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Mental Health Services
Oversight & Accountability Commission

Meeting Materials Packet

Commission Teleconference Meeting
August 24, 2023
9:00 AM – 4:00 PM

MHSOAC
Mental Health Services
Oversight & Accountability Commission

COMMISSION MEETING NOTICE & AGENDA

August 24, 2023

NOTICE IS HEREBY GIVEN that the Commission will conduct a Regular Meeting on **August 24, 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: August 24, 2023

Time: 9:00 AM

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

COMMISSION MEMBERS:
Mara Madrigal-Weiss, *Chair*
Mayra E. Alvarez, *Vice Chair*
Mark Bontrager
Bill Brown, *Sheriff*
Keyondria D Bunch, Ph.D.
Steve Carnevale
Wendy Carrillo, *Assemblymember*
Rayshell Chambers
Shuo Chen
Dave Cortese, *Senator*
Itai Danovitch, MD
Dave Gordon
Gladys Mitchell
Jay Robinson, Psy.D.
Alfred Rowlett
Khatera Tamplen

EXECUTIVE DIRECTOR:
Toby Ewing

ZOOM ACCESS:

FOR COMPUTER/APP USE
Link: https://mhsoac-ca-gov.zoom.us/j/89687854531
Meeting ID: 896 8785 4531

FOR PHONE DIAL IN
Dial-in Number: 1-408-638-0968
Meeting ID: 896 8785 4531

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.

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 and the Commission will honor former Deputy Director Brian Sala for his dedication and service to the Commission.

9:30 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. **July 27, 2023 Meeting Minutes**
   Action
   The Commission will consider approval of the minutes from the July 27, 2023 Commission Meeting.
   - Public Comment
   - Vote

10:00 AM

5. **Data and Transformational Change**
   Information
   The Commission will hear a panel presentation and discuss the use of data as a lever for transformational change; *presented by Melissa Martin-Mollard, Ph.D., Chief of Research and Evaluation, and the following Panelists:*
   - *Sameer Chowdhary: Principal of McKinsey Consulting*
   - *Emily Putnam-Horstein, PhD: Lead researcher with the Children's Data Network and advisor to the California Cradle to Career data exchange*
   - *Daniel Webster, Principal Investigator, California Child Welfare Indicators Project*
   - *Serene Olin: Former Assistant Vice President of Research and Analysis at the National Committee for Quality Assurance and co-author of*

"Behavioral Health Quality Framework: A Roadmap for Using Measurement to Promote Joint Accountability and Whole-Person Care"

- *Marlies Perez: Chief of the Department of Health Care Services Behavioral Health Community Services Division*
  - Public Comment

12:00 PM **6. Lunch**

1:00 PM **7. Universal Mental Health Screening for Children and Youth Project**

Information

Commission staff will provide an overview of the universal mental health screening for children and youth project including a plan to use the $200,000 provided in the 2023-2024 State Budget to accomplish the goals of the project; *presented by Kali Patterson, M.A., Policy Research Supervisor.*

- Public Comment

1:35 PM **8. Commission 2023-2024 Spending Plan**

Action

The Commission will consider approval of the 2023-2024 Fiscal Year Spending Plan and associated contracts; *presented by Norma Pate, Deputy Director.*

- Public Comment
- Vote

1:50 PM **9. Legislative Priorities for 2023**

Action

The Commission will consider legislative priorities for the current 2023-24 legislative session including:

- Assembly Bill 599 (Ward) relating to public health approaches for addressing student drug, alcohol, and tobacco possession and use in schools; presented by Caleb Beaver, Legislative Aide.
- Senate Bill 10 (Cortese) relating to opioid overdose prevention and treatment in schools; presented by Tara Sreekrishnan, Legislative Director; and

- Senate Bill 326 (Eggman) relating to modernization of the Mental Health Services Act; presented by Stephanie Welch, Deputy Secretary of Behavioral Health, California Health and Human Services Agency

Presented by Kendra Zoller, Deputy Director of Legislation.

- Public Comment
- Vote

2:20 PM

10. Commission's 2024-2027 Strategic Plan

Information

The Commission will hear an update on recent community engagement efforts and draft plan components for the Commission's 2024-2027 Strategic Plan; *presented by Boston Consulting Group.*

- Public Comment

3:20 PM

11. Anti-Bullying Social Media Report

Information

The Commission will hear a report out on the youth-driven social media strategy to address race-based bullying, including a demonstration of some of the digital features that provide peer-to-peer support for youth and share successes and future opportunities for youth-designed digital platforms; *presented by Media Cause Staff.*

- Public Comment

4:00 PM

12. Adjournment

MHSOAC
Mental Health Services
Oversight & Accountability Commission

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.

Additional Public Locations:

UC Berkeley SCET
1923 Gridiron Way
CMS 122, MC# 1768
Berkeley, CA 94720

700 S Flower Street
Suite 1000
Los Angeles, CA 90017

20151 Nordhoff Street Chatsworth
CA, 91311

AGENDA ITEM 4

Action

August 24, 2023 Commission Meeting
July 27, 2023 Meeting Minutes

Summary: The Mental Health Services Oversight and Accountability Commission will review the minutes from the July 27, 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) July 27, 2023 Meeting Minutes; (2) July 27, 2023 Motions Summary

Handouts: None

Proposed Motion: The Commission approves the July 27, 2023 Meeting Minutes

State of California

MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

Commission Meeting Minutes

Date July 27, 2023

Time 9:00 a.m.

Location MHSOAC
1812 9th Street
Sacramento, California 95811

Additional Public Locations
UC Berkeley SCET, 1923 Gridiron Way, CMS 122, MC# 1768, Berkeley, CA 94720
700 S Flower Street, Suite 1000, Los Angeles, CA 90017
8700 Beverly Blvd, Los Angeles, CA 90048
10850 Gold Center Drive, Suite 325, Rancho Cordova, CA 95670

Members Participating:

Mara Madrigal-Weiss, Chair
Mayra Alvarez, Vice Chair*
Mark Bontrager
Sheriff Bill Brown
Steve Carnevale
Rayshell Chambers
Shuo Chen*
Itai Danovitch, M.D.*
David Gordon
Jay Robinson, Psy.D.
Alfred Rowlett*
Khatera Tamplen

*Participated remotely.

Members Absent:

Keyondria Bunch, Ph.D.
Assembly Member Wendy Carrillo
Senator Dave Cortese
Gladys Mitchell

MHSOAC Meeting Staff Present:

Toby Ewing, Ph.D., Executive Director
Geoff Margolis, Chief Counsel
Tom Orrock, Deputy Director, Operations
Norma Pate, Deputy Director, Administration and Performance Management
Kendra Zoller, Deputy Director, Legislation
Melissa Martin-Mollard, Ph.D., Chief, Research and Evaluation
Kali Patterson, Research Scientist
Lester Robancho, Health Program Specialist
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 9:05 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.

Lester Robancho, Commission staff, reviewed the meeting protocols.

2: Announcements and Updates

Chair Madrigal-Weiss gave the announcements as follows:

Commission Meetings

- The June 2023 Commission meeting recording is now available on the website. Most previous recordings are available upon request by emailing the general inbox at mhsoac@mhsoac.ca.gov.
- The next Commission meeting will take place on August 24th in Sacramento.

Chair Madrigal-Weiss invited the Committee Chairs to provide updates on their activities.

Client and Family Leadership Committee Update

Commissioner Tamplen, Chair of the Client and Family Leadership Committee (CFLC), provided a brief update of the work of the Committee since the last Commission meeting:

- The CFLC last met on June 14th and discussed the MHSOAC 2024-27 Strategic Plan, the proposed modernization of the Mental Health Services Act (MHSA), and the Community Assistance, Recovery, and Empowerment (CARE) Court program.
- CFLC Members and members of the public look forward to participating in the strategic planning process in the coming months to help the Commission determine the most effective ways to hear input from community partners.
- CFLC Members heard a report out from Commission staff on the proposed modernization of the MHSA. Several concerns were shared including how the MHSA could and should be used to reduce the number of individuals who are unhoused and living with mental health challenges and/or substance use challenges.
- Commission staff provided a presentation on the challenges, opportunities, and community engagement process of the Commission's Full-Service Partnership (FSP) project. CFLC Member discussion emphasized the importance of subject

matter experts and peer services, community connections, and social supports such as self-help support groups to help sustain individuals outside of the FSP programs.

- The CFLC has provided a platform for discussion on the CARE Court program. The hope is that the CFLC can continue to invite the community into discussions and enhance the level of engagement with partners around this issue. Concerns were expressed that the community engagement process has not adequately included or addressed the concerns of those who will be affected most by the CARE Court legislation, including communities of color who may have had negative experiences in court systems and may be impacted the most by the law.
- The goal for future meetings will be to continue to provide updates and the perspective from those with lived experience and family members on the Commission's strategic plan and to ensure that the CFLC's future work is aligned with the Commission's objectives.

Commissioner Tamplen thanked Committee Members and everyone who participated and stated that she looks forward to providing updates as the Committee makes progress on the work of the CFLC.

Cultural and Linguistic Competency Committee Update

Vice Chair Alvarez, Chair of the Cultural and Linguistic Competency Committee (CLCC), provided a brief update of the work of the Committee since the last Commission meeting:

- The CLCC last met on June 27th and discussed the MHSOAC 2024-27 Strategic Plan and the proposed modernization of the MHSA.
- CLCC Members thought through how the goals of the strategic planning process should be aligned with the CLCC, what a robust feedback loop between the CLCC and the Commission would look like particularly for priority projects, and how the CLCC is an avenue for marginalized communities and communities of color to bring this unified voice to the Commission's decision-making process. The CLCC will work with staff to incorporate these recommendations into the strategic planning process.
- CLCC Members asked questions from staff about the language in the proposed modernization of the MHSA and discussed concerns around prevention, early intervention, and the children and youth populations. The discussion echoed much of the conversation from previous Commission meetings but also spoke to the unique needs of communities of color and other marginalized populations such as the LGBTQ community. As much as there is uncertainty or anxiety associated with what is coming regarding the modernization proposal, CLCC Members are confident that the discussions occurring with community partners, experts, and individuals with lived experience expose conversations that ensure that the best approach is being taken moving forward.

Vice Chair Alvarez thanked the CLCC Members for their flexibility with the Committee structure and for their continued discussions in these important areas.

CYBHI Announcement

Chair Madrigal-Weiss stated that the Commission has been working in collaboration with the Department of Health Care Services (DHCS) on the Children and Youth Behavioral Health Initiative (CYBHI), a $4.7 billion investment in the mental health of the most vulnerable children and youth. A portion of that funding, $429 million, is dedicated to scaling evidence-based practices and Community-Defined Evidence Practices (CDEPs) that are based on effectiveness, impact on racial equity, and long-term sustainability.

Chair Madrigal-Weiss stated that the Commission has entered into an interagency agreement with DHCS to administer Grant Rounds 4 and 5. Commission staff has been working with DHCS staff to create the Request for Applications (RFA) for Round 4, which focuses specifically on youth-driven programs. The Commission has designated Vice Chair Alvarez to lead this process. She asked Vice Chair Alvarez to say a few words.

Vice Chair Alvarez acknowledged the strong collaboration with the DHCS throughout this process. This provided an opportunity to work together on shared goals for ensuring that more youth-driven programs are available in communities. Applicants may apply to support the availability of youth-driven programs, open new programs, or expand existing programs. She noted that the RFA reflects the input of community members, specifically young people, around the importance of having safe places to seek help and find leadership opportunities for young people. She stated that she is confident that, through this RFA, programs serving youth from diverse backgrounds, particularly those who are most marginalized and experiencing inequities, will be supported.

Vice Chair Alvarez stated that each of the six Grant Rounds of the CYBHI has an equity focus and Round 4 specifically calls for programs that reduce health disparities by improving equitable access to services for parents, care givers, and children in California that are culturally and linguistically responsive to the needs of the populations of focus. She commended Tom Orrock for his leadership and his team for their work on the RFA. She stated appreciation for the partnership and the spirit of collaboration with the DHCS and the community.

Listening Sessions

Starting next week, the Commission will hold six virtual listening sessions to gather input from community members on the most pressing mental health needs of six underserved populations in California. The purpose of these listening sessions is to inform the next round of advocacy requests for proposals. The Commission will hear a presentation on the findings of this public outreach and consider approving the release of the Requests for Proposals (RFPs) at the September Commission meeting. One listening session will be held for each population, and they will be held in the evening via Zoom. More details and links to join the listening sessions are posted on the website.

Staffing Updates

Chair Madrigal-Weiss invited Dr. Martin-Mollard to share recent staff changes.

Melissa Martin-Mollard, Chief, Research and Evaluation, gave her staffing update:

- Kali Patterson, Research Scientist, has been promoted to Research Scientist Supervisor, overseeing the Policy Projects team.
- Kai LeMasson, Ph.D., Senior Researcher, has been promoted to Research Scientist Supervisor, overseeing the Mental Health Student Services Act (MHSSA) evaluation.
- Kallie Clark, Ph.D., Senior Research Data Analyst, an embedded contract staff on the Research and Evaluation team, has been offered a Research Scientist Supervisor position, overseeing the FSP project.

Chair Madrigal-Weiss announced that Cynthia Burt, Mental Health Specialist, will soon be retiring. She thanked Cynthia Burt for her years of service and wished her well in her retirement.

Chair Madrigal-Weiss announced that Sharmil Shah, Psy.D., Chief of Program Operations and Lead of Innovation, has accepted a position as the Assistant Deputy Director in the Office of Health Workforce Development at the Department of Health Care Access and Information (HCAI). She thanked Dr. Shah for her valuable contributions and years of service with the Commission and wished her the best in her new role.

Commissioners and members of the public expressed their appreciation and gratitude for Sharmil Shah and her work over the years.

3: General Public Comment

Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), thanked the Commission for hosting the listening sessions to gather feedback for the community advocacy grant RFPs. She noted that state advocacy is not often included in RFPs. She stated the hope that the Commission will consider having part of the RFPs pay for state-level advocacy.

Andrea Crook, MHSA Program Manager, Sacramento County, stated the hope that Sharmil Shah will bring all the great work of the MHSOAC over to HCAI of incorporating community voice and the community planning process.

Hector Ramirez, consumer, Los Angeles Department of Mental Health, thanked Stacie Hiramoto for her comment. He stated that consumers in Los Angeles do advocacy work out of their own pockets because there is no state-funded or county-funded consumer advocacy program that funds community involvement regarding the MHSA at the state level. The speaker noted that Los Angeles County not only has the largest resident population in the state of California, but it has one of the largest intersectional populations with Latino, Native American, African American, and Asian and Pacific Islander (API) communities.

Tonya Savice, Director of Advocacy, The Veterans Art Project (VETART), thanked the Commission for funding VETART's three-year innovative project, which is coming to an end. The speaker stated that they have seen how the Pop-Up Community Creative Arts Cafés have helped engage and connect veterans back to the community. A Pop-Up Café will be held on October 17th in Sacramento. The speaker invited everyone to attend to see the art done by veterans and to hear the stories behind the art.

Jerry Hall, BHABrehab.com, urged the Commission to help counties understand key elements on existing code-providing advisory boards to engage consumers, family members, and the community in the community planning process. Most behavioral health committees, work groups, and councils talk about the importance of the community planning process and yet the plans for the community planning process are not given to advisory boards for review and approval. It is important that advisory boards review and approve plans to ensure that communities are engaged.

4: May 25, 2023, and June 15, 2023, Meeting Minutes

Chair Madrigal-Weiss stated that the Commission will consider approval of the minutes from the May 25, 2023, and June 15, 2023, Commission meetings. She stated that meeting minutes and recordings are posted on the Commission's website.

There were no questions from Commissioners and no public comment.

Action: Chair Madrigal-Weiss asked for a motion to approve the May 25, 2023, Meeting Minutes. Commissioner Brown moved, and Commissioner Tamplen seconded, that:

- *The Commission approves the May 25, 2023, Meeting Minutes, as modified.*

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, Robinson, Rowlett, and Tamplen, Vice Chair Alvarez, and Chair Madrigal-Weiss.

Action: Chair Madrigal-Weiss asked for a motion to approve the June 15, 2023, Meeting Minutes. Commissioner Robinson moved, and Commissioner Carnevale seconded, that:

- *The Commission approves the June 15, 2023, Meeting Minutes, as modified.*

Motion passed 9 yes, 0 no, and 2 abstain, per roll call vote as follows:

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

The following Commissioners abstained: Commissioner Gordon and Vice Chair Alvarez.

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.

- Santa Clara County Innovation Project: Approval of $11,938,639 in innovation funding over 4.5 years for their Transgender, Non-Binary, and Gender Expansive (TGE) Center innovation project.

Commissioner Comments & Questions

Chair Madrigal-Weiss asked for a motion to approve the funding for Santa Clara's TGE Center Innovation Project for up to $11,938,639.

Commissioner Gordon moved to approve the Consent Calendar.

Commissioner Tamplen seconded.

Public Comment

Hector Ramirez requested including articulated emphasis that all projects funded or approved by the Commission provide both the required disability accommodations for the community to be able to participate in the services and linguistic accessibility services so that individuals can access all MHSA-funded services. He suggested incorporating in the funding formula an opportunity to include funding to provide accessible and linguistic services in addition to what the counties are asking in their budgets.

Action: Commissioner Gordon moved, and Commissioner Tamplen seconded, that:

- *The Commission approves funding for Santa Clara's TGE Center Innovation Project for up to $11,938,639.*

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

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

6: MHSA Modernization Proposal

Chair Madrigal-Weiss stated that the Commission will hear an update on Senate Bill (SB) 326 (Eggman) and Assembly Bill (AB) 531 (Irwin) followed by panel presentations on the benefits of the proposal and concerns. The Commission will consider taking a position on the Governor's proposal.

Stephanie Welch and Jacey Cooper

Chair Madrigal-Weiss introduced Stephanie Welch and Jacey Cooper and asked them to give their presentations.

Stephanie Welch, Deputy Secretary of Behavioral Health, California Health and Human Services Agency (CalHHS), reviewed the objectives of Governor Newsom's proposal to modernize California's behavioral health system and highlighted some of the recent modifications made to the proposal, which are based on concerns and creative ideas shared by the community. She asked for continued dialogue as the proposal progresses. CalHHS has been working to ensure a more collaborative relationship between CalHHS, the DHCS, and the Commission.

Stephanie Welch addressed the question raised at the last Commission meeting about why CalHHS is doing this. She stated that the intent section of SB 326 contains two pages of jarring statistics about the escalation of youth substance use disorders, marginalized communities not accessing services, the growing need for infrastructure

including workforce, and incarcerated individuals diagnosed with a serious mental illness. She stated that the assumption was that approximately 33 percent of the unhoused population was living with a serious mental illness, but a recent study done by the University of California, San Francisco (UCSF) found that over 65 percent have experienced symptoms of depression, anxiety, trouble concentrating or remembering, or hallucinations in the last 30 days. There is a tremendous unmet need.

Stephanie Welch noted that this does not mean that there was not an incredible need 20 years ago when the MHSA was drafted, but the study shows that some of the needs are different. There seems to be a consensus in the community that, after 20 years, a finetuning of the MHSA is appropriate. For example, the MHSA was drafted prior to mental health services being a part of the everyday health care system and prior to the major reforms being built into the core of the health care delivery system. She stated that this Administration has invested over $10 billion into the overarching behavioral health care continuum.

Stephanie Welch stated that the Medi-Cal medical model is a system of yesterday. For Medi-Cal to be a system of tomorrow, it needs to be redesigned to address the social drivers of health. Leveraging the Medi-Cal system means bringing more federal dollars into the state, obligating the county specialty system and managed care plans to provide certain services, and collectively, over time, having access to more resources for the kinds of services that the MHSA pioneered 20 years ago. This is part of the original intent of the proposal.

Stephanie Welch reviewed modifications to the original legislative language of the proposal made since April. She stated that the Governor is proposing an approximately $4.7 billion general obligation bond to build 6,000 new unlocked community behavioral health beds in residential settings for Californians with mental health challenges and substance disorders, 1,800 permanent supportive housing units for individuals experiencing homelessness who have behavioral health conditions, and another 1,800 interim, transitional, and supportive housing units for veterans with behavioral health conditions. This information is encapsulated in AB 531, the bill vehicle for the bond. These reforms would be subject to voter approval through a ballot measure scheduled for a public vote in March of 2024.

Stephanie Welch stated that feedback received from the community was that prevention and early intervention being a part of the behavioral health services bucket was poor thinking. As a result, changes were made in the language of the legislation for keeping the 20 percent of the prevention and early intervention with a 5-percent set-aside specifically for population-based prevention. Most of the 30 percent of the behavioral health services and supports component will go towards early intervention.

Stephanie Welch stated that another change is the dedicated, ongoing statewide investment in the behavioral health workforce of up to 3 percent of MHSA funds, which are now known as Behavioral Health Services Act (BHSA) funds. $480 million annually will come from the DHCS Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Waiver for a five-year demonstration period.

Stephanie Welch stated that FSP has now been defined in statute. 35 percent of the BHSA will be directed towards funding FSPs. Counties will be unable to report their federal financial participation as part of meeting this 35 percent as it will only be for BHSA expenditures. FSPs have been defined to have an established standard of care with levels that are based on an individual's acuity and criteria for step-down to an FSP level that provides the greatest degree of independence and self-determination. This is an important area for collaboration.

Stephanie Welch stated that the concept of innovation has been reframed. It is the intent to continue to foster ingenuity and to swiftly create responsive services and supports to encourage learning and leaning toward improved outcomes. Having a set-aside component has been difficult for counties to utilize that funding in a swift way. The idea is to preserve the intent of the innovation component without administrative obstacles. Counties will have the flexibility to test and pilot behavioral health innovative models of care and promising practices across all BHSA buckets. The goal of these innovation pilots and promising practices is to build the evidence for the effectiveness of those new strategies so that they can become statewide strategies.

Stephanie Welch stated that, although it will be a quick process, there will be more amendments and changes made to the proposal as it moves through the legislative process.

Jacey Cooper, Chief Deputy Director and State Medicaid Director, DHCS, shared about the DHCS's experience in implementing largescale policy changes focusing on the intersection with behavioral health, and discussed the oversight and accountability pieces within the proposal as much of the conversations have been focused on the categories and other pieces. Data transparency and accountability are valuable to this proposal. She discussed how to maximize Medi-Cal for this proposal and for behavioral health services across the state.

Jacey Cooper discussed the DHCS's role in policy making and oversight across the state. She stated that the DHCS fulfils its role in partnership with counties and providers such as California Advancing and Innovating Medi-Cal (CalAIM), a five-year roadmap, developed through robust community engagement, for fundamentally changing the Medi-Cal system.

Jacey Cooper stated that the DHCS has experience with implementing large-scale initiatives and complex policy and looks forward to collaborating with counties, providers, the Commission, and others to ensure that this important transition is done correctly.

Jacey Cooper reviewed the areas in the proposal where the DHCS is doubling down on transparency and accountability:

- The proposal replaces the existing plan with a new County Integrated Plan for Behavioral Health Services and Outcomes, including all local behavioral health funding and services. For the first time, entities with separate siloed funding streams and separate initiatives will be required to collaborate across all those funding streams.

- The proposal requires the use of stratified local data to identify disparities within the behavioral health system to inform the integrated plan. Data needs to be stratified across all counties to ensure that funding meets needs and closes gaps.
- The proposal establishes a new, annual County Behavioral Health Outcomes, Accountability, and Transparency Report to provide public visibility into county results, disparities, spending, and longitudinal impact on homelessness. This report, for the first time, provides full transparency on the use of behavioral health funding in California across all funding streams.
- The proposal connects the behavioral health system statewide for all Californians, both individuals with Medi-Cal health insurance and individuals with commercial health insurance. All partners need to be held accountable to ensure that services are reimbursed or covered.
- The proposal requires annual data to be submitted to the DHCS on service utilization, performance outcomes, and measures across all behavioral health delivery systems.

Jacey Cooper stated that the behavioral health landscape has significantly changed since the MHSA was passed. The DHCS will also look at county administrative structures to ensure that county plans can be as successful as possible to meet needs.

Jacey Cooper stated that the DHCS looks forward to continuing to collaborate on this critical initiative.

Stephanie Welch added that it is not easy to be a Medi-Cal provider. She acknowledged that all these components will require a great deal of training and technical assistance. She noted that CalHHS is committed to finding solutions.

Commissioner Comments & Questions

Commissioner Chambers stated concern that the plan as currently proposed will detrimentally impact peer providers. Small community-based organizations heavily rely on MHSA funding for community centers and ethnic and advocacy services. Medi-Cal is not billed. There is a major disconnect between the state and the counties and the level of work that will be needed for the training and technical assistance required to prepare community-based organizations to be Medi-Cal providers as part of the implementation of the proposal.

Commissioner Chambers acknowledged that the proposal gives more seats to family members but noted it does not give an equitable number of seats to peers. It is important that peers be represented because peers are the representation of recovery. This is often missed.

Commissioner Chambers stated the need to ensure that there are peer respites and other alternatives to locked treatment. The peer community providers who embody recovery and navigating the system do not have a voice at the table.

Commissioner Brown agreed with the need for more emphasis and more resources being put into the substance use problem, but stated that the approach to the

proliferation of dangerous, illicit, and often lethal drugs like fentanyl and methamphetamine must include a multi-pronged approach. It cannot be done strictly by one approach; it must be brought under control through a blend of not only prevention and treatment efforts but also enforcement efforts that work to complement those. State resources used to be considerable in this area before the closure of the Bureau of Narcotic Enforcement, which used to be the catalyst that led multi-agency task forces throughout the state that addressed major dealers and interdicted major amounts of drugs that were coming into communities. That has never been more important than it is now with the fentanyl epidemic.

Commissioner Brown stated that, although the proposal has key areas that focus on homelessness and substance use disorder, local counties lack acute and subacute beds in their inventories. He provided the example that Santa Barbara County has 450,000 people and 16 psychiatric health facility (PHF) beds, primarily due to federal Medicaid restrictions. He suggested modifying the proposal to include an Institutions for Mental Disease (IMD) exclusion, which is necessary to move forward with a different approach by expanding the size of those facilities in order to provide much better health care services.

Commissioner Brown stated concern for counties that have co-response programs that involve law enforcement working side-by-side with behavioral wellness professionals. The directive that was issued from the DHCS with respect to Medicaid reimbursement specifically excludes those teams that include law enforcement as a component of the co-response. This is reflective of the bias against the model involving law enforcement but that model works well, is well received, and is keeping mentally ill individuals out of jails and into proper treatment and services. This is something that needs to be corrected.

Commissioner Tamplen agreed with Commissioners Chambers and Brown, particularly the comments around the peer community and community providers that will be impacted by the proposal. She stated that, if services are not mandated, they are often lost. The current proposal has innovation funding competing with other valuable resources rather than bringing county innovation ideas to the Commission for approval. Lumping innovation together with other funding will create a huge loss for the state. She stated that it is important for the statute to mandate the continuation of the current collaborative innovation process with the Commission involved and to fund it separately.

Commissioner Tamplen stated appreciation for leveraging Medi-Cal dollars and valuing peer support. There is a need to support the transition process. She stated concern that community health workers and Certified Peer Support Specialists are being lumped into one category when they should be separate.

Commissioner Tamplen stated that peer respites are critical in preventing crisis and increasing access and supporting family members, who are struggling and in crisis too. It is important that a peer support specialist be available to meet individuals where they are. IMDs do not meet required standards of quality care. She requested funding more peer respites.

Commissioner Tamplen stated that everyone agrees with the importance of addressing homelessness, but this proposal does not address housing costs. The issue of

homelessness will continue in California until the high rent costs are addressed. It is not just the MHSA that should be supporting this. Bolder steps need to be taken to address the cost of housing.

Jacey Cooper stated that innovation would be one of the continued requirements of the county three-year planning process as part of the new County Integrated Plan. Counties will still be responsible for engaging local partners.

Commissioner Tamplen noted that the wider community is aware of and has more access to the Commission than sometimes locally. The Commission has been learning about innovations, listening to community, asking questions, and getting the community to ask questions. This has been a valuable, enriching, and informative process for the Commission and the counties.

Commissioner Rowlett stated appreciation for the collaborative approach that has already been demonstrated. He stated that ongoing concerns remain about individuals with substance use disorders getting important, timely treatment and how the proposed shift in eligibility will be accounted for or even paid for. He stated that he does not object to modernization; however, it is important to ensure that that modernization does not adversely affect the existing continuum of care for individuals who are recipients of Medi-Cal who need those outpatient services. Further discussion is required.

Commissioner Rowlett stated that there has been discussion about FSPs and its role in the proposed modernization plan. He stated that it is important to underscore the geographic differences of FSP services, the importance of having outcomes being an embedded feature in FSP services, and the workforce challenges being faced today and how those workforce challenges are incorporated into the proposed modernization plan around FSPs that will not weaken existing FSPs that are working well.

Commissioner Danovitch stated appreciation that everyone has the same goals. He stated that, in principle, consolidating resources through an agency makes sense; however, in practice, there are many challenges. He stated that the purpose of innovation is to facilitate system transformation rather than just incremental growth because of the notion that the system itself, growing in the way that it has been, is not sufficient to determine the enormity of the problems that the population faces. The end goal is to find new solutions and new mechanisms that deliver improved care. The question is how.

Commissioner Danovitch stated that what the MHSA has done and what the Commission has tried to do has been to help shape the system by providing another mechanism outside of the agency to help facilitate and promote change. He stated that he would like to see a strengthening of the Commission and the MHSA. He stated concern that the consolidation of resources and some of what is in the legislation will soften or weaken this extra agency mechanism of helping to shape the system and achieve shared goals.

Commissioner Danovitch stated that some of the big challenges the Commission has faced are transparency, getting data, understanding where opportunities are, and where to be effective. Amendments and modifications to the Governor’s proposal should focus on these issues.

Commissioner Carnevale stated that he appreciated the spirit of collaboration but used the example that it is difficult to collaborate to bake a cake when the cake is already baked and the discussions center around where to slice it. He stated that, in the business world, plans happen very differently. Everyone agrees on the problem. The next steps should be to discuss objectives and outcomes to be achieved, establish a framework to operate within, discuss strategies to implement to accomplish the outcomes, and finally determine the plan. He noted that the Governor's proposal process for some reason goes from the problem straight to the plan but the middle steps are missing.

Commissioner Carnevale stated that the presenters cannot explain what will happen, except through conjecture. There is no way to connect the dots. It makes no sense to get into the details because of the missing pieces. He stated that, if this plan was presented to his company, he would say to go back to the drawing board. The presenters acknowledged that this is a massive change and yet they are running to try to implement something that does not seem very well thought out. The proposed plan may cause more problems than it was intended to solve.

Commissioner Robinson stated that he was intrigued by the comment that it is not easy to be a Medi-Cal provider. He asked why the presenters say that and what is being done to address it.

Stephanie Welch stated that there are local organizations that have small budgets or have no clinical staff. She stated that, under the new benefit, those organizations may contract to provide wellness center services. Certain wellness center services can also include Medicaid dollars. What needs to be determined is how to support organizations that may never have held a contract. There is billing involved and more administrative work, although part of the plan is to make the administrative paperwork easier and less burdensome so more time can be spent with clients. She stated that she is interested in learning more about this issue.

Jacey Cooper stated that the DHCS has been learning about this issue through the expansion of CalAIM with community-based organizations now providing Medi-Cal services. She outlined the many steps involved in transitioning to be a Medi-Cal provider, which is often a barrier. Documentation reform has just been rolled out. Efficiencies have been improved to streamline provider enrollment, including some federal regulations, although there is still room for improvement in the long-standing documentation barriers that have been a burden to Medi-Cal providers.

Jacey Cooper stated that the state delegates responsibility to the counties. Counties look different in the state of California – some keep it in-house, some contract out, and others do a hybrid of the two. Under federal regulations, the federal government considers counties as a managed care plan that must have a contracted network. CalAIM is in the process of solving some of those federal requirements.

Jacey Cooper stated that another factor is that there are not even clear federal behavioral health quality and outcome metrics nationwide. It is important to have standardized guidelines to measure quality and outcomes.

Jacey Cooper stated that all those factors play into why it is difficult to be a Medi-Cal provider.

Commissioner Robinson underscored the need to break down those barriers. He stated that it is undermining the plan if it is difficult for providers to provide services. He stated that workforce challenges are extreme for large employers. Having enough behavioral health providers is also critical to the success of the plan. He asked how this will be addressed.

Jacey Cooper stated that there is a portion of dollars in the proposal earmarked to be directly focused on workforce. Historically, only state dollars have been leveraged, but it is important to ensure that federal dollars are being leveraged around workforce. There is an opportunity with the BH-CONNECT Waiver to add a workforce component: for example, matching a small amount of state funds with approximately 85 percent federal funds to build out workforce pipelines across the state. Workforce issues are being seen across the delivery system. She noted that the COVID-19 pandemic has magnified this issue significantly. The workforce piece is a large component of the proposal.

Commissioner Robinson encouraged looking broadly at workforce beyond behavioral health personnel to construction workers and others who will be a part of this expansion.

Stephanie Welch stated the importance of thinking about the workforce of tomorrow and who will be needed to deliver the type of services that individuals use and want and to ensure that these are workers who are reflective of the diversity of California. This is a tremendous effort and will take a collaborative effort to design properly.

Commissioner Tamplen stated that the March 2024 ballot does not leave enough time for the required discussion on these many issues. This is too rushed.

Chair Madrigal-Weiss stated that California is approximately one year out from a global pandemic. There are many repercussions that are yet unknown and the tsunami is still coming in. She stated concern that the presenters are proposing a huge change when the issues are still happening and are speaking to things that have yet to be identified. There is not a question that the system will be built out, it is more a question about there not being a concrete implementation plan.

Chair Madrigal-Weiss stated that the state has made historic investments in school mental health, yet state leadership for school mental health is not identified in the proposal. This Commission has done tremendous work around that. She emphasized that much is going on with youth; much can be done with prevention and early intervention in the schools.

Vitka Eisen, Le Ondra Clark Harvey, and Jolie Onodera

Chair Madrigal-Weiss introduced Vitka Eisen, Le Ondra Clark Harvey, and Jolie Onodera and asked them to give their presentations.

Vitka Eisen, MSW, Ed.D., CEO, HealthRIGHT 360, discussed the proposal's expansion of behavioral health funding to include services for substance use disorder. She stated that adding substance use disorder as a condition covered under the BHSA is rectifying something that should always have been included in the MHSA when it was passed into

law in 2004. In 2004, California still had the highest number of individuals in prison. Up to 80 percent of those individuals had some condition related to substance use disorder. That group of individuals, made up of primarily Black and brown individuals, were sent to prison to get care. She noted that, at that time, the prisons had possibly the most robust statewide treatment system in California. This is tragic, it is wrong, and it is an inequity.

Vitka Eisen stated that the Drug Medi-Cal Organized Delivery System Waiver was created in 2015 and revolutionized substance use treatment across the country because it made it possible to pay for a full scope of care for individuals with substance use disorder. It was not until then that community-based system of substance use care was created for individuals based on income. Part of that was the prison system.

Vitka Eisen stated that HealthRIGHT 360 serves mostly individuals with no housing or who have unstable housing. Studies show that individuals who are unhoused have poor health outcomes simply by the fact that they are unhoused. Housing increases health and pairing housing with some kind of wraparound service increases health even more. It is important to maintain individuals in housing through services. Being housed increases mental health and decreases substance use.

Vitka Eisen stated that one of the services paid through the Drug Medi-Cal program was for recovery bridge housing post-residential treatment services for individuals who were unhoused. Medi-Cal is limiting at three months – three months of residential treatment and three months in conditional housing with no supporting housing while individuals continue outpatient care after that. There will likely be a deterioration in health with the lack of supportive housing.

Vitka Eisen stated that there are other gaps in care under Drug Medi-Cal that could be alleviated using BHSA funding, such as meeting individuals where they are with wraparound, intensive case management FSPs.

Vitka Eisen stated that there are concerns about the integration of substance use and mental health at the county level. This is a challenge that the state is already working on. Individuals need to get care where they feel comfortable and where they show up. The fact that these things operate as entirely separate funding pools and separate plans is highly problematic for the people receiving services.

Vitka Eisen suggested expanding prevention from a harm-reduction approach to include children who are prenatally exposed to alcohol, in particular. Children who are prenatally exposed to alcohol have a higher risk of mental health and substance use issues if unaddressed at an early age. She urged that this be done with no stigmatism and no fear that a mother will lose her child because this is how children and families do not get services. She suggested that the proposal includes a focus on this high-risk population as part of the prevention and early intervention program.

Vitka Eisen stated that county-based local systems do not always work for the individuals served for several reasons, such as that the county does not have the full range of services needed. She stated many individuals HealthRIGHT 360 serves are transient. Individuals may have registered for Medi-Cal in one county at some point but they are now in another county. This is an interruption in care. She stated, although

there are advantages to county-based local systems, there are also disadvantages in terms of continuity of care.

Vitka Eisen stated that the state has had to step in over the years with some counties to support programs such as harm reduction services and methanol treatment, which is a highly-effective evidence-based intervention against drug overdoses. She suggested that there are times when a regional model may be the best model

Vitka Eisen stated that the substance use disorder workforce has the highest percentage of peer workers in any behavioral health system. She stated the need to create a rate system that supports a livable wage for behavioral health workers to help alleviate the workforce crisis.

Le Ondra Clark Harvey, Ph.D., CEO, California Council of Community Behavioral Health Agencies (CBHA), discussed the proposed dedicated local funding for FSPs and the new planning and reporting requirements on counties. She noted that a large percentage of MHSA utilization for CBHA members is for prevention and early intervention and community services and supports. She provided an overview of the results of a CBHA member survey on the county integrated plan and the annual reports.

Le Ondra Clark Harvey stated that the survey results were that greater transparency and accountability is critical but only if it does not increase administrative burden, accountability must be specifically outlined, money would be better spent to develop one system where all agencies can upload their data, and specifics are needed in order to have meaningful outcomes.

Le Ondra Clark Harvey stated that the survey results of the Medi-Cal payment reform were that financial disincentives for travel time reimbursement and workforce may make it more difficult to utilize Assertive Community Treatment (ACT) and the Forensic Assertive Community Treatment (FACT). The rates that are set up with counties need to account for providers' travel time seeing clients in the field.

Le Ondra Clark Harvey stated the need to focus on fidelity; however, some members say this is counter to the FSP model because the FSP model was created to be a whatever-it-takes program and that there is an inherent flexibility in that. An overfocus on the details of the fidelity to these models may have unintended consequences. This must be paid attention to.

Le Ondra Clark Harvey stated that a general acknowledgment was shared among the members that this work is already being done well and, if there is too much focus here, it can lead to increased administrative burden. FSPs must be looked at wholly within the system of care and what is happing to providers with the demands of CalAIM, CARE Court, and now the modernization of the MHSA. The piecemeal focus on these areas is problematic. Instead of focusing on FSPs, CBHA members recommended building on the 20 years of knowledge that the agencies have and lifting up and building on good models and things that are working in the community.

Jolie Onodera, Senior Legislative Advocate, California Association of Counties (CSAC), discussed the dedicated local funding of 30 percent for housing interventions and the effect of the overall proposal on counties both large and small. She stated that counties broadly agree that the MHSA should be updated, including revisions to the MHSA

funding silos that would offer greater funding flexibility tied to outcomes as well as the addition of substance use disorder; however, counties believe there are ways that the proposal can be strengthened.

Jolie Onodera stated that CSAC believes that increasing county flexibility, particularly for small counties, is key as well as adding some fiscal protections. She stated that flexibility and fiscal protections will also be important in recognition that the proposal does not include new funding; however, it does expand the target population to include those with substance use disorder and requires new and enhanced reporting and planning processes.

Jolie Onodera stated that CSAC believes that narrowing what now is a complex proposal would be helpful to clarify what is being put before the voters versus some of the other proposals that are currently in the bill that do not require voter approval that would become law upon the Governor's signature of SB 326. CSAC also believes that those additional proposals would benefit from a more robust discussion and vetting through the full legislative process.

Jolie Onodera stated that the dedicated funding of 30 percent for housing interventions will have varying impacts across counties depending on size, geography, provider networks, housing availability, and needs of each community. She stated that, for some counties, in the absence of additional flexibilities being added to the proposal, this will be challenging for them to meet and potentially at the expense of other services that are currently being provided. She added that the subcategory restriction for an additional 50 percent for the chronically homeless, coupled with the additional requirements in the proposal, will add additional challenges to ensuring the stability of current programs and services.

Jolie Onodera stated that CSAC feels that generally meeting the 30 percent requirement will result in shifts away from existing provisions for outpatient and crisis services and funding for prevention and early intervention programs that are currently being contracted with community-based organizations. Further, counties currently leverage a significant amount of MHSA funding to draw down federal funds through Medi-Cal.

Jolie Onodera stated that diverting 30 percent of funds for non-medical-billable services such as housing will lose this federal match. It is anticipated that much of the funding lost under the BHSA restructuring will be services including core outpatient crisis and recovery-supporting services. She provided county-specific examples for large, medium, and small counties, and stated that added flexibilities will be helpful for counties to implement some of the policies in the proposal.

Chris Stoner-Mertz and Andrea Wagner

Chair Madrigal-Weiss introduced Chris Stoner-Mertz and Andrea Wagner and asked them to give their presentations.

Chris Stoner-Mertz, CEO, California Alliance of Child and Family Services (California Alliance), discussed the proposed dedicated local funding for population-based prevention and early intervention. She stated that the Governor's attention to

California's homeless crisis is laudable. This issue impacts communities statewide. Solutions are needed to address this crisis.

Chris Stoner-Mertz stated that the California Alliance appreciates the Commission's attention to this topic and the thorough analysis provided in the meeting materials. The Commission's express support of prevention and early intervention services for children and youth is well established through the important initiatives the Commission has led. The California Alliance applauds the recommendations the Commission has put together.

Chris Stoner-Mertz stated that the California Alliance supports the focus and the allowance for substance use disorders to be addressed through the Governor's proposal, but is concerned that adding services that are expected to be provided without additional funding to support them is problematic. The California Alliance wholeheartedly supports the additional accountability. The public behavioral health system needs to be more outcomes-driven rather than simply reporting on the services provided.

Chris Stoner-Mertz stated that, while the California Alliance applauds these elements, it has concern about the impact to services for children, youth, and families, particularly the reduction of articulated funding for prevention services as well as losing some of the requirements that currently exist in regulation that at least 51 percent of those prevention funds are used to support children and youth services.

Chris Stoner-Mertz provided an overview, with a slide presentation, of the current MHSA funding allocations and how the BHSA funding allocations differ, programs funded by and populations served through the MHSA, and types of programs and services funded. She stated that the homelessness problem is very visible in this state but children and youth are not visible in the way that a homeless adult is. Politicians focus on visible issues. She stated concern that children and youth will get lost without a clear set-aside.

Chris Stoner-Mertz stated that the recent Legislative Analyst's Office (LAO) Report outlines the clear loss of funding available for prevention services and that the number of current community services and supports and prevention and early intervention programs that make up most of the current spending that would fit within the new Behavioral Health Services and Supports category will likely see reductions.

Chris Stoner-Mertz stated that the state of California does not have a good track record of taking care of the behavioral health needs of the most vulnerable children and youth. The California Alliance strongly supports the work of the Administration happening through the CYBHI, CalAIM, and other reforms, but continues to be concerned that something will be lost in this reform for children and youth without clearly articulating that some of the funding will go to children and youth.

Chris Stoner-Mertz urged supporting recommendations that maintain a set-aside that prioritizes services for children and youth as well as encouraging the Legislature and Administration to identify other pathways to funding for housing. Other potential funding opportunities can be identified but do not redirect available recourses that mental health

plans need for critical services, especially with the additional substance use services being added to the service array.

Chris Stoner-Mertz stated that the California Alliance strongly agrees with the Commission's emphasis on the essential need for training and technical assistance. The complexity of California's behavioral health funding is like no other state in the nation in providing those with decision-making authority locally with critical tools for planning, implementation, and ongoing technical assistance.

Chris Stoner-Mertz uplifted Commissioner Carnevale's comments and agreed that this proposal is moving too fast. She stated that, with all the other changes that are happening in the system – payment reform just began in July – nonprofit organizations are not sure they are going to make it through this process, particularly the smaller ones. To think that this proposal will go to the ballot in March of 2024 without embracing a planning process to ensure that the needs of all these populations are taken care of is quite frightening. Funding needs to be set aside to support children and youth in this process.

Andrea Wagner, Interim Executive Director, California Association of Mental Health Peer-Run Organizations (CAMHPRO), discussed the proposed dedicated local funding for population-based prevention and early intervention. She stated that, as the only peer support person on the panel, she could not represent the thousands of peers and the dozens of agencies that she works with on a regular basis. She stated that, instead of presenting quantitative data, she would present qualitative data to appeal to everyone's heart about how this proposal will affect the peer community.

Andrea Wagner provided an overview, with a slide presentation, of the programs and individuals who will be most affected, consumer priorities, and biggest concerns. She stated that the Governor's proposal is a threat to CDEPs and peer support programs. She discussed how prevention and early intervention and innovation are essential to the MHSA and reviewed the top-ten consumer priorities that CAMHPRO has gathered over the past three years as a grantee of the MHSOAC Community Advocacy Contracts. She noted that all these priorities fit under prevention and early intervention and innovation.

Andrea Wagner stated that CAMHPRO's biggest concerns with the proposal are the reduction or elimination of prevention and early intervention, innovation, and the community planning process, and the fact that MHSA dollars will be tied to only Medi-Cal billable services. Medi-Cal billable services come with strings attached. Medi-Cal billing and being site certified are cumbersome, obtrusive, and not always wanted or needed to do the job that these services do.

Andrea Wagner stated that organizations that offer services to individuals through peer support and community services that meet individuals where they are without barriers of insurance and bureaucracy will be pushed out of MHSA funding altogether. This includes the 64 peer-run organizations that were funded through the Behavioral Health Workforce Development Fund with the DHCS that cannot get Medi-Cal certified because counties will not open up those contracts, and many community centers, wellness centers, drop-in services, and others will be hit hard by this proposal and pushed out of MHSA funding.

Andrea Wagner stated that the Governor's proposal takes away the core values and guiding principles of the MHSA. The proposal does not modernize the MHSA; it eliminates what makes it special and different. She asked, at a minimum, for the proposal to slow down, listen to the individuals who are giving a sample of the data collected, and provide an analysis of the implementation before asking the community to agree to something that could potentially destroy and eliminate services that the community desperately wants and desperately needs.

Ryan Miller and Will Owens

Chair Madrigal-Weiss introduced Ryan Miller and Will Owens and asked them to give their presentations.

Ryan Miller, Principal Fiscal and Policy Analyst, Legislative Analyst's Office (LAO), discussed the proposal to lower the cap on allowable county reserves on MHSA revenues. He stated that the LAO released a series of posts that initially looked at the Governor's proposal to change the MHSA and is planning future work in the series including looking at the bond bill and potentially some additional work.

Ryan Miller stated that he will discuss the posts that look at the revenue volatility. He estimated that the MHSA millionaires' tax is three times as volatile as the state General Fund revenue, which poses critical challenges for counties in managing these funds. He stated that, in this context, the LAO assessed the Governor's proposal to reduce the amount of reserves that counties are allowed to keep to protect against this volatility. He noted that the major taxes that fund government services in California almost always grow when the economy is good and decline when the economy is in recession, but the MHSA revenue declined year-over-year in 8 out of the 15 years that the LAO reviewed, including in 2015-16, which was in the middle of a solid economic expansion, where the MHSA revenue declined 18 percent year-over-year.

Ryan Miller stated that the LAO originally looked at the historical revenue performance to come up with a reasonable target. Because the MHSA revenue can drop substantially even in good times, the LAO recommended the target for the county reserves to be almost certain to cover up to a 20 percent revenue decline like what has been seen in good times and very likely to cover a 30 percent decline. The LAO concluded that current reserves are too low. The current reserve cap is equal to 33 percent of the community services and supports category when it should be approximately 55 percent of the community services and supports category to give counties reasonable protection against this volatility; therefore, the Governor's proposal moves the reserves in the wrong direction.

Ryan Miller stated, when reviewing this issue, the LAO also looked at when counties could put money into their reserves and when they can withdraw them and concluded that counties should have more flexibility in managing their revenues and reserves. For example, it does not make sense to have a cap on both the maximum allowable reserves and on the annual amount that they can deposit in the reserves, especially since it is the ideal time to put a lot of money aside when revenues are surging so those reserves can be used to protect programs against cuts in the future.

Ryan Miller stated that the LAO recommends, if the Legislature agrees that this proposal should move forward and be presented to the voters, it is an opportunity to revisit the revenue source for the MHSA. He stated that the LAO recommends that the Legislature change the revenue source. The LAO looked at the overall personal income tax revenue, which would have had to have been raised in the past to raise an equivalent amount of what the millionaires' tax has raised. The concept is to instead deposit the millionaires' tax in the state's General Fund and move 2.3 percent of the personal income tax to the MHSA. Counties would have a far more stable revenue source with volatility approximately two-thirds lower, counties would continue to see strong growth from that revenue, and this would come at a small tradeoff to the state that would have a small marginal increase in state revenue volatility. If the Legislature agrees with the Governor that reserve caps should be lower, by making a change like this, a lower reserve cap could be supported without imposing unnecessary fiscal risk on the counties.

Will Owens, Fiscal and Policy Analyst, LAO, discussed the proposed changes to the Commission's role and restructuring of the MHSA funding categories. He stated that Ryan Miller's analysis on the revenue provides an important context to some of the underlying structure of the MHSA funding source as it is now. He discussed the shift in categories of the MHSA and key takeaways.

Will Owens stated that there are limitations on how the LAO came to the numbers in the analysis and how it evaluated them. He stated that these limitations speak to his first point that, in general, the LAO found the Administration's justification of the proposed changes to be incomplete. There are several concerns that the LAO has raised before the Legislature in terms of what the consequences of this shift will be and there is uncertainty when it comes to what current services may need to be shifted or potentially lost, depending on how the proposal moves forward.

Will Owens stated that the LAO generally finds that there is a shift in focus towards FSPs and housing interventions. This creates an issue where currently, based on the analysis, more funding would need to be directed to FSPs and housing and, while those may be policy goals that the Administration and the Legislature may wish to pursue, it would potentially come at a cost of having services that would currently fit under the Behavioral Health Services and Supports bucket redirected away from that. These services include outpatient services, crisis intervention, wellness centers, and outreach where there is an overprescription. There is a lot of uncertainty in how counties will react and what areas counties will prioritize.

Will Owens stated that this leads to the next point that the LAO generally finds that there will be a loss of county flexibility in terms of how these funds could be used. FSP and housing interventions are prescriptive in their use and the Behavioral Health Services and Supports category, while it has a decent amount of county flexibility, has funding available for more services with most of that funding needing to be set aside for early intervention and then the remaining funding hosting outpatient, the reserve requirements, workforce, and education and training. There are many services that are currently being funded or would be funded through the Behavioral Health Services and Supports bucket that it is unclear what would happen.

Will Owens stated that his last point ties into the analysis done on the Commission's responsibilities. The LAO found that the proposal shifts the decision-making and priority-setting away from counties and the Commission and to the Administration. This is through the more prescriptive nature of the categories as proposed.

Will Owens discussed the proposal's shifting of the Commission's authorities and responsibilities. He stated that the LAO did an analysis on the shift in how the proposal changes the role of the Commission. The original proposal included shifting the Commission primarily under the CalHHS as well as changing the structure of the governance of the Commission. Since the original proposal, that shift has been reverted with some exceptions that the governance and structure of the Commission largely remains the same; however, many of the Commission's roles and responsibilities, particularly with its general oversight role and the setting of priorities for prevention and early intervention and innovation programs, are to be either removed or consolidated within the DHCS.

Will Owens stated that, while the general structure of the Commission remains the same, the LAO found that the Commission's ability to act as an independent oversight entity will be hampered by the loss in its regulatory and priority-setting authorities under the proposal. While it will largely remain outside of the current administrative structure and retain its independence, losing that independent authority, rulemaking, and decision-making ability, the LAO finds that that could impact its ability to act and operate independently.

