colusa | 2/1/2022 | 2/4/2022 | 2/15/2022 | 4/3/2023 | 4/4/2023 | |
| Contra Costa | 1/31/2022 | 2/4/2022 | 3/11/2022 | 1/30/2023 | | 2/1/2023 |
| Del Norte | 1/28/2022 | 2/7/2022 | 2/23/2022 | 1/30/2023 | | 2/7/2023 |
| El Dorado | 1/28/2022 | 2/4/2022 | 2/9/2022 | 2/24/2023 | | 2/28/2023 |
| Fresno | 1/26/2022 | 2/7/2022 | 2/16/2022 | 1/31/2023 | 2/2/2023 | 2/10/2023 |
| Glenn | 3/21/2022 | 3/22/2022 | 4/6/2022 | | | |
| Humboldt | 8/15/2022 | 8/16/2022 | 8/24/2022 | 1/31/2023 | | 2/2/2023 |
| Imperial | 1/31/2022 | 2/4/2022 | 2/15/2022 | 1/20/2023 | 1/23/2023 | 2/1/2023 |
| Inyo | 4/1/2022 | 4/12/2022 | | | | |
| Kern | 2/3/2022 | 2/7/2022 | 2/17/2022 | 1/31/2023 | 2/1/2023 | 2/15/2023 |
| Kings | 2/22/2022 | 2/22/2022 | 3/11/2022 | 1/10/2023 | 1/19/2023 | 2/14/2023 |
| Lake | 2/1/2022 | 2/8/2022 | 2/23/2022 | 1/31/2023 | | 2/1/2023 |
| Lassen | 2/2/2022 | 2/8/2022 | 2/17/2022 | 2/8/2023 | 2/9/2023 | 2/14/2023 |
| Los Angeles | 2/1/2022 | 2/7/2022 | 2/22/2022 | 1/31/2023 | 2/2/2023 | 2/17/2023 |
| Madera | 3/25/2022 | 3/29/2022 | 5/19/2022 | 2/8/2023 | 2/9/2023 | 2/14/2023 |
| Marin | 1/31/2022 | 2/7/2022 | 2/9/2022 | 1/30/2023 | 1/31/2023 | 2/3/2023 |
| Mariposa | 1/31/2022 | 2/7/2022 | 2/25/2022 | | | |