Commissioner Comments & Questions

Commissioner Carnevale stated that Ms. Wagner depicted a grim outlook for the peer support system. He asked about teen suicide after this plan is enacted.

Ms. Wagner stated that teen suicide would go up since current supports would most likely have gone away.

Commissioner Carnevale stated his assumption that the proposal would solve homelessness but would drive teen suicide up. He asked the rhetorical question: How have we gotten to the point where California is making these decisions?

Commissioner Chambers thanked Jolie Onodera for her presentation, which addressed a piece that has been missing in the conversation. She asked for additional detail on Los Angeles County in particular.

Jolie Onodera stated that the proposed shift – particularly because Los Angeles County is unique in that it has Measure H, which provides additional funding for housing and homelessness services – with the rigidity of the 30 percent, which currently is being used for other services, would result in a 71 percent reduction in their outpatient and crisis services in order to meet the 30 percent through the use of the MHSA since they are currently able to use those other dollars for some of those services.

Commissioner Chambers stated that the lack of crisis services will result in worse outcomes and even death.

Jolie Onodera agreed that in the absence of services it would be difficult. She stated the need for additional flexibilities across the state to allow for the differences in the counties to ensure continued provision of necessary services

Commissioner Chambers asked for clarification that peer services and wellness centers will also be impacted.

Jolie Onodera stated that outpatient impacts include peer services and wellness centers.

Commissioner Chambers thanked the LAO for their thorough unbiased analysis. She asked for clarification that services will be lost in the implementation of the proposal.

Will Owens stated that there is a reprioritization of specifically current MHSA expenditures towards FSPs and housing. He stated that he hesitates to list the exact services that may be lost, especially on a county-by-county basis. Counties will have to make those decisions but, based on the numbers, it would be expected that services that are currently funded that would fit in that Behavioral Health Services and Supports category would by necessity need to be redirected towards FSPs and housing. What that means county-by-county in terms of the specific types of services is that there definitely would be a refocusing.

Commissioner Chambers asked if the proposal shifts how behavioral health is addressed so it will only focus on housing, substance use, and FSPs.

Will Owens stated that the LAO does not have access to the data to allow a highly-detailed review of the individuals being served. As it is currently funded by the MHSA, there would need to be a shift to include more MHSA funding for housing, which could include a fairly robust array of housing interventions and FSPs. When looking at the services currently being provided under that Behavioral Health Services and Supports bucket, they are primarily outpatient services, wellness centers, and crisis intervention. Almost the entirety of the prevention and early intervention bucket would go towards that Behavioral Health Services and Supports component, which is the component that is overprescribed as proposed. The proposal will redirect the focus.

Jacey Cooper reminded everyone, although some of the priorities are being shifted, that, under Realignment and Medicaid federal rules, counties are obligated to continue to provide the whole continuum of services to individuals who are enrolled in Medi-Cal. This includes all services that are Specialty Mental Health and substance use disorder services. MHSA funds are currently being used as the non-federal share for those services in order to draw down federal funds.

Jacey Cooper stated that there are other federal and state requirements for county partners to continue to provide the obligation of all Specialty Mental Health and substance use disorder services to individuals, based on the benefit that they have elected within the county. This is a federal entitlement and is a requirement in both state statute and federal law.

Commissioner Chambers stated that many individuals do not have Medi-Cal, particularly individuals in wellness centers, drop-in centers, and crisis intervention.

Stephanie Welch stated that the CalHHS has worked hard to make the community planning process more robust, transparent, and inclusive. She stated that she would like to have a better understanding of why there is a concern that changes to that process as proposed are not positive or have some drawbacks. It is important for the public to understand that it is the Administration's and Legislature's intent to make that process more robust.

Stephanie Welch stated that the community planning process is essential because of some of the changes being made. The community planning process will make decisions about some of the conversations being had. She asked for feedback on ways in which that can be strengthened and about the concerns over what the CalHHS did to give the impression that it would not have an effective community planning process.

Commissioner Rowlett underscored the points made by Chris Stoner-Mertz, Dr. Eisen, and Dr. Harvey as related to housing and the availability of housing as it reduces much of the distress. He stated that, although California does have a housing crisis and he endorses what the Administration is trying to do to resolve this crisis, he has yet to enthusiastically endorse this proposal and what it aims to do with housing and the potentially harmful effects on other services as resources are being redirected to housing. He stated that he agrees that individuals do better when housed; however, resources are being redirected that does inevitably, especially given the LAO's analysis, have a harmful effect on services funded out of the community services and supports bucket.

Commissioner Bontrager stated his understanding that one-third of the MHSA funding this year would be approximately $1 billion statewide. He asked, since the proposal is about dedicating $1 billion annually for housing, if there is a way to increase the bond to accomplish those purposes without in perpetuity dedicating this funding for housing. Housing may not be an issue forever. He asked if there is another way to accomplish and achieve the goals of the proposal without forever binding the hands of how funding is allocated through the MHSA.

Ryan Miller stated that technically there is no reason why the bond authority could not be increased. It is something that could be considered. He stated that the LAO would provide the perspective that it is reasonable to fund infrastructure such as behavioral health facilities for a 20- to 30-year period with a bond because it will be in service for a long time and it is reasonable to expect current and future taxpayers to pay for them. Something that would be different with services is that it may make more sense for the services to be funded on an annual basis like through the MHSA as it would be proposed with this 30 percent bucket. Technically speaking, the bond authority could be higher if that was something that the Governor and the Legislature wanted to do.

Commissioner Tamplen stated that she was struck by Commissioner Carnevale's point and question and Ms. Wagner's response and agreed that there are concerns with this proposal. She responded to Stephanie Welch's request for feedback on why there are concerns about the community process. She stated that, when things go fast like this proposal is doing now and like it happened with the CARE Court program, there is a trust that is then broken. The community hears Stephanie Welch saying that CalHHS is

working to have a more robust community planning process and yet the community is experiencing a rushing through of what is very important.

Commissioner Tamplen stated that the concern is that this proposal will impact communities, not to say that the changes around more behavioral health, meeting needs, and addressing homeless issues are not something that the Commission talks about, and that pulling funds from the federal government is not something that counties, providers, and others are not already trying to do. More capacity support around that is needed, but this proposal is being rushed.

Commissioner Tamplen stated that the emphasis is to develop a more robust community planning process. She stated that what the community is saying is that putting this proposal on the March ballot is too soon. She stated the hope that that can be rectified to allow for more conversation on these important issues. She stated that more resources are needed for the MHSA and the individuals being served. Reducing the services that everyone needs so desperately is not the answer.

Stephanie Welch stated that she understands that this process has not been working for individuals to provide adequate input. She stated that that is a helpful clarification versus what is proposed in the statutory changes at the local level. She stated that CalHHS is open to hearing feedback on if they did not do a good job or if there are improvements that need to be made to make this a better process.

Chair Madrigal-Weiss stated that it is some of both. There is more to do and more to discuss. It is important to spend more time on discovery since many things are unknown. She suggested at minimum allowing for the Legislature to make changes without going to ballot. She stated that there is so much happening, and happening quickly only a year and a half post-pandemic. The mental health needs of students are manifesting in unpredictable ways.

Chair Madrigal-Weiss stated appreciation for Commissioner Carnevale's comments about the missing middle piece. It is essential to allow time for these important issues to be discussed.

Public Comment.

Hector Ramirez stated that it is important to reform the MHSA, the Commission, or both. The speaker stated that it was seen during the pandemic that if something needs to be reformed, the Los Angeles County Department of Mental Health is significantly broken, particularly the MHSA. The county's previous executive director disengaged the Latino, Hispanic, disability, Native American, and LGBTQ communities, particularly the transgender community. The county has had no opportunity to highlight that these were some of the populations that were originally supposed to be served by the MHSA and it still has not happened.

Hector Ramirez stated that the lack of accountability and oversight of this Commission has been appropriate but, when using a cost benefit analysis of the amount of funding that will be lost if this proposal does not pass, the Commission must think about the amount of funding that will be lost if it does not act now.

Hector Ramirez stated that most of the population is struggling to get mental health services in Los Angeles County. Most peers are either homeless or in jail due to the

inability to access and leverage what the MHSA was supposed to do. Lack of oversight and accountability in Los Angeles County and the director at that time made it impossible for community members to advocate at the county level and they had an inability to advocate at the state level at this Commission because of issues with advocacy and accessibility.

Michelle Cabrera, Executive Director, County Behavioral Health Directors Association (CBHDA), thanked the Commission for the robust conversation today and stated that the CBHDA aligns with the comments of CSAC. She stated appreciation for the LAO's proposal as the CBHDA has been working to understand the potential impacts. The CBHDA finds a drop in funding for the core outpatient, crisis, and recovery services due to the shifts in funding. Because most of those services are reimbursable under Medi-Cal, there is a significant loss of federal financial participation. For every dollar lost there is equivalent to two dollars.

Michelle Cabrera stated that, as the LAO pointed out, counties do not have anywhere else to go. They are required to fund Medi-Cal and service Medi-Cal beneficiaries as part of their entitlement responsibility, but the MHSA accounts for one-third to provide those Medi-Cal services and approximately one half can be leveraged as a source of non-federal share in Medi-Cal today.

Michelle Cabrera stated that the CBHDA urged the Commission to consider how this will have devastating impacts on individuals' wellbeing and stability, particularly with the outpatient, crisis, and recovery services. The CBHDA appreciates the opportunity to discuss volatility in the MHSA, which is not proposed to be addressed through this proposal but is a real fundamental issue to be grappled with.

Michelle Cabrera stated that there are significant restrictions, in particular, the definition of chronically homeless. She suggested moving away from that federal definition.

Diego Bravo, Resource Development and Policy Manager, Safe Passages, a member of the California Reducing Disparities Project (CRDP), discussed the funding allocation guidelines in the modernization plan. He stated that many community members have big concerns on the modernization proposal as it stands and shared some major limitations in the language.

Diego Bravo stated that Safe Passages and over 60 organizations throughout the state believe it is imperative to preserve the current requirements for local funding of the prevention and early intervention and innovation components of the MHSA. The proposed 5 percent cap on population-based prevention programs is inadequate and will lead to a deficit of population-based prevention work throughout the state. These programs have been proven to be effective, efficient, and cost-effective.

Diego Bravo stated that, when prevention and early intervention is broken up, instead of creating a cohesive system of upstream behavioral health services, they will dramatically reduce funding for services that are designed to be implemented in historically underserved communities. This could lead to broad effects in behavioral health, creating even more racial disparities in mental and behavioral health. He emphasized the importance of these services.

Vera Calloway, California State Certified Peer Specialist, and Chair of the Steering Committee for the California Association of Peer Professionals, shared the experience of having a panic and anxiety attack last weekend, for the first time in 20 years, that she thought would lead to hospitalization. She agreed that the MHSA needs an overhaul but asked why the time is not being allowed to create a truly revolutionary system of care that other states will want to emulate. Haste makes waste. She suggested moving together in a direction that will lead to strength rather than potentially harming individuals with missteps.

Esaia Gonzalez, Veteran Liaison, Life on Earth Art, a community partner with VETART, suggested that space be saved for cannabis patients and that health care providers continue to be educated on the endocannabinoid system.

Stacie Hiramoto thanked the Commission for the time spent on this most important issue. She stated that the wish for a panelist who could speak from the perspective primarily of Black and indigenous people of color (BIPOC) and/or LGBTQ communities because they will bear the brunt of this large policy change. Underserved communities suffered most during the COVID-19 pandemic in terms of experiencing the ravages of the disease, the economic and other impacts, and the recovery and not recovering as quickly. They suffer most because of climate change and every other societal problem. However, just as these populations were not given a seat to provide perspectives and solutions, these populations will suffer most when these large policy changes are implemented.

Stacie Hiramoto thanked Andrea Wagner for bringing up the large concerns that overlap the consumer community and underserved racial, ethnic, and LGBTQ communities, especially regarding prevention and early intervention, the emphasis on a Medi-Cal match, and the community planning process.

Stacie Hiramoto spoke in support of Diego Bravo's comments in terms of prevention, early intervention, and innovations. She stated that this is REMHDCO's most serious concern because it must depend on others to lift concerns that are also important. She also stated concern that the language of the bill does not provide the support for CDEPs.

Steve McNally, family member and Member, Orange County Behavioral Health Advisory Board, speaking as an individual, agreed that there are problems all around but stated that what has not been clearly identified is, if the mental health system is working so well, how $700 million can be taken out of it to help another system that is even more underfunded than mental health. The speaker suggested determining the total amount needed to fix each of the problems and then beginning to prioritize Commissioner Carnevale's comments, as well as presenting the proposal to the people. Once it gets on a proposition, it will fix today's problem without flexibility for tomorrow's problem.

Steve McNally suggested inviting legislators and the panel to present the case at The California Endowment, Sacramento, Oakland, and Los Angeles, because this seems to be headline chasing. As a family member, the speaker has learned that trust and relationships help recovery but California does not have trust at any level. The speaker suggested empowering Californians to help solve this problem and asked Stephanie

Welch to view the public comments because getting out of Sacramento provides a different view of what is going on in California.

Elizabeth Oseguera, Assistant Director of Policy, California Primary Care Association (CPCA), stated that the CPCA appreciates and supports the Administration's goal to expand housing but asks that this not be done to the detriment of prevention, early intervention, and innovation services, which community-based organizations including health centers act in partnership with counties.

Elizabeth Oseguera asked that the process be slowed down to allow for true community input to help bake the idea in partnership with the Administration. This would allow for more time to think creatively about how to fund both services in the MHSA today and have those remain and housing initiatives that the Administration is hoping to move forward. The speaker urged working to change the "or" in the current proposal to an "and" so both can be funded.

Jerry Hall spoke in support of transparency and accessible data in relation to the MHSA evaluation planning and budgeting processes. It has been difficult to find gap analyses or kinds of data that may be critical to the existing work being done. He stated concern that individuals are more interested in careers and political futures than the criticism. The criticism is valuable. This data would provide insight on the challenges and potentially inform rich solutions.

Jerry Hall stated that it is also difficult for the community to provide feedback throughout the year when it is unable to query, review, or test the data. He asked that a wide range of data be made available to allow the community to query the data and make reports or visualizations that can be used to support hypotheses. He stated the need to be mindful about detailing specific outcomes in annual plans, contracts, and reports to demonstrate success and help the community make better-informed contributions.

Tiffany Elliott, Painted Brain, speaking as an individual, stated that, in the early 2000s, there was not a lot of service for individuals who needed regular, ongoing mental health services and therapy was limited to five visits. There were no peer-run services, the emphasis was on what was wrong, and there were many clinical closures approaching 2008. There was no room for descent if medications were not working. The theory was that negative medication outcomes were because the individuals were not taking the medications long enough.

Tiffany Elliott stated that today there is an emphasis on choice, widely-available therapeutic options, peer-run services, what is strong, and choice when it comes to medication. This has been very beneficial. The Governor's proposed changes to the MHSA could move individuals, who are now stable and receiving services that allow them to remain stable, toward crisis, homelessness, loss of employment, and full psychiatric disability.

Tiffany Elliott stated that the proposal provides fewer opportunities for community services and supports, innovations, and prevention and early intervention-funded services for low-income individuals. She encouraged a deep look at how these services will change and what those changes will mean for individuals who may not be in crisis or on the streets now, but who will end up there if too much is changed too quickly.

Richard Gallo, consumer and advocate and Volunteer State Ambassador, ACCESS California, a program of Cal Voices, stated concern with these fast-paced changes. Much of this has been created to support three programs: CARE Court, CalAIM, and the MHSA Modernization act. It dismantles the spirit of the MHSA and taps the MHSA funding to use on other priorities. The speaker stated that the proposal does not mention the plans for the California Medi-Cal Peer-Support Certification, which of the three programs supported by the proposal it will be part of, or where it is in the process. The speaker stated that the California Mental Health Services Authority (CalMHSA) has invested in 5,000 peer workers throughout California to be part of the workforce movement.

Richard Gallo stated that the FSPs need to be 100 percent persons with lived experience since this is what the funding is for. The Commission has failed to transform the mental health system, especially with the severely mentally ill unhoused community, in not creating peer programs and services throughout California. The speaker stated the need to educate the community to vote down this bond measure and for the Commission to fund advocacy projects because the Governor's proposal will fail.

Stephanie Ramos, California Association of Peer Professionals (CAPP) and Cal Voices, on behalf of the CAPP, emphasized the importance of peers. When the MHSA began, there was an influx of individuals with lived experience working in the system. With this new legislation, there is a huge potential for that to change. There are current big investments in community health workers and wellness coaches where they are having their certification go through state departments rather than a JPA.

Stephanie Ramos stated that there is preference for non-peer workers in a lot of ways throughout the system. With CalAIM implementation, peers are starting to begin given billing quotas where they might have disciplinary action if those quotas are not met – and if they are, they get some extra PTO. She stated that the impacts of these policy changes are already beginning to be seen when not really incorporating a lived experience into those.

Stephanie Ramos also reminded everyone that, oftentimes, housing developments go up, a ton of money goes out to those developers, and counties do not own that housing. There is a limited contract period in which that housing must be provided to community members, thinking of long-term investments and how this will play out in the long run once those contracts are no longer in place and where to put individuals who will continue to need housing.

Stephanie Ramos's sibling receives services through an FSP and those services have been instrumental in keeping them well over the years, but the speaker reminded everyone that, as FSPs and clinical services begin to see increases, the focus is going back the medical model and medication. Medications do not work for everyone. They do not suddenly bring someone back to what could be called normal where they can meet the desired outcomes. People need more than that medical model service.

Clare Cortright, peer and attorney, pointed out that the Administration has not defined housing intervention in SB 326. The LAO estimated that $800 million per year must be spent on housing interventions, but half of that only on the chronically unhoused with a focus on encampments. Under SB 326, counties may no longer spend a housing dollar

on someone unless they meet with federal definitions of chronically homeless, currently homeless, or at risk of homelessness. The MHSA currently allows the housing dollar to be spent on anyone in the target population. The Governor's proposal narrows the population that can have housing money spent on them. The speaker stated that concerns have been raised today about losing services but the speaker stated concern that someone who is not in that federal definition will be left out and can lose housing.

Clare Cortright stated that the Administration has emphasized voluntary unlocked beds, but the speaker stated concern that that is language from AB 531. None of that language is in the housing intervention section of SB 326. SB 326 housing intervention sections are unrelated to the bond; they are two different things.

Clare Cortright stated that the June PowerPoint presentation from the Administration gave an example of a use of housing intervention funds, which was for a person "placed" in a residential treatment facility where there was no Medi-Cal funding to pay for the stay and the person only had social security supplemental income that could not pay for the stay. The June presenter stated that the housing intervention money could be used as a patch to pay for that stay. Included in housing intervention is clinical treatment but that is not housing.

Katy Sommerfeld, consumer and advocate, CAMHPRO, speaking as an individual, stated that there is a fear that this modernization proposal will fund CARE Court and that the new jobs that will be created are to support that. Many of those providers who will be needed are against the whole system to begin with. This will be a detriment to the workforce, especially the peer workforce. Inevitably, services will be taken away from prevention and early intervention and other outpatient services such as wellness centers, crisis, etc. and individuals who utilize those services to maintain their wellness will be at risk of suffering deeper in their mental health as Tiffany Elliott highlighted, above.

Katy Sommerfeld asked when it will be demonstrated how peers will bill for services under Medi-Cal if it moves in this direction, especially if they are not state-certified. It seems that non-certified peer jobs will be even more negatively impacted with this proposal and peers are only one of the professions that will be impacted. The speaker suggested looking at how this will impact peers with decades of experience in the other racial and ethnic demographics that are not represented with certification.

Katy Sommerfeld stated that the future of care support feels uncertain and grim with this proposal.

Melissa Hannah, Executive Director, United Parents, thanked Chris Stoner-Mertz, Dr. Harvey, and Andrea Wagner who spoke on behalf of and lifted the voice of children, youth, families, and peers. Because of the partnership with and continued prevention and early intervention funding from the county and the Commission, United Parents has been able to provide beneficial peer, parent, partner, and support services in the community. United Parents has recently been pushed to start billing Medi-Cal. There have been many issues. The Medi-Cal system feels like the fail-first system for community-based organizations.

Laurel Benhamida, Ph.D., Muslim American Society – Social Services Foundation and REMHDCO Steering Committee, spoke about the financial realities of prevention and early intervention for reducing mental health disparities. She stated that there are not enough clinicians in California to meet present and future needs for early intervention clinical services for non-English-speaking individuals in their native languages. There are not enough tested, competent language interpreters in California to meet present and future needs for early intervention.

Laurel Benhamida reviewed the costs of tested, competent, ethical interpreters and noted that the clinician and interpreter are almost always paid for two hours. A monolingual English-speaking clinician can serve half as many non-English speaking people as English-speaking people but there is another approach to mental health care. She stated that the peer specialist has a wisdom gained from one to lifelong years of lived experience and skill in providing this approach.

Susan Gallagher, Executive Director, Cal Voices, stated that trust is lost when presenters do not stay to hear public comment. The speaker stated concern that the CalHHS has not engaged the public directly except through Commissions or other agencies. They also only respond to Commission questions, not questions asked by community members. This all adds to the lack of trust. This needs to be recognized by the Administration because it is a form of arrogance.

Susan Gallagher stated that much has been said about the reductions in community supports and services from $1.3 billion to $620 million. Then, this same reduced pot of money will be used to serve an entirely new population of stand-alone substance abuse with mandated Medication Assisted Treatment (MAT) services – not recovery-oriented or wrap groups, but medical-model services. Although medications can save lives, it is not what the MHSA should be funding. Perhaps the opioid settlement money should be funding that. The speaker asked what Realignment is going to be funding in the future if the MHSA has backed nearly all Realignment.

Susan Gallagher stated that Cal Voices would like to see peer support in CalAIM and is concerned that peer support language in not included there.

Rachel Shearer, consumer and advocate, stated concern that this financial restructuring will potentially fund CARE Court, which has involuntary interventions for substance use disorder. Funding CARE Court with the same pot of money takes services from elsewhere, as have been outlined today. Forced interventions are not research-based or a best practice. The speaker urged that more individuals with lived experience be brought to the table when discussing these policies that are meant to help them.

Rachel Shearer stated that they are in full support of individuals with substance use disorder getting as much help and support as they need and increasing funding for those services, but anything that involves involuntary or forced interventions is like throwing money into the void. It also introduces populations of individuals with substance use disorder who are not interested in cessation into programs where there are individuals who are interested in recovery. The speaker stated that there are often long waiting lists to get into some of these services. Individuals are being prioritized because of forced interventions that could then lead individuals who are there voluntarily for services out of getting services.

Danny Thirakul, Public Policy Coordinator, California Youth Empowerment Network (CAYEN), echoed the sentiments and comments of fellow peers regarding the preservation of prevention and intervention, especially as it relates to the LGBTQ youth in the community. There is currently a huge anti-LGBTQ movement in schools. He stated that school districts are considering and have already adopted policies that would help students. The services provided through prevention and early intervention to local communities or community-based organizations will be vital for those youth.

Danny Thirakul stated that the proposal includes adding family members with children with mental health challenges or substance use disorder as members of the Commission. He stated that CAYEN highly recommends increasing the peer voice, by requesting the addition of two transition age youth (TAY) representatives on the Commission to give a fuller perspective of the family environment regarding these issues.

Danny Thirakul stated that this proposal will create drastic changes in the system. He stated the need for continued discussion to address concerns. The push to put this proposal on the March ballot cripples this process. He stated that CAYEN recommends moving this proposal to the November ballot. This would provide additional time to discuss this proposal and engage a larger voter base, specifically the youth population.

Corey Hashida, Senior Advocate, Steinberg Institute, stated that the Steinberg Institute supports this transformational proposal that the Governor and the Administration have put out. He stated that the package of proposed changes to not just the MHSA but across the behavioral health system – especially in terms of measuring outcomes and bringing more spending transparency into the system – together bring the MHSA and the system into alignment of the original vision of the MHSA, building off pioneering pieces of legislation, such as AB 34 and AB 2034, authored by Darrell Steinberg, founder of the Steinberg Institute, which led to comprehensive and wraparound care for the most vulnerable populations.

Dana Paycao, Senior Policy Associate, National Center for Youth Law (NCYL), stated that the NCYL shares the Administration's goals to address homelessness; however, it also shares and uplifts the concerns expressed by others today that the proposal will divert funds from prevention and early intervention. This will be harmful for youth who currently rely on MHSA-funded programs and services. She noted that the NCYL appreciates that the FSPs now include a set-aside for upstream prevention and language that directs counties to prioritize early intervention services for youth; however, this alone is insufficient and does not meet the current funding levels for children.

Dana Paycao stated that the NCYL respectfully requests that considerations be made to maintain current funding levels for prevention and early intervention programs for children and youth, along with ensuring that a portion of those served in FSPs and housing interventions include youth and families. Investing in the health of children is critical to ensuring that they become thriving adults.

Nora Lynn, Associate Director of Health, Children Now, stated that Children Now respectfully opposes SB 326, unless amended. Children Now is thankful for the investments being made by the Legislature and Administrations in children's mental

health and is especially thankful to the Commission for work it has done to support children and youth over the years. She stated that Children Now is deeply concerned about the impact of SB 326 on children and youth.

Nora Lynn stated that the MHSA has worked to fill in critical funding gaps where the state has under-invested and is a critical resource to the continuum of mental health support for children and youth. While Children Now agrees that the MHSA should be updated, it is troubled by the state's short-sighted strategy in rerouting key investments away from children. Children Now recommends that the Legislature set aside funds for children and youth in every category of MHSA funding and hopes the Commission will take a similar stance.

Commissioner Discussion

Chair Madrigal Weiss asked the members of the panel to stay in contact with Commission staff to continue to communicate and work together to information the Administration on these important issues.

7: Lunch

Commissioners took a 30-minute lunch break.

8: Community Engagement Framework

Chair Madrigal-Weiss stated that the Commission will hear a presentation on best practices for community engagement to support Commission projects and elevate the voices of marginalized communities. She introduced the speaker and asked him to give his presentation.

Sergio Aguilar-Gaxiola, M.D., Ph.D., Director, UC Davis Center for Reducing Health Disparities, provided an overview, with a slide presentation, of the definition, best practices, the Interdisciplinary Collaboration and Cultural Transformation Model (ICCTM) community engagement, partners, outcomes, and lessons learned.

Sergio Aguilar-Gaxiola stated that community engagement is a critical ingredient to improve the health and mental health of all communities through reducing health disparities. He reviewed the best practices that came out of the ICCTM, a five-year multi-phase MHSA innovation project, which was the first project that combined the National Culturally and Linguistically Appropriate Services (CLAS) Standards and community engagement.

Sergio Aguilar-Gaxiola provided the following recommendations:

- Put community engagement in "the water" of what the MHSOAC does in collaboration with its partners. It will necessitate an organizational cultural change (e.g., include community engagement in the MHSOAC Strategic Planning Process, be guided by community engagement best practices, etc.).
- Take the lead and become a model agency on community engagement and advocate that every state agency should have an established community engagement plan as part of their strategic plan (i.e., lead a paradigmatic shift to incorporate the "Seeking Mode" and go where people are).

- Sponsor legislation to fortify community engagement across all state agencies.
- Advocate for the state to fund community engagement at a level on par with the disparities that need to be addressed.
- Advocate for the inclusion of meaningful community engagement in the Modernization Act.
- Provide training on community engagement best practices to various stakeholders and how to successfully do community engagement with accountability (i.e., outcomes and impact).
- Continue to support the statewide Learning Collaborative training counties.

Sergio Aguilar-Gaxiola stated that a paradigm shift needs to happen from the "waiting mode," waiting for those in need to come to services where they are treated for conditions when symptoms are set, complications ensue, and normal function is lost, to the "seeking mode," where providers go to them and intervene before symptoms appear or when they start, and preserve normal function for as long as possible.

Commissioner Comments & Questions

Commissioner Tamplen asked about incentives and recognizing community wisdom and their contributions to the process.

Sergio Aguilar-Gaxiola stated the need for constancy in order to develop trustworthiness. Building trust is key. He discussed providing incentives such as free vaccines, gift cards, and others.

Commissioner Rowlett referred to the lessons learned: be sincere, simple, and straight-forward, and shut up and listen, and stated that individuals experiencing homelessness often say that there is a lack of sincerity in service providers. The lessons learned are the key to success. He thanked Sergio Aguilar-Gaxiola for endorsing the importance of having a diverse workforce to do this work.

Public Comment.

Jerry Hall stated concern that the community planning process is a legislative-funded mechanism in every county. One of its requirements is that advisory boards approve community planning processes in annual plans. One of the biggest problems is that there is no enforcement mechanism so the community engagement process is not documented and is not itemized in the budget so the public does not know how much money is being spent on the process. The speaker suggested having functioning community engagement processes where advisory boards are meaningfully engaged and trained, not just 15 minutes before a forum but throughout the year, in order to grow subject matter experts who can provide advisory boards better feedback so that better feedback can then be given to the supervisors.

Richard Gallo agreed with the previous speaker about the community planning process at the county level not being done the way it should be. There are behavioral health directors who do not have buy-in with the community planning process. They think it should be done the old way before the MHSA was created. They do not want consumer

and family member feedback. This is part of the reason that counties are not making a transformative change to improve the mental health system along with the MHSOAC.

Susan Gallagher stated that the MHSA put community at the forefront of everything done in the behavioral health system. It is important that that continue even though it has not been perfected. The modernization of the MHSA must utilize a shared community process and a shared decision-making process. The statute must include specific language in order to build trust in the community about what they are being told to accept in this proposal. The speaker stated appreciation for the Commission for its commitment to this issue.

Commissioner Discussion

Chair Madrigal-Weiss referred to the Recommendations slide and noted that the Commission is already working on some of them. She asked staff to further explore Dr. Aguilar-Gaxiola's recommendations and report back with ideas to help the Commission be more intentional about pursuing some of those recommendations.

Commissioner Tamplen agreed.

Commissioner Carnevale stated that it would be interesting from a data viewpoint to see if there is any data about the return on investment (ROI) of programs in the community versus out of the community and if there is any data work the Commission can do to support this as a subsegment of prevention and early intervention.

9: Universal Mental Health Screening Initiative

Chair Madrigal-Weiss tabled this Agenda Item to the next Commission meeting.

10: Commission 2023-24 Spending Plan

Chair Madrigal-Weiss tabled this Agenda Item to the next Commission meeting.

11: Adjournment

Chair Madrigal-Weiss stated that the next Commission meeting will take place on August 24th. There being no further business, the meeting was adjourned at 3:14 p.m.

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motions Summary
Commission Meeting
July 27, 2023

Motion #: 1

Date: July 27, 2023

Proposed Motion:

The Commission approves the May 25, 2023 Meeting Minutes, as modified.

Commissioner making motion: Commissioner Brown

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	Not Voting
1. Commissioner Bontrager	☒	☐	☐	☐	☐
2. Commissioner Brown	☒	☐	☐	☐	☐
3. Commissioner Bunch	☐	☐	☐	☒	☐
4. Commissioner Carnevale	☒	☐	☐	☐	☐
5. Commissioner Carrillo	☐	☐	☐	☒	☐
6. Commissioner Chambers	☒	☐	☐	☐	☐
7. Commissioner Chen	☐	☐	☐	☐	☒
8. Commissioner Cortese	☐	☐	☐	☒	☐
9. Commissioner Danovitch	☒	☐	☐	☐	☐
10. Commissioner Gordon	☒	☐	☐	☐	☐
11. Commissioner Mitchell	☐	☐	☐	☒	☐
12. Commissioner Robinson	☒	☐	☐	☐	☐
13. Commissioner Rowlett	☒	☐	☐	☐	☐
14. Commissioner Tamplen	☒	☐	☐	☐	☐
15. Vice-Chair Alvarez	☒	☐	☐	☐	☐
16. Chair Madrigal-Weiss	☒	☐	☐	☐	☐

Motions Summary
Commission Meeting
July 27, 2023

Motion #: 2

Date: July 27, 2023

Proposed Motion:

The Commission approves the June 15, 2023 Meeting Minutes, as modified.

Commissioner making motion: Commissioner Robinson

Commissioner seconding motion: Commissioner Carnevale

Motion carried 9 yes, 0 no, and 2 abstain, per roll call vote as follows:

Name	Yes	No	Abstain	Absent	Not Voting
1. Commissioner Bontrager	☒	☐	☐	☐	☐
2. Commissioner Brown	☒	☐	☐	☐	☐
3. Commissioner Bunch	☐	☐	☐	☒	☐
4. Commissioner Carnevale	☒	☐	☐	☐	☐
5. Commissioner Carrillo	☐	☐	☐	☒	☐
6. Commissioner Chambers	☒	☐	☐	☐	☐
7. Commissioner Chen	☐	☐	☐	☐	☒
8. Commissioner Cortese	☐	☐	☐	☒	☐
9. Commissioner Danovitch	☒	☐	☐	☐	☐
10. Commissioner Gordon	☐	☐	☒	☐	☐
11. Commissioner Mitchell	☐	☐	☐	☒	☐
12. Commissioner Robinson	☒	☐	☐	☐	☐
13. Commissioner Rowlett	☒	☐	☐	☐	☐
14. Commissioner Tamplen	☒	☐	☐	☐	☐
15. Vice-Chair Alvarez	☐	☐	☒	☐	☐
16. Chair Madrigal-Weiss	☒	☐	☐	☐	☐

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motions Summary
Commission Meeting
July 27, 2023

Motion #: 3

Date: July 27, 2023

Proposed Motion:

That the Commission approves funding for Santa Clara's TGE Center Innovation Project for up to $11,938,639.

Commissioner making motion: Commissioner Gordon

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 Voting
1. Commissioner Bontrager	☒	☐	☐	☐	☐
2. Commissioner Brown	☒	☐	☐	☐	☐
3. Commissioner Bunch	☐	☐	☐	☒	☐
4. Commissioner Carnevale	☐	☐	☐	☐	☒
5. Commissioner Carrillo	☐	☐	☐	☒	☐
6. Commissioner Chambers	☒	☐	☐	☐	☐
7. Commissioner Chen	☐	☐	☐	☐	☒
8. Commissioner Cortese	☐	☐	☐	☒	☐
9. Commissioner Danovitch	☒	☐	☐	☐	☐
10. Commissioner Gordon	☒	☐	☐	☐	☐
11. Commissioner Mitchell	☐	☐	☐	☒	☐
12. Commissioner Robinson	☒	☐	☐	☐	☐
13. Commissioner Rowlett	☒	☐	☐	☐	☐
14. Commissioner Tamplen	☒	☐	☐	☐	☐
15. Vice-Chair Alvarez	☒	☐	☐	☐	☐
16. Chair Madrigal-Weiss	☒	☐	☐	☐	☐

AGENDA ITEM 5

Information

August 24th, 2023 Commission Meeting
Data and Transformational Change

Summary: The Mental Health Services Oversight and Accountability Commission will hear informational presentations from a panel of experts on the importance of data for decision making, program and policy improvement, and public trust. The panel will discuss opportunities for improved data collection, sharing, and collaboration across the mental health system.

Background: Data was identified as one of four key priorities for the Commission during the January 2023 strategic plan report out. The Commission's Research and Evaluation team manages a portfolio of projects that help to inform and shape mental health policy and priorities. These include: legislatively mandated reports on Full Service Partnerships, Triage, and the Mental Health Student Services Act; policy projects, including suicide prevention, prevention and early intervention, and the impact of firearm violence project; and transparency tools such as the Fiscal Transparency Suite, which is available on the Commission's website. Additionally, the Commission maintains a data center of linked administrative datasets that is used to analyze outcomes of clients who receive mental health services, including educational, criminal justice, and hospitalization outcomes. These projects and policy research initiatives are useful for identifying best practices and lessons learned, as well as creating recommendations for improved statewide coordination around key areas within mental health. However, California does not have a framework or core set of metrics for behavioral health to hold the system accountable. Without this framework, it is difficult to make decisions about where to invest resources to improve the system so that individuals, families, and communities can flourish.

A panel of presenters will share their perspectives on data as a tool for transformational change. The presentations and panel discussion will help Commissioners consider what actions can be taken by the Commission to elevate and support data collection, sharing, analysis, and collaboration across the mental health system.

Enclosure (6): (1)Presenter Bios; (2) Briefing Memo; (3)Behavioral Health Quality Framework: A Roadmap for Using Measurement to Promote Joint Accountability and Whole-Person Care (NCQA); (4) Mental Health in California: Waiting for Care (California Health Care Foundation's Health Care Almanac); (5)Transforming Mental Health Care in the United States (RAND Corporation); (6) Invitation Letters

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

Proposed Motion: None

Data Presentation
Biographies

Sameer Chowdhary, specializes in healthcare and business technology. He is also well versed with payer and provider organizations and has advised them on analytics and operations-related topics, while helping them boost their bottom line by introducing and optimizing processes related to claims processing, enrollment and billing, medical management, payment accuracy, and claims recovery. Sameer leads McKinsey's work in payer operations and is a core leader in McKinsey's transformation center of excellence in North America. Sameer's expertise lies in helping health insurance organizations achieve operational excellence and optimize their cost baselines.

Emily Putnam-Horstein, PhD, MSW, is the John A. Tate Distinguished Professor for Children in Need and the Faculty Co-Director of the Children's Data Network. She also maintains an appointment as a research specialist with the California Child Welfare Indicators Project at UC Berkeley. Emily's current research focuses on the application of epidemiological methods to improve the prevention of non-fatal and fatal child abuse and neglect. Her analysis of large-scale, linked administrative data has provided insight into where scarce resources may be most effectively targeted and informs understanding of maltreated children within a broader, population-based context. Her research has been used to develop risk stratification tools, including those implemented in Allegheny County, Pennsylvania, and Los Angeles County, California. These tools support caseworkers and supervisors in reviewing hundreds of factors relevant to a child's risk and safety when making initial screening and triaging decisions. Emily is the recipient of the Forsythe Award for Child Welfare Leadership from the National Association of Public Child Welfare Administrators and the Commissioner's Award from the Children's Bureau. Emily graduated from Yale University with a BA in Psychology, received her MSW from Columbia University, and earned her Ph.D. in Social Welfare from the University of California at Berkeley.

Daniel Webster, PhD, is a Senior Project Scientist in the School of Social Welfare at U.C. Berkeley. Dr. Webster serves as Principal Investigator of the California Child Welfare Indicators Project which carries out quarterly production, dissemination, and technical assistance on performance measures in support of the state's Outcomes and Accountability System. He has provided consultation to child welfare agencies in jurisdictions across the country on understanding and applying longitudinal data to promote continuous quality improvement, and has co-instructed courses with colleagues from Chapin Hall at the University of Chicago on advanced analytics for child welfare administrators. Dr. Webster is an HHS appointee of the California Child Welfare Council for which he co-chairs the Data Linkages and Information Sharing Committee, and he is also a member of statewide committees such as SACWIS Oversight and the County Welfare Directors Association Operations and Children's committees. He graduated with honors from the University of Texas at Austin, holds a master's degree in developmental psychology from the University of Chicago, and received his M.S.W. and doctorate with distinction from the School of Social Welfare at U.C. Berkeley.

Serene Olin, PhD, is a Principal at Health Management Associates. Dr. Olin is a clinical psychologist with over 20 years of translational research and leadership experience at the federal, state and local levels. She applies research evidence and evaluation results to drive change strategies, programming, and policy. She is a subject matter expert in behavioral health and health equity, implementation science, and the use of quality performance metrics to drive equitable healthcare access and outcomes. Dr. Olin has expertise in developing frameworks and roadmaps for improving service delivery, including testing practical methods, strategies, and tools to improve the integration of evidence-based care. Prior to joining HMA she served as Assistant Vice President of Research and Analysis at the National Committee for Quality Assurance (NCQA), a leading national quality measurement and accreditation organization. She led the development of NQCA's publication, "Behavioral Health Quality Framework: A Roadmap for Using Measurement to Promote Joint Accountability and Whole-Person Care" (available at https://www.ncqa.org/blog/new-behavioral-health-study/).

Prior to industry, she was deputy director of a National Institute of Mental Health-funded research center (at Columbia University and New York University), dedicated to improving the quality of state-delivered mental health care services for youth and their families. While there, she led several key efforts that were adopted by the state of New York to improve quality of care, including a set of quality indicators for peer-delivered services, targeted strategies to improve state rollouts of EBP trainings, and simulated patient approaches to assess access to care and patient experience. She has published extensively on her work in both peer-reviewed journals and policy briefs.

At HMA, she works with states, counties, health plans, providers, and consumers to improve behavioral health care quality in real world context. Within California, this includes conducting behavioral health needs assessments as well as implementation of CalAIM initiatives, the CARE Act for the seriously mentally ill population, and the Children and Youth Behavioral Health Initiative. As a clinician researcher, she is passionate about leveraging her clinical and methodological skills, as well as awareness of local policies and context, to help her clients develop actionable solutions.

Marlies Perez, MA, has been a Division Chief with the California Department of Health Care Services since May 2013 and at the state level in behavioral health since 2001. Currently, Ms. Perez leads the Community Services Division (CSD) which is charged with policy development, oversight, compliance, and monitoring of approximately $10 billion in behavioral health prevention, harm reduction, treatment, recovery services, housing, and infrastructure projects. Ms. Perez is also California's Single State Authority on Substance Use Disorders for the Substance Abuse and Mental Health Services Administration. Ms. Perez has a bachelor's degree in international relations and a master's degree in organizational management.

Mental Health Services
Oversight & Accountability Commission

Data Panel Presentation

August 24, 2023 Public Hearing Brief

Purpose

Data was identified as one of the priorities for the Commission during the January 2023 strategic plan report out. Research, evaluation, and data analysis is imperative to the Commission as it informs and shapes mental health policy and priorities. The Commission has allocated 2 hours to focus on data during the August Commission meeting.

During this time, there will be an initial presentation on the value of data for accountability and building public trust. This will be followed by a panel discussion on mental health data and to understand current barriers, opportunities, and promising models for statewide data systems to support access, quality, outcomes, and transparency.

Background

A discussion on how data can be used to build public trust and foster system transformation is timely given the Governor's proposed 2024 ballot initiative to improve how California responds to mental health needs, substance use disorders, and homelessness. A key aspect of the proposal is to improve statewide accountability, transparency, and access to behavioral health services. The proposal specifies that there is need to set specific data measures that are made public so that impact and progress are transparent and trackable.

The goals of this proposal are aligned with other statewide initiatives. For example, CalAIM, a multiyear reform led by the California Department of Health Care Services, seeks to transform Medi-Cal to be more coordinated and equitable. The California Health Care Foundation described the importance of data sharing and aggregation between different parts of the system. "The success of both local and state data sharing initiatives are critical in enabling whole-person care."[i]

Policy and research think tanks also point to data as a key component to transformational change of our mental health system. In their report, How to Transform the U.S. Mental Health System: Evidence-based Recommendations, the Rand Corporation highlights the importance of "patient-important outcomes" for treatment planning and assessments of care quality. The authors stress the importance of aligning provider-based and patient-based goals, including "patient outcomes, such as social functioning and occupational goals."[ii]

Data alone will not solve the persistent and entrenched issues of mental illness, substance use, and homelessness; however, it is a valuable, necessary, and important tool and capability that can be harnessed to help us, as a system, do better for individuals, families, and communities.

Panel: Opportunities with Data

Invited panelists will provide insight on how to measure impact, barriers to collecting and evaluating data, and opportunities to drive transformational change with data. They will also provide insight on their perspective on what should be the data priorities to better understand the impact on mental health funding in California on outcomes for mental health consumers. Additionally, they will identify opportunities for administrative and programmatic improvements.

Proposed panelists will include the following:

1. Sameer Chowdhary, Principal, McKinsey Consulting
2. Emily Putnam-Horstein, PhD, Lead researcher with the Children's Data Network and advisor to the California Cradle to Career data exchange
3. Daniel Webster, PhD, Principal Investigator, California Child Welfare Indicators Project
4. Serene Olin, PhD, Former Assistant Vice President of Research and Analysis at the National Committee for Quality Assurance and co-author of *Behavioral Health Quality Framework: A Roadmap for Using Measurement to Promote Joint Accountability and Whole-Person Care*
5. Marlies Perez, MA, Chief of the Department of Health Care Services Behavioral Health Community Services Division

Considerations

- What does successful collaboration around data sharing look like?
- What can we learn from other disciplines/fields about how to use data for transformational change?
- How do we involve community partners in these conversations and get their perspective and input?
- What are the barriers for better data, both in terms of data infrastructure as well as collecting the right information?
- What are initial steps that can be taken to have less siloed and fragmented data reporting?
- Where have you seen innovation and best practices around metrics/data and what can we learn from those practices?

[i] https://www.chcf.org/resource/calaim-in-focus/data-exchange/
[ii] https://www.rand.org/pubs/research_briefs/RBA889-1.html

Behavioral Health Quality Framework: A Roadmap for Using Measurement to Promote Joint Accountability and Whole-Person Care

A White Paper

May 2021
Lauren Niles & Serene Olin
The National Committee for Quality Assurance (NCQA)

In Brief

Mental health (MH) conditions and substance use disorders (SUD), collectively referred to in this report as "behavioral health (BH) conditions," are a leading cause of disease burden in the United States, surpassing both cardiovascular disease and cancer.[1] As of 2019, nearly 1 in 5 adults in the United States had a diagnosed MH condition, and 1 in 12 people over the age of 12 had a diagnosed SUD.[2] Individuals with BH conditions experience higher morbidity, poorer health outcomes, and a 20-year lower life expectancy than the general population.[3] These poorer outcomes occur even though care for people with BH conditions accounts for a disproportionate share of total health care spending. Payers and stakeholders are increasingly looking to value-based payment models to integrate BH and physical health (PH) care to improve outcomes and manage costs.

The current fragmented and inequitable state of BH care calls for a quality measurement framework that can be used to guide and hold entities jointly accountable for improving care access and outcomes for individuals with BH conditions. To guide development of this framework, the National Committee for Quality Assurance (NCQA) employed a mixed-methods approach involving an environmental scan and key stakeholder interviews to evaluate the current BH quality measurement landscape and better understand the needs and challenges of entities responsible for BH care across the health care system.

Findings

An environmental scan of 39 active federal programs that collectively use over 1,400 quality measures and metrics uncovered the following:

- Federal programs, especially those focused on BH care, rely heavily on metrics and nonstandardized quality measures, limiting use for benchmarking and value-based payment models.
- Standardized quality measures used in federal programs are a mix of BH and PH measures.
- Standardized BH quality measures used in federal programs focus on narrowly specified conditions or processes and are misaligned and used variably across programs.
  - *Only 35 unique standardized BH quality measures were used across all federal programs; 16 were used only in a single program.*
  - *Four measures were most frequently used across programs: Follow-Up After Hospitalization for Mental Illness; Screening for Depression and Follow-Up Plan; Initiation and Engagement of Alcohol and Other Drug Abuse and Dependence Treatment; Preventive Care and Screening: Tobacco Use—Screening and Cessation Intervention.*
- BH integration is inconsistently and insufficiently measured by current standardized measures.

Key stakeholder interviews with entities operating at different levels of the delivery system in five diverse state Medicaid models that participate in federal programs yielded the following insights about the current use of quality measures for delivery, management, and improvement of care for populations with BH needs:

- BH care is supported through a complex assortment of funding streams, often to augment inadequate BH coverage with ancillary services.
- Current BH quality reporting efforts are burdensome and limit resources for improving and measuring aspects of BH care most meaningful to different levels of the delivery system.
- Entities across the delivery system have unique and unmet quality measurement needs, as illustrated in the table below *(Meaningful Aspects of BH Care Quality).*
- BH integration is viewed as key to addressing access and stigma, but entities are unclear on who is accountable for driving integration and how to measure its quality.
- Large-scale solutions and incentives are seen as necessary to improve BH data challenges.
- Existing BH quality measures have challenged efforts to monitor quality during COVID-19.

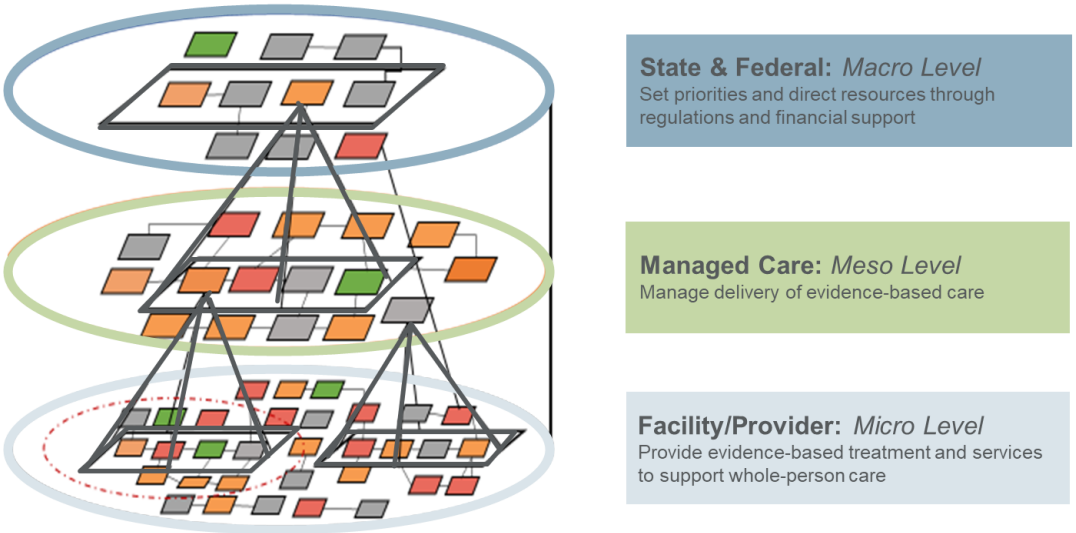
Meaningful Aspects of BH Care Quality, by Delivery System Level

	Measure Category	State	Managed Care	Facility
OUTCOMES	BH symptom and functioning improvement (i.e., measurement-based care)	X	X	X
	Patient goal attainment		X	X
	Patient experience		X	X
	Social outcomes (e.g., kindergarten readiness, crime rate, employment rate)	X		
	BH integration—outcomes and effectiveness	X	X	
	Cost	X	X	
	Equity in BH outcomes	X	X	X
PROCESSES	Social service coordination (e.g., link to social service agency)		X	X
	Health care coordination/referral success		X	X
	Evidence based treatment (e.g., Fidelity to Cognitive Processing Therapy model)	X		X
	Patient goal setting	X	X	X
	BH integration—processes (e.g., data sharing, warm handoffs)		X	X
	Equity (e.g., equitable access to BH care)	X	X	X

Recommendations

To drive improvements in BH quality and promote joint accountability across entities responsible for serving individuals with BH needs, we propose a **BH Quality Framework,** adapted from the Applegate Alignment Model. This framework prioritizes alignment and use of meaningful sets of quality measures, uniquely targeted to each level of the health care system, that coordinate and assess progress towards population-level goals. Bundles of measures and metrics are transparently defined, measured, and coordinated, and data use is based on each entity's unique position and relationship with respect to goals and populations served. The illustration below shows how this framework can be applied to promote collaboration and joint accountability for whole-person care.

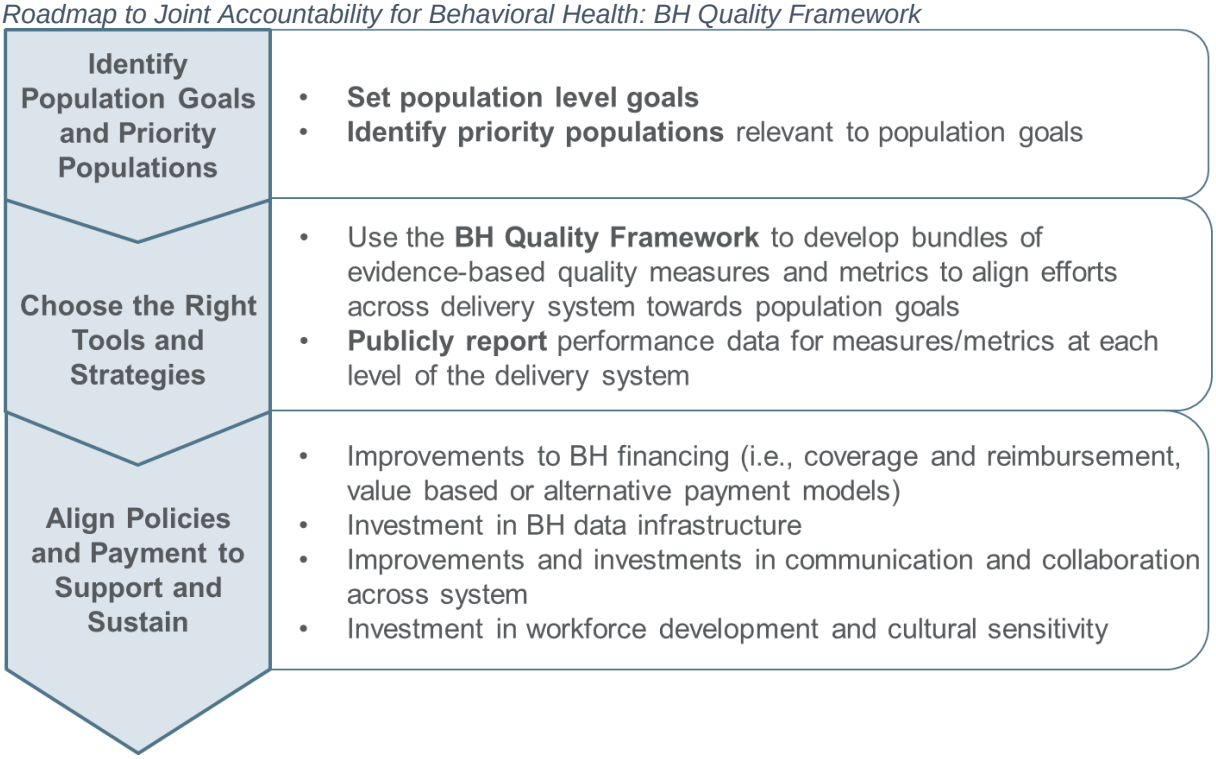
BH Quality Framework: Approach for Aligning Measures Across Levels of a Delivery System



To support implementation of the BH Quality Framework, we propose a roadmap that includes three primary components:

1. Identification of population goals and priority populations, with a strong focus on care equity,
2. Purposeful, coordinated alignment of measures and metrics across different levels of the delivery system to drive common goals, and
3. Alignment of policies and payment models to support and sustain efforts.

Roadmap to Joint Accountability for Behavioral Health: BH Quality Framework



Federal and state entities are positioned to drive improvements in BH care and impact population health goals by setting priorities and directing resources through regulations and financial support—but stakeholders, organizations, and individuals at all levels of the delivery system play a critical role. The BH Quality Framework calls for convening a diverse group of stakeholders that includes state policymakers, payers, providers, and consumers to jointly prioritize population goals for BH, develop relevant measure bundles, and address known inequities in care that stymie progress toward high-quality BH care.

By aligning and coordinating efforts across the delivery system, meaningful quality measures can spur accountability through transparency and payment. Purposeful alignment and coordinated quality measurement activities that consider each entity's sphere of influence while keeping a line of sight to shared goals can empower stakeholders to make informed decisions and minimize burden. There have recently been momentous federal and state investments to help mitigate the COVID-19 pandemic's impact on BH, but there is a critical need for a clear framework and approach to driving and measuring BH care quality and outcomes. The BH Quality Framework provides a testable model for guiding these efforts.

Acknowledgments

Behavioral Health Quality Framework: A Roadmap for Using Measurement to Promote Joint Accountability and Whole-Person Care was supported by the California Health Care Foundation (CHCF), which works to ensure that people have access to the care they need, when they need it, at a price they can afford. Visit www.chcf.org to learn more.

Special thanks to the individuals representing the 21 entities across California, Washington, Colorado, Louisiana, and Pennsylvania who volunteered their time to participate in this work.

We would also like to acknowledge the input of NCQA staff, including Sarah Hudson Scholle, Sepheen Byron, Kristine Toppe, and Jennifer Lenz.

Further, we would like to thank the members and NCQA staff organizers of NCQA's Public Sector Advisory Council who provided early input on the findings of this work.

We are also grateful to the following individuals who provided comments and insights to preliminary drafts of interview guides and/or products along the way: Molly Finnerty (NYS Office of Mental Health), Catherine Teare (CHCF), Tanya Dansky (MemorialCare Medical Group).

This paper was authored by NCQA staff:

Serene Olin, PhD,
Assistant Vice President
Research and Analysis

Lauren Niles, MPH, DrPH Candidate
Senior Research Associate
Performance Measurement

We would also like to acknowledge the substantial contributions of Joe Castiglione and Tam Nguyen-Louie, who were part of the core team at NCQA. We are also grateful to Sarah Laurie, MPH, Health Care Analyst, who supported data analysis for the environmental scan, and Raesah Ettawil, MPA, Assistant Director, who supported writing the state profiles.

CHCF Contract Officer: We are grateful for the support and guidance of Katherine Haynes, MBA, Senior Program Officer, People-Centered Care, CHCF.

Contents

Section 1: The Challenge of Measuring BH Care Quality

State of behavioral health care in the United States

Mental health (MH) conditions and substance use disorders (SUD), collectively referred to in this report as "behavioral health (BH) conditions," are a leading cause of disease burden in the United States, surpassing both cardiovascular disease and cancer.[4] As of 2019, nearly 1 in 5 adults (51.5 million) in the United States had a diagnosed MH condition, and 1 in 12 (20.4 million) individuals over the age of 12 had a diagnosed SUD.[5]

Individuals with BH conditions experience higher morbidity, poorer health outcomes, and lower life expectancy than the general population. The excess in mortality—particularly among those with severe mental illness—has been referred to as a "public health scandal."[3,6,7] This inequity reflects several factors, including higher risks for chronic diseases (including cancer), higher rates of accidental and nonaccidental deaths, and poorer access to medical care among those with BH needs, compared to the general population.[8] Yet despite the high prevalence and social and economic impact of BH in the United States, only 12% of individuals with SUD and 45% with MH receive specialty services, underscoring pervasive challenges to care access and coordination.[5]

Disparities in access to and engagement in BH care also disproportionately impact communities of color.[9] The COVID-19 pandemic has exacerbated these disparities: Black and Latinx communities both suffer a greater COVID-19 disease burden and worse access to BH services.[10]

State and federal policy solutions to address these challenges include BH parity; expansion of Medicaid; efforts to integrate BH with medical care; and broad legislation related to improving access to treatment for MH and SUD (e.g., 2018 Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment [SUPPORT] for Patients and Communities Act). The BH crisis, worsened by the COVID-19 pandemic, brought about additional policies to promote BH care access (e.g., Coronavirus Aid, Relief, and Economic Security [CARES] Act, American Rescue Plan Act of 2021).[11,12,13]

Tackling BH to manage health care costs

As national health care reform efforts focus on reducing costs and increasing efficiency, the spotlight has shifted to variations and inequities in care and cost across health conditions and settings. Individuals with comorbid SUD and MH conditions have been identified as a high-need, high-cost group that accounts for a disproportionate share of total health care spending across publicly and commercially insured lives.[14] And BH conditions have an outsized impact on medical costs: The average cost of treatment for medical conditions is between 2.8 and 6.2 times higher for individuals with BH conditions than for those without BH conditions.[14] Although individuals with BH conditions account for more than half of all health care spending, BH services account for only 4.4% of this cost.[14] Payers and stakeholders are increasingly looking to value-based payment models and opportunities to integrate BH and physical health (PH) care to improve outcomes and manage costs.[15,16]

Role of quality measurement

Quality measures provide information about health care quality, evaluate the impact of policies and service delivery initiatives on care quality, and inform stakeholder decisions. Impactful quality measures can be leveraged to create accountability through transparency (public reporting) and can be incorporated into payment programs to drive improvement in care quality. Although quality measures to assess MH and SUD care are available, there is a paucity of measures for many important conditions and relevant outcomes, a limited focus on high-need, high-cost populations, and limited use in quality improvement and value-based payment programs. Among the MH and SUD measures used in accountability programs, the average performance has remained stable or has declined over time.[17] These trends in performance stand in contrast to trends in PH measures, which have shown modest incremental gains over the same period.[17]

As national efforts evolve to pay for value rather than volume, value-based payment models that are guided by robust quality measures are urgently needed to support equitable, coordinated care for

underserved populations with BH needs. Unfortunately, investment in BH quality measurement has lagged behind investment in other areas of health, adding to existing challenges to improve BH care quality.[18] There is a clear need for investing resources in evaluating, implementing, and developing a meaningful and coordinated set of measures to drive improvements in BH care quality and outcomes.[17,18]

Calls for a behavioral health care delivery framework

The current fragmented and inequitable state of BH care delivery and management calls for a measurement framework that can be guide and hold entities jointly accountable for improving care access and outcomes for individuals with BH conditions.

To guide development of such a framework, the National Committee for Quality Assurance (NCQA) employed a mixed-methods approach to evaluate the current BH quality measurement landscape and gain a better understanding of the needs and challenges of entities that are responsible for BH care across the delivery system. Specifically, this report provides a synthesis of insights gained from:

1. An **environmental scan and gap analysis** of BH measures and metrics used in active federal programs.
2. **Key stakeholder interviews** about the current use of quality measures for the delivery, management, and improvement of care for populations with BH needs.

The sections below provide an overview of the findings from this work, as well as the resulting recommendation and accompanying roadmap for use of a BH Quality Framework to achieve joint accountability across entities responsible for serving individuals with BH needs.

Section 2: Environmental Scan

Federal agencies are engaged in both funding and subsequent oversight of a large proportion of BH care delivery through direct contracting, accountability programs, demonstration programs, and accreditations. To better understand how the quality of BH care and management is evaluated by federal agencies, our environmental scan and gap analysis focused on BH quality measures used in Federal Reporting Programs *(see callout box for definition)*.

Through a web-based search of all federal agency sites, conducted in October 2020, NCQA identified 86 Federal Reporting Programs. Of these, we analyzed 39 active programs that were national in scope and included standardized reporting requirements for assessing care quality (see *Appendix A* for details). Among these programs, 6 focused on BH care (e.g., Section 1115 SUD Demonstration program), 27 focused on general medical care (e.g., Medicare Shared Savings Program), and the remaining 6 focused on integrated BH and medical care, hereafter called “behavioral health integration (BHI)” (e.g., Certified Community Behavioral Health Clinic program).

What is a Federal Reporting Program?

Initiatives funded through federal agencies (e.g., Centers for Medicare & Medicaid Services) that disperse funds to entities operating in the health delivery system to incentivize improvements in care delivery, management, or quality. These initiatives can take the form of active demonstrations, value or alternative based payment initiatives, accreditations, or certifications. For more information on our selection criteria and the programs identified, see *Appendix A*.

To characterize the reporting requirements used by federal programs to assess care quality, NCQA categorized and defined measures as standardized quality measures, nonstandardized quality measures, and metrics (*see callout box for definitions*). Standardized quality measures, which have been inventoried through the National Quality Forum (NQF) endorsement process[19] or included in the Centers for Medicare & Medicaid Services Measures Inventory Tool (CMIT),[20] were further categorized into three domains: BH, PH, and cross-cutting. The "cross-cutting" measure designation included concepts such as family or patient perceptions of care, care continuity and coordination, patient safety, and social determinants of health.

Defining data used in Federal Reporting Programs

Standardized quality measures: Data used to quantify and compare the quality of health care in a standardized and structured way. In this study, standardized quality measures have undergone testing and have been endorsed by NQF or have met criteria for inclusion in the CMIT. They include specifications that allow comparison across entities or programs.

Nonstandardized quality measures: Data used to quantify and compare the quality of health care in a structured way. Data are not NQF-endorsed or included in CMIT.

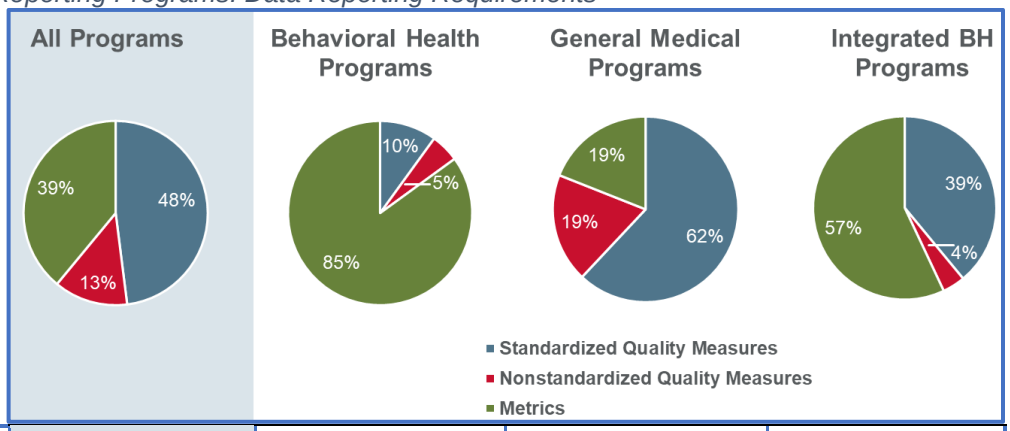
Metrics: Data used to monitor progress toward program implementation or goals; for example, utilization of service counts or counts of patients who have engaged in a particular service. Unlike measures, metrics may not allow apples-to-apples comparison across entities due to lack of standardization and specification.

Key insights about the state of quality measurement across Federal Reporting Programs are detailed below.

Key Insight 1: Federal programs, especially those focused on BH care, rely heavily on metrics and nonstandardized quality measures.

Of the 1,410 measures and metrics used across the 39 Federal Reporting Programs included in this study, 48% were standardized quality measures, 13% were nonstandardized quality measures, and 39% were metrics *(Figure 1).* Notably, BH and BHI programs included a higher proportion of metrics (85% and 57%, respectively) than general medical programs (19%), and a lower proportion of standardized quality measures (10% and 39%, respectively) than general medical programs (62%) *(Figure 1).*

Figure 1: Federal Reporting Programs: Data Reporting Requirements



	All Programs	Behavioral Health Programs	General Medical Programs	Integrated BH Programs
Number of Programs	39	6	27	6
Median Number of Measures & Metrics per Program	24	37	17	23
Range of Number of Measures & Metrics per Program	1-217	16-127	1-217	5-55

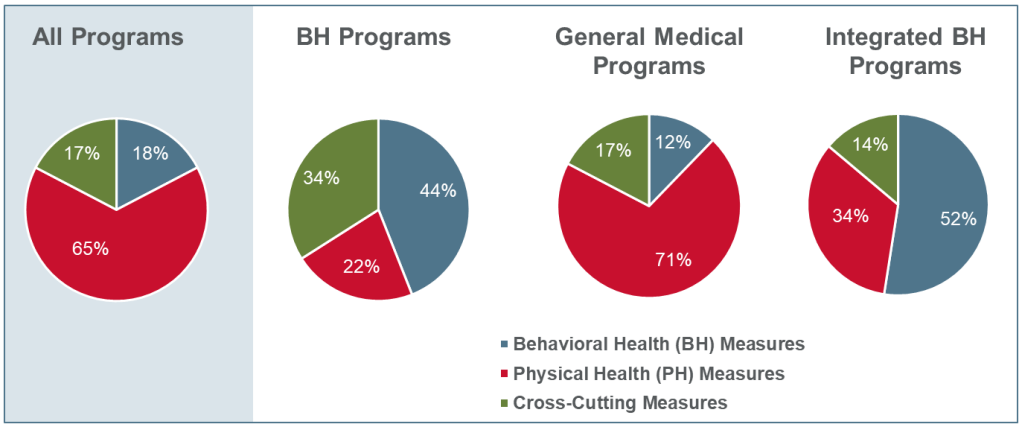
Differences were also identified in the number of measures and metrics required for reporting among program types. Overall, BH programs were found to be more burdensome, with a higher median number of required measures and metrics than general medical programs and BHI programs *(Figure 1).* Common metrics in BH and BHI programs measure cost, program enrollment, network adequacy, diagnoses, service utilization, and patient and caregiver experience.

These findings suggest that existing standardized quality measures may not meet the needs of BH and BHI programs and their stakeholders, and reliance on metrics or nonstandardized quality measures limits their usefulness in benchmarking programs and/or value-based payment models.

Key Insight 2: Standardized quality measures used in Federal Reporting Programs include a mix of BH and PH quality measures.

Following our review, we found that standardized measures selected for use in programs mirrored program goals (programs focused on BH included a higher proportion of BH measures) *(Figure 2).* Programs generally employed a mixture of BH, PH, and cross-cutting measures, suggesting that they may be working to foster whole-person care through reporting. Cross-cutting measures identified in programs captured data on patient experience, social service access, patient safety, cost, and care coordination. The highest proportion of cross-cutting measures (34% of standardized quality measures) was found in BH programs, compared to general medical programs (17%) and BHI programs (14%).

Figure 2: Standardized Quality Measures, by Measure Type

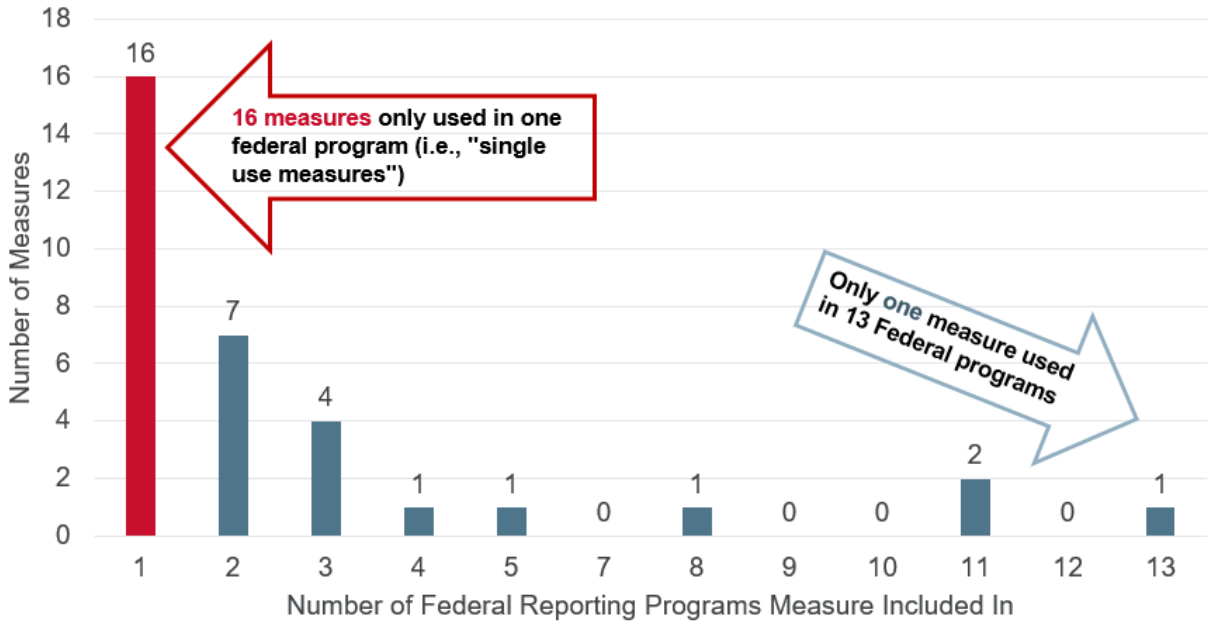


Key Insight 3: Standardized BH quality measures used in Federal Reporting Programs focus on narrowly specified conditions or processes and are misaligned and used variably across programs.

We identified 35 unique standardized BH quality measures across federal programs. Of these, 31 (86%) were process measures, 1 was an intermediate outcome measure and 3 were outcome measures. We did not identify any BH structural measures. Most measures were narrowly specified and related to evidence-based treatment processes for specific BH conditions (e.g., depression, schizophrenia). Most relied on administrative claims data. A few used patient-reported data for screening, symptom monitoring, or functional status monitoring. These findings are consistent with other published findings related to gaps in quality measurement for BH, including those identified by Pincus et al.[17] and Patel et al.[21]

Figure 3 shows how frequently the 35 unique standardized BH quality measures are used across the 39 identified federal programs. Of the 35 BH measures, 16 were used only once. Single-use measures varied with regard to the population of focus (e.g., depression, dementia, SUD) and intent (e.g., symptom assessment, screening, monitoring smoking abstinence).

Figure 3: Use of the 35 Unique Standardized BH Quality Measures Across Federal Programs



Notably, four standardized BH quality measures were most frequently used in federal programs *(Table 1).* All assess narrow care processes and rely on administrative claims data and focus on screening for depression and tobacco use, SUD treatment access, and follow-up after acute hospitalizations for mental illness. Together, these efforts suggest federal priorities to incentivize broader aspects of BH care (e.g., patient-reported outcomes) or the use of more granular clinical data from electronic systems to improve BH care delivery, and quality may be hampered by limitations of existing standardized measures and reporting capabilities. Consequently, insights about care for a wider range of BH conditions, treatments, and outcomes are limited.

Table 1: Most Frequently Used BH Quality Measures Across Federal Reporting Programs

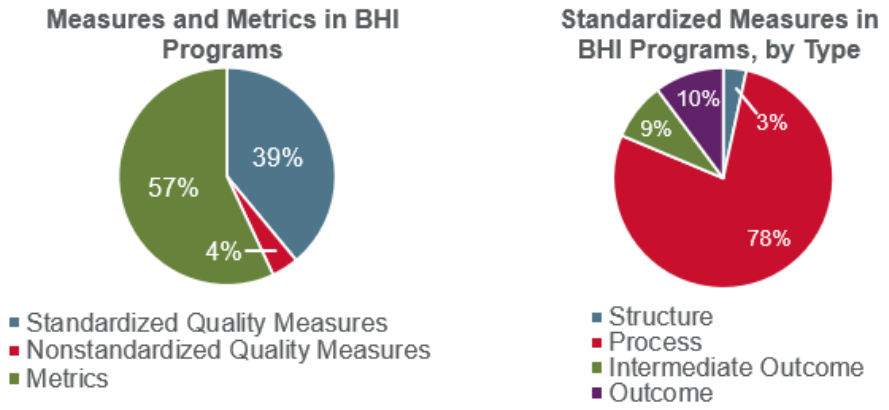
	Number of Federal Programs Measure Used In	NQF Number	Developer	Measure Type (Donabedian)	Data Source
Follow-up After Hospitalization for Mental Illness	13	0576	NCQA	Process	Claims
Screening for Depression and Follow-Up Plan	11	0418	CMS	Process	Claims, Registry
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	11	0004	NCQA	Process	Claims
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	8	0028	NCQA	Process	Claims

Overall, the narrow focus of existing standardized BH quality measures, high frequency of single-use measures, and variability of measure use across programs suggest significant opportunity to better align efforts to both reduce waste and improve coordination in the quality measurement landscape.

Key Insight 4: BH integration is inconsistently measured across BHI Federal Reporting Programs, and efforts lack measures of critical aspects of whole-person care.

The increasing focus on integrating BH and PH care as a way to address challenges in BH care access and quality has led to calls for implementation of national quality measures related to BHI.[17] We thus examined, in detail, the six federal programs aimed specifically at BHI *(Appendix A)*. Among these programs, we saw higher reliance on metrics—rather than on standardized quality measures—to assess quality and hold reporting entities accountable (57% and 39% of data collected in BHI programs, respectively) *(Figure 4)*. This finding may suggest a paucity of relevant or feasible standardized quality measures from which to select for use in programs and a lack of alignment across the health care system for how to best evaluate BHI.

Figure 4: Reporting Requirements in BH Integration Programs



A review of the standardized quality measures used in federal BHI programs (summarized in *Appendix A*) resulted in insights. First, measures used in these programs predominantly focused on narrow processes and relied on administrative claims data. Second, across all BHI programs, no quality measures assessed access to social services, integrated care practices, organizational structure, or cost of care—all criteria of higher levels of integrated care, as defined by the SAMHSA Center for Integrated Health Solutions.[22] Third, quality measures related to care coordination (e.g., *Closing the Referral Loop: Receipt of Specialist Report*), a critical component of BHI, were infrequently seen. These notable gaps in standardized and structured quality measures in BHI programs limit the ability to assess the effectiveness of the programs' efforts and ascertain if they are driving and incentivizing whole-person care.

Section 3: Key Stakeholder Interviews with States Participating in Federal Initiatives

To enrich environmental scan insights on the role of quality measurement in driving BH care, we conducted a series of key stakeholder interviews that focused on state Medicaid systems. Medicaid is the largest single payer of BH services and state Medicaid programs represent an area of both innovation and financial model diversity. Ultimately, five exemplary diverse states were selected for inclusion.

The five states—California, Washington, Colorado, Louisiana, and Pennsylvania—were selected to optimize 1.) geographic variation, 2.) diversity in financial models for BH care delivery, and 3.) innovation in BH, according to an index of their participation in BH or BHI Federal Reporting Programs. *Table 2* highlights the characteristics of each state's BH care delivery model. *Appendix B* contains information on each state's Medicaid delivery model, how each state incentivizes and assesses the quality of BH care, and current innovation regarding BH care delivery and management.

Table 2: Description of State BH Medicaid Models

	California	Washington	Colorado	Pennsylvania	Louisiana
State Medicaid Information					
Medicaid Enrollment (2020)	11,289,937	1,779,628	1,141,130	2,980,867	1,515,189
CHIP Enrollment (2020)	1,297,062	70,271	73,984	177,944	135,051
Proportion Medicaid Budget for BH	3.4%	15%	9%	15.1%	9%
Medicaid BH Coverage and Management					
BH Financing Model: Carve-In/Out	Traditional specialty carve-out for SMI/SED and SUD	Carve-in	BH carve-out	BH carve-out	Carve-in
Differentiation by BH Severity	Y	N	N	N	N (except Coordinated System of Care for children)
BH Payment Model	VBP: Mild/Mod FFS: SMI, SUD	VBP	VBP for BH (vs. FFS for PH)	VBP and FFS	VBP
Entity Responsible for BH Care Management & Coordination	County MH plans (specialty) and managed care plans (non specialty)	MCOs (integrated) or "BH Services Only" contracts through MCOs	Regional Accountable Entities	BH MCOs, through contracts with counties (or state office of MH and Substance Abuse Services, if county opts out)	Managed Care Entities

BH= Behavioral Health; **MH**= Mental Health; **PH**= Physical Health; **SMI**= Serious Mental Illness; **SED**= Severe Emotional Disturbance; **VBP**= Value Based Payment; **FFS**= Fee for Service

In each of the five selected states, we interviewed at least one entity operating at the following levels of accountability: 1.) state BH and/or Medicaid agency, 2.) managed care organization (MCO) or managed BH care organization (MBHCO), and 3.) facility (practice/clinic). For states where county or regional entities play a significant role in BH service management and delivery, interviews also included an entity at that level.

We conducted 21 interviews *(Table 3)*. Interviews focused on how entities finance and deliver BH care, current BH quality strategies and tools, how quality improvement efforts align with quality measurement efforts, and how quality efforts have been impacted by COVID-19. Information about the methods used in this analysis, as well as interview questions and domains, can be found in *Appendix C*.

Table 3: Characteristics of Entities Involved in Key Stakeholder Interviews

Level of Delivery System	Entity	Number of Interviews Conducted
State	State Medicaid Office or Agency	5
	County or Regional Medicaid Office (Not Managed Care)	2
Managed Care	Managed Care Organization	4
	Managed Behavioral Health Care Organization	2
Facility	Health Care Practice or Clinic (Facility)	6

Key insights emerged from the interviews, highlighted below in detail.

Key Insight 1: BH care is supported through a complex assortment of funding streams, often to augment coverage with ancillary services.

Organizations operating at all levels of the health system rely on multiple funding streams to manage and deliver BH care, with the greatest complexity observed at the facility level. At the state level, funding streams include taxes, state provisions, and federal dollars. Facilities and MCOs reported the need to frequently augment state Medicaid benefits with auxiliary services that are either not reimbursable or not fully covered by grants, federal demonstration program dollars, or participation in various programs. These include wraparound care (e.g., in-home services, flexible funding for food or housing services), case management, and services rendered by particular BH providers or trained specialists (e.g., marriage and family therapists, peer support specialists). Facilities and MCOs stressed the need for more flexible funding to drive whole-person care, citing earmarked funds as antithetical to patient-centered care efforts.

Supplementing Medicaid Funding

*"…**We have 32 funding streams.** And every single one comes with a unique set of requirements."*

—Facility

Many facilities and MCOs, even those operating in states that carve in BH services, expend significant resources on identifying and procuring supplemental funding to address critical needs of their BH populations, especially for those with complex needs. This finding suggests that existing BH benefits are inadequate to support critical services that address social determinants of BH.

Key Insight 2: Current BH quality reporting efforts are burdensome and limit resources for improving and measuring aspects of care quality most meaningful at different levels of the system.

Entities operating at all levels of the delivery system, but especially MCOs and facilities, are burdened by existing quality oversight requirements. Our work identified three primary sources of burden:

1. The sheer volume of reporting requirements associated with funding oversight. Entities that rely on multiple funding streams and participate in multiple accountability programs can be held responsible for reporting thousands of quality measures and metrics each year.
2. Variation across oversight and accountability reporting requirements, including documentation requirements, reporting systems, formats, and frequency of submissions.
3. Lack of meaningful measures and reliance on homegrown metrics in reporting requirements.

Burden: Number of Quality Measures Associated with Funding Oversight

"Every year, for every product line, when you combine it all together, ***we submit 2,700 measures****."*
—Managed Care Organization

Burden: Documentation and Reporting Processes for Funding Oversight

"Right now, we estimate that ***our staff spend 40% of their time documenting.*** *That is 40% of their time they could be spending with consumers, and instead they're doing paperwork."*
—Managed Care Organization

Burden: Reliance on Homegrown Metrics

*"We always struggled with having really good measures around behavioral health, mental health, substance use. At the national level, at the time, back in 2014****, there were not really good national measures. … So, we didn't wait around for NQF or national folks to figure it out."***
—State Agency

The high volume of misaligned quality oversight requirements limits the capacity for measuring what entities believe to be the most important aspects of BH quality. Interviewed MCOs and facilities unanimously reported having limited remaining resources to innovate or measure additional aspects of care that may be more valuable for the population outside established quality reporting requirements. Multiple facilities mentioned that they were contractually required to report on measures used in state or MCO-level accountability programs, especially the Medicaid Core Set, which they did not feel were relevant to their level of the delivery system. Lack of standardization and misalignment of measures across and within care delivery systems result in performance data that cannot be used for benchmarking and challenges BH provider capacity to participate in value-based payment models.

Limited Remaining Resources to Measure What Matters

"… There's so much effort put into the reporting requirements that it's ***hard to step back and have the energy and resources to then go, "What do we care about?"***
—Facility

Key Insight 3: Entities at different levels of the delivery system have unique—and unmet—quality measurement needs**.**

Interviewed entities describe existing BH measures as rudimentary, limited primarily to measures of penetration, utilization, and narrow processes of BH care, and insufficient for improving care for their BH populations. Entities operating at different levels of the delivery system shared distinct opinions about aspects of quality that matter most to them *(Table 4)*.

Key quality concepts universally regarded as important across the system include improvement in BH symptoms and functioning, equity in BH outcomes, and patient goal-setting processes. What's interesting is that while the concept of equity was prioritized by entities for both process and outcome measurement, there was no common or clear vision for what this should look like. In fact, many entities described structural components of care when discussing ways they might measure care equity, including assessing cultural competency of staff, culturally sensitive care workflows, and provider diversity. With regard to equity outcome measures, entities discussed a need to measure disparities in outcomes for individuals with BH conditions by stratifying measures by sex, race, ethnicity, and geographic location.

Discussing Equity: Stratifying Existing Measures

"That includes starting to ***stratify the measures by race and ethnicity*** *to really start to dive deeper into making sure that we're really measuring what matters at the end of the day, and it may show us things that we didn't see at first."*
—State Agency

States expressed interest in BH quality measures related to cost of care, outcomes of BHI (depending on model—MH with SUD or BH with PH), and social outcomes (e.g., incarceration, employment). While states did not articulate a clear vision about what constitutes an important outcome of BHI, they did express that they want a more objective way to measure and assess the effectiveness of such care models.

MCOs also expressed interest in measuring cost of care and BHI outcomes and were interested in patient-centered care related to patient goal attainment and experience, as well as care processes such as linking patients to relevant social services, care referrals, BHI processes, and patient goal setting.

Facilities expressed interest in many of the same measures of outcomes (with the exception of cost and BHI outcomes). Facilities were adamant that measures of cost, social outcomes, and BHI outcomes were inappropriate as accountability measures for their level of the delivery system because they do not see themselves as having the right levers or resources to impact outcomes in these areas. However, facilities did express interest in measures that assess BHI care processes (e.g., data sharing, warm handoff for BH evaluation), linking patients to relevant social services, care referrals, and patient goal setting. Facilities also expressed interest in assessing use of and fidelity to evidence-based care for BH.

Table 4: Meaningful Aspects of BH Care Quality by Delivery System Level

	Measure Category	State	Managed Care	Facility
OUTCOMES	BH symptom and functioning improvement (measurement-based care)	X	X	X
	Patient goal attainment		X	X
	Patient experience		X	X
	Social outcomes (e.g., kindergarten readiness, crime rate, employment rate)	X		
	BH integration—outcomes and effectiveness	X	X	
	Cost	X	X	
	Equity in BH outcomes	X	X	X
PROCESSES	Social service coordination (e.g., link to social service agency)		X	X
	Health care coordination/referral success		X	X
	Evidence based treatment (e.g., Fidelity to Cognitive Processing Therapy model)	X		X
	Patient goal setting	X	X	X
	BH integration—processes (e.g., data sharing, warm handoffs)		X	X
	Equity (e.g., equitable access to BH care)	X	X	X

Despite reported challenges with BH quality measures, a few facilities highlighted their success in managing populations with BH needs through innovative quality measurement efforts. For example, one multi-site facility, in collaboration with other facilities in its area and with financial support of a privately funded demonstration program, developed a common set of 12 core measures it felt were meaningful. The set included both patient- and staff-reported measures of care equity, integration, and patient well-being.

Discussing Equity: New Concepts

"It's a four-point scale, from 'agree' to 'disagree'… ***'I believe my care team feels comfortable around people who look like me and/or sound like me.'*** *And the next one is, 'At times I feel I am treated differently here based on my race, ethnicity, and or gender identity.'"*

—Facility

Another facility, which operates as a Federally Qualified Health Center (FQHC), self-funded development of a set of internal measures of whole-person care that assessed BHI processes, including warm handoffs between different provider types and treatment continuity across PH, BH, and dental care. The facility also developed a standardized way to collect patient demographic data alongside quality data, to drive equity through transparency and measure stratification.

Across levels of the delivery system, entities noted that existing BH quality measures are insufficient for driving high-quality BH care. Currently, expanding and improving quality measurement is limited to individual entities or small groups of entities within systems.

Relevant Quality Measures

*"It's really about putting the harm reduction model in action—**first help patients identify what is important to them, help them address what is important to them, and then tackle the next thing**. A1c might be further down on the list, but it will eventually appear on the list for most people. There is no stronger determinant [of care quality] from my perspective on whether or not someone is able to sustain care they're seeking and their recovery... and **if there's nobody else [measuring], then I guess we're going to have to do it.**"*

—Facility

Key Insight 4: BHI is viewed as key to addressing access and stigma, but entities lack clarity about who is accountable for driving integration and how to measure its quality.

Across all levels of the delivery system, entities embraced the concept of BHI to improve access to BH care and to address stigma, but they were less certain about who should be responsible for supporting BHI implementation and what quality measures should be used to assess the impact of BHI on quality and outcomes for individuals with BH conditions.

BHI efforts are heavily influenced by the financial, operational, and clinical realities in a system, such as restrictions on same-day billing for BH and PH (financial), 42 CFR Part 2 data protections (operational), and provider BH and BHI training (clinical). Entities across the delivery system expressed differing opinions about their ability to impact and drive integration efforts and the degree to which they should be held accountable. For example, some MCOs noted that practice-level "culture shifts" and care delivery processes must first take place and providers must be willing to work collaboratively before payment or reimbursement policies can be an effective tool. Some facilities felt that true integration could only be achieved when there is a streamlined or singular funding mechanism that prioritizes and incentivizes full-person care.

Customizing Approaches to Integrated Care

"***I think trying to have one kind of version of what integrated care looks like is kind of a fool's errand.*** *…Everybody does it differently, everybody has different capabilities, everybody has different goals, everybody has different realities in which they operate in their communities."*

—State Agency

Measuring the Quality of BHI Efforts

*"I could go on for hours about how behavioral health integration measurably improves clinician quality of life, clinician productivity, the ability of practices to take on a higher number of complex attributed patients. ...**But then we just see a bunch of screening rates and other things that aren't all that important or compelling in terms of what's the business case for behavioral health integration.** We just think it's a logical thing to do."*

—Managed Care Organization

Entities recognize standardized quality measures for measuring BHI processes and resulting care quality outcomes as critical for accountability, value-based purchasing efforts, and establishing a business case for BHI efforts. Although there is no clear vision about what BHI quality measures would include, entities noted that a group or bundle of quality measures and metrics would be more effective than any single measure.

Key Insight 5: Large-scale solutions and incentives are regarded as necessary to improve BH data.

Standardized data collection and exchange is critical for care coordination and patient-centered, whole-person care, yet there are significant infrastructure challenges in the BH care delivery system. At the highest level, fragmented financial models for BH care delivery create challenges to data exchange across the delivery system. Additional challenges include lack of BH data standards, inconsistent data protections and confidentiality requirements, and limited and nonintegrated BH information technology.

BH Data Exchange

"*… There is not one standard. Every standard is customized… so* ***each and every interface has to be tested and built, and there's a lot of work and money and effort.*** *In the end, you get a few more data hits*."
—Managed Care Organization

Why Is BH Data Different from PH Data?

*"****Outside of primary care or [an] ACO program, there really wasn't a meaningful use type push for behavioral health.*** *There aren't measures that really look at behavioral health and there's just no measure focus.* ***The market is not organized.*** *You basically have a handful of large traditional county or mental health center systems, hospitals, SUD providers, and then this wild west of independent, small mom and pop [,] mostly independent therapists. …* ***so, when we get to like, "Oh, well, we're going to do a value-based payment model or a vendor-based network for behavioral [care]," all of those underlying resources are not there or have not evolved in the same way."***
—Managed Care Organization

To account for the lack of standardized data exchange, organizations managing and treating individuals with BH conditions rely on piecemeal and laborious exchange of individual data elements, primarily to meet quality oversight requirements, rather than assessing full-person care for care delivery improvement. For example, one MCO highlighted how it negotiates a yearly license with its managed BH organization that allows sharing of specific data elements needed to report quality measures. While this labor-intensive yearly process does allow limited exchange of some data, it does not allow either organization to see the full picture of a member's care for the purpose of improving health outcomes, nor is it a scalable solution.

Current BH data exchange is limited and stymied by long-standing financial and regulatory barriers that represent a legacy of stigma and systemic bias toward individuals with BH conditions. Many entities noted that the most impactful way to realize widescale progress toward purposeful exchange of BH data is through federal incentives, such as those used in general health care (e.g., the former Meaningful Use program).

Key Insight 6: BH quality measures challenged efforts to monitor quality during the COVID-19 pandemic.

Multiple entities noted they could not effectively monitor care quality during the pandemic with existing quality measures. Because existing measures primarily focus on care utilization, when care patterns were disrupted during the COVID-19 pandemic, they were not useful. Entities discussed how more relevant BH measures—focused on patient goal setting and attainment, connecting patients to relevant services, and outcomes—would have better equipped them to understand the pandemic's real impact on BH care quality.

Monitoring BH Quality During COVID-19

"*I would say a lot of attention has gone into understanding how COVID is potentially impacting other performance measures like ED utilization…* ***There's a lot of concern because those measures are tied to a reimbursement rate or an incentive pool.*** *And, so, I think a lot of the focus has been on that* ***rather than turning forward and saying, 'How do we ensure that the services that are going on now are meeting quality standards?'"***
—Managed Care Organization

Section 4: Recommendations and Next Steps

The COVID-19 pandemic and consequent social and economic hardships have amplified the need for high-quality BH care, especially among underserved groups. As a result, under the Biden Administration, the Department of Health & Human Services (HHS) identified BH as a priority area and put in motion a series of historic investments in BH systems, services, and innovation. Examples of these investments include $3 billion in American Rescue Plan funding for Substance Abuse and Mental Health Services Administration (SAMHSA) block grants to address the BH crisis[24] and increased Federal Medical Assistance Percentage for certain Home and Community-Based Services to expand BH capacity.[23] HHS also established a new Behavioral Health Coordinating Council to "facilitate collaborative, innovative, transparent, equitable, and action-oriented approaches to addressing the HHS' behavioral health agenda." [24] Now, more than ever, we need robust quality measures and tools to assess how this significant investment in BH services impacts care quality and outcomes.

Need for a system framework

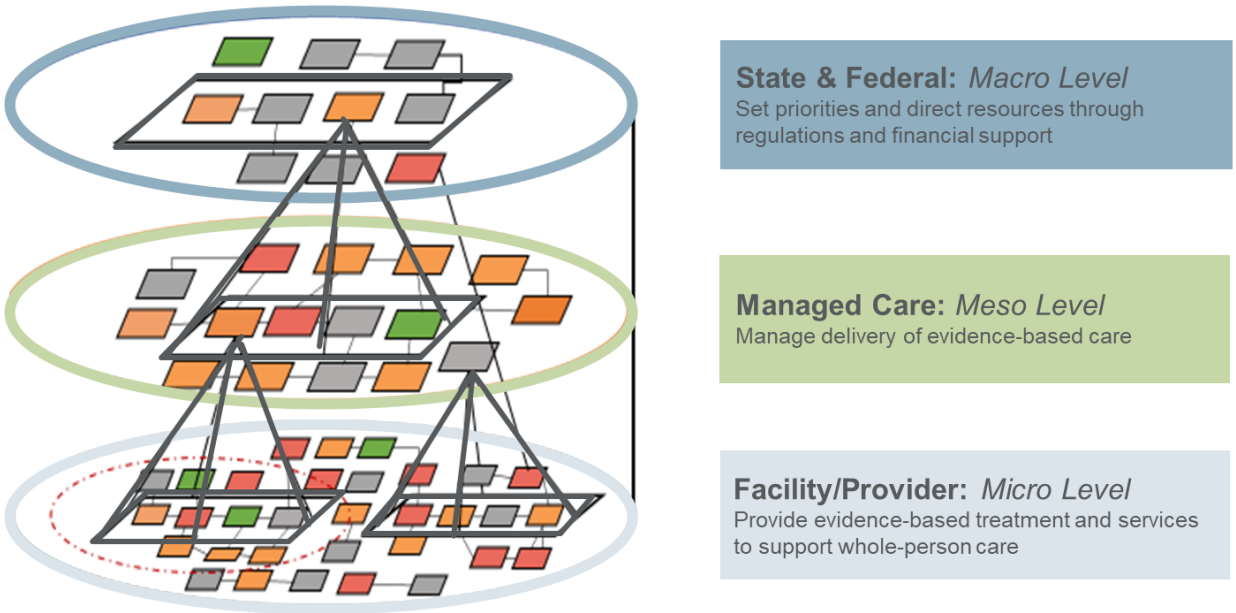
To drive improvements in BH quality and promote joint accountability across entities responsible for serving individuals with BH needs, we propose developing a **BH Quality Framework** that includes three components: 1.) use of a population health management structure to guide efforts, 2.) purposeful, coordinated alignment of measures and metrics across the delivery system to drive common goals, and 3.) investment in infrastructure supports to ensure accountability and drive improvement.

What is a BH Quality Framework?

The fragmented nature of BH care delivery in the United States calls for a coordinated approach to manage and deliver care to populations with BH needs. The guiding principles of this approach should be grounded in care equity and include a focus on underserved populations that have been historically marginalized due to stigma, misperceptions about BH, and inadequate access to treatment.

We apply the Applegate Alignment Model to highlight an approach for collaboration, cooperation, and coordination across a fragmented delivery system. This model calls for prioritizing the use of meaningful bundles of quality measures targeted to each level of the delivery system and coordinated to achieve population level goals.[25] The model *(Figure 5),* or **BH Quality Framework,** calls for both top-down and bottom-up strategies to engage stakeholders in identifying priority populations, an end-user defined set of quality measures, and transparent public reporting of quality data.

Figure 5: BH Quality Framework: Aligning Measures Across the Delivery System

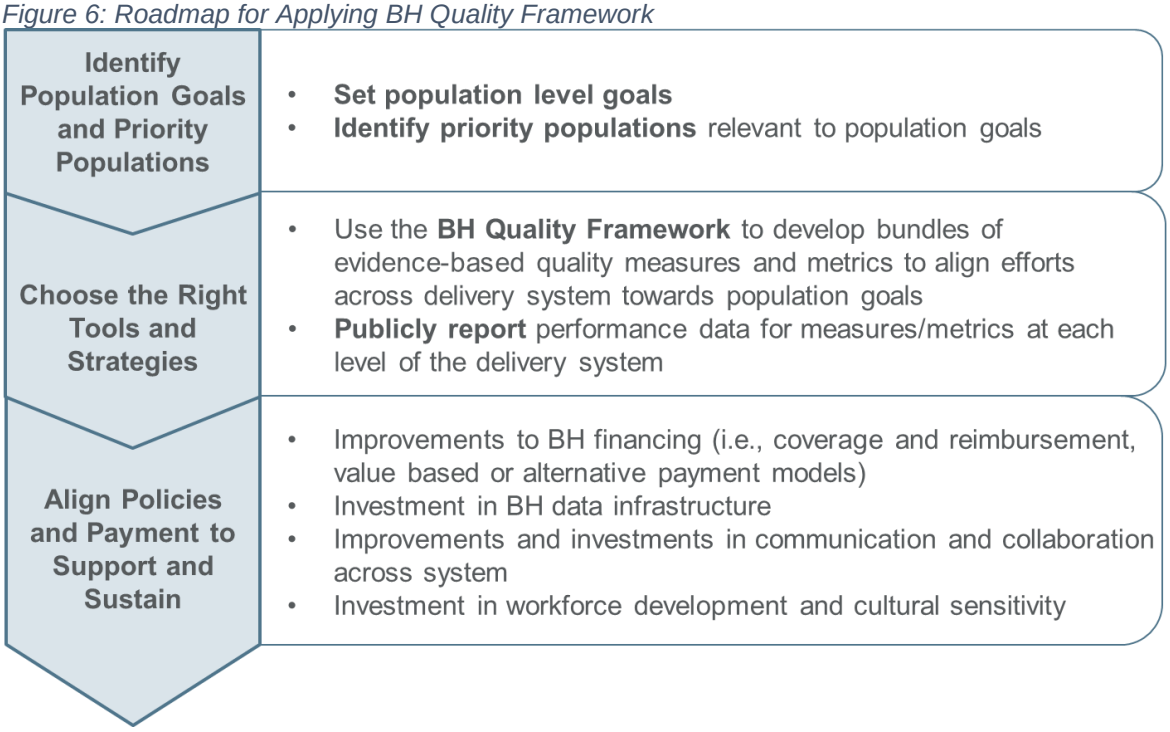


Stakeholders at each level of the system (macro or state/federal; meso or MCO; micro or facility) will identify the most salient, meaningful, and relevant performance measures and metrics. In this model, the goal is not to replicate measures across system levels; rather, measure bundles are transparently defined, measured, and coordinated, with each entity using data to improve care based on its unique position and relationship to its populations and the prioritized goal. Below, we illustrate how this framework can promote collaboration and joint accountability for whole-person care.

Proposed Roadmap to Joint Accountability: Applying the BH Quality Framework

Federal and state entities are positioned to drive improvements in BH care and impact population health goals by setting priorities and directing resources through regulations and financial support. The BH Quality Framework calls for convening a diverse group of stakeholders that includes state policymakers, payers, providers, and consumers to jointly prioritize population goals for BH and target underserved, marginalized populations. Below, we highlight key steps that could drive joint accountability efforts *(Figure 6)*.

Figure 6: Roadmap for Applying BH Quality Framework



Step 1: Identify Priority Goals and Relevant Populations

To achieve a joint accountability framework for BH, stakeholders across the system should convene to identify population health goals and priority populations. They should apply an equity lens and systematically address gaps in access and outcomes among populations with BH needs. For example, given the ongoing opioid epidemic in the United States and the exacerbation and increase in deaths during the COVID-19 pandemic, a priority population goal may involve reducing opioid-related overdose and mortality. Populations at risk may include individuals with diagnosed opioid use disorder (OUD), individuals who have experienced an adverse opioid-related drug event (e.g., intentional or unintentional opioid overdose), and individuals who rely on prescribed opioid analgesics to manage pain associated with a chronic condition or medical procedure (e.g., fibromyalgia, dental surgeries). When setting goals, opportunities to address known disparities in health care should not be overlooked, such as poorer follow-up rates following non-fatal opioid overdose events among Black individuals compared to non-Hispanic White individuals, or the disproportionate number of OUD deaths among Black patients.[26,27]

Step 2: Choose the Right Tools and Strategies

Following identification of population goals and relevant populations, stakeholders should convene to establish bundles of meaningful quality measures and metrics for use at each level of the delivery system. Convening a diverse and representative group of stakeholders from across the delivery system is critical because targeting the drivers of BH inequities requires understanding the needs, resources, and change levers unique to each entity.

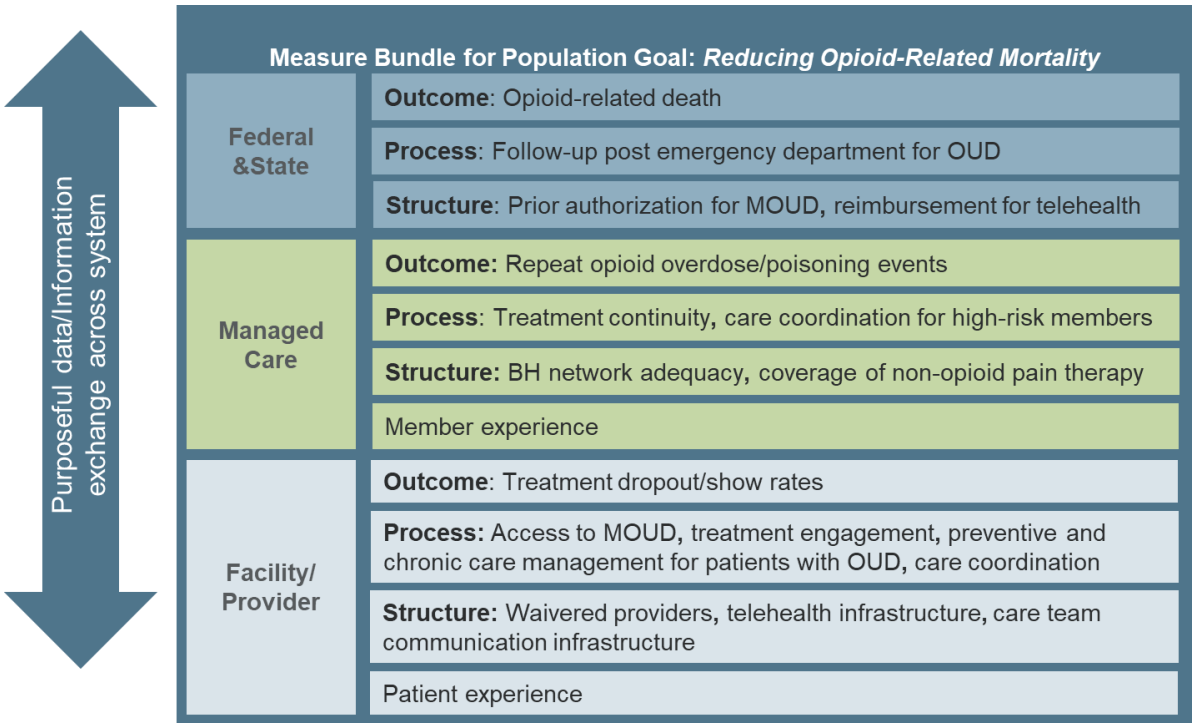
Selecting measures for use. Measures identified for use at each level of the system must be meaningful to the entities that will report them, must be based on high-quality evidence, and must have a relationship to measures used by adjacent entities at the same level (horizontal alignment) and entities at different levels (vertical alignment). Alignment across and between levels of the delivery system will facilitate a coordinated approach to impacting population goals and outcomes.