DHCS Status Chart of County RERs Received
April 27, 2023, Commission Meeting

| County | FY 20-21 Electronic Copy Submission | FY 20-21 Return to County | FY 20-21 Final Review Completion | FY 21-22 Electronic Copy Submission | FY 21-22 Return to County | FY 21-22 Final Review Completion |
|---|---|---|---|---|---|---|
| Mendocino | 2/1/2022 | 2/7/2022 | 2/24/2022 | 1/31/2023 | | 2/2/2023 |
| Merced | 1/27/2022 | 2/7/2022 | 2/8/2022 | 1/19/2023 | | 1/23/2023 |
| Modoc | 4/27/2022 | 4/28/2022 | 4/28/2022 | 3/23/23 | 4/4/2023 | 4/5/2023 |
| Mono | 1/18/2022 | 2/7/2022 | 2/17/2022 | 1/31/2023 | | 2/2/2023 |
| Monterey | 2/2/2022 | 2/7/2022 | 2/9/2022 | 1/31/2023 | 2/2/2023 | 2/2/2023 |
| Napa | 2/7/2022 | 2/8/2022 | 3/3/2022 | 1/31/2023 | 2/1/2023 | 2/13/2023 |
| Nevada | 1/31/2022 | 2/2/2022 | 2/3/2022 | 1/31/2023 | 2/1/2023 | 2/2/2023 |
| Orange | 1/31/2022 | 2/3/2022 | 2/17/2022 | 1/31/2023 | | 2/1/2023 |
| Placer | 1/31/2022 | 3/17/2022 | 4/13/2022 | 1/31/2023 | 2/1/2023 | 2/14/2023 |
| Plumas | 7/14/2022 | 7/14/2022 | 11/29/2022 | 2/14/2023 | 2/15/2023 | 2/21/2023 |
| Riverside | 1/31/2022 | 2/4/2022 | 3/11/2022 | 1/31/2023 | 2/1/2023 | 2/15/2023 |
| Sacramento | 1/31/2022 | 2/3/2022 | 3/11/2022 | 1/25/2023 | 1/26/2023 | 1/27/2023 |
| San Benito | 2/13/2023 | 2/13/2023 | 2/27/2023 | | | |
| San Bernardino | 3/23/2022 | 3/23/2022 | 3/29/2022 | 1/31/2023 | | 2/6/2023 |
| San Diego | 1/31/2022 | 2/3/2022 | 2/18/2022 | 1/31/2023 | 1/31/2023 | 2/14/2023 |
| San Francisco | 1/31/2022 | | 2/4/2022 | 1/31/2023 | 2/1/2023 | 2/16/2023 |
| San Joaquin | 3/22/2022 | 3/23/2022 | 3/25/2022 | 1/31/2023 | | 2/1/2023 |
| San Luis Obispo | 1/26/2022 | 2/2/2022 | 2/7/2022 | 12/30/2023 | 1/6/2023 | 1/19/2023 |
| San Mateo | 1/31/2022 | 8/3/2022 | 8/4/2022 | 3/6/2023 | 3/24/2023 | 4/3/2023 |
| Santa Barbara | 1/26/2022 | 1/26/2022 | 2/10/2022 | 12/23/2023 | 2/7/2023 | 2/15/2023 |
| Santa Clara | 1/31/2022 | 2/15/20222 | 2/18/2022 | 1/31/2023 | 1/31/2023 | 2/16/2023 |
| Santa Cruz | 3/25/2022 | 3/25/2022 | 4/4/2022 | 4/6/2023 | | |
| Shasta | 1/25/2022 | 1/26/2022 | 2/10/2022 | 1/31/2023 | 2/2/2023 | 2/16/2023 |
| Sierra | 1/31/2022 | 2/2/2022 | 2/28/2022 | 1/27/2023 | 1/30/2023 | 2/16/2023 |
| Siskiyou | 7/18/2022 | 7/18/2022 | 8/10/2022 | 2/6/2023 | 2/7/2023 | 2/9/2023 |
| Solano | 1/31/2022 | 2/2/2022 | 2/8/2022 | 1/31/2023 | 1/31/2023 | 2/15/2023 |

DHCS Status Chart of County RERs Received
April 27, 2023, Commission Meeting

| County | FY 20-21 Electronic Copy Submission | FY 20-21 Return to County | FY 20-21 Final Review Completion | FY 21-22 Electronic Copy Submission | FY 21-22 Return to County | FY 21-22 Final Review Completion |
|---|---|---|---|---|---|---|
| Sonoma | 1/31/2022 | 2/3/2022 | 2/22/2022 | 1/31/2023 | 2/2/2023 | 3/6/2023 |
| Stanislaus | 1/31/2022 | 2/2/2022 | 2/15/2022 | 1/31/2023 | 2/2/2023 | 2/3/2023 |
| Sutter-Yuba | 2/9/2022 | 2/10/2022 | 2/15/2022 | 1/31/2023 | 2/2/2023 | 3/6/2023 |
| Tehama | | | | | | |
| Tri-City | 1/31/2022 | 2/2/2022 | 5/25/2022 | 1/25/2023 | 1/25/2023 | 2/16/2023 |
| Trinity | 7/5/2022 | 7/5/2022 | 7/27/2022 | | | |
| Tulare | 1/31/2022 | 2/2/2022 | 2/10/2022 | 1/31/2023 | 1/31/2023 | 2/15/2023 |
| Tuolumne | 1/31/2022 | | 2/4/2022 | 3/29/2023 | 3/30/2023 | 4/5/2023 |
| Ventura | 1/28/2022 | 2/2/2022 | 2/14/2022 | 1/30/2023 | 1/30/2023 | 1/31/2023 |
| Yolo | 1/31/2022 | 2/2/2022 | 2/2/2022 | 1/31/2023 | 2/2/203 | 3/15/2023 |
| **Total** | **58** | **55** | **57** | **51** | **37** | **49** |

Mental Health Services
Oversight & Accountability Commission

1812 9th Street, Sacramento, CA 95811
(916) 500-0577
www.mhsoac.ca.gov

# 2023 Commission Meeting Dates (Tentative)

| |
|---|
| **May 25th** |
| **June (tentatively no meeting)** |
| **July 27th** |
| **August 24th** |
| **September 28th** |
| **October 26th** |
| **November 16th** |
| **December (tentatively no meeting)** |