Development of measure bundles should consider traditionally marginalized groups that experience disparities in care—such as children with special needs, racial and ethnic minorities, and individuals with complex BH and health conditions—and should begin with evaluating existing quality measures and agreed-on standards used in active programs. Such efforts are likely to reveal gaps in existing measures (such as those discussed in *Sections 1 and 2* of this report) or highlight where current measures require adaptation, expansion, or replacement. Transparency and standardization are critical to ensure that measure bundling is coordinated, meaningful, and does not result in proliferation of new or single-use measures for similar care constructs.

Ensuring transparency in measurement. Use of the BH Quality Framework should be accompanied by incentivization of data sharing and transparency across the delivery system. Because measures at each level must have a relationship to measures at adjacent levels and might be based on data that is not available at adjacent levels (e.g., facility-level measures based on clinical data, MCO measures based on administrative claims data), transparency is critical for anticipating challenges and adapting BH care management and delivery to support whole-person care and population outcomes. To ensure transparency and data accessibility, web-based dashboards that display current performance for all measures and metrics across the system should be considered.

Example. *Figure 7* illustrates how measures and metrics can be aligned to address the population-level goal of reducing opioid-related mortality.

Figure 7: Aligning Quality Measures Across the Delivery System to Address Population-Level Goals



State stakeholders might prioritize a bundle of quality measures that includes their primary outcome of interest (opioid related mortality) as well as other process and structure measures that support the same outcome, including follow-up care after acute opioid-related events, prior authorizations and coverage of medications to treat OUD (MOUD), and maintenance of state Prescription Drug Monitoring Programs.

MCO stakeholders: To support progress toward reducing opioid-related deaths, states might develop contracts with MCOs to incentivize a focus on the goal. Because they have visibility into claims for ER services for opioid-related overdoses, MCOs might concentrate their efforts on reducing repeat overdose events (which are predictive of future opioid-related mortality).[28] MCOs might also establish process and structure measures to encourage evidence-based interventions and processes that promote treatment continuity and reduce overdose events and mortality (e.g., adequate coverage of MOUD, BH network adequacy, coverage of non-opioid pain management, care coordination or case management services for high-risk individuals who were recently released from incarceration or who had a previous overdose event).

Facility/provider stakeholders: MCOs can then contract with facilities and providers that prioritize outcomes. In this case, because treatment adherence is associated with reduced risk of overdose, facilities and providers might track patient engagement or dropout rates.

The measures in facility-level bundles may differ by the facility/provider type and their role in managing opioid misuse or abuse. In this example, process measures might be related to ensuring that at-risk individuals receive adequate pain management for chronic conditions and have access to and continuity of MOUD. Structural measures might assess availability of buprenorphine-waivered providers, facility telehealth infrastructure, and care coordination supports for managing individuals with complex conditions.

Step 3: Align Policies and Payment to Sustain

Driving a BH Quality Framework to achieve population-level goals requires that effective regulations, policies, and payment structures are in place to incentivize engagement and joint accountability

among payers, delivery systems, public health and social service organizations, community-based organizations—and patients. While stakeholders at all levels should convene to identify opportunities for system advancement, stakeholders at different levels will have different roles, given their position in the system and their leverage opportunities. Below we highlight four key areas that should be prioritized to support implementation of a BH Quality Framework *(Figure 8)*.

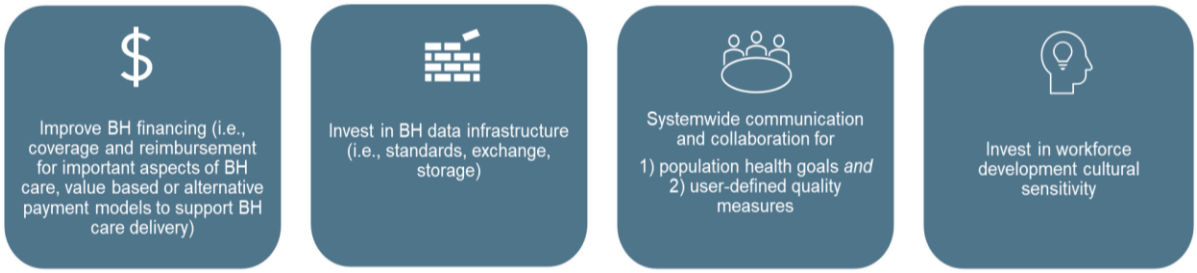
BH financing. Effective implementation of a joint accountability framework requires continued progress in payment reform that incentivizes value over volume and focuses on shared goals, community engagement, leadership alignment, and data exchange.[29] Systems must work to reconcile and reform existing regulations that challenge BHI, increase flexible funding resources, and improve coverage of and reimbursement for important aspects of whole-person care, including reimbursement for wraparound care and case management. Efforts to address the BH workforce shortage are also critical. To incentivize development of a more robust BH workforce, reimbursement for BH support services provided by auxiliary providers (e.g., peer specialists, case managers) must be a priority.

Data infrastructure. Significant investment and incentives are needed to improve the standardization, storage, and purposeful exchange of BH data across entities that provide direct services and manage care for individuals with BH conditions. Although recent efforts in use of digital platforms, health information exchanges, and tele-behavioral health platforms are being leveraged to improve data infrastructure, entities interviewed for this study expressed that federal initiatives like the 2009 Meaningful Use program could help drive large-scale improvements to BH data infrastructure.

Systemwide communication and collaboration. Effective use of the BH Quality Framework to spur system transformation is contingent on stakeholder buy-in, collaboration, and communication. Entities in the delivery system should be incentivized to set population goals and define bundles of quality measures and metrics that will collectively drive common outcomes. A starting point for this type of collaboration is multi-stakeholder quality measurement advisory groups assembled by state agencies or MCOs.

Workforce and cultural sensitivity development. Creating a systemwide culture of joint accountability requires investment in a multi-level workforce to promote a focus on common goals and whole-person care. Investment in development and training the health care workforce to provide high-quality, culturally competent BH care will equip entities at all levels to engage in meaningful progress toward equitable care.

Figure 8: Infrastructure to Support BH Quality Framework



Conclusion

NCQA recommends testing the proposed BH Quality Framework to promote joint accountability for whole-person BH care. To assess the framework's viability, we encourage pilot work using the roadmap outlined above.

Federal and state entities are positioned to drive improvements and impact population health goals for individuals with BH conditions by setting priorities and directing resources through regulations and financial support—but stakeholders, organizations, and individuals at all levels of the delivery system play a critical role. The BH Quality Framework calls for convening a diverse group of stakeholders that

includes state policymakers, payers, providers, and consumers to prioritize population goals for BH, develop relevant measure bundles, and address known inequities in care that stymie progress.

By aligning and coordinating efforts across the delivery system, meaningful quality measures can drive accountability through transparency and payment. Purposeful alignment and coordinated quality measurement within each entity's sphere of influence, while keeping a sightline to shared goals, can empower stakeholders to make informed decisions while minimizing burden. There have been momentous federal and state investments to mitigate the COVID-19 pandemic's impact on BH, but there is a critical need for a clear framework and approach to driving BH care quality and outcomes. The BH Quality Framework provides a testable model for guiding these efforts.

Looking Ahead: Potential Opportunities to Pilot the BH Quality Framework in California

As we explain in in *Appendix B*, Medi-Cal (California's Medicaid Program) is administered through the state Department of Health Care Services (DHCS) and includes three delivery options for public MH treatment: managed care plans, fee-for-service plans, and county MH plans. By January 1, 2022, DHCS intends to transition all existing managed care authorities into one consolidated 1915(b) California managed care waiver—*CalAIM: California Advancing and Innovating Medi-Cal*—that will prioritize integration of the Medi-Cal delivery systems, alignment of funding sources, and attention on SDOH. A key aspect of the *Medi-Cal (CalAIM)* proposal relates to reforming BH payment and administrative oversight requirements for counties and shifting from a cost-based reimbursement structure to a value-based reimbursement structure that incentivizes outcomes and BHI.

Opportunities to pilot framework
Using the BH Quality Framework as a guide, stakeholders in California could work collaboratively to identify a high-need priority goal and relevant populations for impact. Following this, stakeholders can reach consensus around an aligned and coordinated set of bundled quality measures and metrics across entities within the system. The pilot of the BH Quality Framework could be statewide, in more near-term efforts, and/or be part of the full integration plans that will be tested under *CalAIM* starting as early as 2027.

Build upon existing scaffolding
Of note, there are already multiple active stakeholder groups in California, including the California County BH Directors Association, the California MH Services Authority, the California Department of Health Care Services BH Task Force, and multiple MCO and facility-led quality measurement groups. These groups suggest that multi-level collaboration is a natural extension of current state efforts.

Appendix

Appendix A: Environmental Scan Supplemental information

Figure A1: Federal Reporting Program Identification and Selection for Study Inclusion (as of October 2020)

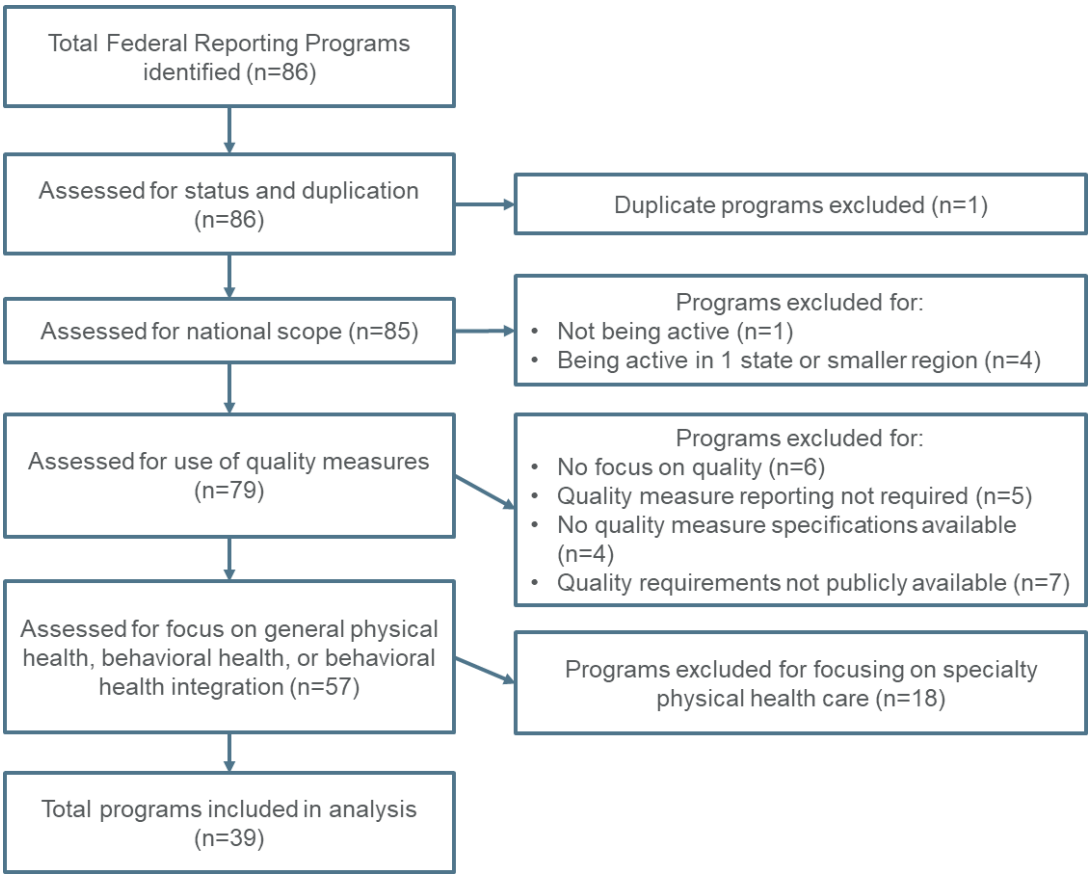


Table A2: Federal Reporting Programs Included in Environmental Scan (N=39)

Program	Sponsoring Agency	Demonstration (Y/N)	Reporting Entity	Program Type		
				Gen. Med.	BH	BHI
1. Substance Abuse Prevention and Treatment Block Grant (SABG)	SAMHSA		States		X	
2. Community Mental Health Services Block Grant (MHBG)	SAMHSA		States		X	
3. Section 1115 SMI/SED Demonstration	CMS	Y	States		X	
4. Section 1115 SUD Demonstration	CMS	Y	States		X	
5. Medicaid 1115 Community Engagement	CMS	Y	States		X	
6. Inpatient Psychiatric Facility Quality Reporting Program (IPFQR)	CMS		Inpatient		X	
7. Integrated Care for Kids (InCK) Model	CMS (CMMI)	Y	Multilevel			X
8. Certified Community Behavioral Health Clinics	SAMHSA, CMS, ASPE	Y	Multilevel			X

Program	Sponsoring Agency	Demonstration (Y/N)	Reporting Entity	Program Type		
				Gen. Med.	BH	BHI
9. Promoting Integration of Primary and Behavioral Health Care Cooperative Agreements [PIPBHC]	SAMHSA, CMS		States			X
10. Health Centers Program	HRSA		Practices			X
11. Comprehensive Primary Care Plus (CPC+) Model	CMS (CMMI)	Y	Practices			X
12. Maternal Opioid Misuse (MOM) Model	CMS (CMMI)	Y	States			X
13. Community Health Access and Rural Transformation Model: Community Transformation Track	CMS	Y	Multilevel	X		
14. Financial Alignment Initiative for Medicare-Medicaid Enrollees: Capitated model	CMS (CMMI)	Y	States	X		
15. Financial Alignment Initiative for Medicare-Medicaid Enrollees: Managed Fee-for-service model	CMS (CMMI)	Y	States	X		
16. CMS Adult Core Set	CMS		States	X		
17. CMS Child Core Set	CMS		States	X		
18. Medicare Advantage (including Star Rating measures)	CMS		MA Organizations	X		
19. Next Generation ACO Model	CMS (CMMI)	Y	ACOs	X		
20. Direct Contracting Model Options	CMS (CMMI)	Y	ACOs	X		
21. Medicare Shared Savings Program	CMS		ACOs	X		
22. Medicare-Medicaid Plans (MMP)	CMS		Health plans	X		
23. Marketplace Quality Rating System	CMS		Health plans	X		
24. Inpatient Rehabilitation Facilities (IRF) Quality Reporting Program	CMS		Inpatient	X		
25. Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program	CMS		Inpatient	X		
26. Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents: Phase Two	CMS (CMMI)	Y	Inpatient	X		
27. Hospital Outpatient Quality Reporting	CMS		Hospitals	X		
28. Hospital Inpatient Quality Reporting (IQR) Program	CMS		Hospitals	X		
29. Long-Term Care Hospital (LTCH) Quality Reporting Program	CMS		Hospitals	X		
30. Hospital Readmissions Reduction Program	CMS		Hospitals	X		
31. Hospital Value-Based Purchasing (VBP) Program	CMS		Hospitals	X		
32. Bundled Payments for Care Improvement (BPCI) Advanced Model	CMS (CMMI)	Y	Hospitals	X		
33. Skilled Nursing Facility (SNF) Quality Reporting Program	CMS		Inpatient	X		
34. Rural Community Hospital Demonstration	CMS (CMMI)	Y	Hospitals	X		
35. Programs of All Inclusive Care for the Elderly (PACE)	CMS		Community-based programs	X		
36. Independence at Home Demonstration	CMS (CMMI)	Y	Practices	X		
37. Primary Care First Model	CMS (CMMI)	Y	Practices	X		
38. Merit-Based Incentive Payment System (MIPS) Program	CMS		Practices, providers	X		
39. Medicaid Health Homes Program	CMS		States	X		

Table A3: Quality Measures in Federal Reporting Programs Focused on Behavioral Health Integration

	Certified Community Behavioral Health Clinics	Comprehensive Primary Care Plus Model	Health Centers Program	Integrated Care for Kids Model	Maternal Opioid Misuse Model	Promoting Integration of Primary and BH Care Cooperative Agreements	Total
Measures and Metrics							
NQF or CMIT endorsed	22 (69%)	17 (100%)	11 (20%)	8 (62%)	1 (20%)	0 (0%)	59 (39%)
Not NQF or CMIT endorsed	2 (6%)	0 (0%)	3 (6%)	1 (8%)	0 (0%)	0 (0%)	6 (4%)
Metric	8 (25%)	0 (0%)	41 (75%)	4 (31%)	4 (80%)	28 (100%)	85 (57%)
Type of NQF-Endorsed and CMIT Measure							
Donabedian Measure Type							
Structure	0 (0%)	1 (5%)	0 (0%)	1 (13%)	0 (0%)	n/a	2 (3%)
Process	19 (86%)	12 (71%)	9 (82%)	6 (75%)	0 (0%)	n/a	46 (78%)
Intermediate Outcome	1 (5%)	2 (12%)	1 (9%)	1 (13%)	0 (0%)	n/a	5 (8%)
Outcome	2 (9%)	2 (12%)	1 (9%)	0 (0%)	1 (100%)	n/a	6 (10%)
Data Source*							
Admin/Claims	18 (82%)	12 (71%)	7 (64%)	7 (88%)	0 (0%)	n/a	44 (75%)
EHR	6 (27%)	9 (53%)	10 (91%)	5 (63%)	0 (0%)	n/a	30 (51%)
Survey	1 (5%)	2 (12%)	0 (0%)	1 (13%)	1 (100%)	n/a	5 (8%)
Paper medical records	4 (18%)	7 (41%)	10 (91%)	3 (38%)	0 (0%)	n/a	24 (41%)
Other	6 (27%)	1 (6%)	5 (45%)	1 (13%)	0 (0%)	n/a	13 (22%)
Measure Domains							
General Medical Domains (Subtotal)	**3 (14%)**	**7 (41%)**	**8 (73%)**	**2 (25%)**	**0 (0%)**	n/a	**20 (34%)**
General medical screening or diagnostic assessment and prevention	1 (5%)	6 (35%)	8 (73%)	2 (25%)	0 (0%)	n/a	17 (29%)
Access to general medical care	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	n/a	0 (0%)
General medical outcomes	2 (9%)	1 (6%)	0 (0%)	0 (0%)	0 (0%)	n/a	3 (5%)

	Certified Community Behavioral Health Clinics	Comprehensive Primary Care Plus Model	Health Centers Program	Integrated Care for Kids Model	Maternal Opioid Misuse Model	Promoting Integration of Primary and BH Care Cooperative Agreements	Total
BH Domains (subtotal)	**19 (86%)**	**4 (24%)**	**3 (27%)**	**4 (50%)**	**1 (100%)**	n/a	**31 (53%)**
BH screening or assessment and follow-up	7 (32%)	2 (12%)	2 (18%)	2 (25%)	0 (0%)	n/a	13 (22%)
BH evidence-based treatment	11 (50%)	1 (6%)	0 (0%)	2 (25%)	0 (0%)	n/a	14 (24%)
BH patient-centered care	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	n/a	0 (0%)
Access to behavioral healthcare	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	n/a	0 (0%)
BH outcomes	1 (5%)	1 (6%)	1 (9%)	0 (0%)	1 (100%)	n/a	4 (7%)
Cross-Cutting Measures (Subtotal)	**0 (0%)**	**6 (35%)**	**0 (0%)**	**2 (25%)**	**0 (0%)**	n/a	**8 (14%)**
Family/patient perception of care	0 (0%)	1 (6%)	0 (0%)	0 (0%)	0 (0%)	n/a	1 (2%)
Continuity and coordination of care	0 (0%)	1 (6%)	0 (0%)	1 (13%)	0 (0%)	n/a	2 (3%)
Social service access	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	n/a	0 (0%)
Patient safety	0 (0%)	2 (12%)	0 (0%)	0 (0%)	0 (0%)	n/a	2 (3%)
Cost, efficiency, and utilization	0 (0%)	2 (12%)	0 (0%)	1 (13%)	0 (0%)	n/a	3 (5%)
Total Measures	**22**	**17**	**11**	**8**	**1**	**n/a**	**59**

Measures may allow use of more than one type of data and thus may be counted in more than one category.

CPC+ = Comprehensive Primary Care Plus InCK = Integrated Care for Kids MOM = Maternal Opioid Misuse
PIPBHC = Promoting Integration of Primary and BH Care Cooperative

Appendix B: State Profiles

California

Administration & Financing

California's Medicaid Program, *Medi-Cal*, is administered through the state Department of Health Care Services (DHCS) and includes three delivery options for public mental health (MH) treatment: managed care plans (MCP), fee-for-service (FFS) plans, and county mental health plans (MHP).[30] For California residents with mild to moderate MH conditions, DHCS contracts with MCPs to deliver both MH and physical health (PH) services on a capitated basis.[31]

For Medicaid beneficiaries and residents severe mental illness (SMI) and without insurance, DHCS contracts with county MHPs through an FFS model financed through a 1915(b) waiver to provide MH services.[31,32,33] For state residents with a substance use disorder (SUD) who are in Medicaid or are uninsured, services are available through the county under two models. The first model comprises FFS *Drug Medi-Cal* plans that cover a limited set of services through state contracts. The second model (previously known as the *Drug Medi-Cal Organized Delivery System*) is a managed care model financed through a Section 1115(a) waiver.[34]

California's estimated $5.6 billion Medicaid budget for MH services in state fiscal year (FY) 2020–2021 is funded through federal funds (59%), state funds (11%), and local funds from the 1991 and 2011 realignments, the Mental Health Services Act (MHSA), and other local funds (roughly 30%). The federal and state funds portion of MH services in Medi-Cal represent approximately 3% of total Medicaid funding in the 2020–2021 Budget Act. (Local funds for MH are not appropriated as part of the state Medi-Cal budget.)[35]

Innovation

DHCS developed a framework to build on the achievements of *Medi-Cal* 2020 (2015–2020 1115 Medicaid Waiver) that will address delivery system fragmentation and other priorities. By January 1, 2022, DHCS intends to transition all existing managed care authorities into one consolidated 1915(b) California managed care waiver, *CalAIM: California Advancing and Innovating Medi-Cal,* that will prioritize integration of the Medi-Cal delivery systems, alignment of funding sources, and increased attention for social determinants of health. [36] Under *CalAIM*, California will also pursue efforts to eliminate duplicate processes for quality improvement and performance measurement.

Behavioral Health Accountability

With regard to accountability for mild and moderate MH care, DHCS requires MCPs to report annually on Managed Care Accountability Sets (MCAS) that include measures for MH and SUD treatment selected primarily from the Medicaid Adult and Child Core Sets.[37] Additionally, in FY 2019–2020, DHCS implemented a value-based reimbursement model for risk-based accountability of MCPs, including the Value-Based Payment Program and the Behavioral Health Integration Incentive Program, to incentivize improvement of PH and MH outcomes.[38] Participants in these programs will be evaluated using quality measures, many of which are included in the Medicaid Core Sets and HEDIS.

With regard to accountability for severe MH managed through counties, DHCS, local and state authorities, and the legislatively mandated Mental Health Services Oversight and Accountability Commission (MHSOAC) provide funding and financial oversight. MHPs must report annually on MHSA programs and expenditures and must submit three-year plans on how they will use funds to address community-based needs.[39] Tracked outcomes of interest for MHSOAC include school failure, incarceration, suicide, homelessness, unemployment, out-of-home placement, and prolonged suffering.

Washington

Administration & Financing

The Washington state Health Care Authority (HCA) provides funding and oversight for BH services for Washington's Medicaid and CHIP programs, known collectively as *Apple Health*.[40] Most *Apple Health* enrollees access BH treatment through managed care organizations (MCO) that offer fully integrated PH and BH care. Individuals who are not eligible for managed care (e.g., dual-eligible Medicare/Medicaid beneficiaries) can access BH benefits through Behavioral Health Services Only (BHSO) operated by MCOs under a Section1915(b) waiver.[41] Regardless of insurance status or income level, individuals experiencing an MH crisis can access a Behavioral Health—Administrative Services Organization (BH-ASO) (partially funded through federal block grants). BH-ASOs may also provide noncrisis MH services to low-income individuals not eligible for *Apple Health* but who meet other program criteria.[42]

15% of Apple Health's $21 billion biennial Medicaid budget goes toward BH. In the FY 2019–2021 budget, the state general fund accounted for over one-third of the public mental health budget and federal sources made up nearly two-thirds.[43]

Innovation

In 2014, the Washington State Legislature mandated a two-step transition to integrated care, beginning with integration of MH and SUD treatment services and proceeding to full integration of managed care for PH and MH services by January 2020.[44] Over 84% of full-benefit Medicaid beneficiaries are now enrolled in one of five MCOs that contract with the state to serve each county.[45, 46]

As part of the *Healthier Washington* initiative, the state developed the Medicaid Transformation Project (MTP) through a Section 1115 demonstration waiver approved by CMS in January 2017. At the core of the MTP are nine regional Accountable Communities of Health (ACH), self-governing organizations of regional coalitions focused on improving health and transforming care delivery in their communities. ACHs play an integral role in advancing MTP initiatives, including long-term services and supports, supportive housing and supported employment, and institutions for mental diseases waivers for SUD and MH.

Behavioral Health Accountability

In 2014, the Washington Legislature established the Statewide Common Measure Set, which includes both PH and BH measures and is used to for both state population health monitoring and for value-based contracting. By the end of 2021, HCA seeks to drive 90% of state-financed health care into value-based arrangements. ACH's, providers, and partnering organizations are also eligible for incentive payments by achieving value-based plan milestones.[47] HCA drives quality improvement through transparent goal setting and performance measure rate display through both *Results Washington* and *Results HCA*. The Washington Health Alliance, a private nonprofit organization, publishes a yearly statewide "Community Checkup" report that includes quality measure performance scores for clinics, medical groups, hospitals, health plans, counties, and each of the nine ACHs operating in the state. The measures included in the Community Checkup report change in response to changing priorities, but currently include measures to monitor progress of BH integration and access to MH and SUD treatment services.[48, 49]

Colorado

Administration & Financing

The Colorado Department of Health Care Policy & Financing (HCPF) oversees the state's Medicaid program, *Health First Colorado*. Medicaid services in Colorado are coordinated by seven Regional Accountability Entities (RAE) that finance care delivery through a hybrid approach, with BH services under a capitated model and PH services under an FFS model.[50,51] BH care for Colorado residents who are uninsured or underinsured is managed by the Office of Behavioral Health in the Colorado Department of Human Services.[52]

9% of the $10.7 billion state Medicaid budget was allocated to BH programs in FY 2019–2020.[53] Of note, a 2019 State Behavioral Health Task Force proposed that Colorado work to consolidate the over 60 unique funding streams that finance state BH services, to reduce inefficiencies and fragmentation.[54]

Innovation

In 2011, HCPF launched the Accountable Care Collaborative (ACC) to improve members' health and reduce costs. Operating under a Section 1915(b) waiver, the ACC program is a hybrid model that combines elements of the Accountable Care Organization and Primary Care Case Management Entity models.[55] Phase one of ACC focused on connecting *Health First Colorado* members to primary care providers, improving health outcomes and controlling costs. Phase two advances Health First Colorado's care delivery and payment model. Objectives include integration of PH and BH, transitioning to value-based care, enhancing care coordination and patient engagement, and promoting greater accountability and transparency.[56]

Behavioral Health Accountability

HCPF uses key performance indicators (KPI) to assess the overall performance of the ACC and reward RAEs for improved health outcomes and cost efficiencies. RAEs have the opportunity to earn back HCPF-withheld administrative PMPM payments by meeting performance thresholds on KPIs, which include both PH and BH measures.[57] Additionally, the BH Incentive Program allows RAEs to earn up to 5% above their annual capitation payment by meeting participation performance requirements and targets across five MH and SUD measures.[58] HCPF is developing a public reporting dashboard to publish data on KPIs, including clinical and utilization measures, for greater transparency and accountability.[59]

Pennsylvania

Administration & Financing

97% of state Medicaid beneficiaries are enrolled in the fully capitated managed care program, *HealthChoices*. Oversight for *Physical HealthChoices* and CHIP falls to the Office of Medical Assistance Programs (OMAP); oversight of the *Behavioral HealthChoices* program and six state mental hospitals and one restoration center fall to the Office of Mental Health and Substance Abuse Services (OMHSAS). *Behavioral HealthChoices* is a carve-out model managed at the county level through capitated agreements between behavioral health managed care organizations (BH-MCO) and local county entities. Pennsylvania counties have the "right of first opportunity" to enter into direct agreements with BH-MCOs for provision of BH benefits and, to date, 43 counties have opted into these direct contracts. For the 24 counties that waived this option, OMHSAS contracts directly with a BH-MCO to administer the *Behavioral HealthChoices* program.[60]

In 2018, the Department of Human Services (DHS) implemented its managed long-term services and supports (MLTSS) program, *Community HealthChoices (CHC),* for low-income older adults and adults with physical disabilities. CHC, which is administered by the Office of Long-Term Living, provides PH and LTSS services for individuals over age 21 who are either dually enrolled in or eligible for Medicaid and Medicare, or are eligible for both Medicaid and nursing facility care. SUD care for Pennsylvania residents who are uninsured or underinsured is managed by the Department of Drug and Alcohol Programs, which also manages licensing and certification of drug and Alcohol Treatment Facilities and administers funding for community-based SUD services to the state's 47 Single County Authorities.[61]

15% of the state's $32.2 billion dollar Medicaid budget in FY 2020–2021 went toward provision and management of BH services.[62]

Innovation

In 2016, OMHSAS and OMAP launched the Integrated Care Program (ICP) pay for performance (P4P) program for state PH managed care organizations (PH-MCOs) and BH-MCOs to integrate physical and BH care management activities for members diagnosed with serious and persistent mental illness (SPMI) or SUD.[63] MCOs that demonstrate collaboration are eligible to receive financial incentives based on

performance on five quality measures. DHS is exploring options to increase the number of measures and expand beyond the SPMI and SUD populations.

In 2018, Pennsylvania received a five-year grant from SAMHSA for the PIPBHC (Promoting the Integration of Primary and Behavioral Health Care) program to develop a comprehensive approach to improve the overall wellness of special populations, such as adults with SUD, children with serious emotional disturbance, and adults with co-occurring mental illness and physical health conditions.[64] In 2020, the governor announced his administration's plan for Whole-Person Health Reform, which includes three initiatives to expand and prioritize integrated care and value-based purchasing reforms.[65]

Behavioral Health Accountability

The Pennsylvania Department of Health Services requires yearly reporting of quality measures, which include HEDIS measures; measures in the Medicaid Adult, Child, and BH Core Sets; and state-developed "Pennsylvania Performance Measures." The department conducts Quarterly Quality Review Meetings to review MCO performance against stated goals, monitor performance, and establish new targets. In 2021 OMHSAS intends to launch a P4P program that will provide incentive payments to county-based primary contractors based on HEDIS measure performance and improvement goals.

Louisiana

Administration & Financing

84% of Medicaid beneficiaries in Louisiana are enrolled in the state Medicaid managed care program, *Healthy Louisiana*, which provides full coverage for both PH and specialized behavioral health (SBH) through managed Care Entities (MCEs).[66] The Office of Behavioral Health (OBH), within the Louisiana Department of Health (LDH), provides oversight for *Healthy Louisiana* BH services, coordinates BH care for uninsured populations, and operates two state psychiatric facilities.[67] For children and youth with complex BH challenges who are at risk for out-of-home placement, the Coordinated System of Care, a prepaid inpatient health plan that operates under a 1915(c) HCBS waiver, provides intensive home and community-based supportive services.[68]

The OBH FY 2020 budget was approximately $13 billion. Federal sources contributed to nearly three-quarters of the budget, while the state's general fund and other state funds accounted for 15% and 11% of the *Healthy Louisiana* budget, respectively.[69] 9% of Louisiana's total Medicaid budget goes toward BH services.

Innovation

In 2008, the Louisiana legislature mandated local administration of the state's BH system as part of a statewide integrated human services delivery system.[70] Ten independent health care authorities, *Human Service Districts* (or *Local Government Entities*), provide services including screening and assessment, emergency crisis care, and clinical casework services for both insured and uninsured residents with MH conditions, SUDs, and developmental disabilities.[71] In 2018, Louisiana received a five-year PIPBHC grant from SAMHSA to promote the integration of primary and BH services among four Federally Qualified Health Centers (FQHC) in the state.

Behavioral Health Accountability

Louisiana requires all MCEs to report annually on a set of quality performance measures, including measures from the Medicaid Adult and Child Core Sets, HEDIS, Agency for Healthcare Research and Quality Prevention Quality Indicators, CAHPS® (Consumer Assessment of Healthcare Providers and Systems), and state-specified measures. LDH withholds 1% of MCEs' monthly capitated payments for the measurement year, which can be earned back by meeting or improving on performance measurement targets established by LDH. LDH also requires MCEs to submit Performance Improvement Projects, including one LDH-approved BH project, each contract year.[72]

Appendix C: Stakeholder Interview Methods

Interview guides and survey questions were developed to solicit data from organizations in each of the following domains: 1.) organizational structure and financing of BH care; 2.) accountability through BH quality measurement; 3.) BH quality improvement priorities; 4.) alignment of BH quality measurement across accountability levels; and 5.) impact of COVID-19 on BH care delivery and quality measurement.

Following transcription, interview data was coded using the qualitative Framework Method[73] to systematically analyze data and identify key themes and issues. Two research team members reviewed transcripts and developed a codebook, which was updated and revisited throughout coding to account for emergent themes. Following establishment of interrater reliability (0.82), the research team coded all interviews, using weekly check-in meetings to discuss ongoing coding memos, uncertainties or questions in code application, and any need for revisions to the codebook. Following coding, the research team further refined codes into broader themes and into a final thematic framework used to identify key insights. The team organized the framework by delivery system level to help identify patterns across like entities or within systems.

To enhance validity of results, preliminary study findings were presented to NCQA external stakeholder groups. Study participants were also invited to provide input on our summaries of their state profiles.

Table C1 contains the five domains and related questions used to guide stakeholder interviews.

Table C1: Interview Domains and Topics Covered Through Key Stakeholder Interviews

Domain	Interview Guide Questions
Organizational Structure and Financing	• How are BH services delivered and financed? • How are different entities incentivized to deliver high quality BH services through their unique payment model? • How are entities incentivizing or being incented to integrate BH care?
Accountability Through Quality Measurement	• How is the quality of BH services assessed? • How is the quality of integrated BH care assessed? • How does BH data for quality measurement flow between accountable entities in different care delivery models?
Quality Improvement Priorities	• How are quality measurement and quality improvement strategies aligned in different entities?
Alignment Across Accountability Levels	• What are the challenges, and successes around aligning BH quality measures for reporting within and across levels of the delivery system? • How are entities aligning measurement across levels of the delivery system?
Impact of COVID-19 on MH/SUD Care Quality and Measurement	• How is the quality of BH care monitored during public health emergencies such as COVID-19? • How are entities using telehealth to provide BH care during COVID-19 and how are they monitoring the quality of care delivered?

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CALIFORNIA

Health Care Almanac

CHCF

JULY 2022

Mental Health in California

Waiting for Care

Executive Summary

Mental illnesses are among the most common health conditions faced by Californians: Nearly 1 in 7 California adults experiences a mental illness, and 1 in 26 has a serious mental illness that makes it difficult to carry out daily activities. One in 14 children has an emotional disturbance that limits functioning in family, school, or community activities.

A number of positive changes have helped strengthen California's mental health system. These changes include federal and state laws mandating parity in coverage of mental and physical illness, and the expansion of Medi-Cal eligibility and scope of mental health services under the Affordable Care Act. In addition, there have been numerous public and private efforts to expand access to care, encourage better integration of physical and mental health care, and reduce stigma. Nonetheless, a majority of Californians who need it fail to receive needed care.

Using the most recent data available, *Mental Health in California: Waiting for Care* provides an overview of mental health statewide: disease prevalence, suicide rates, supply and use of treatment providers, and mental health in the criminal justice system. The report also highlights available data on quality of care and mental health care spending.

KEY FINDINGS INCLUDE:

- The prevalence of serious mental illness varied by income, with much higher rates of mental illness for both children and adults in families with incomes below 100% of the federal poverty level.
- Rates of serious psychological distress reported by California adolescents and adults increased between 2016 and 2019.
- California's rate of suicide was below both the national rate and the Healthy People 2030 target, although rates varied within the state by gender, race/ethnicity, and county.
- Close to two-thirds of adults with a mental illness and two-thirds of adolescents with major depressive episodes did not get treatment.
- People incarcerated in California's jails and prisons have high rates of mental illness. In 2019, 30% of female prison inmates and 20% of the male prison population received mental health treatment while incarcerated.

Note: See the current and past editions of Mental Health in California at www.chcf.org/collection/behavioral-health-california-almanac.

CONTENTS

Mental Illness Defined

The following are definitions of categories of mental illness used in this publication:

Any mental illness (AMI) is a categorization for adults 18 and older who currently have, or at any time in the past year have had, a diagnosable mental, behavioral, or emotional disorder, regardless of the level of impairment in carrying out major life activities. This category includes people whose mental illness causes serious, moderate, or mild functional impairment.

Serious mental illness (SMI) is a categorization for adults 18 and older who currently have, or at any time during the past year have had, a diagnosable mental, behavioral, or emotional disorder resulting in functional impairment that interferes with or limits major life activities.

Serious emotional disturbance (SED) is a categorization for children 17 and under who currently have, or at any time during the past year had, a mental, behavioral, or emotional disorder resulting in functional impairment that substantially limits functioning in family, school, or community activities.

Serious psychological distress (SPD) is a measure of psychological distress in the past year using the Kessler 6 series for adolescents and adults.*

Anxiety disorder is excessive anxiety and worry occurring more days than not for at least six months to the degree that it interferes with daily activities such as job performance, school work, and relationships.

Major depressive episode (MDE) is a period of at least two weeks when a child or adult has experienced a depressed mood or loss of interest or pleasure in daily activities and has had a majority of specified depression symptoms.

Mental illness encompasses many diagnoses, including depression, anxiety, and schizophrenia. These diagnoses may affect a person's thinking, mood, or behavior. Some disorders are short-lived. Others are persistent and can lead to difficulty with functioning and to disability. Psychotherapies, behavioral management, and medications have been proven effective in promoting recovery from mental illnesses.

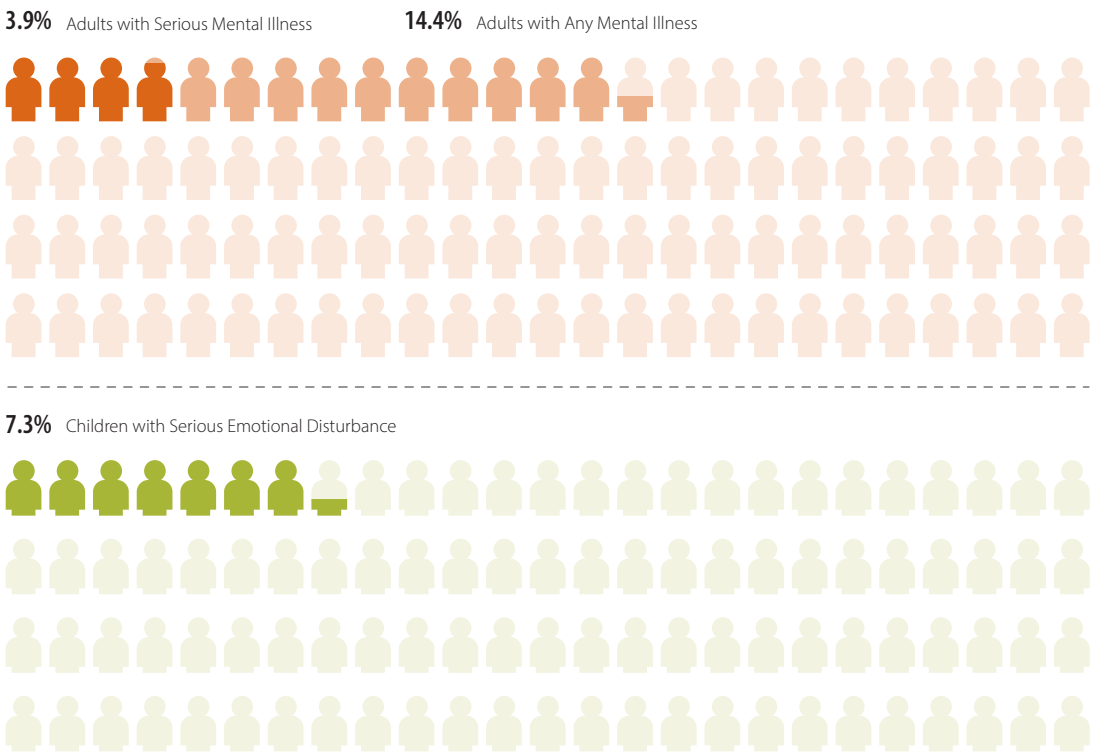
* For more information, see Ronald C. Kessler et al., "Screening for Serious Mental Illness in the General Population with the K6 Screening Scale: Results from the WHO World Mental Health (WMH) Survey Initiative," *Intl. Journal of Methods in Psychiatric Research* 19, no. S1 (June 2010): 4–22.

Sources: *Impact of the DSM-IV to DSM-5 Changes on the National Survey on Drug Use and Health [Internet]*, Substance Abuse and Mental Health Services Administration (SAMHSA), June 2016, table 3.15; *Behavioral Health Barometer: California, Volume 6: Indicators as Measured Through the 2019 National Survey on Drug Use and Health and the National Survey of Substance Abuse Treatment Services*, SAMHSA, 2020; and 58 Fed. Reg. 29422 (May 20, 1993).

Incidence of Mental Illness

Adults and Children, California, 2019

PERCENTAGE OF POPULATION



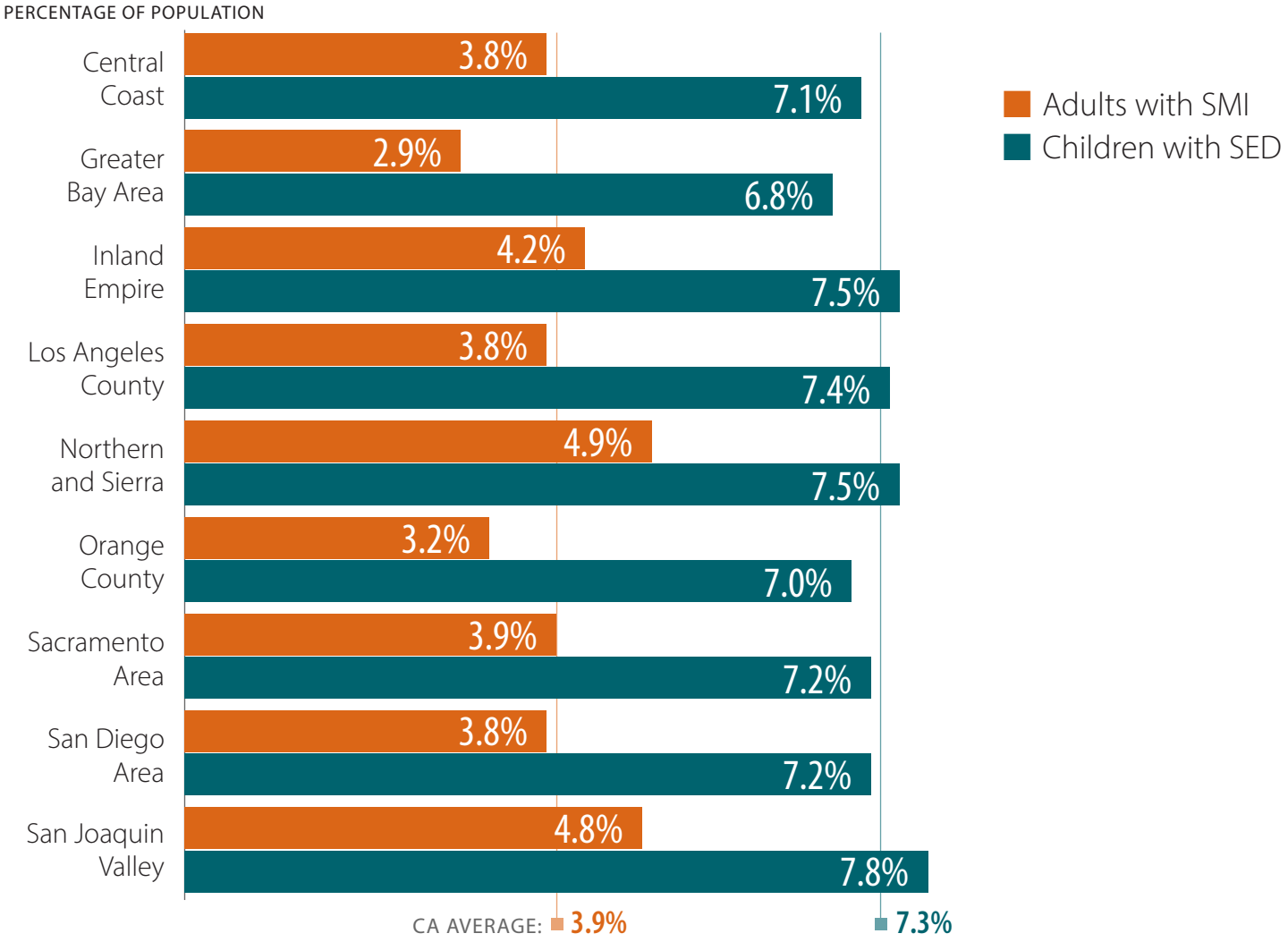
In 2019, one in 26 adults in California experienced a serious mental illness that resulted in difficulty carrying out major life activities. About one in seven adults experienced a mental, behavioral, or emotional disorder (any mental illness). One in 14 children in California had a serious emotional disturbance that could interfere with functioning in family, learning, or getting along with people.

Notes: *Serious emotional disturbance* is a categorization for children age 17 and under. *Serious mental illness* is a categorization for adults age 18 and older. Children do not have an equivalent "any mental illness" designation. See page 3 for full definitions. See page 59 for a description of the methodology used to develop these estimates.

Source: Charles Holzer and Hoang Nguyen, "Estimation of Need for Mental Health Services," received June 28, 2021.

Adults with SMI and Children with SED, by Region

California, 2019



Notes: *Serious emotional disturbance* (SED) is a categorization for children age 17 and under. *Serious mental illness* (SMI) is a categorization for adults age 18 and older. See page 3 for full definitions. See page 59 for a description of the methodology used to develop these estimates. See Appendix for a map of counties included in each region.

Source: Charles Holzer and Hoang Nguyen, "Estimation of Need for Mental Health Services," received June 28, 2021.

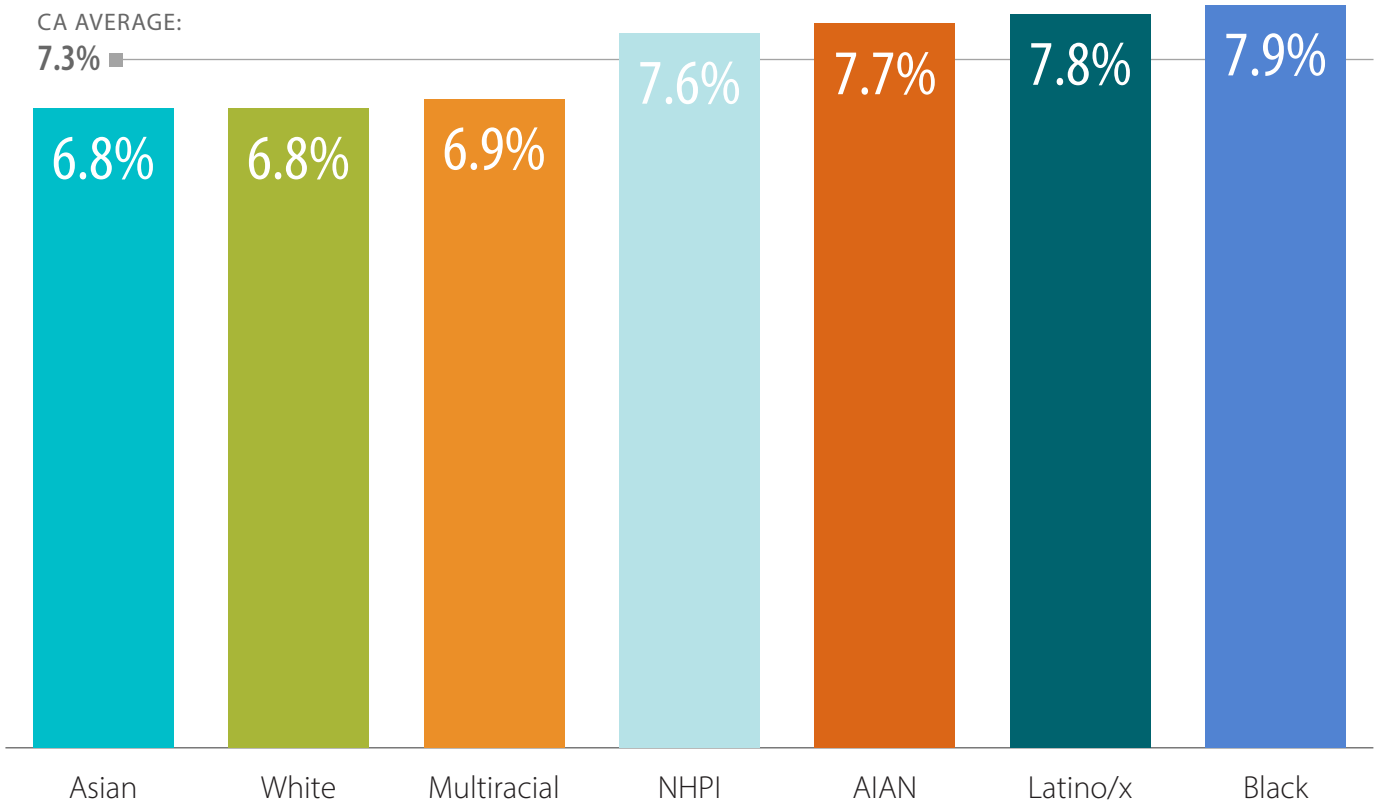
Mental Health
Prevalence

The prevalence of serious mental illness among adults ranged from highs in Northern and Sierra (4.9%) and San Joaquin Valley (4.8%) to a low in the Greater Bay Area (2.9%). The rate of serious emotional disturbance among children in California regions did not vary much by region.

Children with SED, by Race/Ethnicity
California, 2019

Serious emotional disturbance in California children varied slightly by race/ethnicity.

PERCENTAGE OF CHILD POPULATION

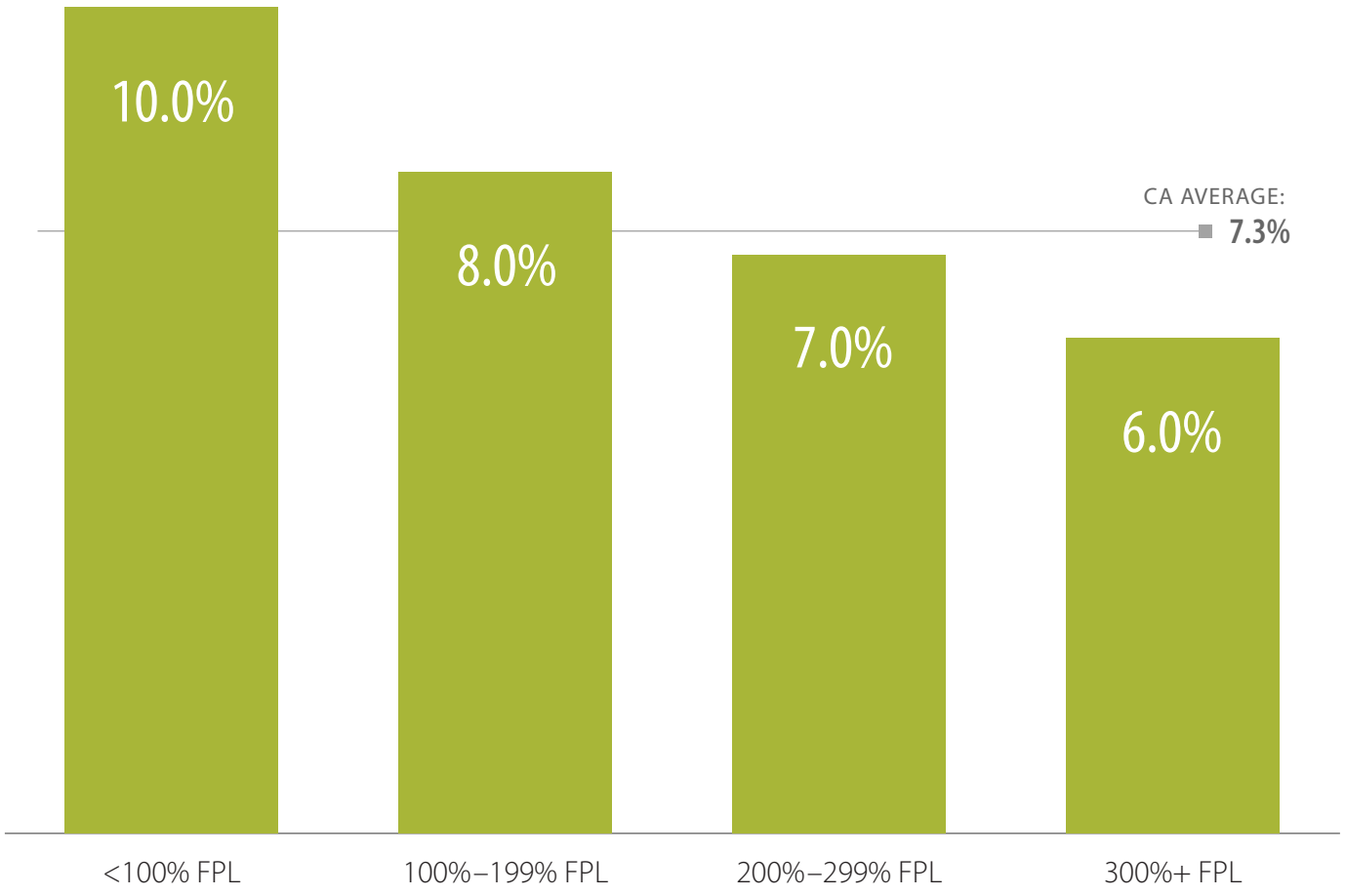


Notes: *Serious emotional disturbance* (SED) is a categorization for children age 17 and under. See page 3 for full definitions. See page 59 for a description of the methodology used to develop these estimates. *NHPI* is Native Hawaiian and Pacific Islander. *AIAN* is American Indian and Alaska Native. Source uses *African American*, *Hispanic*, and *Native American*.

Source: Charles Holzer and Hoang Nguyen, "Estimation of Need for Mental Health Services," received June 28, 2021.

Children with SED, by Income
California, 2019

PERCENTAGE OF CHILD POPULATION



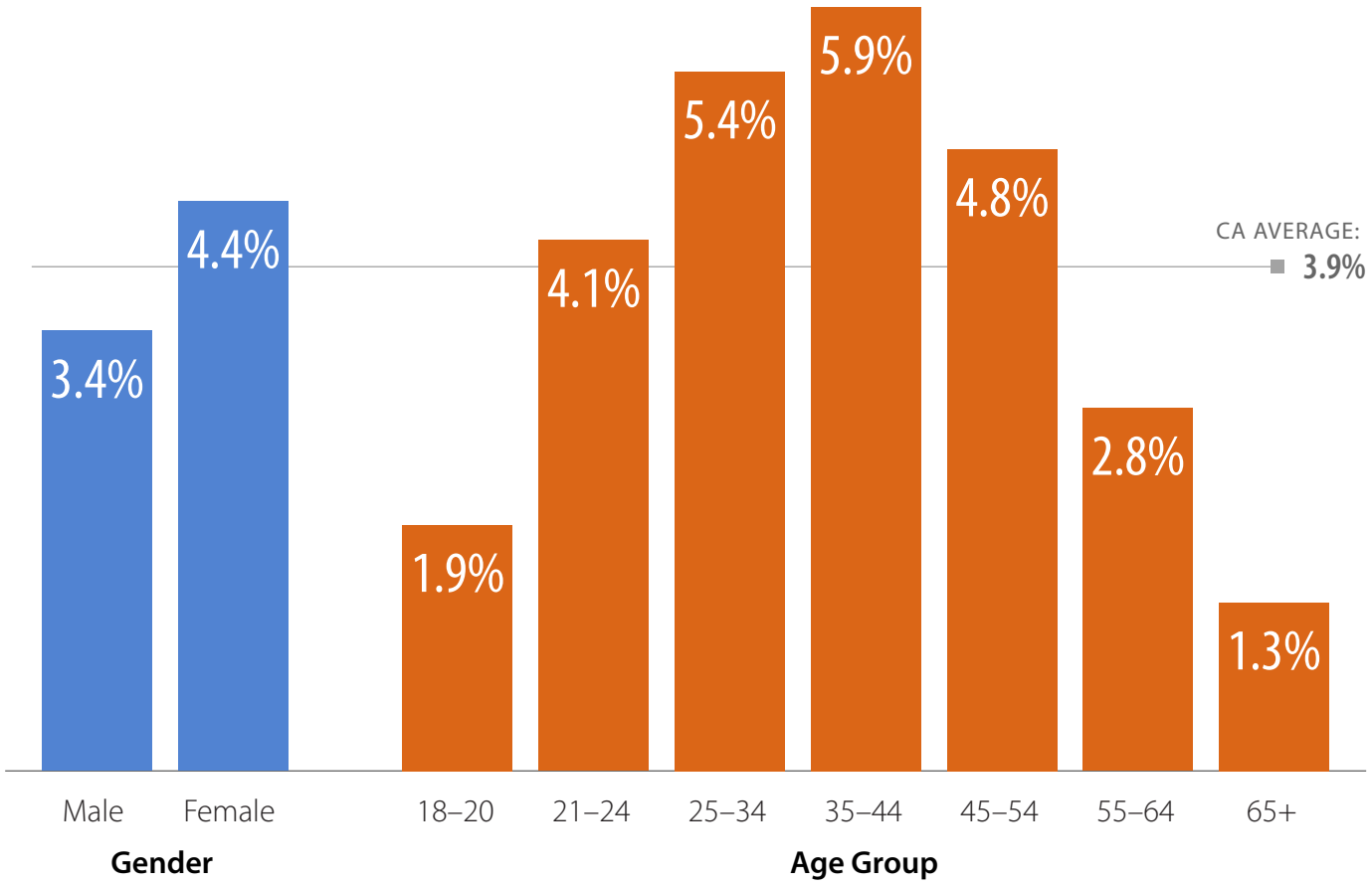
Notes: *Serious emotional disturbance* (SED) is a categorization for children age 17 and under. See page 3 for full definitions. *FPL* is federal poverty level; 100% of FPL in 2019 was an annual income of $12,490 for an individual and $25,950 for a family of four. Excludes 2% of children for whom the level of income could not be determined. See page 59 for a description of the methodology used to develop these estimates.

Source: Charles Holzer and Hoang Nguyen, "Estimation of Need for Mental Health Services," received June 28, 2021.

Serious emotional disturbance is more common among children in families with lower incomes. One in 10 children in families below the federal poverty level experienced a serious emotional disturbance.

Adults with SMI, by Gender and Age Group
California, 2019

PERCENTAGE OF ADULT POPULATION



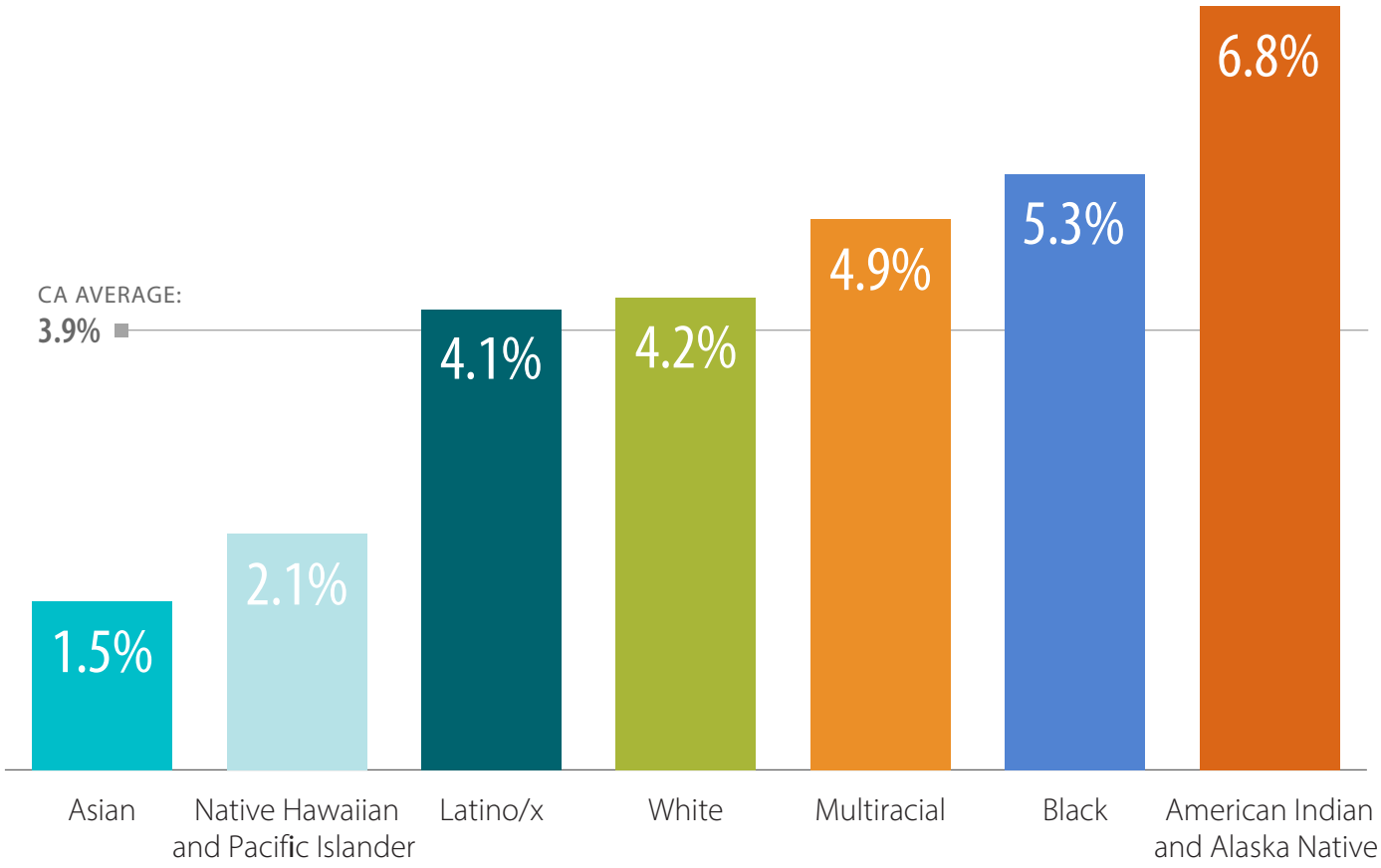
In California, females were slightly more likely than males to experience serious mental illness (SMI). Californians age 35 to 44 had the highest rate of SMI, and those 65 and over had the lowest rate.

Notes: Source did not include additional gender categories. *Serious mental illness* (SMI) is a categorization for adults age 18 and older. See page 3 for full definitions and page 59 for a description of the methodology used to develop these estimates.

Source: Charles Holzer and Hoang Nguyen, "Estimation of Need for Mental Health Services," received June 28, 2021.

Adults with SMI, by Race/Ethnicity
California, 2019

PERCENTAGE OF ADULT POPULATION



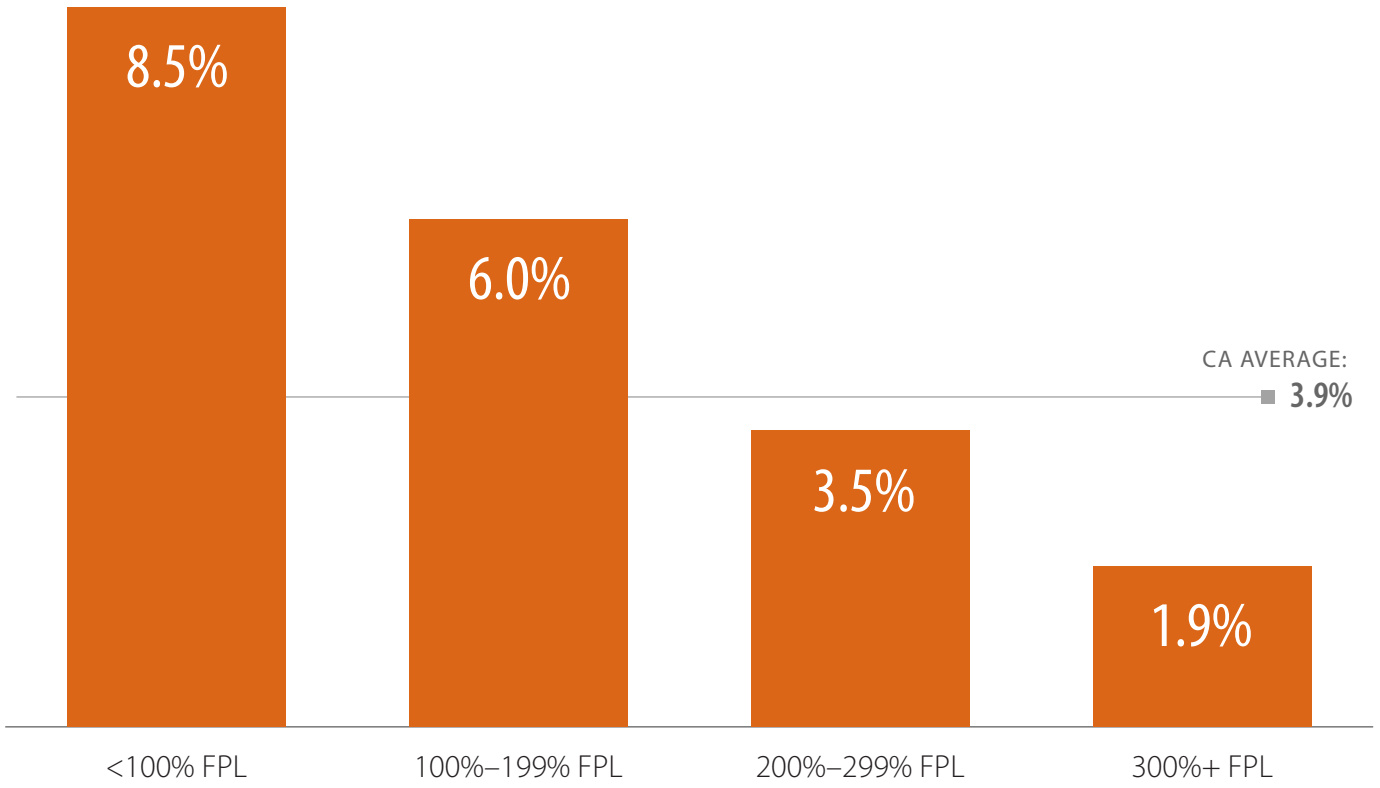
Rates of serious mental illness (SMI) among California adults varied considerably among racial and ethnic groups. American Indian and Alaska Native adults experienced the highest rates.

Notes: *Serious mental illness* (SMI) is a categorization for adults age 18 and older. See page 3 for full definitions and page 59 for a description of the methodology used to develop these estimates. Source uses *African American, Hispanic,* and *Native American*.

Source: Charles Holzer and Hoang Nguyen, "Estimation of Need for Mental Health Services," received June 28, 2021.

Adults with Serious Mental Illness, by Income
California, 2019

PERCENTAGE OF ADULT POPULATION



Notes: *Serious mental illness* is a categorization for adults age 18 and older. See page 3 for full definitions. *FPL* is federal poverty level. In 2019, 100% of FPL was defined as an annual income of $12,490 for an individual and $25,550 for a family of four. Excludes 2% of adults for whom the level of income could not be determined. See page 59 for a description of the methodology used to develop these estimates.

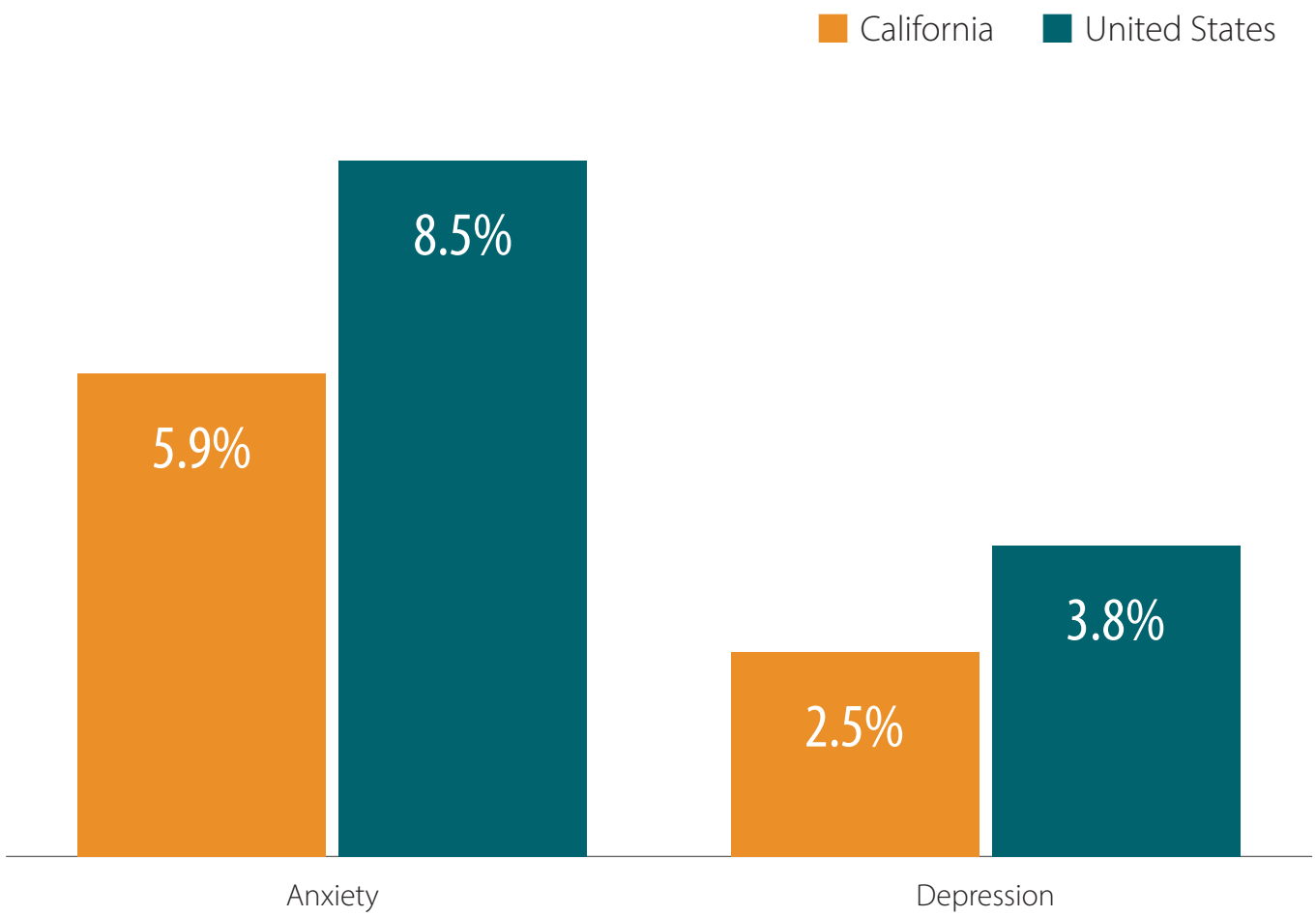
Source: Charles Holzer and Hoang Nguyen, "Estimation of Need for Mental Health Services," received June 28, 2021.

The prevalence of serious mental illness was highest among Californians with the lowest incomes. Nearly one in 12 adults in families with incomes below 100% of the federal poverty level had serious mental illness.

Children with Anxiety or Depression

California vs. United States, 2018 and 2019

PERCENTAGE OF CHILDREN WITH . . .



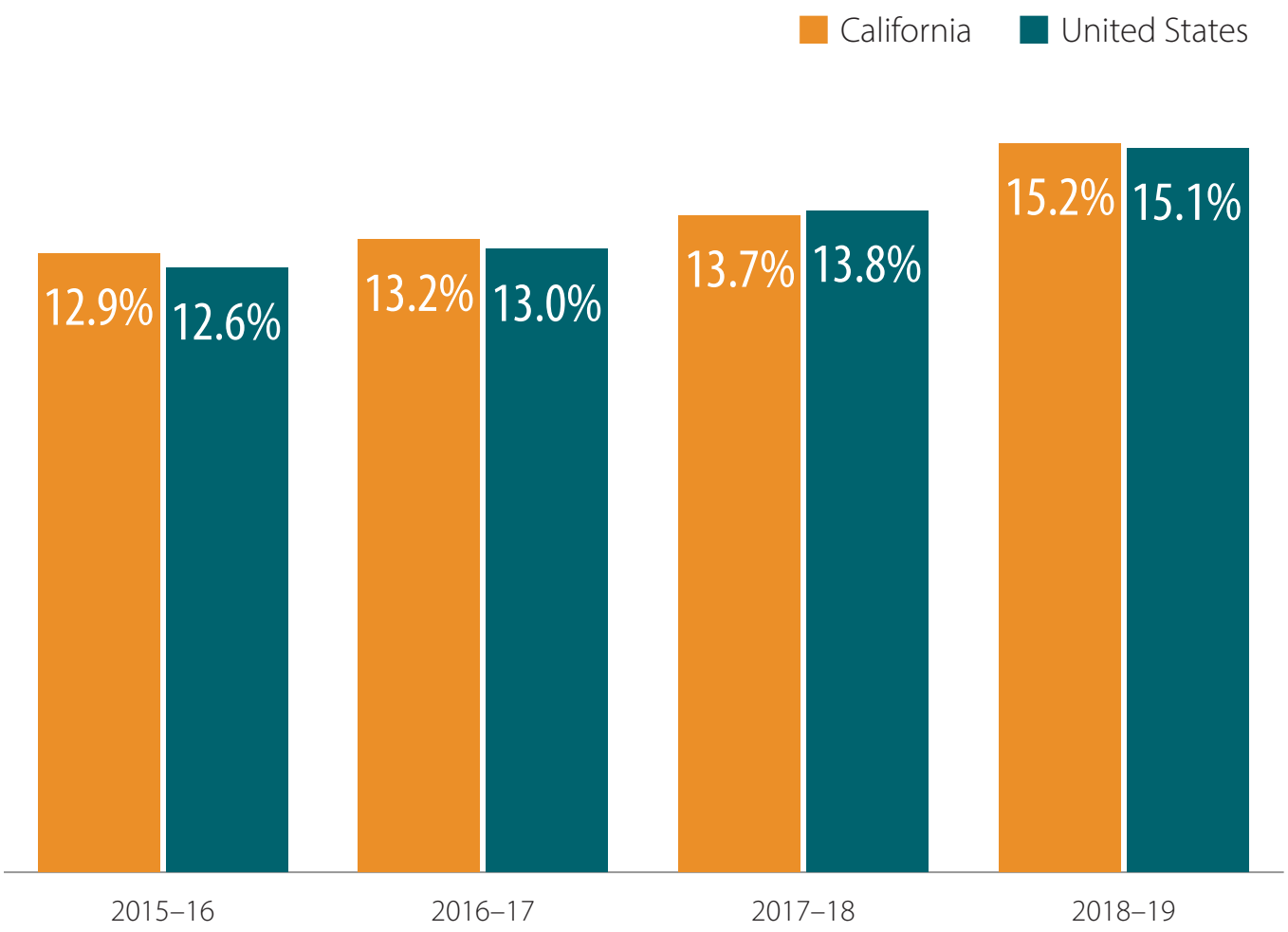
Notes: *Children* are age 3 to 17. *Depression* is a mood disorder with symptoms that can include persistent sadness and hopelessness. *Anxiety* symptoms may include being tense or uptight, seeking reassurance, or feeling restless or on edge. These conditions can interfere with work and school performance and affect a child's relationships with peers and parents. Information about children's health conditions is based on recollection of the child's parent or caregiver and is not independently verified. Combined data from 2018 and 2019 surveys.

Source: "Health Outcomes – Children: Heat Map," America's Health Rankings.

In 2018 and 2019, approximately 6% of California children experienced anxiety and about 3% experienced depression. National rates for both anxiety and depression were higher than California rates.

Adolescents Reporting an MDE in the Past Year

California vs. United States, 2015–16 to 2018–19



Notes: *Adolescents* are age 12 to 17. *MDE* is major depressive episode. Respondents with unknown past-year MDE data were excluded. State estimates are based on a small area estimation procedure in which two years of state-level National Survey on Drug Use and Health (NSDUH) survey data are combined with local-area county and census block group / tract-level data.

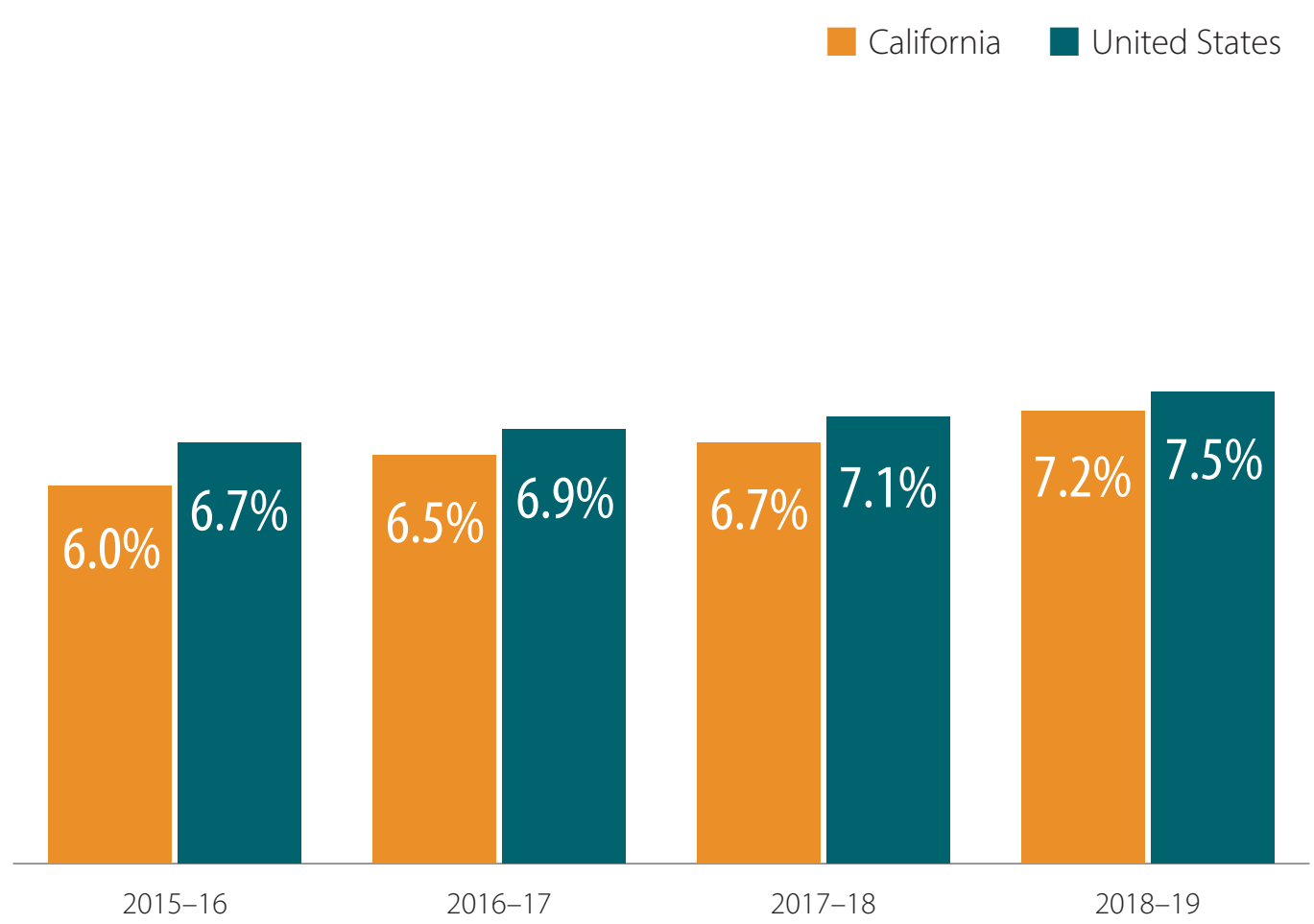
Source: "Interactive NSDUH State Estimates," Substance Abuse and Mental Health Services Administration.

Between 2015–16 and 2018–19, the percentage of adolescents reporting a major depressive episode (MDE) increased in California and the United States. One in seven adolescents reported experiencing an MDE in the past year in 2018–19. Approximately 70% of teens who have an MDE experience functional limitations that meet criteria for severe impairment (not shown).*

* "Mental Health Information: Statistics — Major Depression," National Institute of Mental Health, figure 2.

Adults Reporting an MDE in the Past Year

California vs. United States, 2015–16 to 2018–19



Notes: *Adults* are age 18 and older. *MDE* is major depressive episode. Respondents with unknown past-year MDE data were excluded. State estimates are based on a small area estimation procedure in which state-level National Survey on Drug Use and Health (NSDUH) data from two consecutive survey years are combined with local-area county and census block group / tract-level data from the state to provide more precise state estimates.

Source: "Interactive NSDUH State Estimates," Substance Abuse and Mental Health Services Administration.

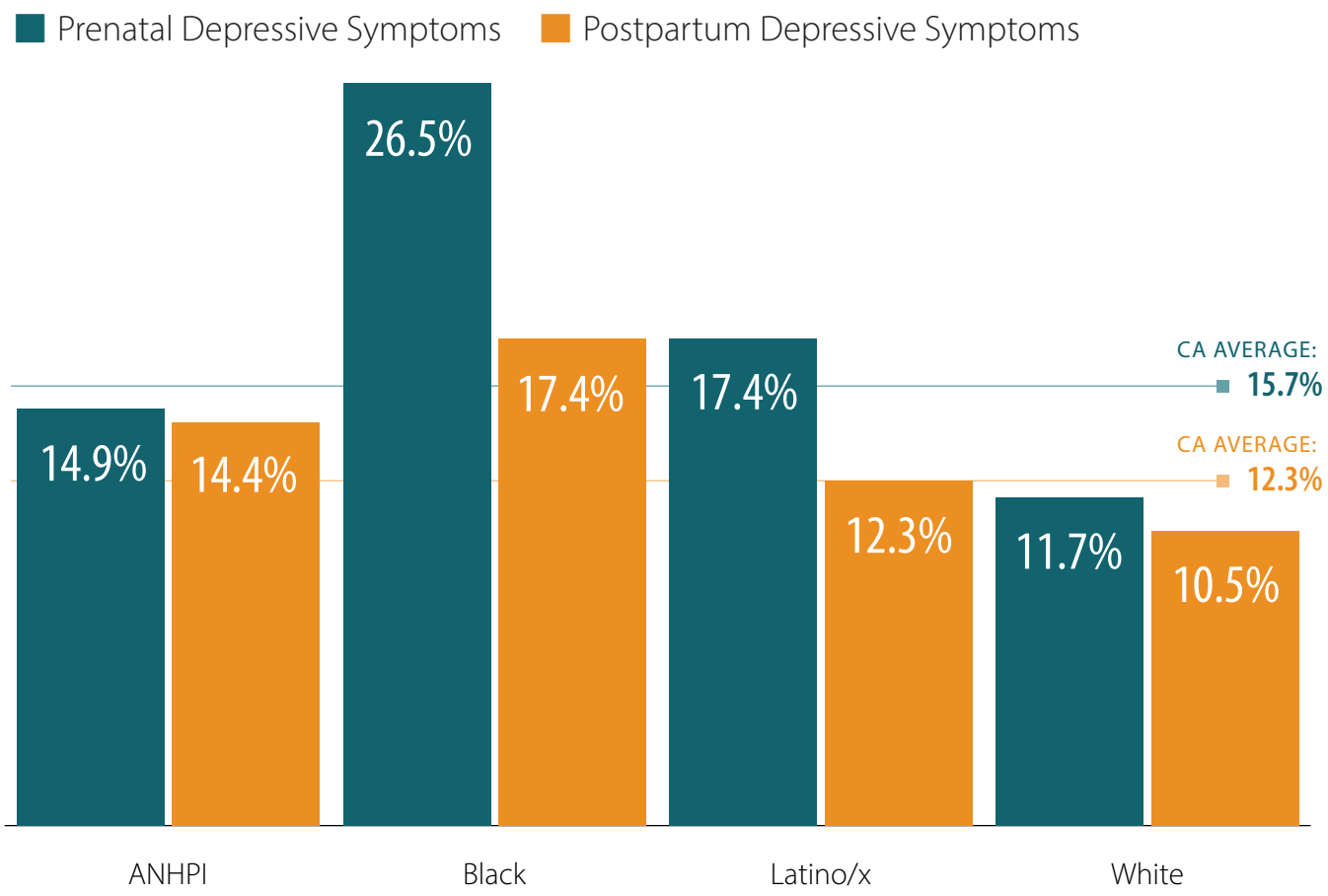
Between 2018 and 2019, 7% of adults in California reported experiencing a major depressive episode (MDE) in the past year. The percentage of adults reporting an MDE was slightly lower in California than in the United States between 2015-16 and 2018-19. Almost two-thirds of adults with MDE experience functional limitations that meet criteria for severe impairment (not shown).*

* "Mental Health Information: Statistics — Major Depression," National Institute of Mental Health, figure 1.

Perinatal Depressive Symptoms by Race/Ethnicity

California, 2016 and 2017

PERCENTAGE OF BIRTHING PEOPLE WITH A RECENT LIVE BIRTH



Notes: *Birthing people* is used to recognize that not all people who give birth identify as women. *ANHPI* is Asian, Native Hawaiian, and Pacific Islander. Source uses *women, Asian and Pacific Islander,* and *Latino. Depressive symptoms* include feeling sad, empty, or depressed for most of the day and losing interest for two weeks or longer in most things usually enjoyed. *Prepartum* is during pregnancy. *Postpartum* is after the birthing person's most recent birth. Data based on a population-based survey of 13,062 women with a recent live birth; 2016 and 2017 data were combined.

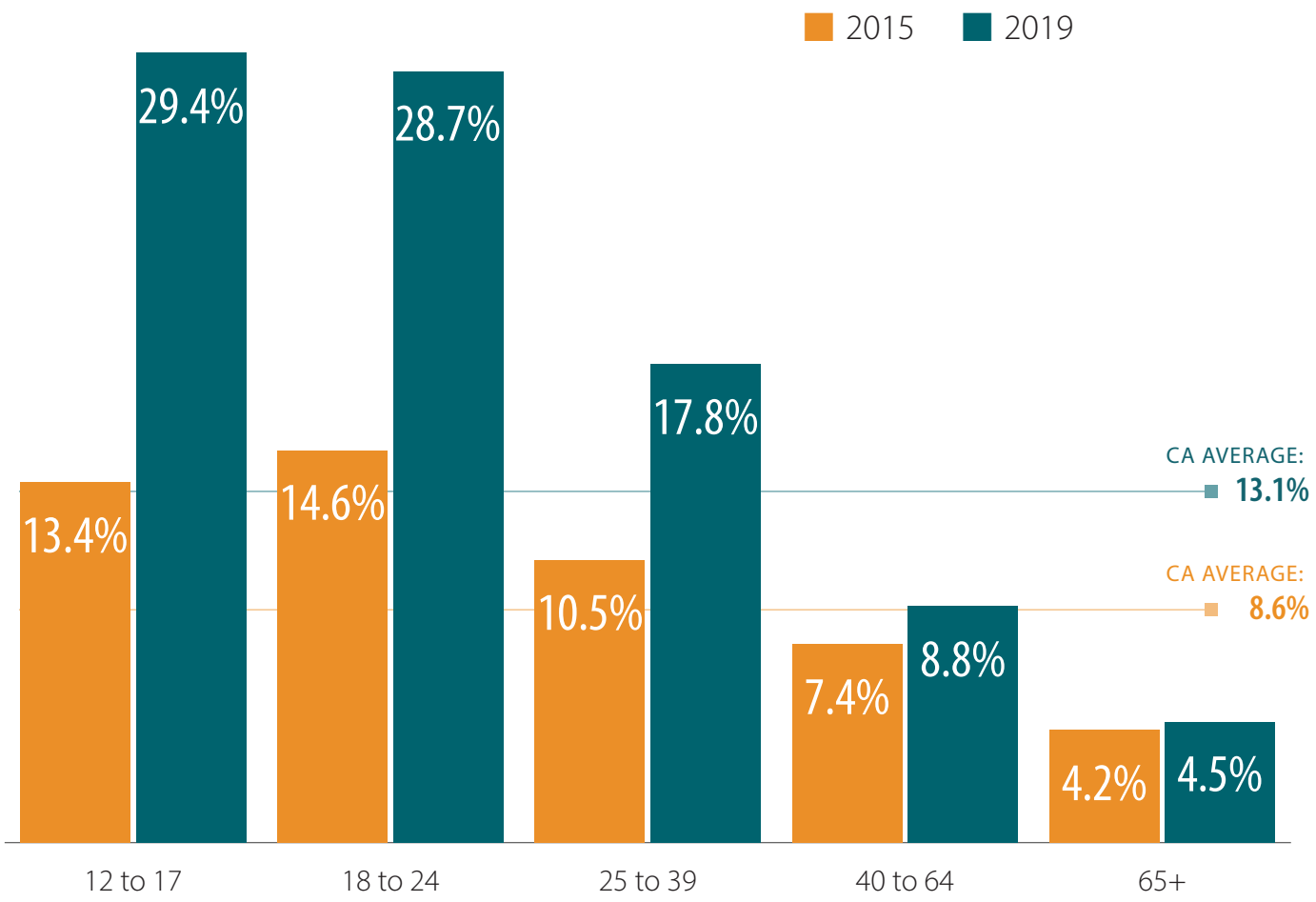
Source: *2020 Edition — Quality of Care: Maternal Health and Childbirth*, California Health Care Foundation, March 2020.

One in six birthing people experienced prenatal depressive symptoms, and one in eight experienced postpartum depressive symptoms, in 2016 and 2017. Rates varied by race and ethnicity. Black birthing people experienced significantly higher rates of prenatal and postpartum depressive symptoms than people of other races/ethnicities.

Serious Psychological Distress in the Past Year, by Age Group

California, 2015 and 2019

PERCENTAGE OF POPULATION

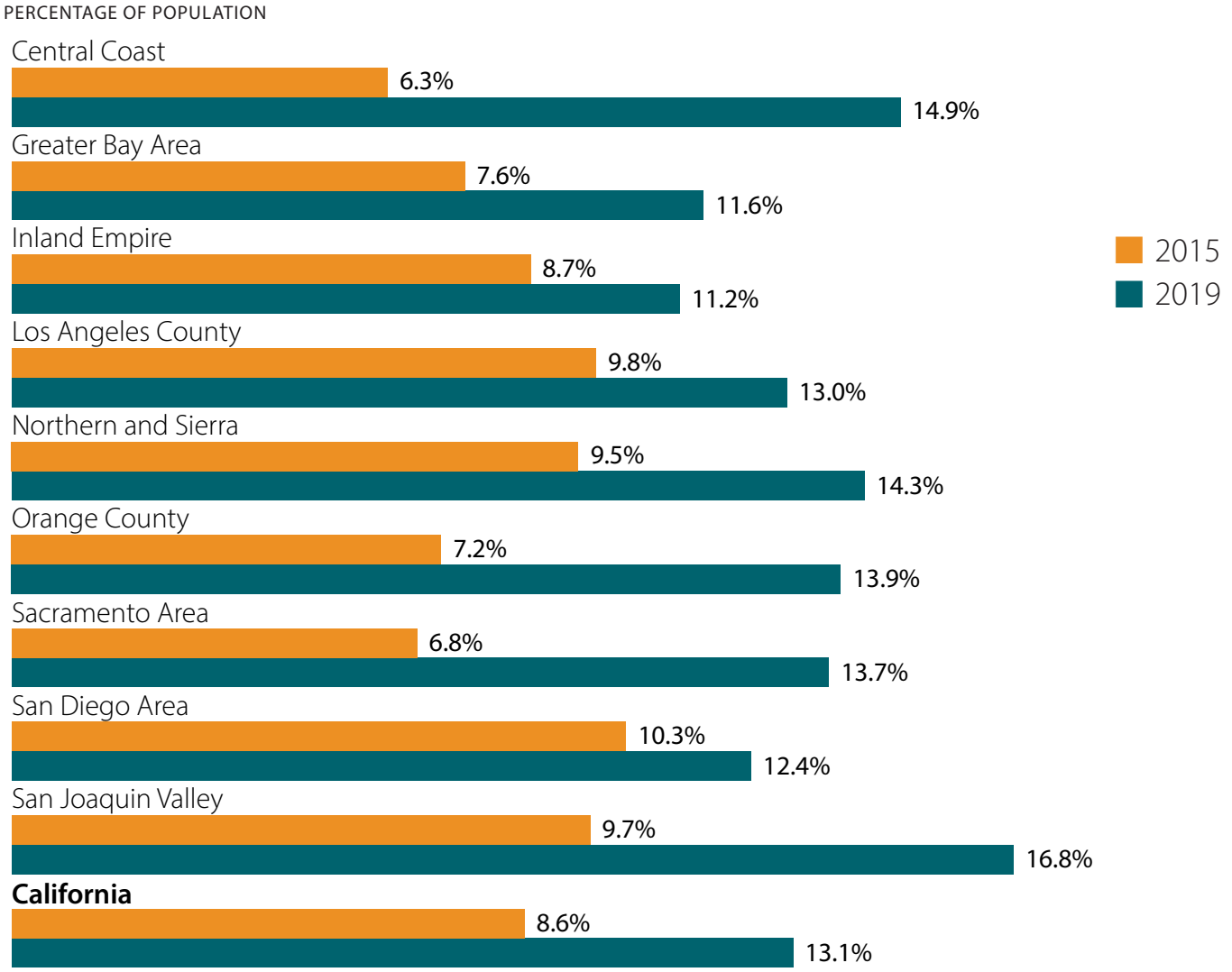


Notes: *Serious psychological distress* (SPD) is a categorization for adolescents and adults. SPD is assessed for the worst month in the past year. See page 3 for full definitions.

Source: "AskCHIS," UCLA Center for Health Policy Research.:

In 2019, about 30% of people age 12 to 24 experienced serious psychological distress (SPD). These rates increased dramatically from 2015 to 2019. Rates of SPD decline with age, and were under 5% among those age 65 and older.

Adults with Serious Psychological Distress in the Past Year, by Region, California, 2015 and 2019



Notes: Source did not include additional gender categories. *Adults* are age 18 and older. *Serious psychological distress* (SPD) is a categorization for adolescents and adults. See page 3 for full definitions. SPD is assessed for the worst month in the past year.

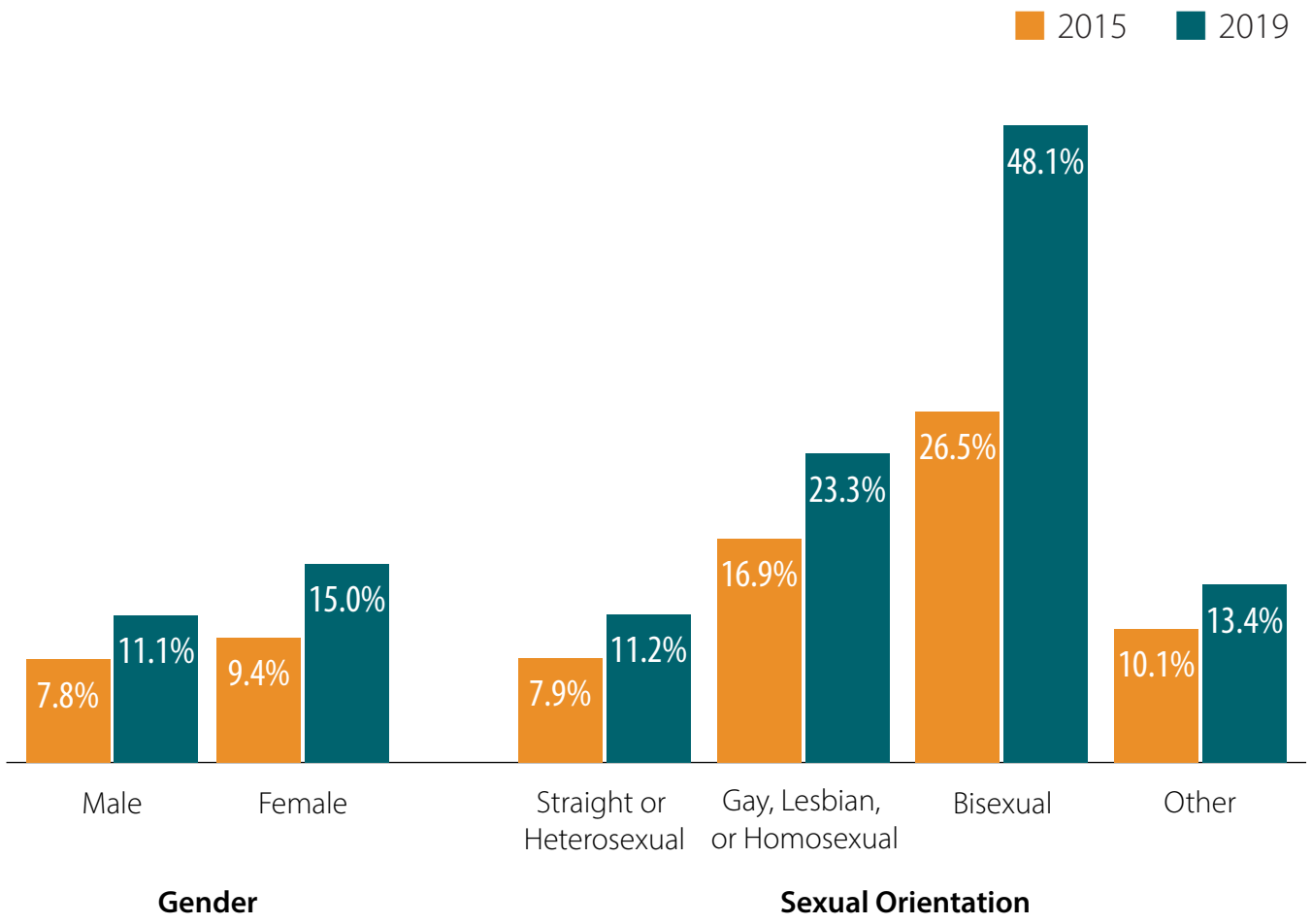
Source: "AskCHIS," UCLA Center for Health Policy Research.:

Mental Health
Prevalence

In California, the percentage of adults who reported experiencing serious psychological distress increased by 50%, from 8.6% in 2015 to 13.1% in 2019. Rates for the Central Coast and Sacramento Area doubled. In 2019, the San Joaquin Valley had the highest rate (16.8%) and the Inland Empire had the lowest rate (11.2%).

Adults with Serious Psychological Distress in the Past Year, by Gender and Sexual Orientation, California, 2015 and 2019

PERCENTAGE OF ADULTS



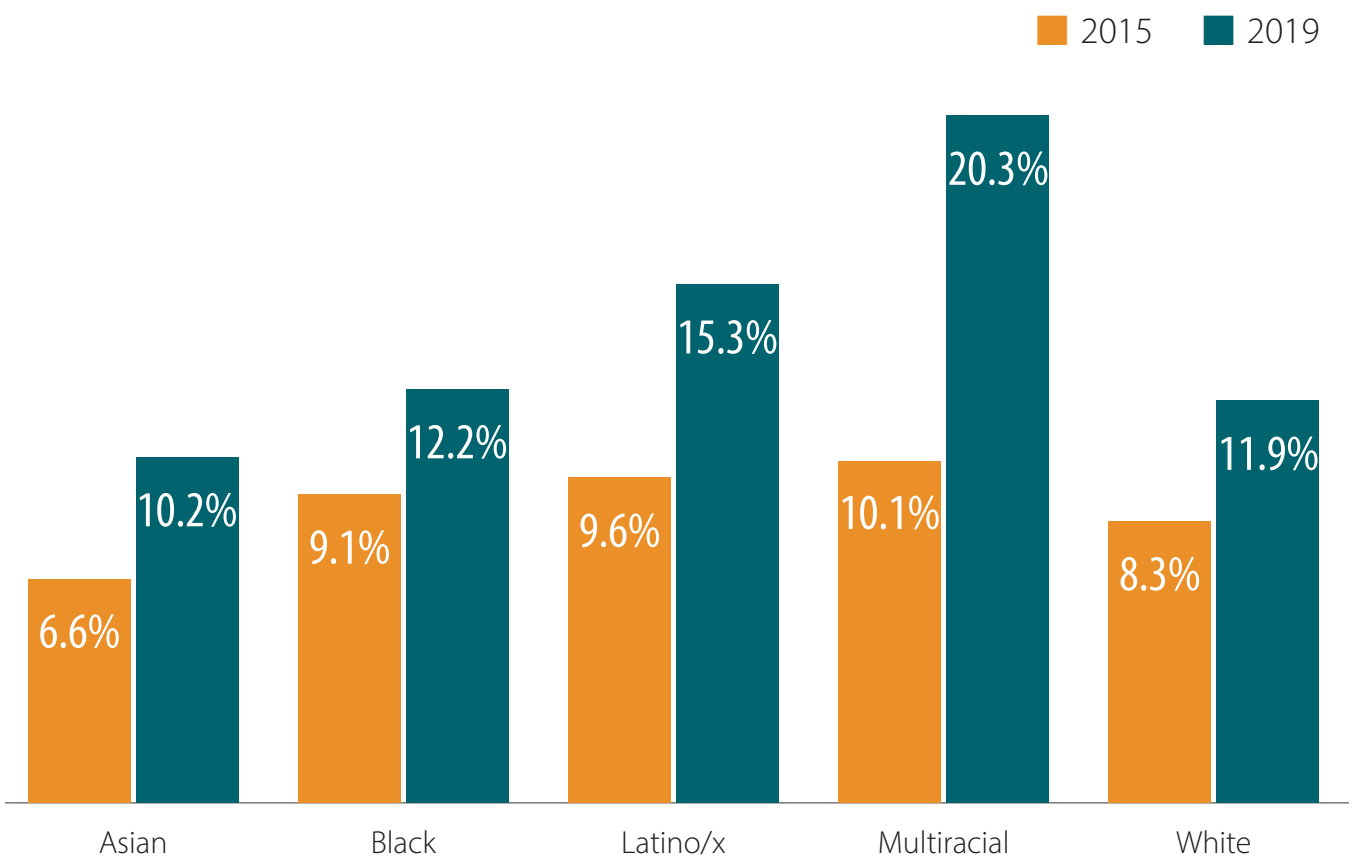
Notes: Source did not include additional gender categories. *Serious psychological distress* (SPD) is a categorization for adolescents and adults. See page 3 for full definition. SPD is assessed for the worst month in the past year. Sexual orientation was self-reported. *Other* is not sexual, celibate, none or other in the source.

Source: "AskCHIS," UCLA Center for Health Policy Research.

Adult females in California were more likely than males to experience serious psychological distress (SPD). The rates for females increased 60% from 2015 to 2019. Rates of SPD for adults who are bisexual or who are gay, lesbian, or homosexual were higher than for adults who are straight or heterosexual. Rates for adults who are bisexual increased more than 80% from 2015 to 2019.

Adults with Serious Psychological Distress in the Past Year by Race/Ethnicity, California, 2015 and 2019

PERCENTAGE OF ADULTS



Notes: *Adults* are age 18 and older. *Serious psychological distress* (SPD) is a categorization for adolescents and adults. See page 3 for full definitions. SPD is assessed for the worst month in the past year. Results for *American Indian / Alaska Native* and *Native Hawaiian / Pacific Islander* are not shown because they were statistically unstable. Source uses *Latino*, *Black or African American*, and *Two or More Races*.

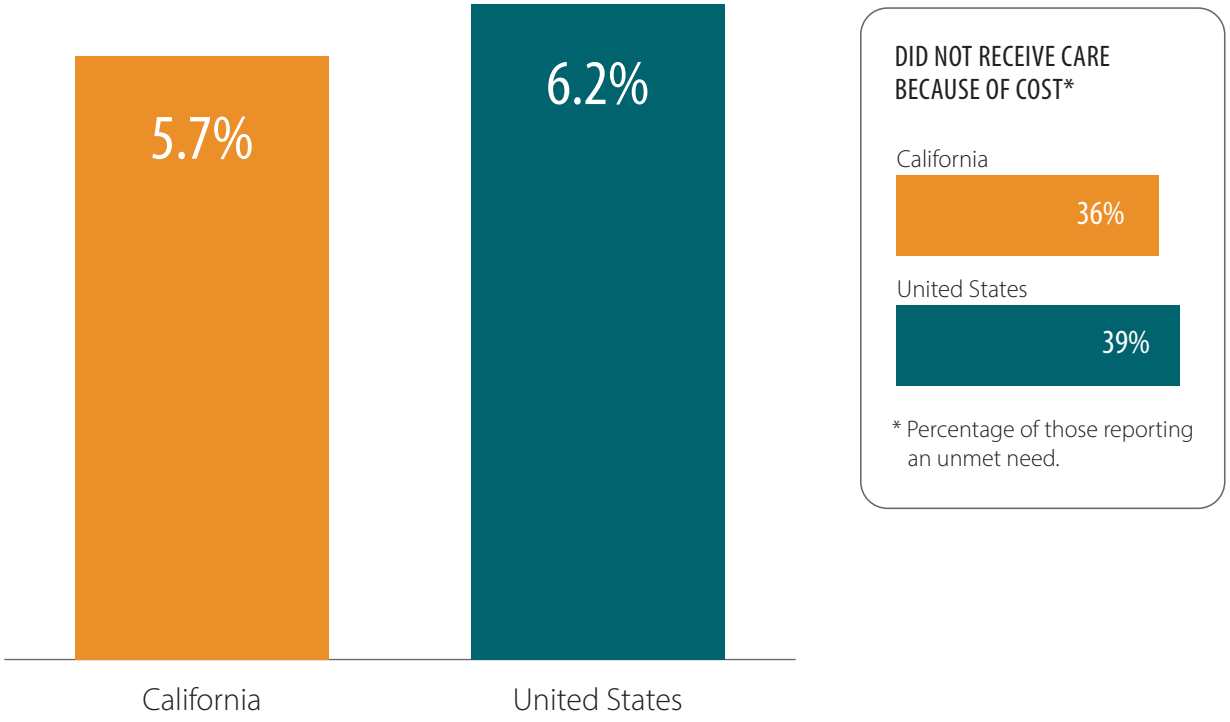
Source: "AskCHIS," UCLA Center for Health Policy Research.

Rates of serious psychological distress in California adults varied among racial and ethnic groups. Rates for all groups increased between 2015 and 2019, with the rate doubling for people who are multiracial. Asian Californians had the lowest rate in both years.

Unmet Need for Mental Health Treatment, Adults

California vs. United States, 2018 to 2019

PERCENTAGE OF ADULTS



Approximately 6% of both California and US adults reported needing mental health treatment or counseling but not being able to get it. Over a third of these adults reported that they did not receive treatment due to cost.

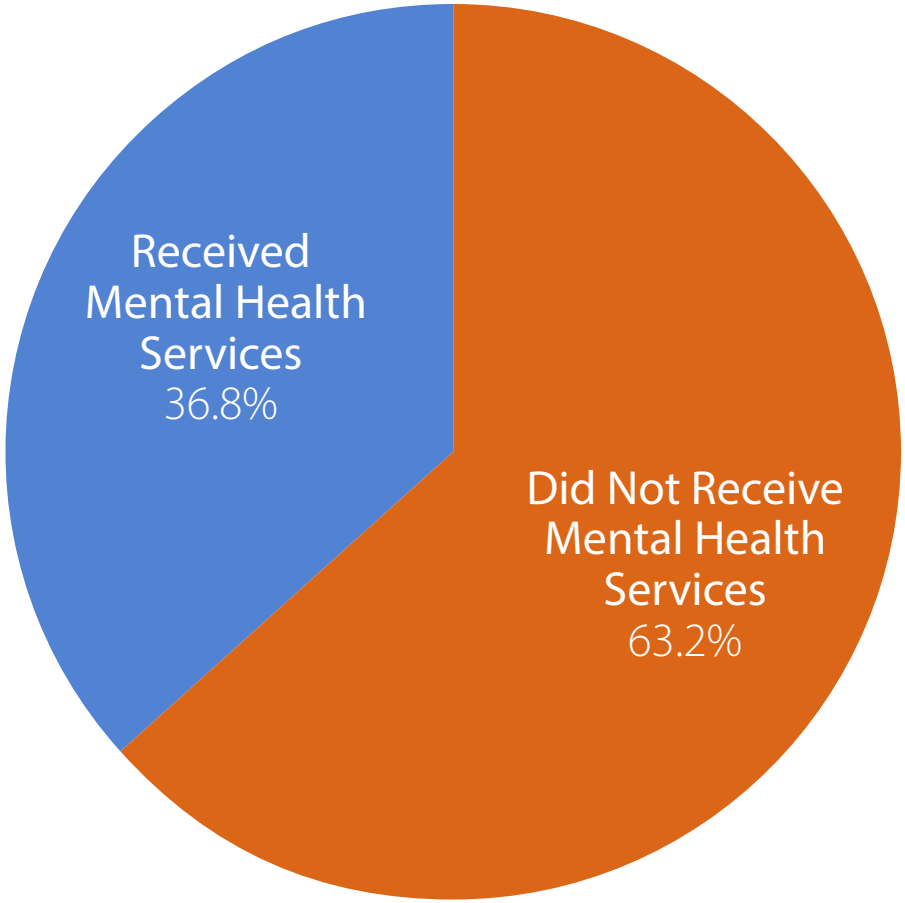
Notes: *Adults* are age 18 and above. *Unmet need* is defined as a perceived need for mental health treatment or counseling in the past year that was not received.

Sources: "Adults Reporting Unmet Need for Mental Health Treatment in the Past Year," KFF; and "Adults Reporting Unmet Need for Mental Health Treatment in the Past Year Because of Cost," KFF, accessed November 30, 2021.

Mental Health Service Use

Adults with AMI, California, 2017 to 2019

PERCENTAGE WHO . . .



Notes: Estimates are annual averages based on combined 2017 to 2019 National Survey on Drug Use and Health data. *Mental health service* use is defined as receiving treatment or counseling for any problem with emotions, nerves, or mental health in the 12 months before the interview in any inpatient or outpatient setting, or the use of prescription medication for treatment of any mental or emotional condition that was not caused by the use of alcohol or drugs. Respondents with unknown service use were excluded. Estimates of any mental illness were based on self-report of symptoms indicative of any mental illness. *Any mental illness* (AMI) is a categorization for adults age 18 and older. See page 3 for full definitions.

Source: *Behavioral Health Barometer: California, Volume 6: Indicators as Measured Through the 2019 National Survey on Drug Use and Health and the National Survey of Substance Abuse Treatment Services*, Substance Abuse and Mental Health Services Administration, 2020.

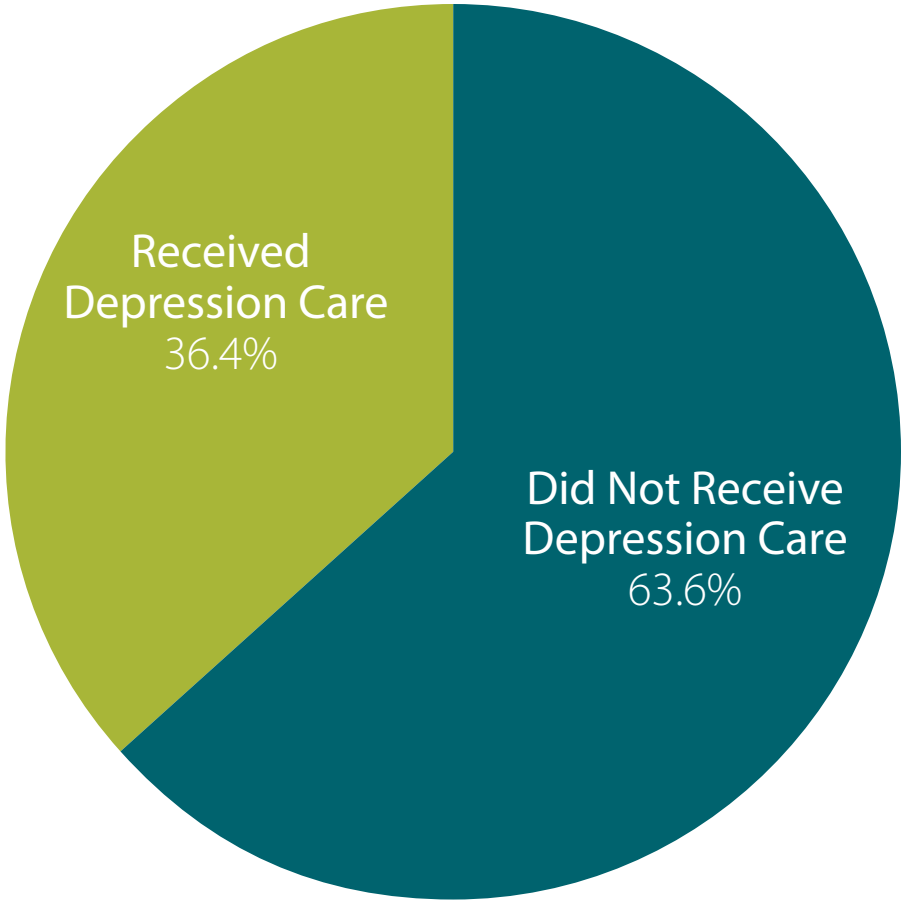
Among California adults with any mental illness, slightly more than one-third reported receiving mental health services, which include treatment, counseling, or prescription medication, during the past year. This was lower than the national rate of 43.6% (not shown). While adults in California with serious mental illness were more likely to receive treatment, 40% did not get any (not shown).*

* "Mental Health in California," KFF.

Treatment for Major Depressive Episode

Adolescents, California, 2016 to 2019

PERCENTAGE REPORTING MDE IN THE PAST YEAR WHO . . .



Between 2016 and 2019, about one in three California adolescents who reported experiencing symptoms of major depressive episode during the past year received treatment. This was lower than the national rate of 41.8% and the Healthy People 2030 target of 46.6% (not shown).

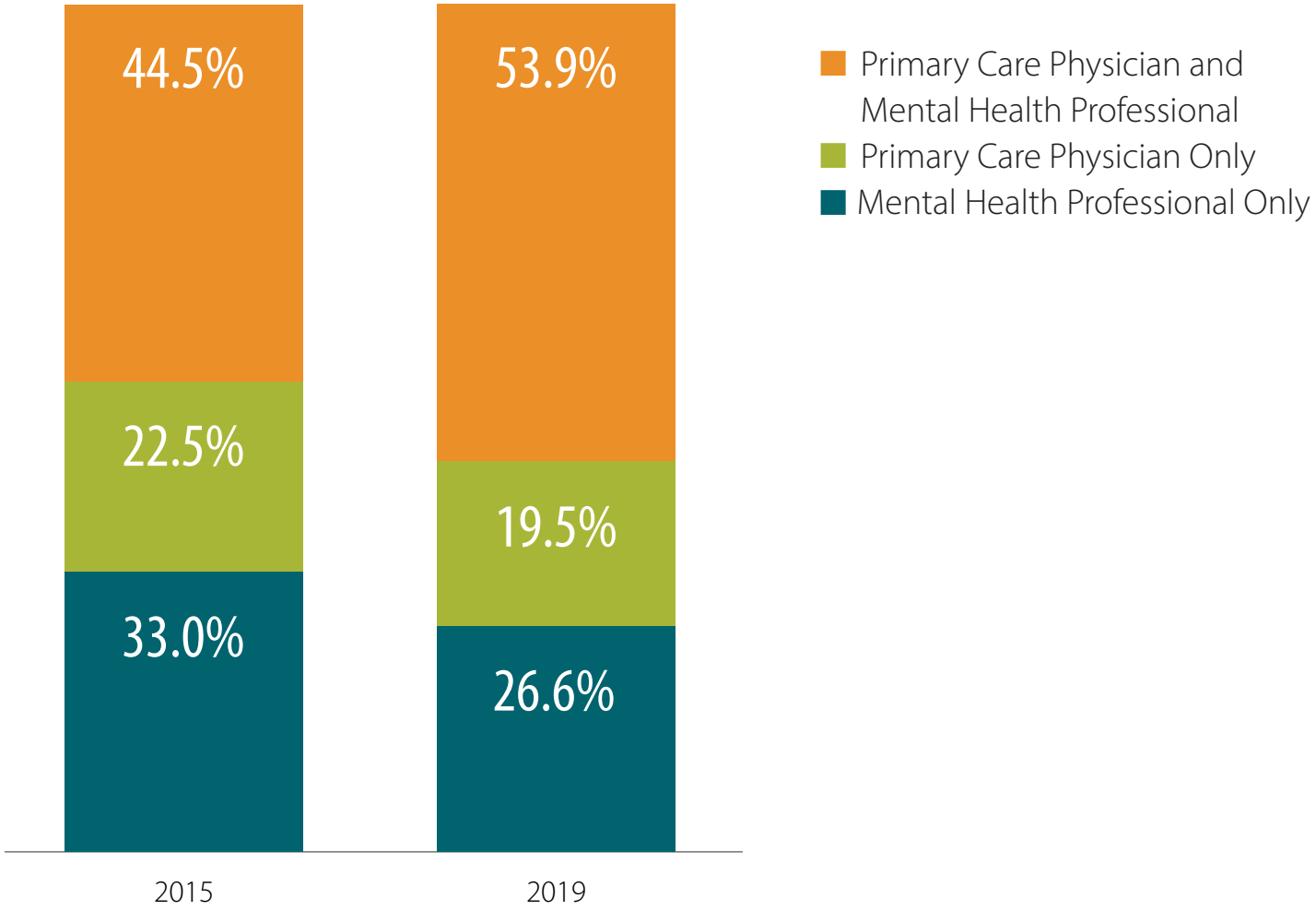
Notes: *Adolescents* are age 12 to 17. Estimates are annual averages based on combined 2016 to 2019 NSDUH data. *MDE* is major depressive episode. Respondents with unknown past-year MDE or treatment data were excluded.

Source: *Behavioral Health Barometer: California, Volume 6: Indicators as Measured Through the 2019 National Survey on Drug Use and Health and the National Survey of Substance Abuse Treatment Services*, Substance Abuse and Mental Health Services Administration, 2020.

Mental Health Care in Past Year by Type of Provider,

Adults with SPD, California, 2015 and 2019

PERCENTAGE OF ADULTS WITH SPD RECEIVING CARE FROM . . .



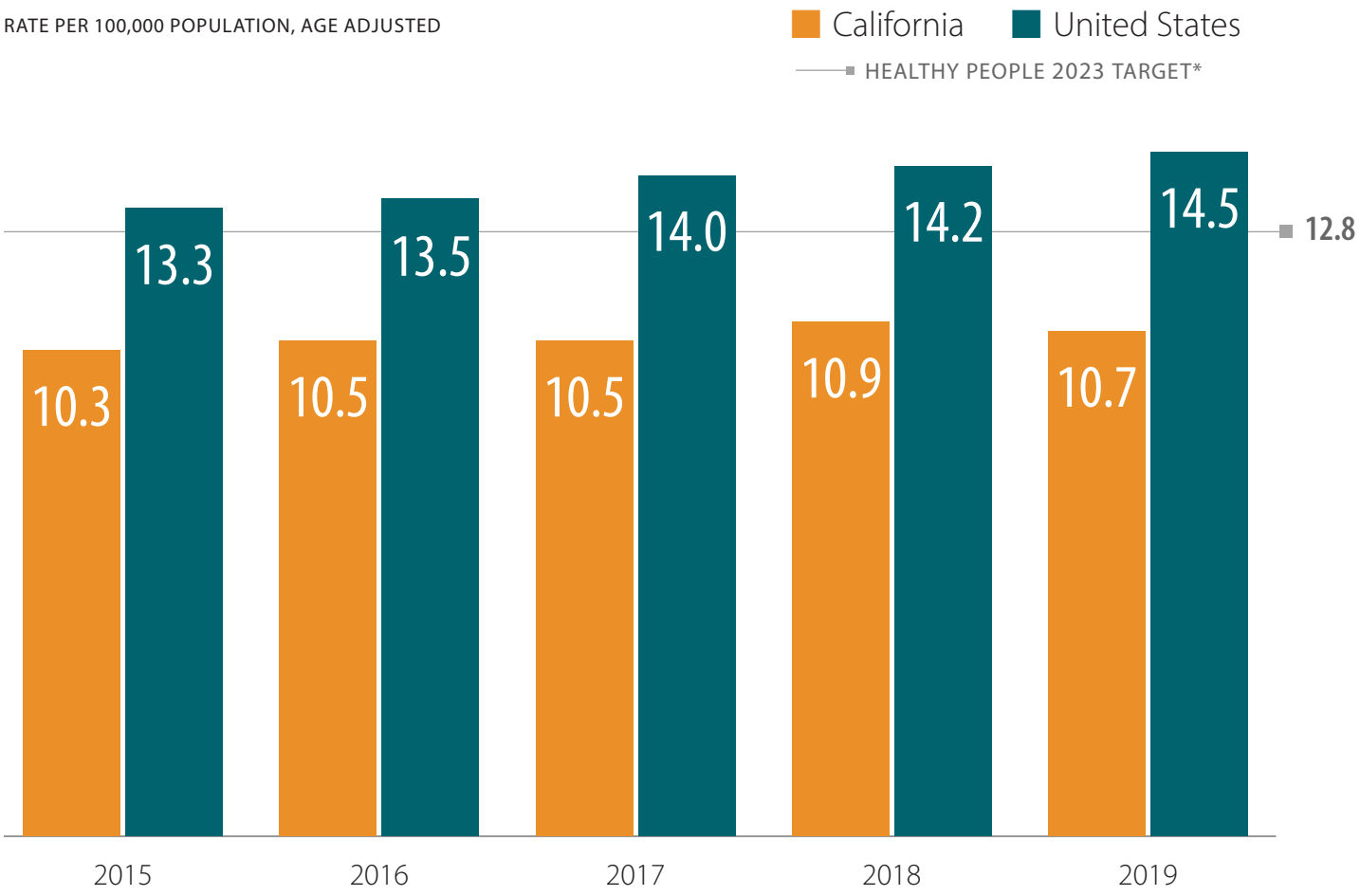
Notes: *Serious psychological distress* (SPD) is a categorization for adults age 18 and older. See page 3 for full definition. Adults with SPD who reported receiving care for mental/emotional problems in the past 12 months indicated whether they had seen a primary care physician or other professional such as a counselor, psychiatrist, or social worker for these problems.

Source: "AskCHIS," UCLA Center for Health Policy Research.

Of the 1.8 million California adults with serious psychological distress in 2019 who received care for mental/emotional issues, about half received that care from both a mental health professional and a primary care physician.

Suicide Rate

California vs. United States, 2015 to 2019



* Healthy People is a set of goals and objectives with 10-year targets designed to guide national health promotion and disease prevention efforts.

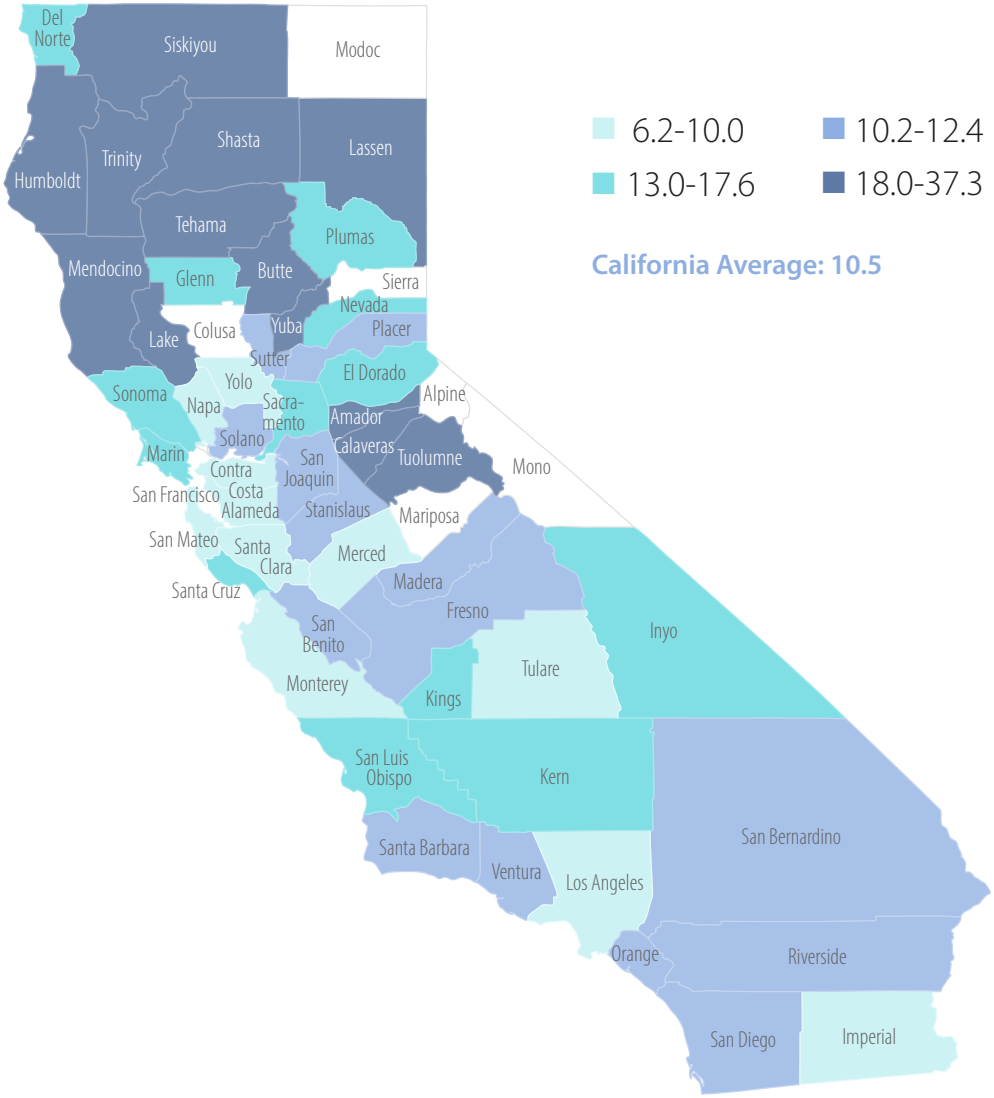
Notes: *Suicide* is death from a self-inflicted injury. Data are based on information from death certificates filed in the 50 states and the District of Columbia and are processed by the National Center for Health Statistics. Data for 2019 are based on records of deaths that occurred during 2019 and were received as of July 27, 2020.

Sources: Sherry L. Murphy et al., "Deaths: Final Data for 2015" (PDF), *National Vital Statistics Reports* 66, no. 6 (Nov. 27, 2017); Jiaquan Q. Xu et al., "Deaths: Final Data for 2016" (PDF), *National Vital Statistics Reports* 67, no. 5 (July 26, 2018); Kenneth D. Kochanek et al., "Deaths: Final Data for 2017" (PDF), *National Vital Statistics Reports* 68, no. 9. (June 24, 2019); Sherry L. Murphy et al., "Deaths: Final Data for 2018" (PDF), *National Vital Statistics Reports* 69, no. 13 (Jan. 12, 2021); and Jiaquan Q. Xu et al., "Deaths: Final Data for 2019" (PDF), *National Vital Statistics Reports* 70, no. 8 (July 26, 2021).

California's suicide rate remained relatively stable from 2015 to 2019 and was consistently lower than both the national rate and the Healthy People 2030 target.

Suicide Rate, by County, California, 2017 to 2019

RATE PER 100,000 POPULATION, AGE ADJUSTED, THREE-YEAR AVERAGE



Notes: *Suicide* is death from self-inflicted injury. Data are from registered death certificates. Suicide rates were not available for Alpine, Colusa, Mariposa, Modoc, Mono, and Sierra Counties.

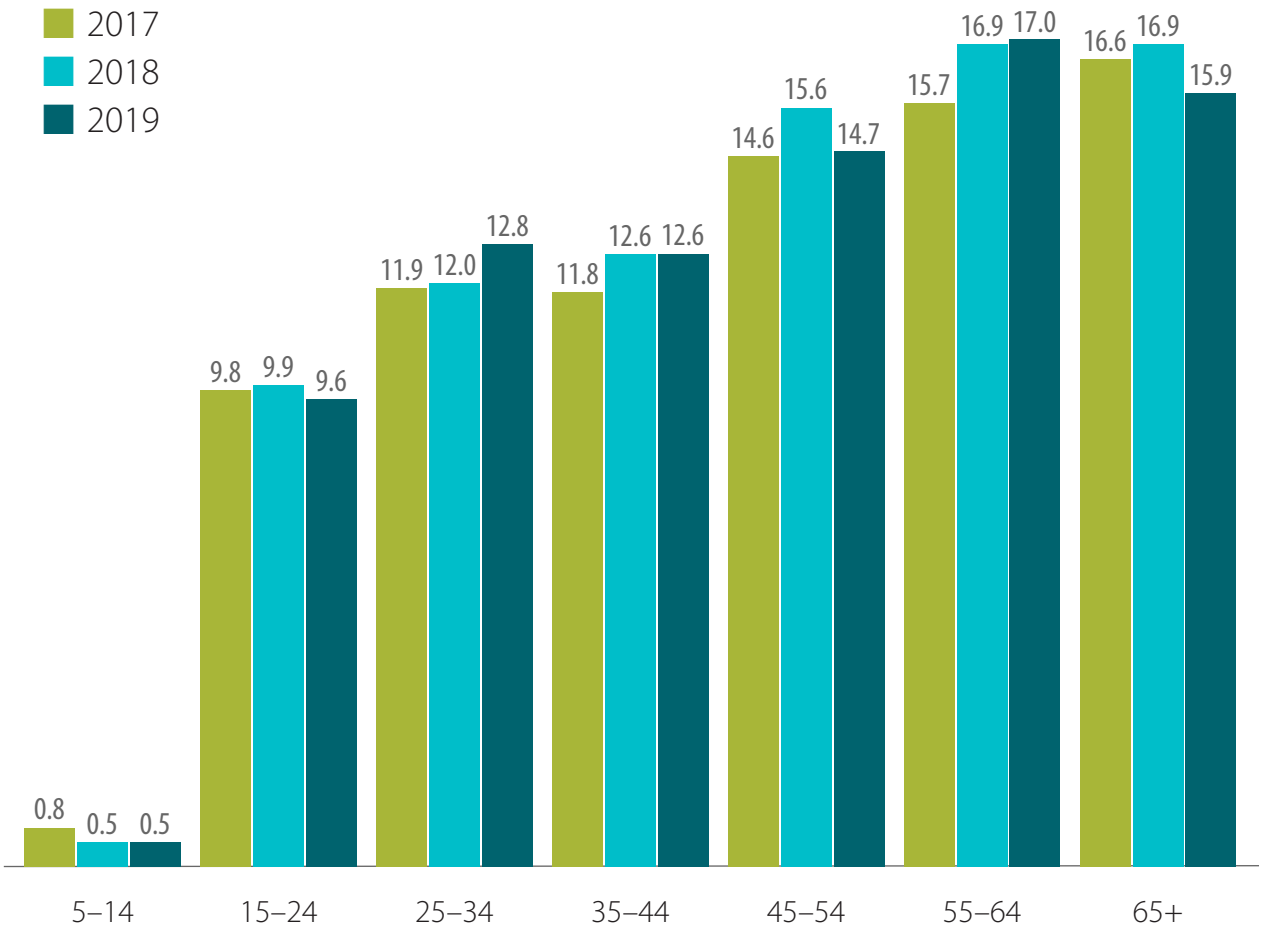
Source: "Living Well / Reducing Suicide," Let's Get Healthy California.

Mental Health
Suicide

Suicide rates varied by county in California. The 2017–19 suicide rate per 100,000 population ranged from a high of 37.3 in Trinity County to a low of 6.2 in Imperial County.

Suicide Rate, by Age Group
California, 2017 to 2019

RATE PER 100,000 POPULATION



Notes: *Suicide* is death from self-inflicted injury. Data are based on death certificates from California residents compiled through the Vital Statistics Cooperative Program.
Source: "Underlying Cause of Death 1999-2019" on CDC WONDER Online Database, Centers for Disease Control and Prevention, 2020.

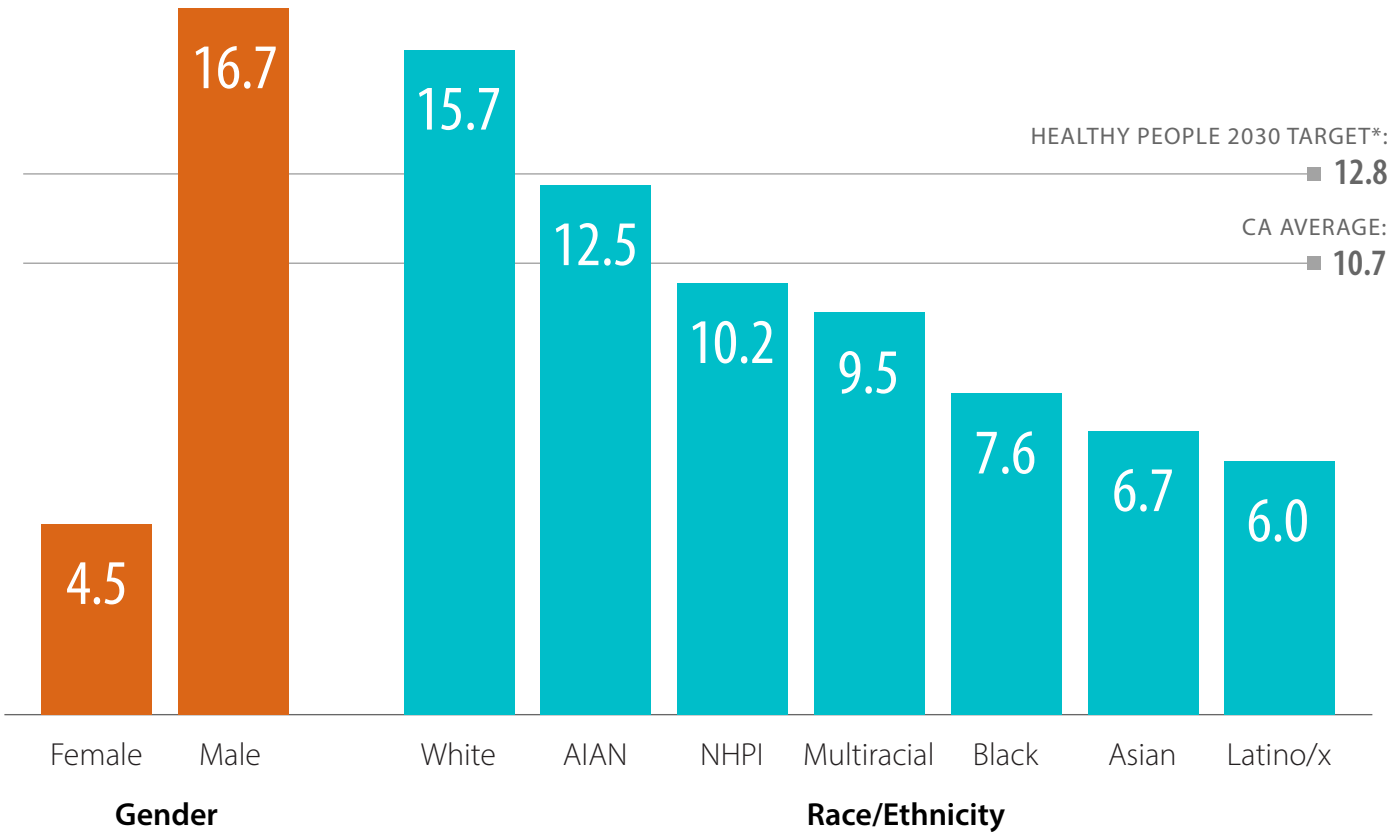
Suicide rates for Californians age 15 and older generally increase with age. Multiple suicide risk factors may affect adults age 65 and older, including psychiatric and neurocognitive disorders, social exclusion, bereavement, cognitive impairment, and physical illnesses.*

* Ismael Conejero et al., "Suicide in Older Adults: Current Perspectives," *Clinical Interventions in Aging* 13 (Apr. 20, 2018): 691–99.

Suicide Rate, by Gender and Race/Ethnicity

All Ages, California, 2017 to 2019

PER 100,000 POPULATION, AGE ADJUSTED, THREE-YEAR AVERAGE



Suicide rates differed by gender and by race/ethnicity. Males were over three times as likely as females to die by suicide. Rates for White Californians were higher than the state average and than the rates for other races/ethnicities.

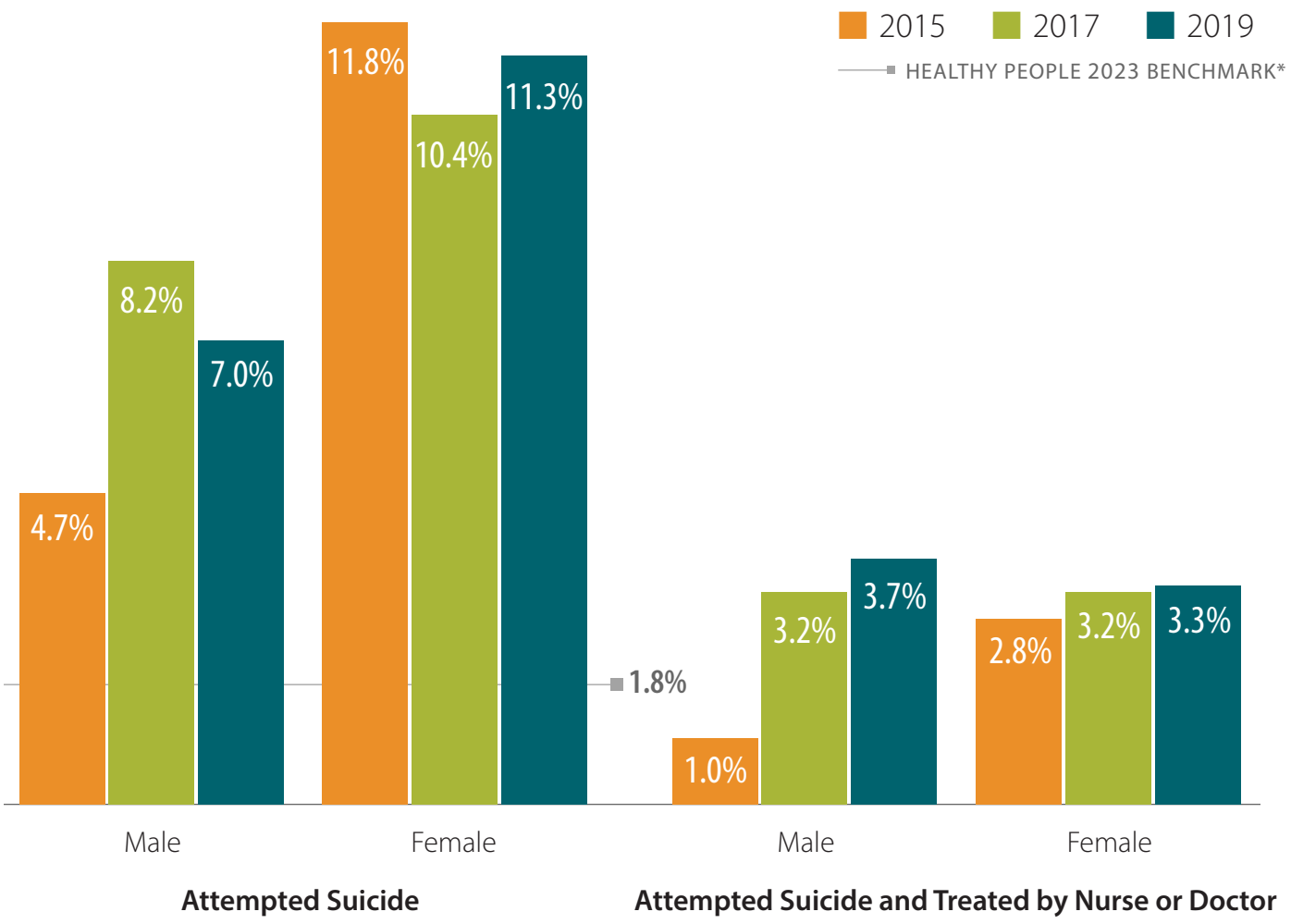
* Healthy People is a set of goals and objectives with 10-year targets designed to guide national health promotion and disease prevention efforts.

Notes: Source did not include additional gender categories. *Suicide* is death from self-inflicted injury. Data do not include out-of-state deaths for California residents, nor in-state deaths for non-California residents. Cause of death is determined by coroner or medical examiner. *AIAN* is American Indian and Alaska Native. *NHPI* is Native Hawaiian and Pacific Islander. Source uses *Latino* and *Multi-race*. Data are not included for those whose race/ethnicity is other/unknown.

Source: "Living Well / Reducing Suicide," Let's Get Healthy California.

Suicide Attempts and Treatment, High School Students,
by Gender, California, 2015, 2017, and 2019

PERCENTAGE OF HIGH SCHOOL STUDENTS



Among California high school students, rates of self-reported suicide attempts in the prior year were higher for females than for males. For males, suicide attempts that required medical treatment more than tripled between 2015 and 2019.

* Healthy People is a set of goals and objectives with 10-year targets designed to guide national health promotion and disease prevention efforts.

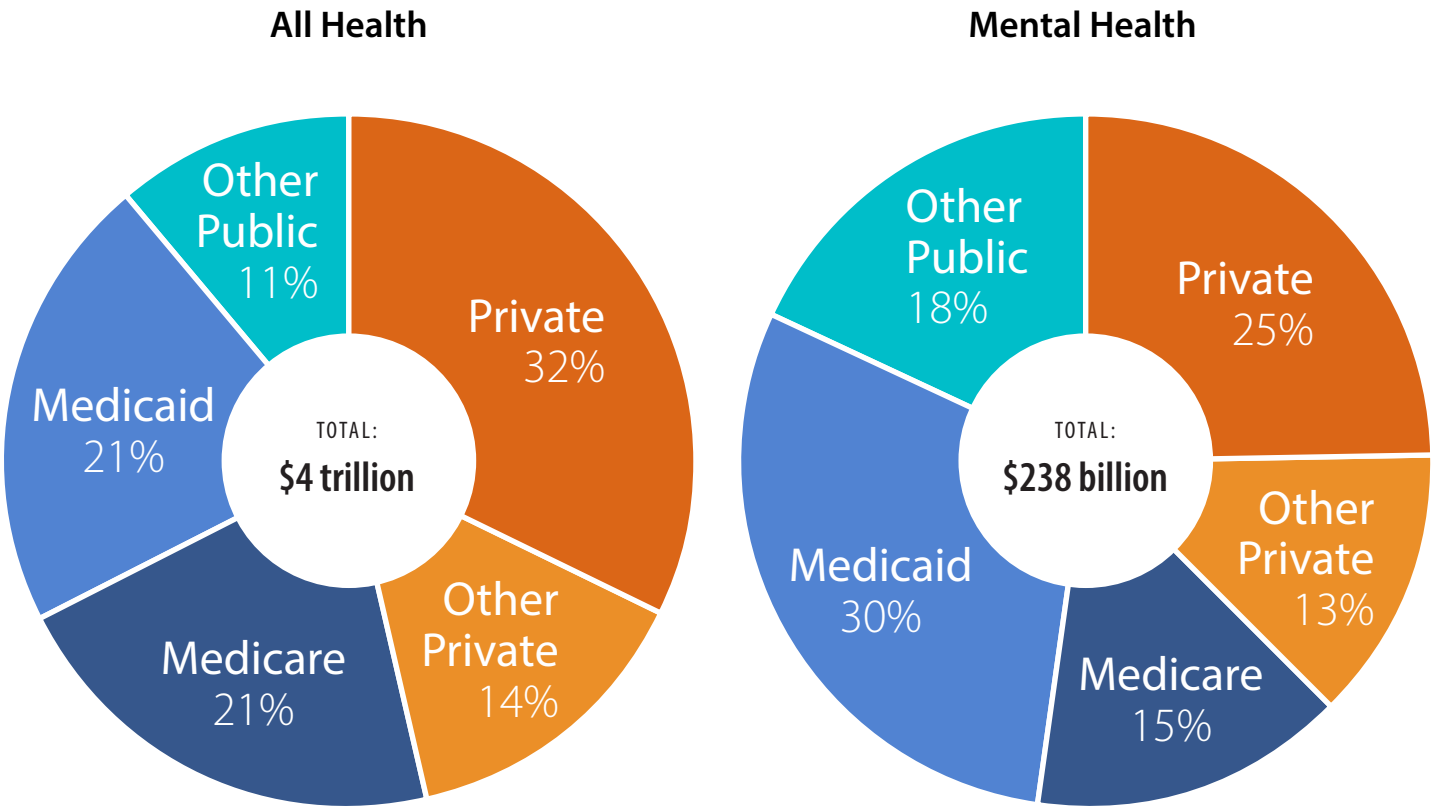
Note: Source did not include additional gender categories.

Source: "High School YRBS: Youth Online," Centers for Disease Control and Prevention.

Expenditures for Health and Mental Health Services, by Payer

United States, 2020 Projected

PERCENTAGE OF TOTAL SPENDING



Notes: Expenditures are projections. *Other public* includes other federal, state, and local payers. *Other private* includes out-of-pocket and other private expenditures. Mental health estimates include clinical treatment, rehabilitative services, and medications and exclude activities to prevent mental illness and unpaid peer support services. Estimates of Medicare and private insurance mental health spending are based on claims. Payments for all other payers are based on survey and other data sources. Overall health expenditures are from the Centers for Medicare & Medicaid Services National Health Expenditure Accounts.

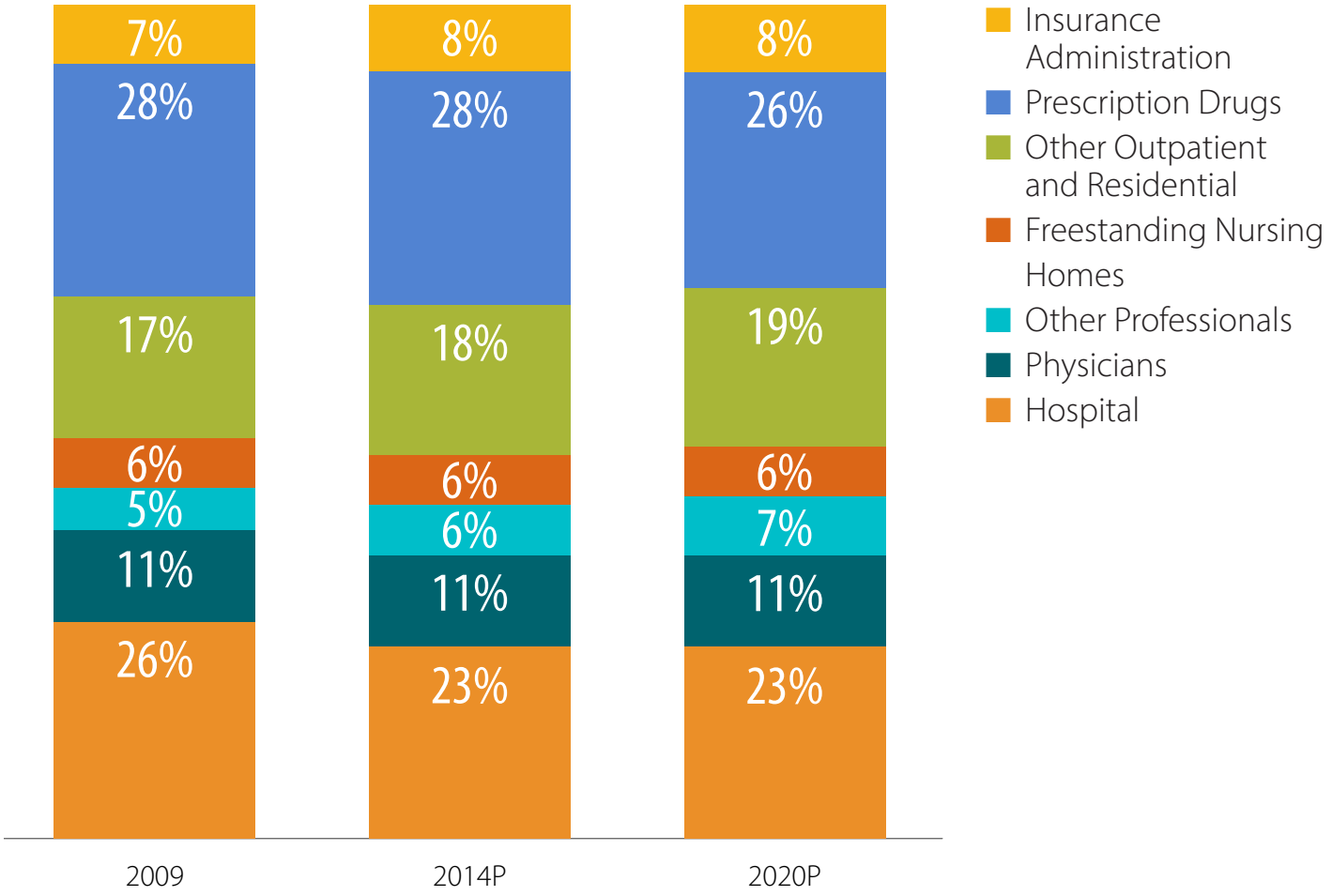
Source: *Projections of National Expenditures for Treatment of Mental and Substance Use Disorders, 2010-2020*, Substance Abuse and Mental Health Services Administration, October 2014.

Mental Health
Spending

Total US mental health expenditures in 2020 were projected to be $238 billion, or 6% of total health care expenditures. Public payers (Medicaid, Medicare, and other public) were projected to pay for 63% of mental health expenditures, compared to 53% of overall health expenditures.

Mental Health Expenditures, by Service Category

United States, 2009, 2014, and 2020



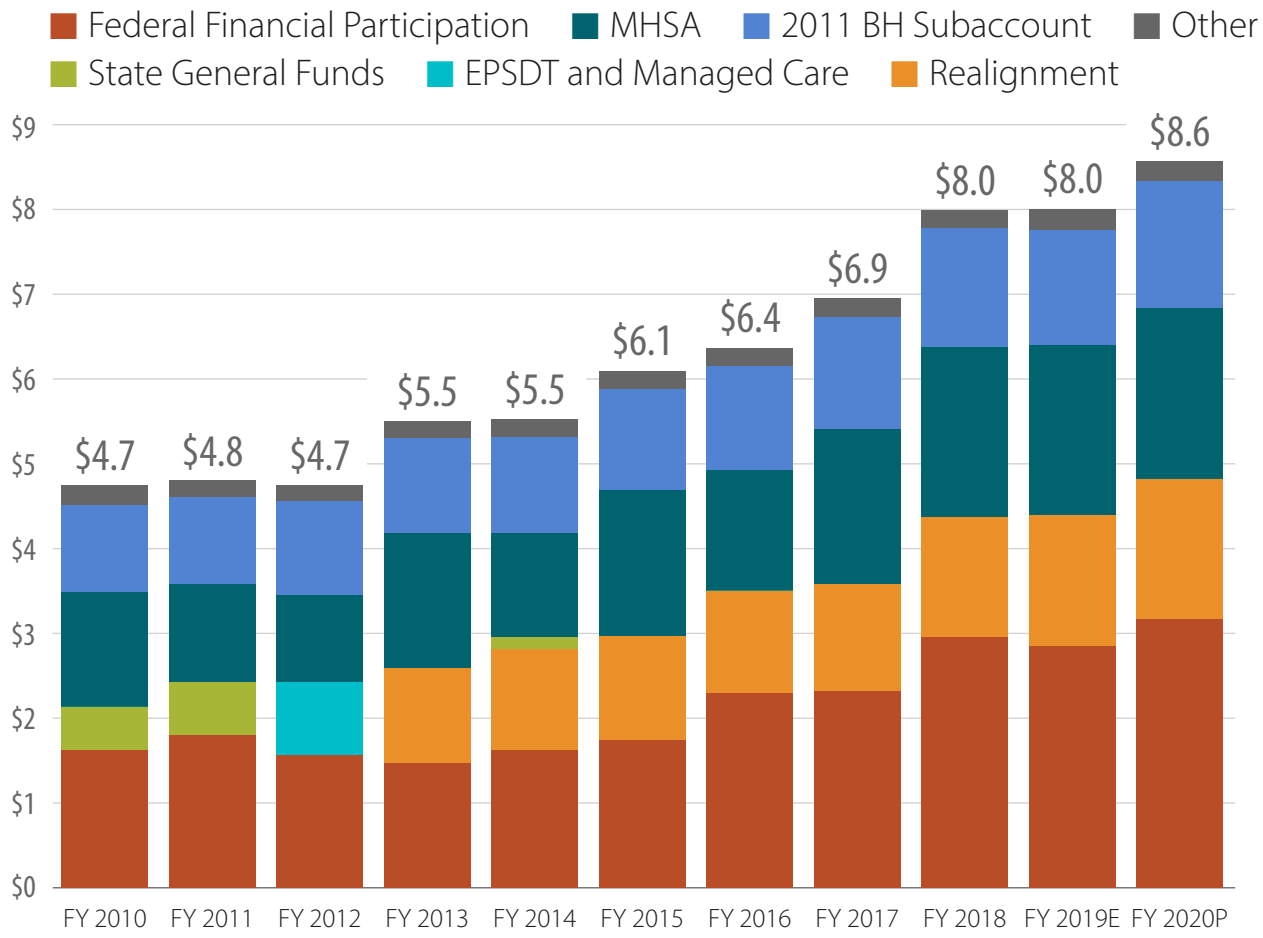
Notes: *P* is projection. *Other professionals* covers services provided in establishments operated by health practitioners other than physicians and dentists, including psychologists, psychoanalysts, psychotherapists, clinical social workers, professional counselors, substance abuse counselors, and marriage and family therapists, as well as other health professions. *Other outpatient and residential* includes specialty mental health centers, specialty substance abuse centers, and freestanding home health.

Source: *Projections of National Expenditures for Treatment of Mental and Substance Use Disorders, 2010-2020*, Substance Abuse and Mental Health Services Administration, October 2014.

Between 2009 and 2020, the distribution of total US mental health expenditures was projected to remain relatively stable.

California County Mental Health Funding
FY 2010 to FY 2020

IN BILLIONS



Notes: *BH* is behavioral health. *MHSA* is Mental Health Services Act. *EPSDT* is Early and Periodic Screening, Diagnosis, and Treatment. *E* is estimated, and *P* is projected. These figures encompass revenues received or projected to be received by counties to support the Medicaid and safety-net mental health services they provide. Other public mental health services, such as forensic services in state hospitals and mental health services and medications provided by Medicaid health plans and Medi-Cal fee-for-service, are not included.

Source: *Financial Report* (PDF), Mental Health Oversight and Accountability Commission, May 23, 2019.

Funding of California's county-based mental health system was projected to increase 81% from FY 2010 to FY 2020, with the federal reimbursement that counties receive for providing specialty mental health treatment to Medi-Cal enrollees (federal financial participation) nearly doubling.

Medi-Cal Mental Health Services

Medi-Cal mental health services are available through Medi-Cal managed care plans and county mental health plans.

Medi-Cal managed care plans cover the following nonspecialty mental health services:

- Individual and group psychotherapy
- Psychological testing
- Outpatient services for monitoring drug therapy
- Psychiatric consultation
- Some other mental health services

Specialty mental health services are for enrollees who meet certain medical necessity criteria and are administered by county mental health plans. The criteria for specialty mental health services changed effective January 1, 2022. They are different for adult Medi-Cal enrollees and those under age 21.

Specialty mental health services include:

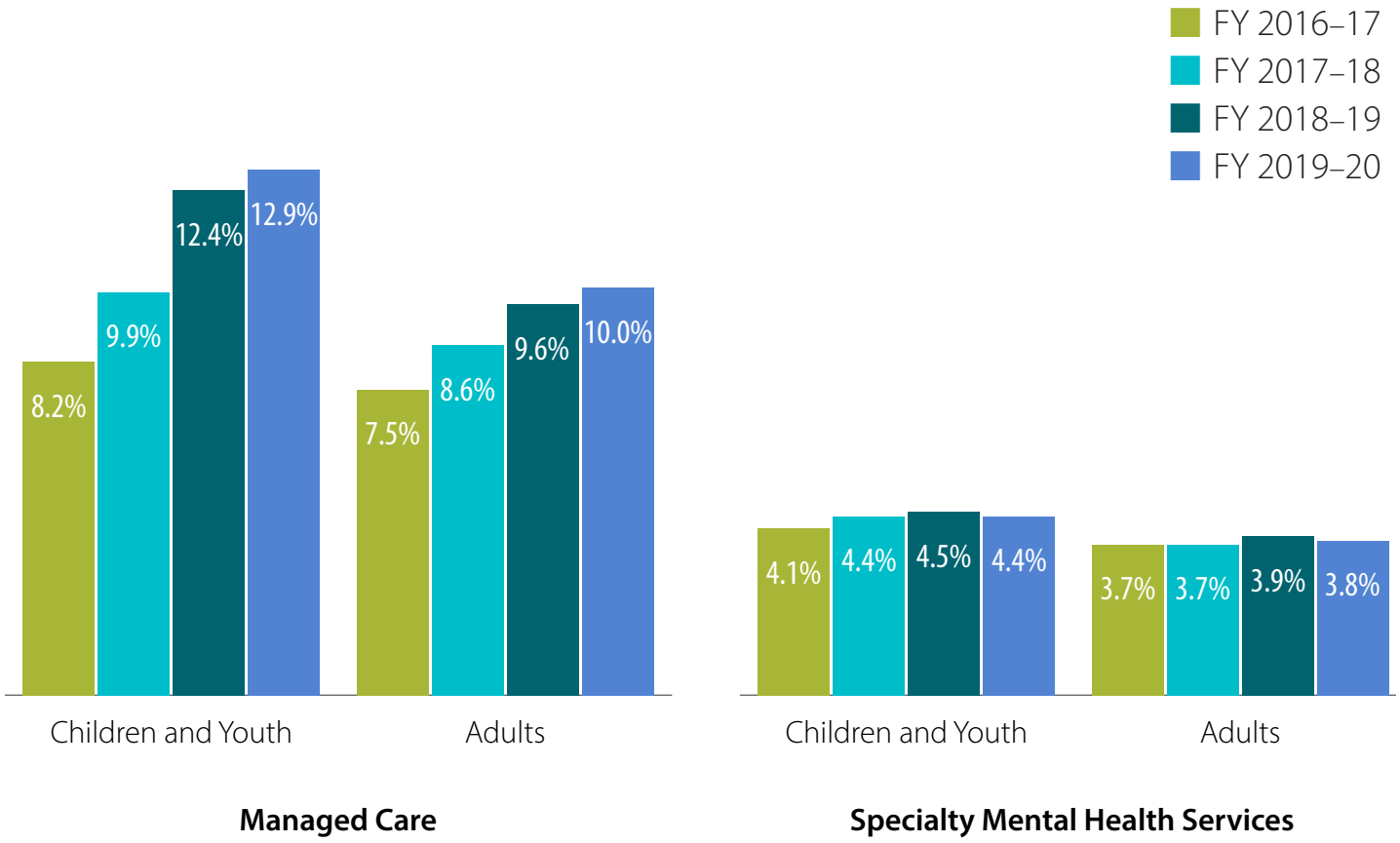
- Rehabilitative mental health services, including medication support, day treatment, crisis services, residential care, and others
- Psychiatric inpatient hospital services
- Psychiatric nursing facility care
- Targeted case management
- Psychiatric services
- Psychological services

Sources: Kimberly Lewis and Abigail Coursolle, *Issue Brief: Mental Health Services in Medi-Cal*, National Health Law Program, January 12, 2017; Shaina Zurlin, "Criteria for Beneficiary Access to Specialty Mental Health Services (SMHS), Medical Necessity and Other Coverage Requirements" (PDF), BHIN 21-073, California Dept. of Health Care Services (DHCS), December 10, 2021; and *Assessing the Continuum of Care for Behavioral Health Services in California* (PDF), DHCS, January 10, 2022.

Medi-Cal Mental Health Visits

by Delivery System, Children and Youth vs. Adults, California, FY 2017 to FY 2020

PERCENTAGE OF MEDI-CAL ELIGIBLES WHO HAD AT LEAST ONE MENTAL HEALTH VISIT



Notes: Percentage of certified Medi-Cal enrollees who had at least one mental health visit in the managed care or specialty mental health services system. *Certified enrollees* have been deemed qualified and enrolled into Medi-Cal.* Fiscal year is July 1 through June 30 of the named year. *Children and youth* are age 20 and younger. *Adults* are age 21 and older.

* "Fast Facts," California Dept. of Health Care Services, last modified May 31, 2022.

Sources: *Performance Dashboard AB 470 Report Application*, California Health and Human Services (CHHS) Open Data Portal, last updated July 12, 2021; and *Children and Youth Mental Health Services Utilization by Sex*, CHHS Open Data Portal, last updated July 9, 2021.

Use of Medi-Cal mental health services provided through managed care increased substantially between FY 2017 and FY 2020, with visit rates for children increasing by 57%. The increase was due, in part, to a significant increase in the number of developmental screenings reported. Approximately 4% of children and adults had at least one specialty mental health services visit across the four years.

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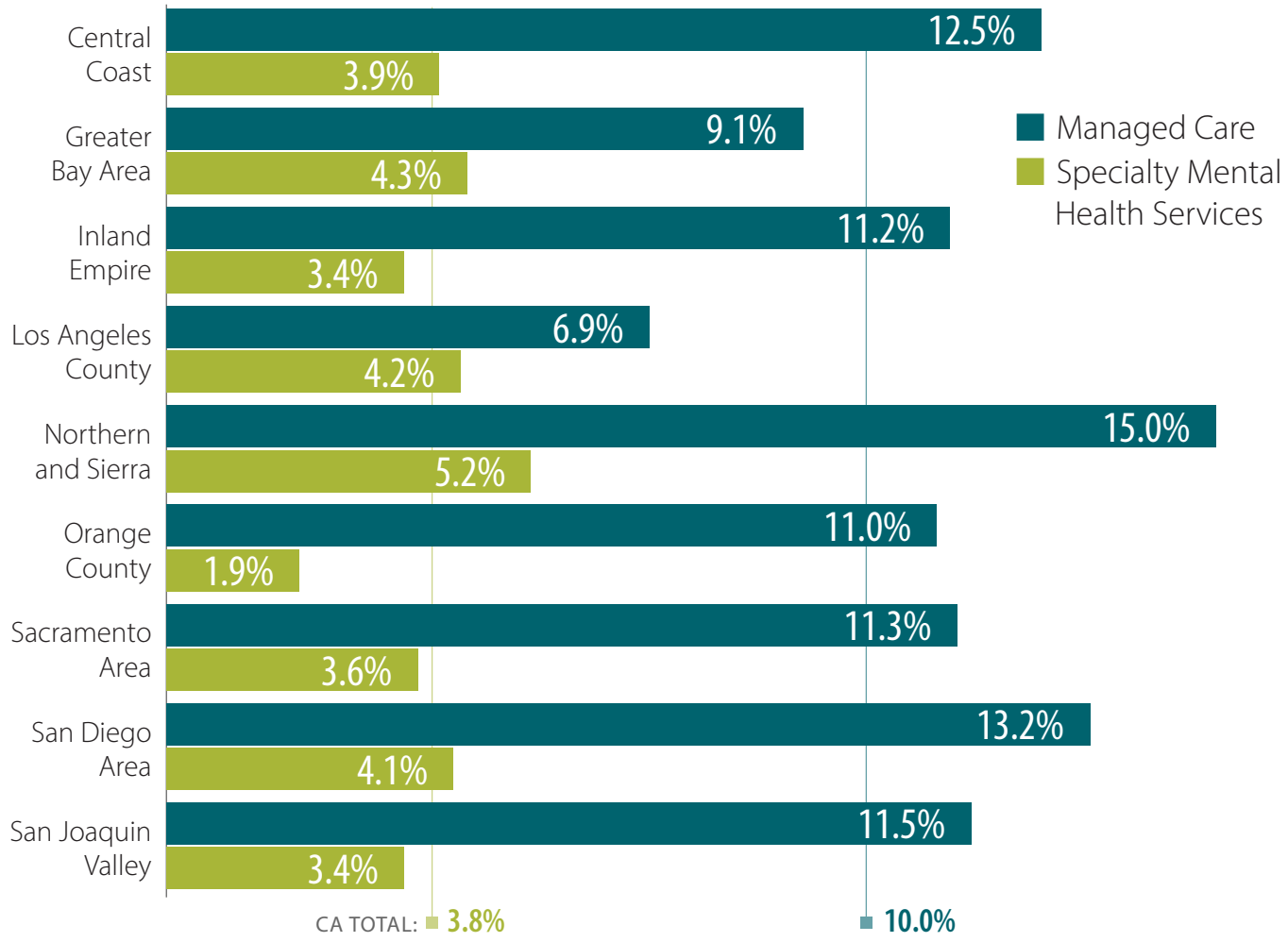
Medi-Cal Mental Health Visits

by Delivery System and Region, Adults, California, FY 2020

PERCENTAGE OF ADULTS ENROLLED IN MEDI-CAL WHO HAD AT LEAST ONE MENTAL HEALTH VISIT



Notes: Percentage of certified Medi-Cal enrollees who had at least one mental health visit from the managed care or specialty mental health services (SMHS) system. *Certified enrollees* have been deemed qualified and enrolled into Medi-Cal.* Fiscal year is July 1 through June 30 of the named year. *Adults* are age 21 and older. Managed care and SMHS rates exclude male enrollees from Alameda County and all enrollees from Alpine and Yolo Counties. SMHS rates exclude all Alpine County enrollees.

* "Fast Facts," California Dept. of Health Care Services, last modified May 31, 2022.

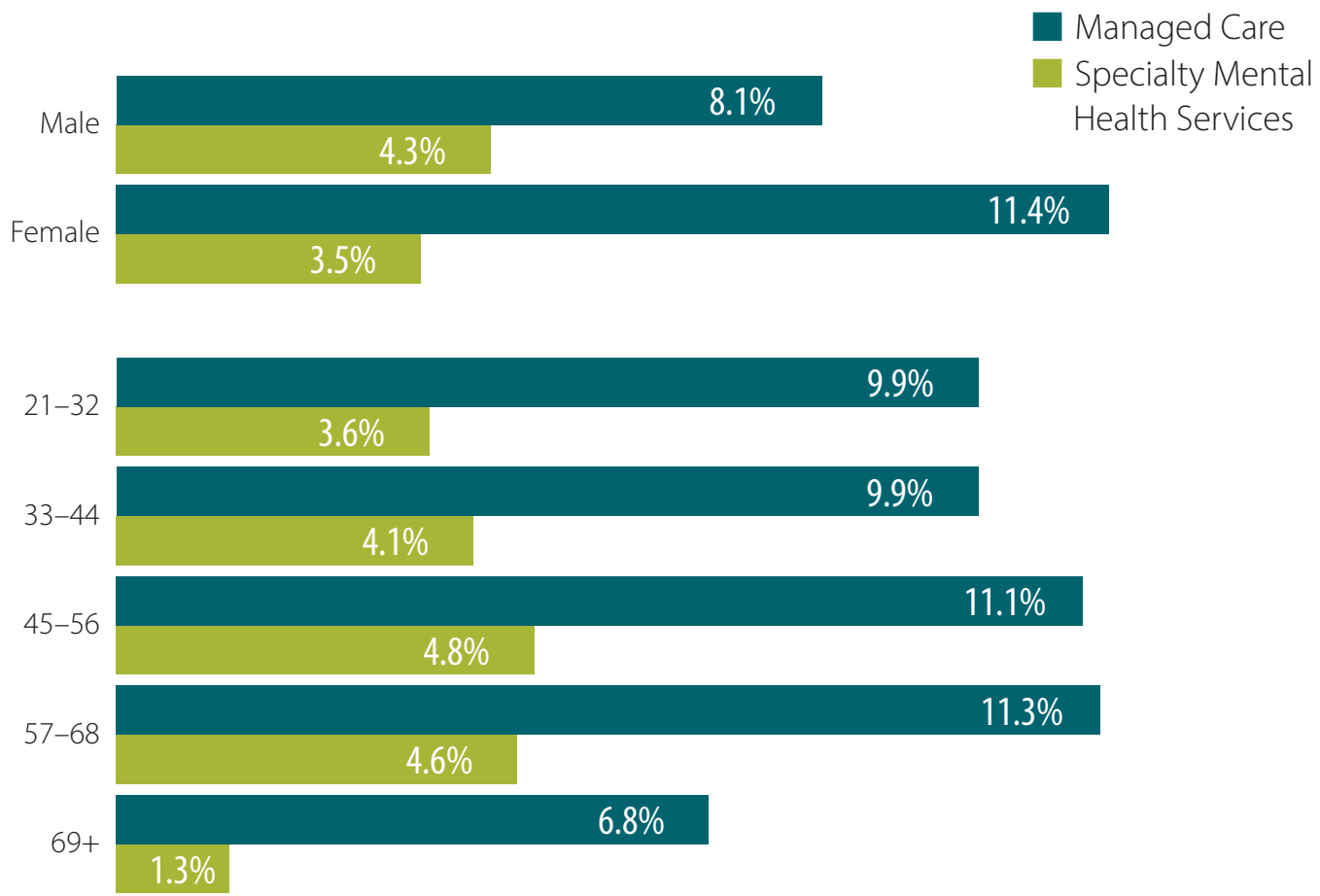
Source: Author calculation based on *Adult Mental Health Services Utilization by Sex (Suppressed)*, California Health and Human Services Open Data Portal, last updated July 12, 2021.

Adults in the Northern and Sierra region had the highest rates of mental health visits in both Medi-Cal delivery systems. Adults in Los Angeles County had the lowest rate of mental health visits in the Medi-Cal managed care system, while adults in Orange County had the lowest rate of mental health visits delivered in the specialty mental health services system.

Medi-Cal Mental Health Visits

by Delivery System, Age and Gender, Adults, California, FY 2020

PERCENTAGE OF ADULTS ENROLLED IN MEDI-CAL WHO HAD AT LEAST ONE MENTAL HEALTH VISIT



Females enrolled in Medi-Cal were 40% more likely than male enrollees to have had at least one mental health visit through the managed care system. In both systems, enrollees age 69 and older were less likely than those in other age groups to have had at least one mental health visit.

Notes: Source did not include additional gender categories. Percentage of certified Medi-Cal enrollees who had at least one mental health visit from the managed care or specialty mental health services system. *Certified enrollees* have been deemed qualified and enrolled into Medi-Cal.* Fiscal year is July 1 through June 30 of the named year. *Adults* are age 21 and older.

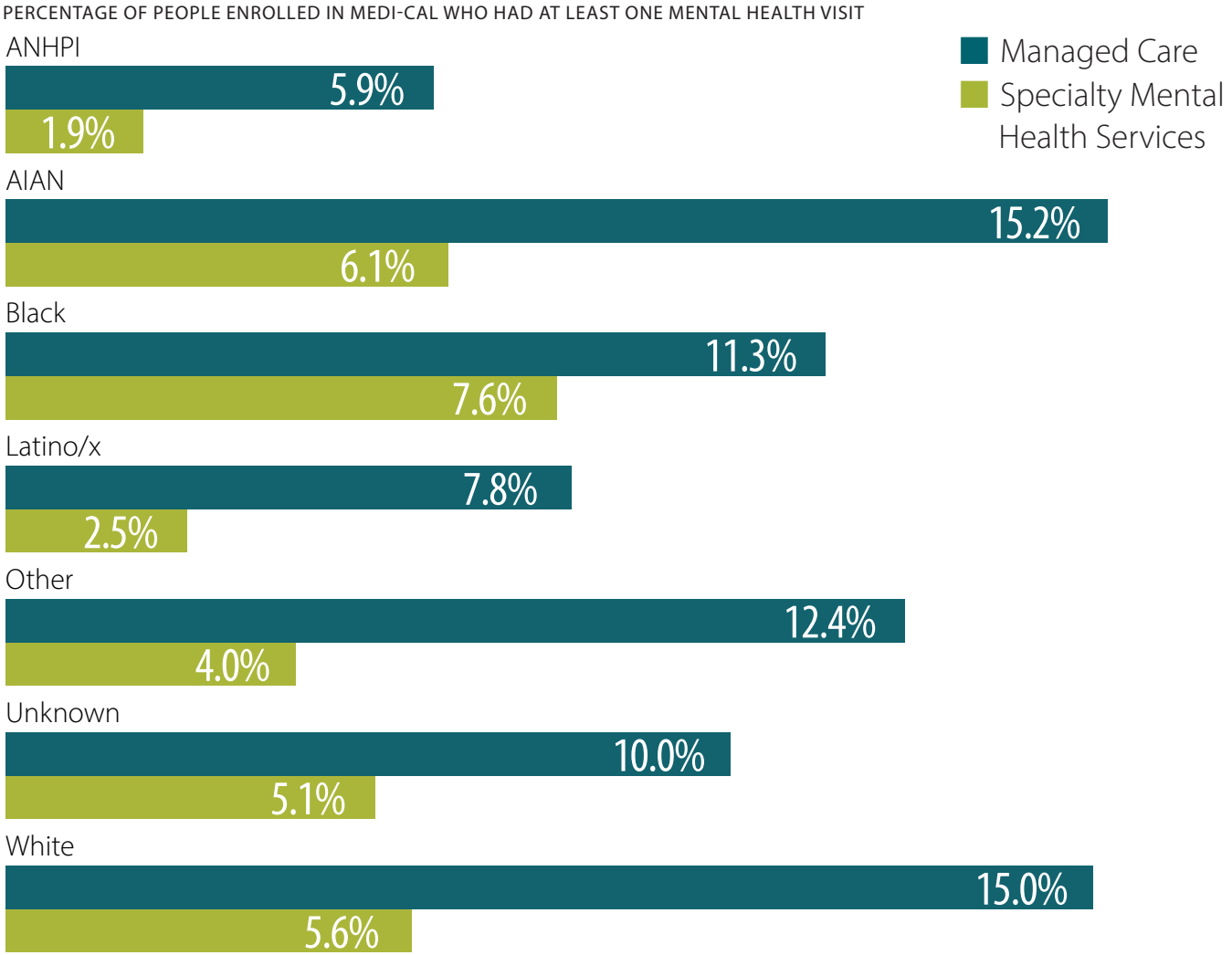
* "Fast Facts," California Dept. of Health Care Services, last modified May 31, 2022.

Source: "MHS Dashboard Adult Demographic Datasets and Report Tool," California Health and Human Services Open Data Portal, last updated September 28, 2021.

Medi-Cal Mental Health Visits

by Delivery System and Race/Ethnicity, Adults, California, FY 2020

In California, the percentage of adults enrolled in Medi-Cal who had mental health visits in the managed care and specialty mental health services system varied by race/ethnicity.



Notes: *ANHPI* is Asian, Native Hawaiian, and Pacific Islander. *AIAN* is American Indian and Alaska Native. Percentage of certified Medi-Cal enrollees who had at least one mental health visit from the managed care or the specialty mental health services system. *Certified enrollees* have been deemed qualified and enrolled into Medi-Cal.* Data source uses *Hispanic*. Fiscal year is July 1 through June 30 of the named year. *Adults* are age 21 and above.

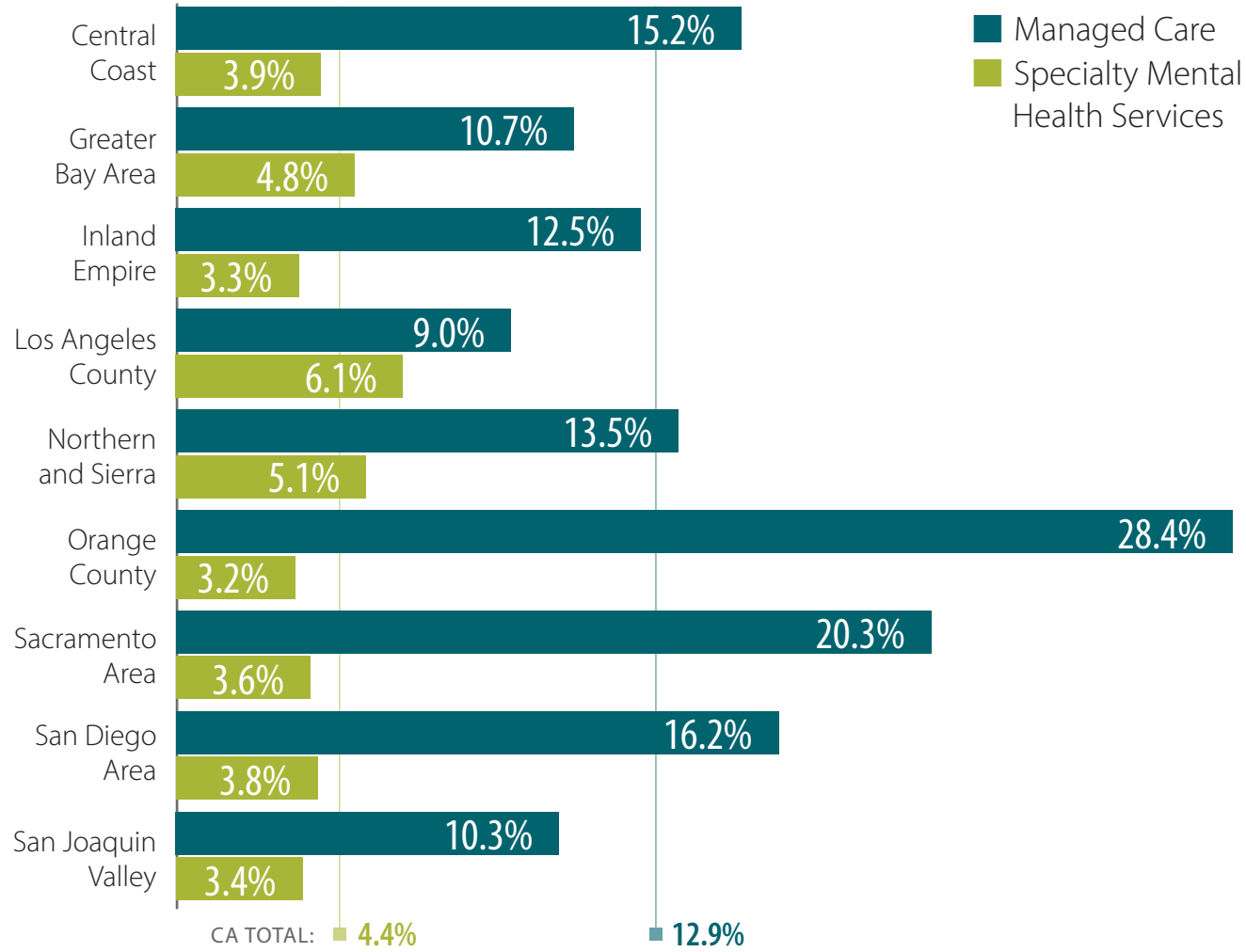
* "Fast Facts," California Dept. of Health Care Services, last modified May 31, 2022.

Source: "MHS Dashboard Adult Demographic Datasets and Report Tool," California Health and Human Services (CHHS) Open Data Portal last updated July 9, 2021.

Medi-Cal Mental Health Visits

by Delivery System and Region, Children and Youth, California, FY 2020

PERCENTAGE OF CHILDREN AND YOUTH ENROLLED IN MEDI-CAL WHO HAD AT LEAST ONE MENTAL HEALTH VISIT



Notes: Percentage of certified Medi-Cal enrollees who had at least one mental health visit from the managed care or specialty mental health services (SMHS) system. *Certified enrollees* have been deemed qualified and enrolled into Medi-Cal.* Fiscal year is July 1 through June 30 of the named year. *Children and youth* are age 0 through 20. Managed care and SMHS rates exclude enrollees from Alpine, Sierra, and Yolo Counties.

* "Fast Facts," California Dept. of Health Care Services, last modified May 31, 2022.

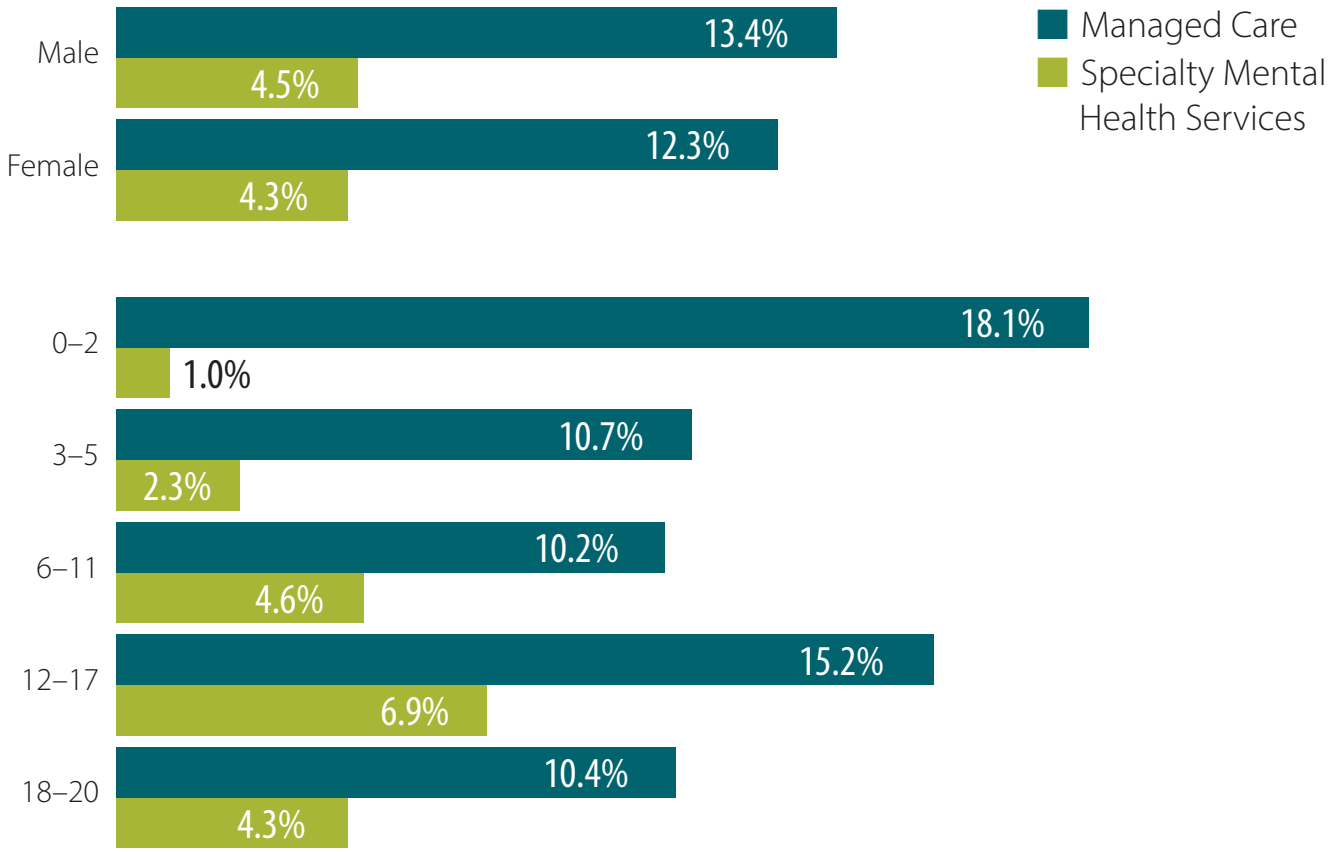
Source: Author calculations based on *Children and Youth Mental Health Services Utilization by Sex*, California Health and Human Services Open Data Portal, last updated July 9, 2021.

Regions differed in the rate that children and youth use the two Medi-Cal mental health delivery systems. Rates in the managed care system ranged from a high of 28% in Orange County to a low of 9% in Los Angeles County.

Medi-Cal Mental Health Visits

by Delivery System, Age and Gender, Children and Youth, California, FY 2020

PERCENTAGE OF CHILDREN AND YOUTH ENROLLED IN MEDI-CAL WHO HAD AT LEAST ONE MENTAL HEALTH VISIT



Notes: Source did not include additional gender categories. Percentage of certified Medi-Cal enrollees who had at least one mental health visit from managed care or the specialty mental health services system. *Certified enrollees* have been deemed qualified and enrolled into Medi-Cal.* Fiscal year is July 1 through June 30 of the named year. *Children and youth* are age 0 through 20.

* "Fast Facts," California Dept. of Health Care Services, last modified May 31, 2022.

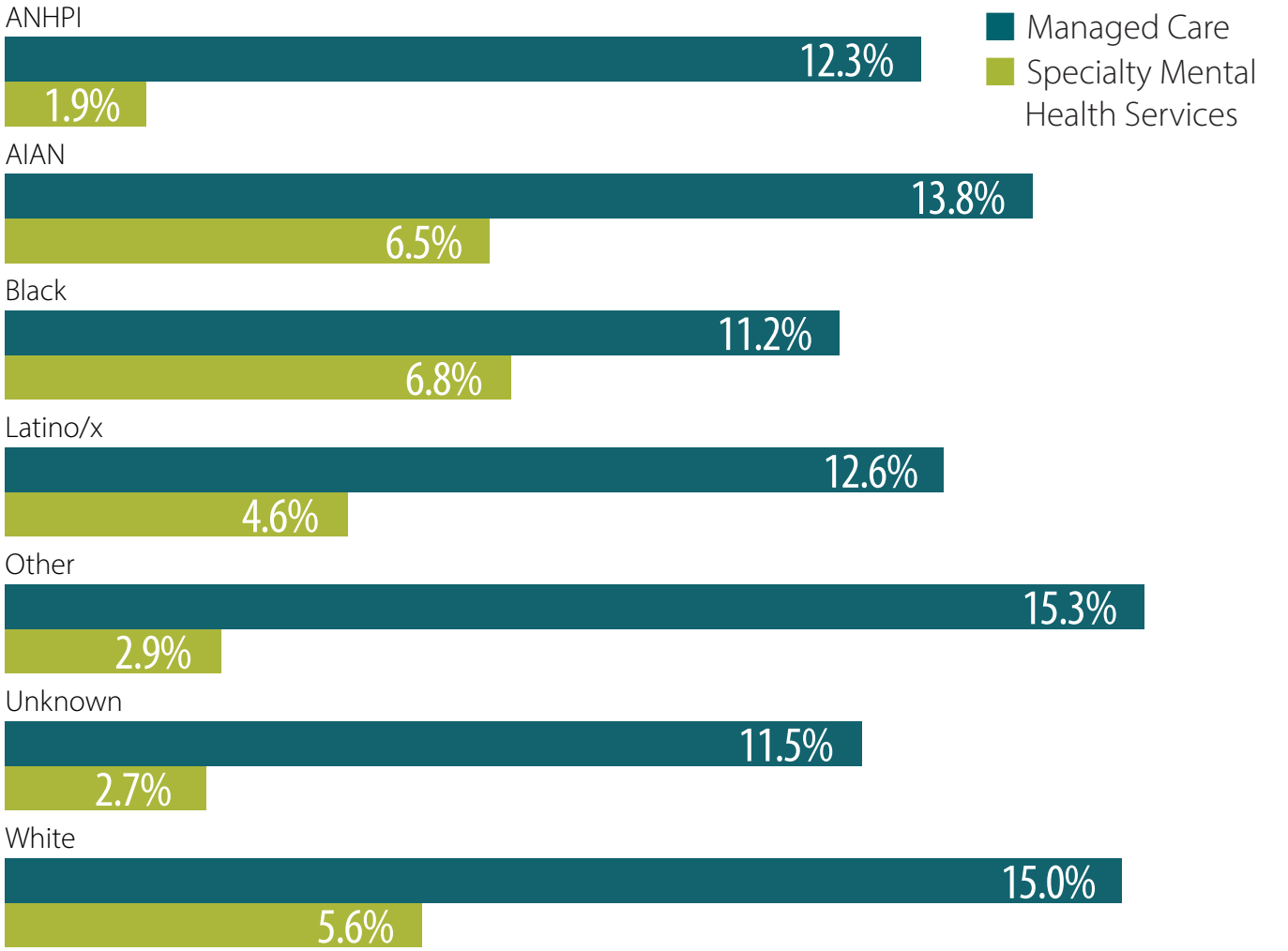
Source: *Children and Youth Mental Health Services Utilization by Sex*, California Health and Human Services Open Data Portal, last updated July 9, 2021.

For children and youth under 21 in Medi-Cal, there was little difference by gender in the rates at which they received mental health services in the two Medi-Cal delivery systems. Children age two and under were most likely to have a managed care visit (18%) and least likely to have a specialty mental health services visit. Of those age two and under with a managed care mental health visit, 85% had a developmental screening.

Medi-Cal Mental Health Visits

by Delivery System and Race/Ethnicity, Children and Youth, California, FY 2020

PERCENTAGE OF PEOPLE ENROLLED IN MEDI-CAL WHO HAD AT LEAST ONE MENTAL HEALTH VISIT



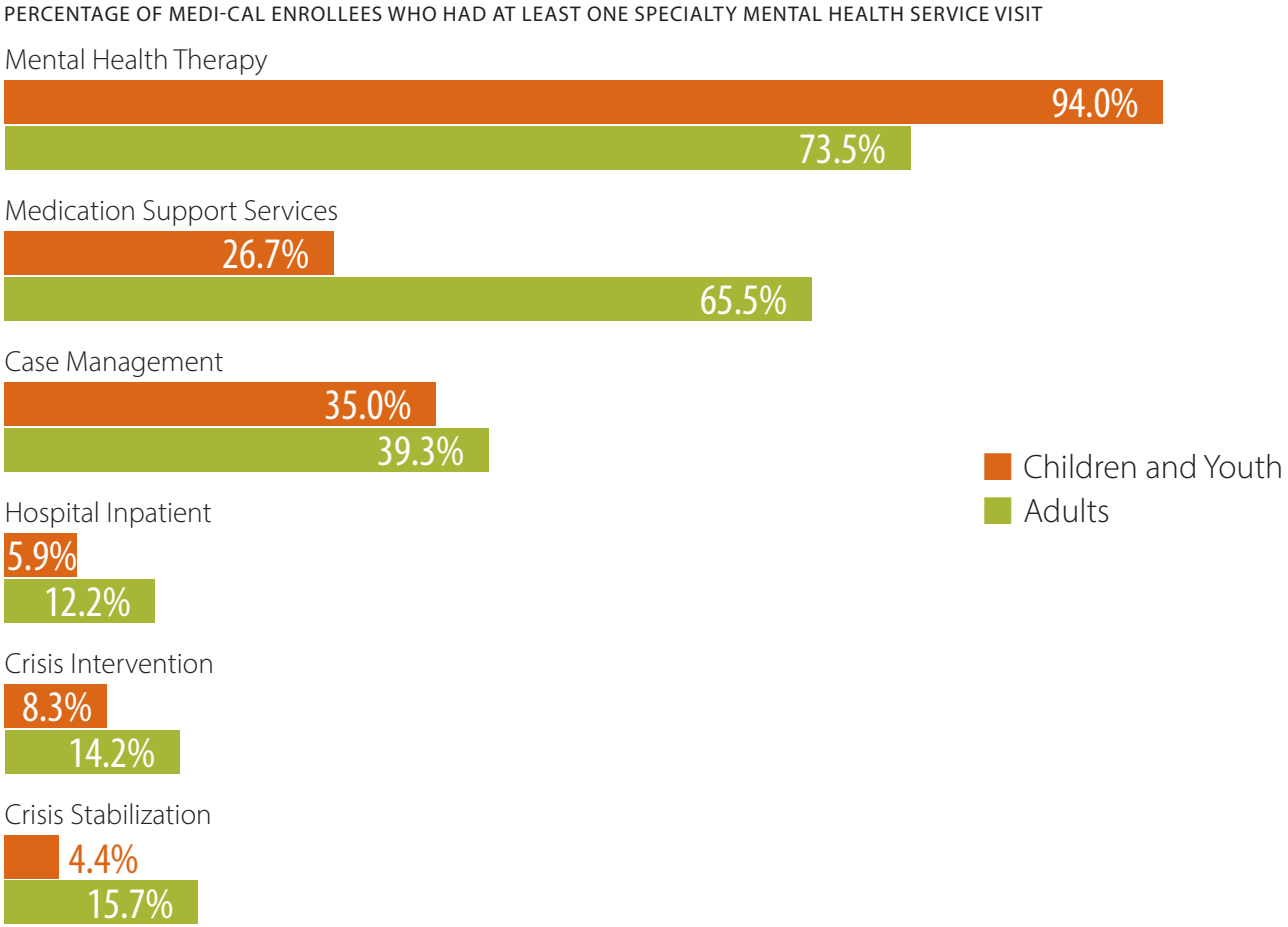
Notes: Percentage of certified Medi-Cal enrollees who had at least one mental health visit from the managed care or the specialty mental health services system. *Certified enrollees* have been deemed qualified and enrolled into Medi-Cal.* Data source uses *Hispanic*. Fiscal year is July 1 through June 30 of the named year. *Children and youth* are age 0 through 20. *ANHPI* is Asian, Native Hawaiian, and Pacific Islander. *AIAN* is American Indian and Alaska Native.

* "Fast Facts," California Dept. of Health Care Services, last modified May 31, 2022.

Source: *Children and Youth Mental Health Services Utilization by Race Group*, CHHS Open Data Portal, last updated July 9, 2021.

In California, the percentage of children and youth enrolled in Medi-Cal who had mental health visits in the managed care and specialty mental health services systems varied by race/ethnicity.

Selected Medi-Cal Specialty Mental Health Services
by Age Group and Service Category, California, FY 2020



Notes: The specialty mental health services (SMHS) delivery system provides Medi-Cal services for adults and children who meet medical necessity criteria, which consist of having a specific covered diagnosis, functional impairment, and meeting intervention criteria. For enrollees under age 21, federal law requires state Medicaid programs to provide services when they are necessary to correct or ameliorate a child's illness or condition. *Mental health therapy* is individual and group therapy and other interventions (source uses *mental health services*); *case management* assists enrollees to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services (source uses *case management/brokerage); hospital inpatient* includes psychiatric health facility, inpatient administrative days, county SMHS, and fee-for-service psychiatric inpatient hospital days. If Medi-Cal enrollees used more than one type of hospital care, they would be counted twice. *Children* are age 0 through 20; *adults* are age 21 and older. Fiscal year (FY) is July 1 through June 30 of the named year.

Sources: Author calculations based on *Adult SMHS Utilization*, California Health and Human Services (CHHS) Open Data Portal, last updated December 10, 2021; and *Children and Youth Specialty Mental Health Services Utilization*, CHHS Open Data Portal, last updated December 10, 2021.

Almost all children and youth receiving county specialty mental health services (SMHS) used therapy, and about one-quarter used medication. Approximately three-quarters of adults receiving SMHS used therapy, and approximately two-thirds used medication. Multiple services may be used. Over one-third of children and adults used case management for assistance in accessing treatment and other services.

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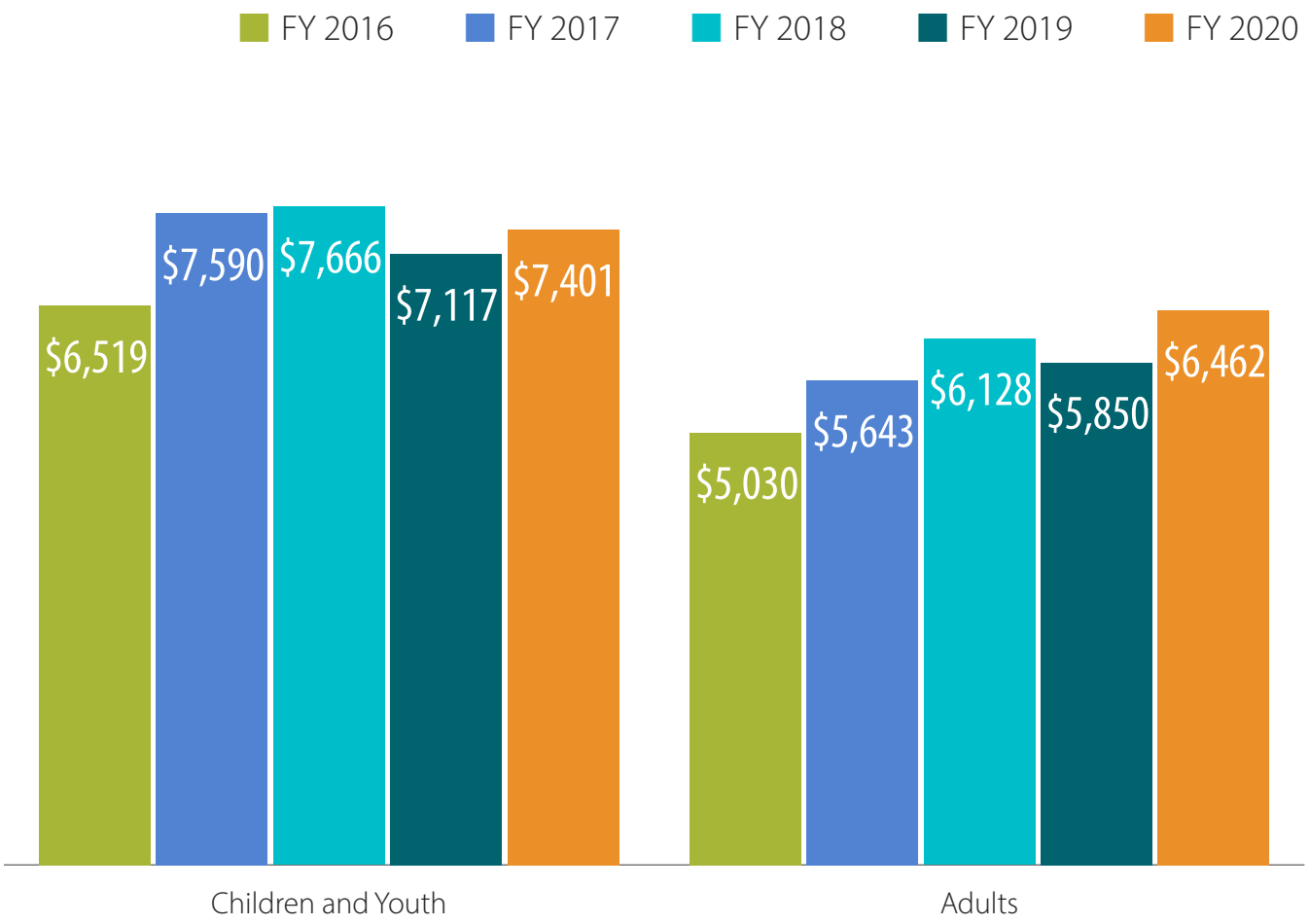
Medi-Cal Specialty Mental Health Services Expenditures per Service User, by Age Group, California, FY 2016 to FY 2020

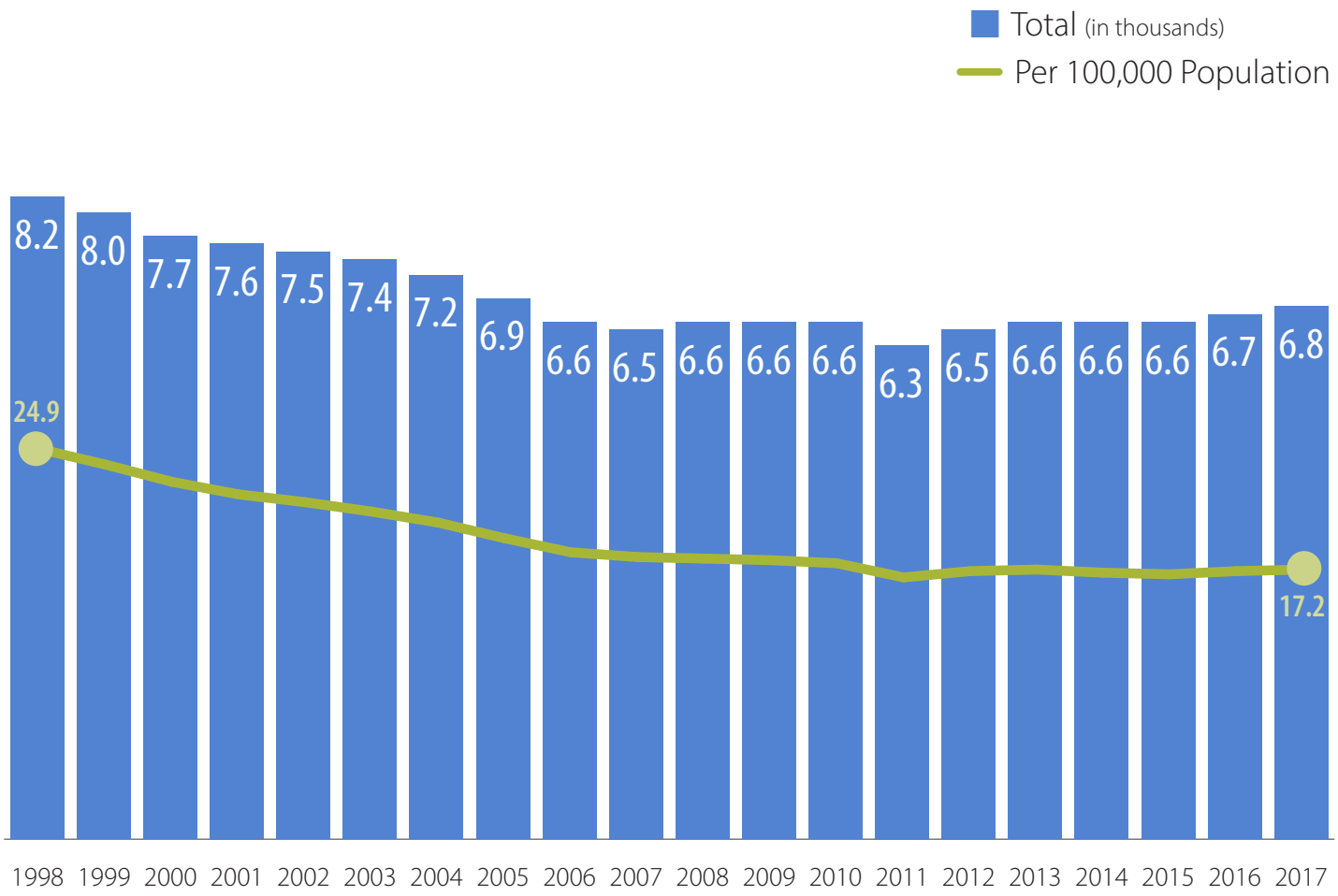


Notes: The specialty mental health services (SMHS) delivery system provides Medi-Cal services for children and adults who meet medical necessity criteria, which consist of having a specific covered diagnosis, functional impairment, and meeting intervention criteria. For enrollees under age 21, federal law requires state Medicaid programs to provide services when they are necessary to correct or ameliorate a child's illness or condition. Expenditures are the costs of all SMHS used in the fiscal year, divided by the number of Medi-Cal enrollees who used at least one SMHS service. Excludes costs of any Medi-Cal managed care mental health services. *Children and youth* are age 0 to 20; *adults* are age 21 and older. Fiscal year (FY) is July 1 through June 30 of stated year.

Sources: Author calculations based on *Adult SMHS Utilization*, California Health and Human Services (CHHS) Open Data Portal, last updated December 10, 2021; and *Children and Youth Specialty Mental Health Services Utilization*, CHHS Open Data Portal, last updated December 10, 2021.

Expenditures per Medi-Cal enrollee using county specialty mental health services were higher for children and youth than for adults. Expenditures for adults increased by 28% from FY 2016 to FY 2020. During the same time expenditures for children and youth increased by 14%.

Acute Psychiatric Inpatient Beds
California, 1998 to 2017



Notes: Acute psychiatric inpatient beds include those in psychiatric units in general acute care hospitals (including city and county hospitals), acute psychiatric hospitals, and psychiatric health facilities (PHFs). Acute psychiatric inpatient beds are licensed to provide one of the following types of psychiatric service: adult, child/adolescent, geriatric psychiatry, psychiatric intensive care, or chemical dependency. PHFs do not have to meet the same facility regulations as hospitals, and provide medical care through arrangements with other providers. Excludes acute and intermediate beds in California state hospitals, which treat forensic patients committed by criminal courts, and civil patients involuntarily committed by civil courts because they are a danger to themselves or others. (See page 57.)

Source: *California's Acute Psychiatric Bed Loss* (PDF), California Hospital Assn., February 2019.

Acute psychiatric beds in both general acute care and psychiatric hospitals are used for people who require 24-hour care for a psychiatric crisis. In California, the number of psychiatric beds per 100,000 population decreased 31% from 1998 through 2017 as 35 facilities either closed or eliminated psychiatric units.

Adult and Child/Adolescent Acute Psychiatric Inpatient Beds

by County, California, 2017

Notes: Acute psychiatric inpatient beds include those in psychiatric units in general acute care hospitals (including city and county hospitals), acute psychiatric hospitals, and psychiatric health facilities (PHFs). Acute psychiatric inpatient beds are licensed to provide one of the following types of psychiatric service: adult, child/adolescent, geriatric psychiatry, psychiatric intensive care, or chemical dependency. PHFs do not have to meet the same facility regulations as hospitals, and provide medical care through arrangements with other providers. Excludes acute and intermediate beds in California state hospitals, which treat forensic patients committed by criminal courts, and civil patients involuntarily committed by civil courts because they are a danger to themselves or others. (See page 57.)

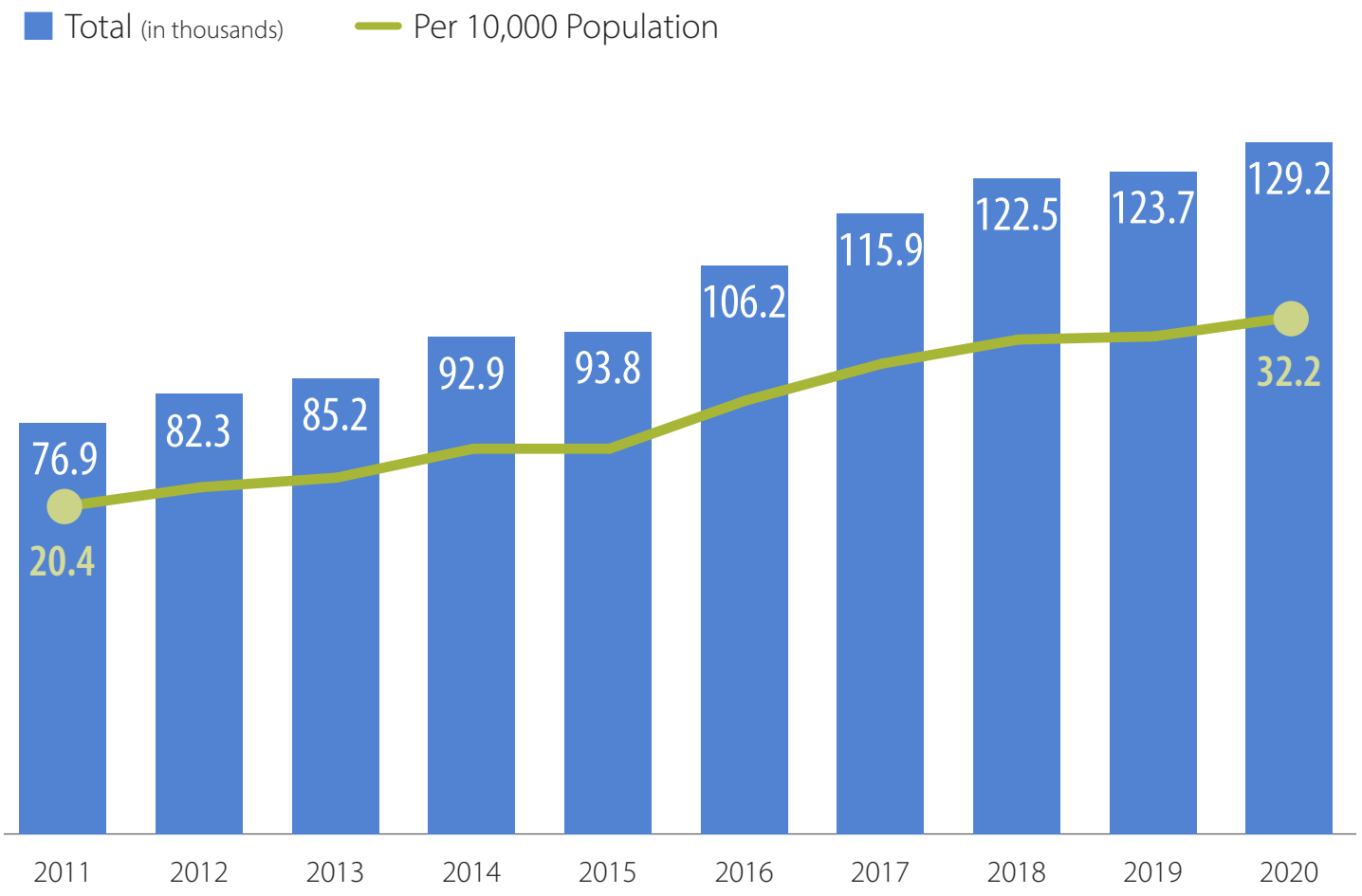
Source: *California's Acute Psychiatric Bed Loss* (PDF), California Hospital Assn., February 2019.

In California, there was significant geographic variation in the availability of beds for psychiatric inpatient care. Twenty-five counties had no adult acute psychiatric beds, and 43 counties had no acute psychiatric beds for children.

Emergency Department Discharges to Psychiatric Care
California, 2011 to 2020

People experiencing mental health crises frequently receive care in hospital emergency departments.

ED VISITS WITH DISPOSITION TO PSYCHIATRIC CARE



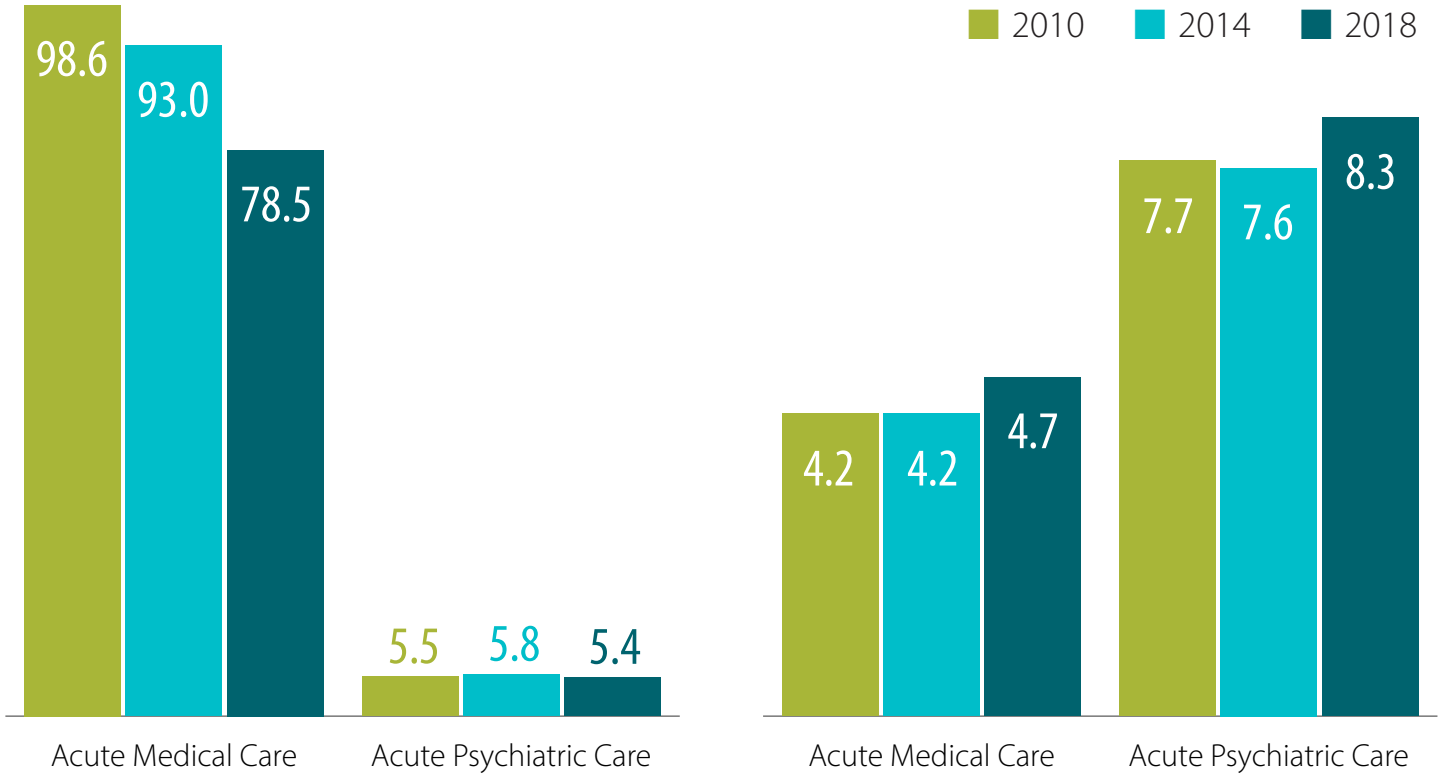
Notes: *ED* is emergency department. Disposition to psychiatric care includes discharges or transfers to a psychiatric hospital or distinct psychiatric unit of a hospital, including planned inpatient readmissions. *Visits* are the total of ED visits and ED admissions with a disposition to inpatient psychiatric care. Due to data limitations, 2011 through 2014 figures include only those from ED visits and not ED admissions.

Sources: Author calculations based on *Hospital Emergency Department - Characteristics by Facility (Pivot Profile)* (2010–20), California Health and Human Services Open Data Portal; and *Report P-2A: Total Population Projections, 2010–2060: California and Counties (2019 Baseline)*, California Dept. of Finance, July 19, 2021.

Hospital Discharges and Length of Stay

Acute Medical vs. Acute Psychiatric, California, 2010, 2014, and 2018

There were far fewer acute psychiatric hospital stays per population than acute medical stays. Average lengths of stay for acute psychiatric care were considerably longer than average stays for acute medical care.



Notes: Includes discharges from general acute hospitals, acute psychiatric facilities, and psychiatric health facilities (PHFs). PHFs do not have to meet the same facility regulations as hospitals, and provide medical care through arrangements with other providers. Discharges from chemical dependency recovery care, physical rehabilitation care, and skilled nursing / intermediate care are not shown.

Sources: Author calculation based on "Type of Care by County of Residence," in "Hospital Inpatient Discharge Rates — County Frequencies" (2010), Office of Statewide Health Planning and Development; *Hospital Inpatient Characteristics – Type of Care by Patient County of Residence* (2014 and 2018), California Health and Human Services Open Data Portal; and *Report P-2A: Total Population Projections, 2010–2060: California and Counties (2019 Baseline)*, California Dept. of Finance, July 19, 2021.

Mental Health Professions

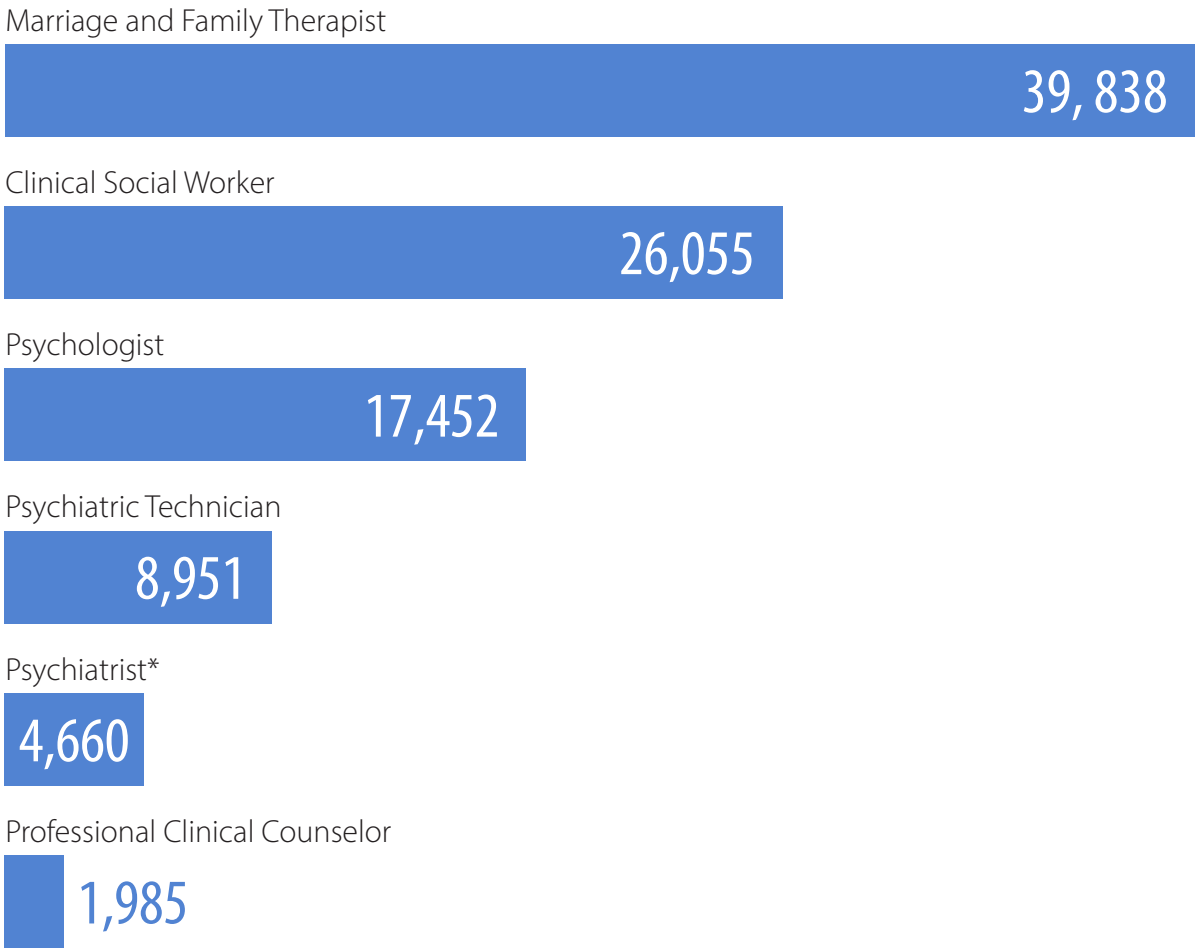
PROFESSION	CREDENTIALS, QUALIFICATIONS, AND CUSTOMARY PRACTICE	PSYCHOTROPIC MEDICATIONS	PSYCHOLOGICAL TESTING	TREATMENT PLANNING	THERAPY	CASE MANAGEMENT	REHABILITATION AND SUPPORT
Physicians	MD/DO with general licensure as physician and surgeon	✔		✔			
Psychiatrists	MD/DO with a specialty in psychiatry, some with a second specialty in child and adolescent psychiatry	✔		✔	✔		
Psychiatric Clinical Nurse Specialists (CNS)	Advanced practice nurses, with a master's or doctoral degree, who specialize in psychiatry	✔		✔	✔		
Nurses	RNs and LVNs with and without specialty psychiatric training, plus licensed psychiatric technicians			✔		✔	✔
Psychologists	Clinical psychologists licensed at the doctoral level, perhaps specializing in psychological or neuropsychological assessment, including diagnostic test administration, assessment, and treatment recommendations		✔	✔	✔		
Licensed Independent Clinical Social Workers (LICSW), Mental Health Counselors (LMHC), and Marriage and Family Therapists (MFT)	Master's level clinicians licensed by the state LICSWs and LMFTs are eligible for reimbursement under Medi-Cal and Medicare as independent practitioners outside of a clinic.			✔	✔	✔	✔
Occupational Therapists (OT)	Licensed OT			✔		✔	✔
Unlicensed Mental Health Workers Qualified Under the California Medi-Cal Rehabilitation Option	Mental health workers with high school, associate's, or bachelor's degrees providing (under supervision) care management, rehabilitation, behavior management, mentoring, milieu support, respite, and other supportive roles			✔		✔	✔

Notes: *MD/DO* is medical doctor / doctor of osteopathic medicine. *RN* is registered nurse. *LVN* is licensed vocational nurse.

Sources: California Welfare and Institutions Code; and California Business and Professions Codes.

All licensed mental health practitioners are qualified to conduct assessments, determine diagnoses, develop treatment plans, and provide therapies. Unlicensed mental health staff, including peer providers, offer important case management, rehabilitation, and support services.

Mental Health Professionals
California, 2020



California had 98,941 licensed mental health professionals in 2020. Marriage and family therapists composed the greatest share, more than double the number of licensed psychologists.

* Includes psychiatrists who have completed residency training and are active in patient care at least 20 hours per week

Sources: Public Information Licensee List, California Dept. of Consumer Affairs; Survey of Licensees (private tabulation), Medical Board of California, January 2020; and *Annual Estimates of the Resident Population for Counties in California: April 1, 2010 to July 1, 2019* (CO-EST2019-ANNRES-06), US Census Bureau, last modified March 26, 2020.

Licensed Mental Health Professionals, by Region
California, 2020

PER 100,000 POPULATION

HIGHER THAN STATE AVERAGE

	LICENSED PSYCHIATRISTS*	LICENSED CLINICAL SOCIAL WORKERS	LICENSED MARRIAGE AND FAMILY THERAPISTS	LICENSED PROFESSIONAL CLINICAL COUNSELORS	LICENSED PSYCHOLOGISTS	PSYCHIATRIC TECHNICIANS
Central Coast	11.6	61.8	144.4	5.2	47.1	52.6
Greater Bay Area	18.7	82.8	135.3	6.8	72.6	17.9
Inland Empire	8.2	39.0	60.8	3.7	15.9	40.9
Los Angeles County	12.0	81.1	106.2	4.0	48.7	8.8
Northern and Sierra	5.8	65.4	100.3	5.5	21.8	12.8
Orange County	7.9	56.8	106.3	5.6	40.1	15.2
Sacramento Area	12.3	72.6	98.4	5.7	37.6	12.4
San Diego Area	13.3	64.8	94.1	7.3	55.0	3.1
San Joaquin Valley	6.2	35.5	48.2	2.5	16.2	58.3
California	**11.8**	**65.9**	**100.8**	**5.0**	**44.2**	**22.7**

* Includes psychiatrists who have completed residency training and are active in patient care at least 20 hours per week.

Note: See Appendix for a map of counties included in each region.

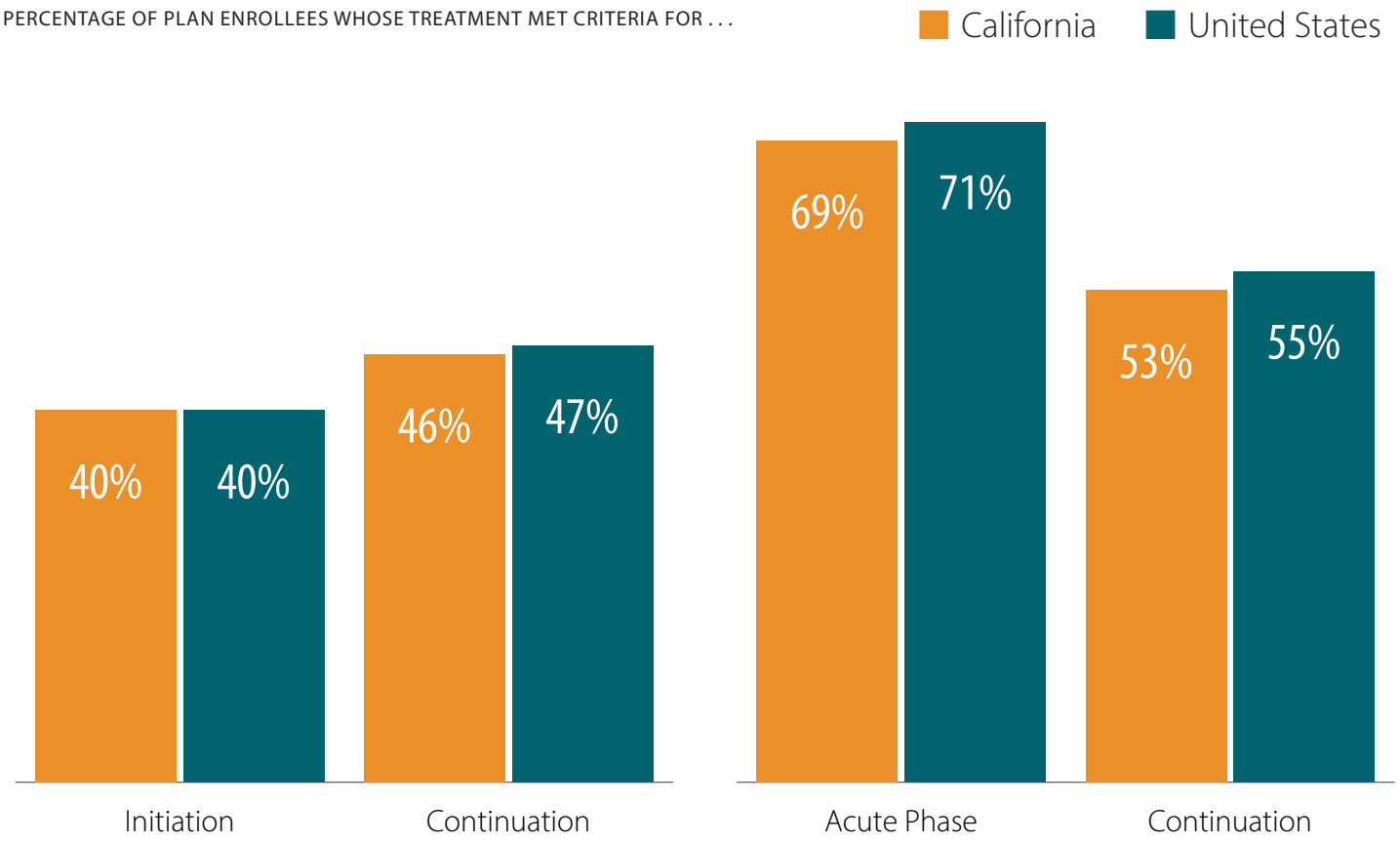
Sources: Public Information Licensee List, California Dept. of Consumer Affairs; Survey of Licensees (private tabulation), Medical Board of California, January 2020; and *Annual Estimates of the Resident Population for Counties in California: April 1, 2010 to July 1, 2019* (CO-EST2019-ANNRES-06), US Census Bureau, last modified March 26, 2020.

The number of mental health professionals per population varied considerably by region in California. The Greater Bay Area's rates were higher than the state average for almost all of the professions shown, while the Inland Empire and San Joaquin Valley regions had rates that were lower than average for almost all of the professions shown.

Medication Treatment for Selected Mental Health Conditions

Commercial HMO and PPO Plans, California vs. United States, 2019

PERCENTAGE OF PLAN ENROLLEES WHOSE TREATMENT MET CRITERIA FOR . . .



Children Prescribed Medication for ADHD

Adults Prescribed Antidepressant Medication

Notes: For children (age 6 to 12), the initiation phase shows how well the health plan did at making sure children prescribed a medication for attention deficit hyperactivity disorder (ADHD) had a follow-up visit within the first month after starting medication. The continuation phase measures how well the health plan did at making sure children prescribed a medication for ADHD remained on medication for about seven months and had at least two additional follow-up visits during the nine months after the first month on the medication and initial follow-up visit. For adults 18 and older, the acute phase shows how well the health plan did at making sure patients diagnosed with depression received treatment during the first 12 weeks following the start of treatment, and the continuation phase measures how many patients treated for depression remained on antidepressant medication for six months following the start of treatment.

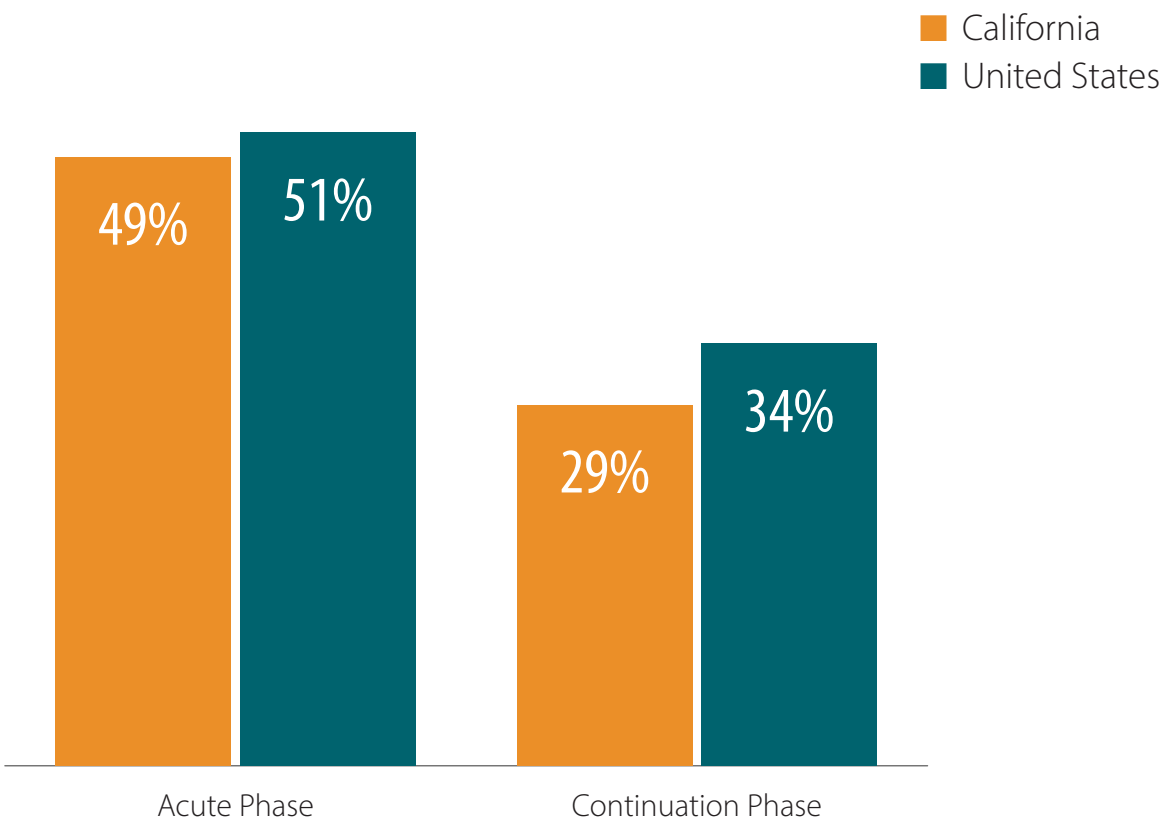
Source: "California Health Plans Compared to Health Plans Nationwide," Office of the Patient Advocate.

Less than half of children in California HMOs and PPOs who were prescribed medication for attention deficit hyperactivity disorder had a follow-up visit within a month after starting medication, and two visits in the following nine months. Almost 70% of California adults in HMO and PPO plans who were prescribed antidepressant medication took it for the first 12 weeks, and more than half remained on the medication six months. In both cases, California and US rates were similar.

Antidepressant Medication, Adults Enrolled in Medicaid

California vs. United States, FFY 2019

PERCENTAGE OF PLAN ENROLLEES WHOSE TREATMENT MET CRITERIA FOR . . .



Half of adults enrolled in Medicaid plans in California and the US who were diagnosed with major depression and were newly treated with antidepressant medication remained on that medication for 12 weeks. In California, less than a third continued on antidepressant medication for six months.

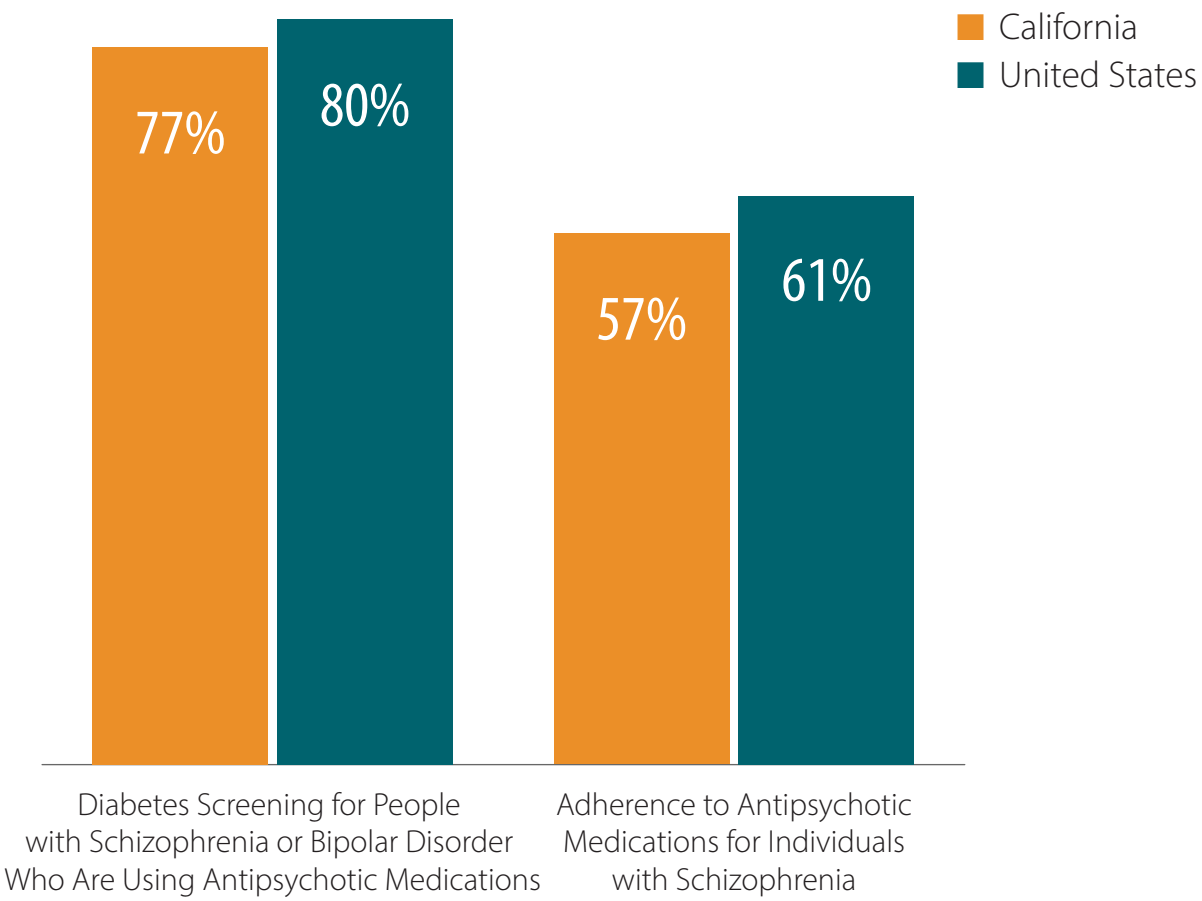
Notes: *Adults* are age 18 to 64. The acute phase shows the percentage of adults enrolled in Medicaid diagnosed with major depression who were treated with and remained on antidepressant medication for 12 weeks. The continuation phase shows the percentage of adults diagnosed with major depression who were treated and remained on the medication for six months. Measure is a weighted average of adults enrolled in managed care plans and fee-for-service. Federal fiscal year (FFY) 2019 is October 2018 through September 2019.

Sources: *Adult Health Care Quality Measures Dataset, FFY 2019*, Centers for Medicare & Medicaid Services (CMS), October 2020; and *Quality of Behavioral Health Care in Medicaid and CHIP: Findings from the 2019 Behavioral Health Core Set — Chart Pack* (PDF), CMS, February 2021.

Antipsychotic Medication, Adults Enrolled in Medicaid

California vs. United States, FFY 2019

PERCENTAGE OF PLAN ENROLLEES WHOSE TREATMENT MET CRITERIA FOR . . .



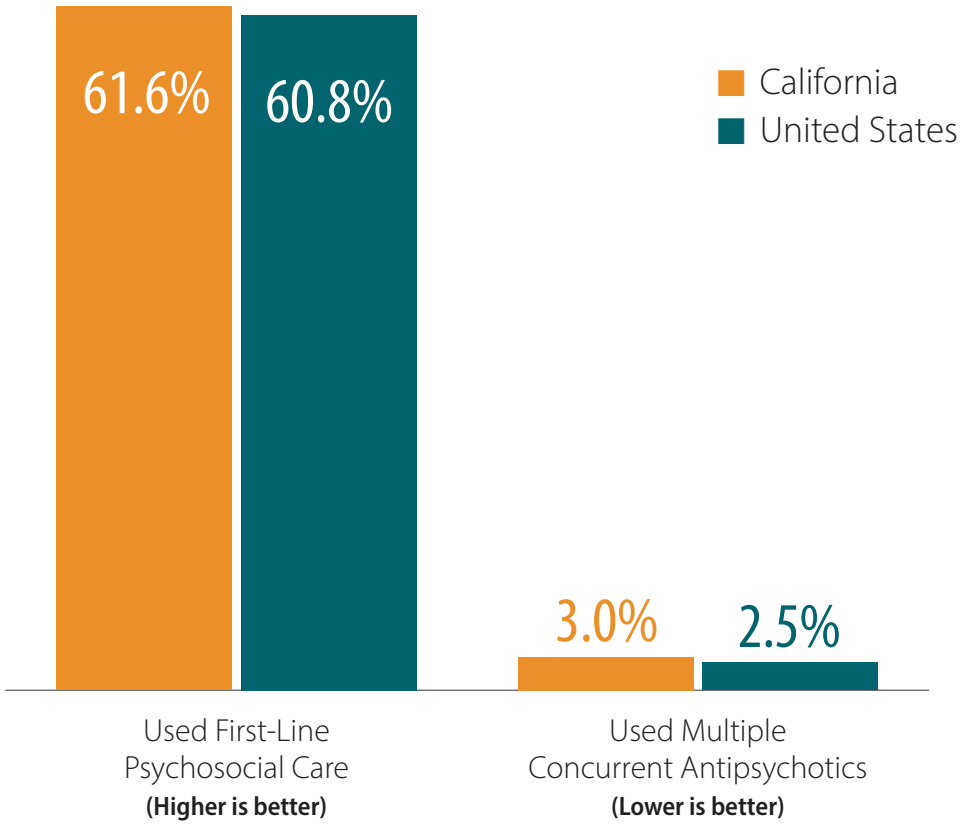
Notes: *Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications* assesses adults age 18–64 with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year. *Adherence to antipsychotic medications for individuals with schizophrenia* assesses adults age 18 and older who have schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period. Federal fiscal year (FFY) 2019 is October 2018 through September 2019.

Sources: *Adult Health Care Quality Measures Dataset, FFY 2019*, Centers for Medicare & Medicaid Services (CMS), October 2020; and *Quality of Behavioral Health Care in Medicaid and CHIP: Findings from the 2019 Behavioral Health Core Set — Chart Pack* (PDF), CMS, February 2021.

Close to 60% of adults enrolled in Medi-Cal who were prescribed antipsychotic medications for schizophrenia remained on them for at least 80% of their treatment period. Antipsychotic medications can raise the risk of diabetes. About 75% of adults enrolled in Medi-Cal who were prescribed antipsychotic medications were screened for diabetes.

Antipsychotic Medication, Children and Youth Enrolled in Medicaid, California vs. United States, FFY 2019

PERCENTAGE OF PLAN ENROLLEES PRESCRIBED AN ANTIPSYCHOTIC MEDICATION WHO . . .



Notes: *Use of first-line psychosocial care* is the percentage of children and youth with a new prescription for an antipsychotic medication who had documentation of psychosocial care as a first-line treatment. Excludes those who have a Food and Drug Administration primary indication for an antipsychotic. *Use of multiple concurrent antipsychotics* is the percentage of children and youth who were on two or more concurrent antipsychotic medications for an extended period (90 consecutive days or more). *Children and youth* are age 1 to 17. Source uses *children and adolescents*. Federal fiscal year (FFY) 2019 is October 2018 through September 2019. Measures are weighted averages of managed care and fee-for-service enrollees.

Sources: *2019 Child and Adult Health Care Quality Measures Quality* (FFY 2019), Centers for Medicare & Medicaid Services (CMS), October 2020; and *Quality of Behavioral Health Care in Medicaid and CHIP: Findings from the 2019 Behavioral Health Core Set — Chart Pack* (PDF), CMS, February 2021.

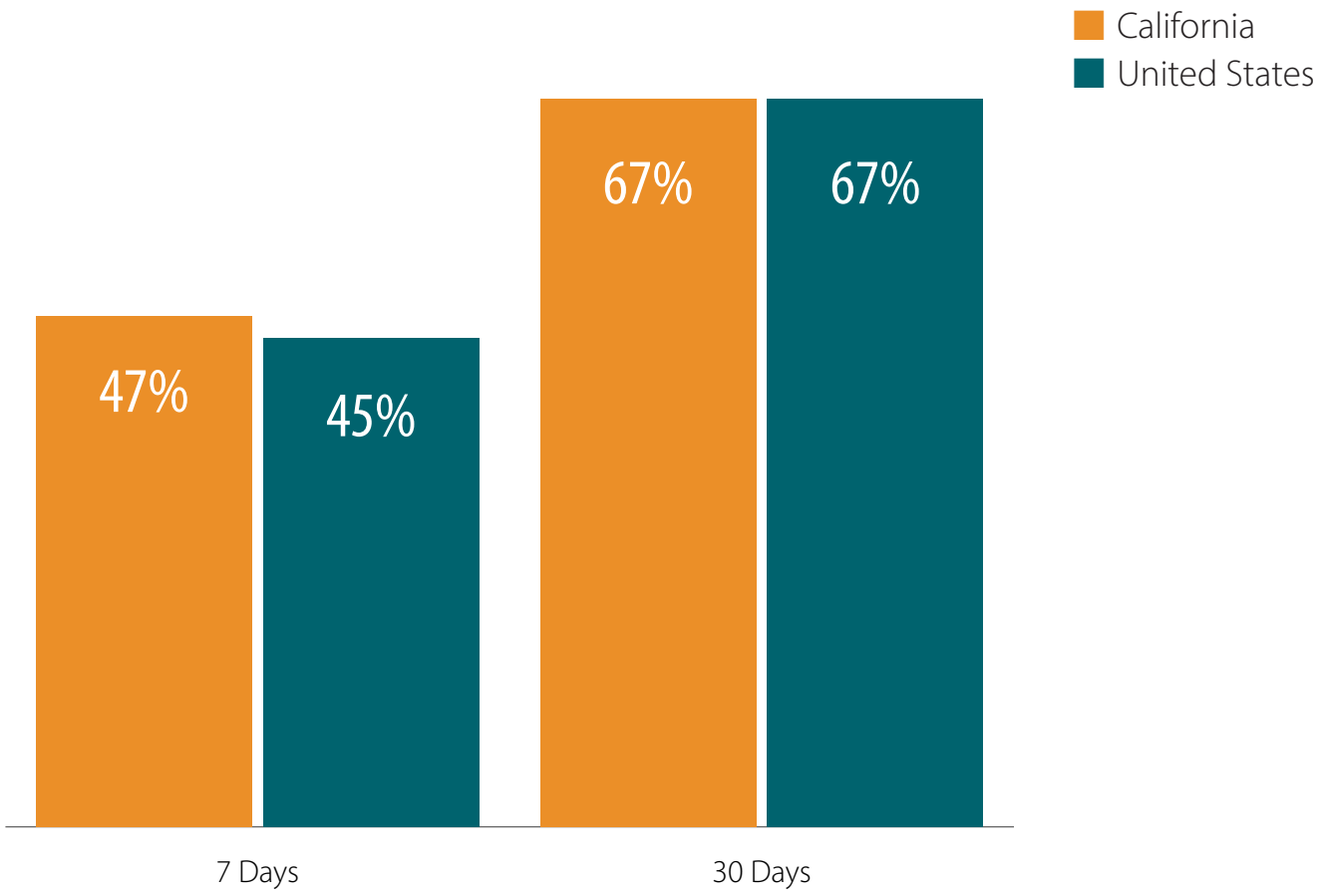
The Pediatric Quality Measures Program states that children and youth who are prescribed new antipsychotic medication should receive psychosocial treatment before or at the same time as medication, and that the use of multiple antipsychotics should be minimized.* Slightly more than 60% of children on antipsychotics who were enrolled in Medi-Cal received psychosocial treatment. Three percent of children enrolled in Medi-Cal were on multiple antipsychotics for 90 days or more.

* "HEDIS Measures for the Safe & Judicious Use of Antipsychotic Medications in Children and Adolescents: What Are the Antipsychotic Medication Use Measures?," National Committee for Quality Assurance.

Follow-Up After Hospitalization for Mental Illness

HMO and PPO Plans, California vs. United States, 2019

PERCENTAGE OF DISCHARGES WITH A FOLLOW-UP VISIT WITHIN . . .



Notes: Percentage of patients hospitalized for a mental illness who were seen by a mental health provider within 7 days and 30 days after leaving the hospital. Includes HMO and PPO health plan members age six and older.* *HMO* is health maintenance organization. *PPO* is preferred provider organization. The California plans' scores are the average across all California HMO and PPO health plans. National results are from health plans throughout the US and were calculated giving equal weight to each plan's score regardless of its enrollment.

* "Follow-Up After Hospitalization for Mental Illness (FUH)," Nat'l Committee for Quality Assurance.

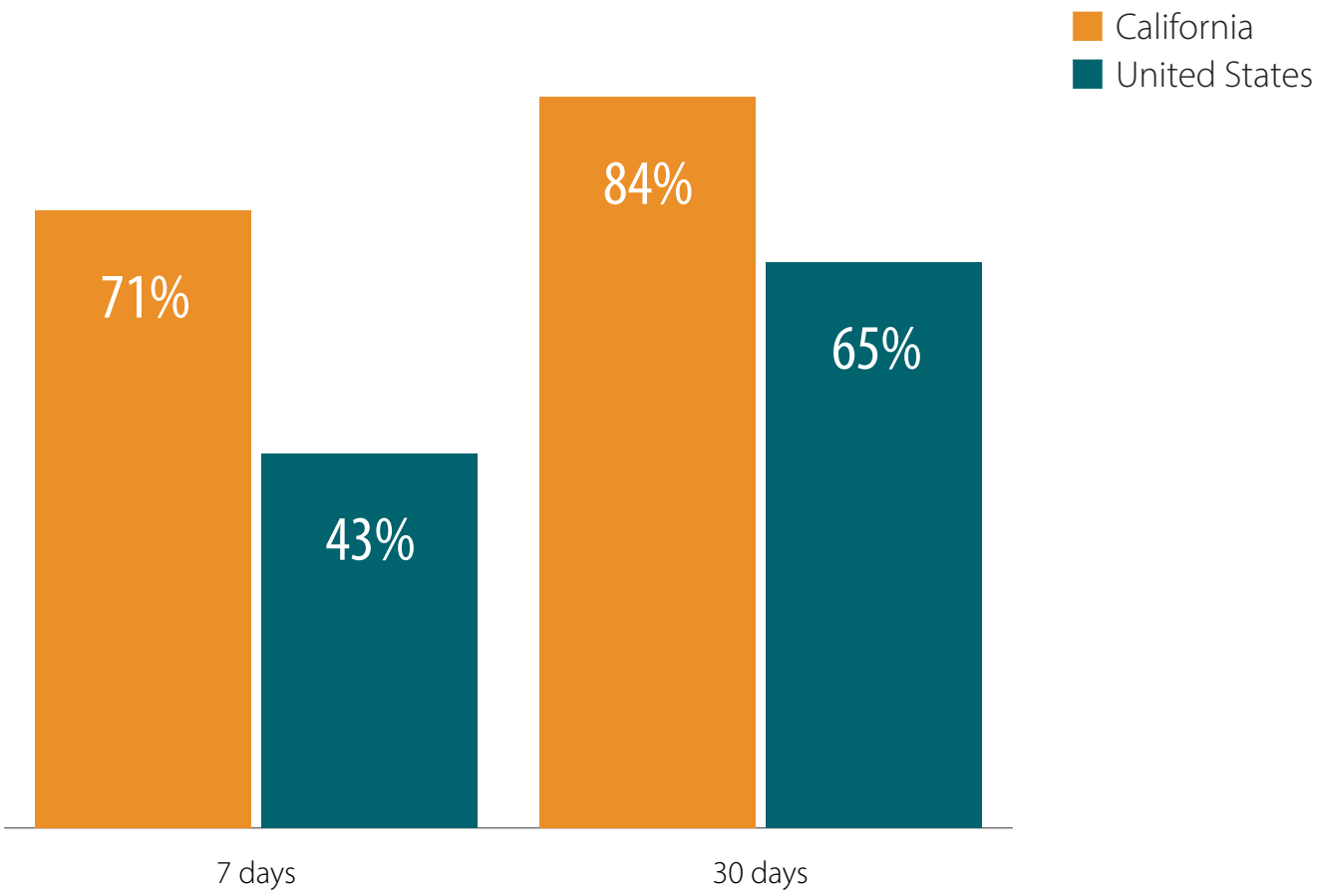
Source: "California Health Plans Compared to Health Plans Nationwide," Office of the Patient Advocate.

Prompt follow-up with a mental health provider after hospitalization for a mental illness helps care and medication management. California and United States HMO and PPO plans had similar rates of follow-up care. Close to half of patients were seen within seven days after discharge, and two-thirds were seen within 30 days after discharge.

Follow-Up After Hospitalization for Mental Illness

Children Enrolled in Medicaid, California vs. United States, FFY 2019

PERCENTAGE OF DISCHARGES WITH A FOLLOW-UP VISIT WITHIN . . .



Notes: Percentage of discharges for children age 6 to 17 hospitalized for treatment of mental illness or intentional self-harm with a follow-up visit within 7 and 30 days after discharge. Federal fiscal year (FFY) 2019 is October 2018 through September 2019. Measure is a weighted average of children enrolled in Medicaid managed care plans and fee-for-service, and the Children's Health Insurance Program.

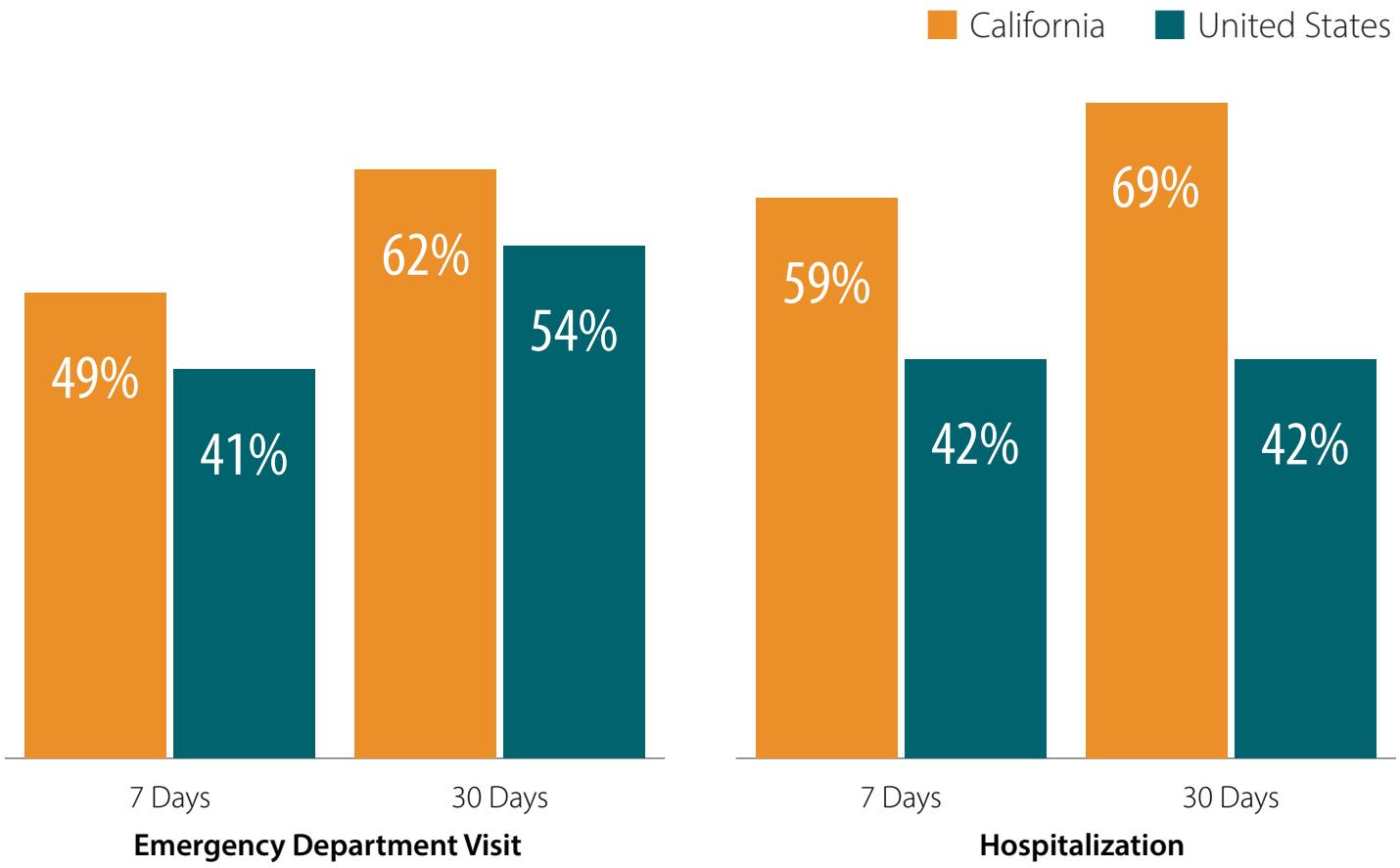
Sources: *2019 Child and Adult Health Care Quality Measures Quality* (FFY 2019), Centers for Medicare & Medicaid Services (CMS), October 2020; and *Quality of Behavioral Health Care in Medicaid and CHIP: Findings from the 2019 Behavioral Health Core Set — Chart Pack* (PDF), CMS, February 2021.

High percentages of children enrolled in Medicaid received follow-up care after hospitalization for mental illness or intentional self-harm. In California, 71% of children had a follow-up visit within seven days after discharge, and 84% had a visit within 30 days after discharge, both exceeding the national rates.

Follow-Up After ED Visit and Hospitalization for Mental Illness

Adults Enrolled in Medicaid, California vs. United States, FFY 2019

PERCENTAGE OF MENTAL HEALTH VISITS / HOSPITALIZATIONS WITH A FOLLOW-UP VISIT WITHIN . . .



Notes: Percentage of emergency department (ED) visits and discharges for adults 18 and over who had a principal diagnosis of mental Illness or intentional self-harm with a follow-up visit within 7 days and 30 days of the ED visit. Percentage of discharges for adults 18 and over hospitalized for mental Illness or intentional self-harm with a follow-up visit within 7 days and 30 days after discharge. Federal fiscal year (FFY) 2019 is October 2018 through September 2019. Measure is a weighted average of adults enrolled in managed care plans and fee-for-service.

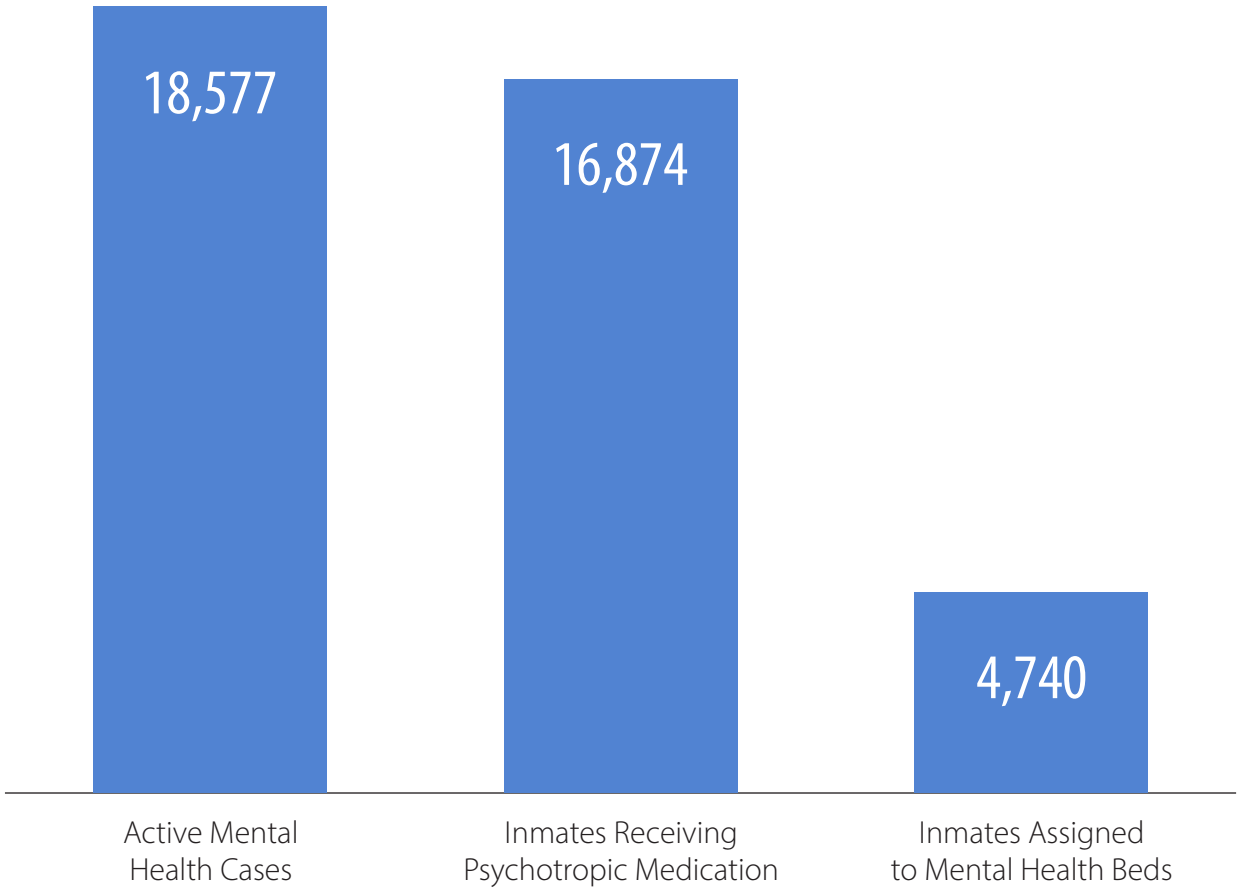
Sources: *2019 Child and Adult Health Care Quality Measures Quality* (FFY 2019), Centers for Medicare & Medicaid Services (CMS), October 2020; and *Quality of Behavioral Health Care in Medicaid and CHIP: Findings from the 2019 Behavioral Health Core Set — Chart Pack* (PDF), CMS, February 2021.

Medi-Cal rates of follow-up care exceeded those for Medicaid programs nationally. Sixty-two percent of adults enrolled in Medi-Cal who had an emergency department visit, as well as almost 70% of those hospitalized for mental illness, had a mental health visit within 30 days of discharge.

Mental Health Services in Jail

California, as of December 31, 2020

NUMBER OF INMATES



Notes: *Active mental health* cases refers to people in jail who are identified as having a psychological disorder and who are actively in need of and receiving mental health services. The number of mental health cases and the numbers of people receiving other mental health services in jail are counted on December 31, and so represent a point-in-time count. Average daily jail population is the December monthly average, excluding people on holding status. Only jails that reported all indicators are included in the calculations. Excludes Alpine County jails that did not report any of the measures.

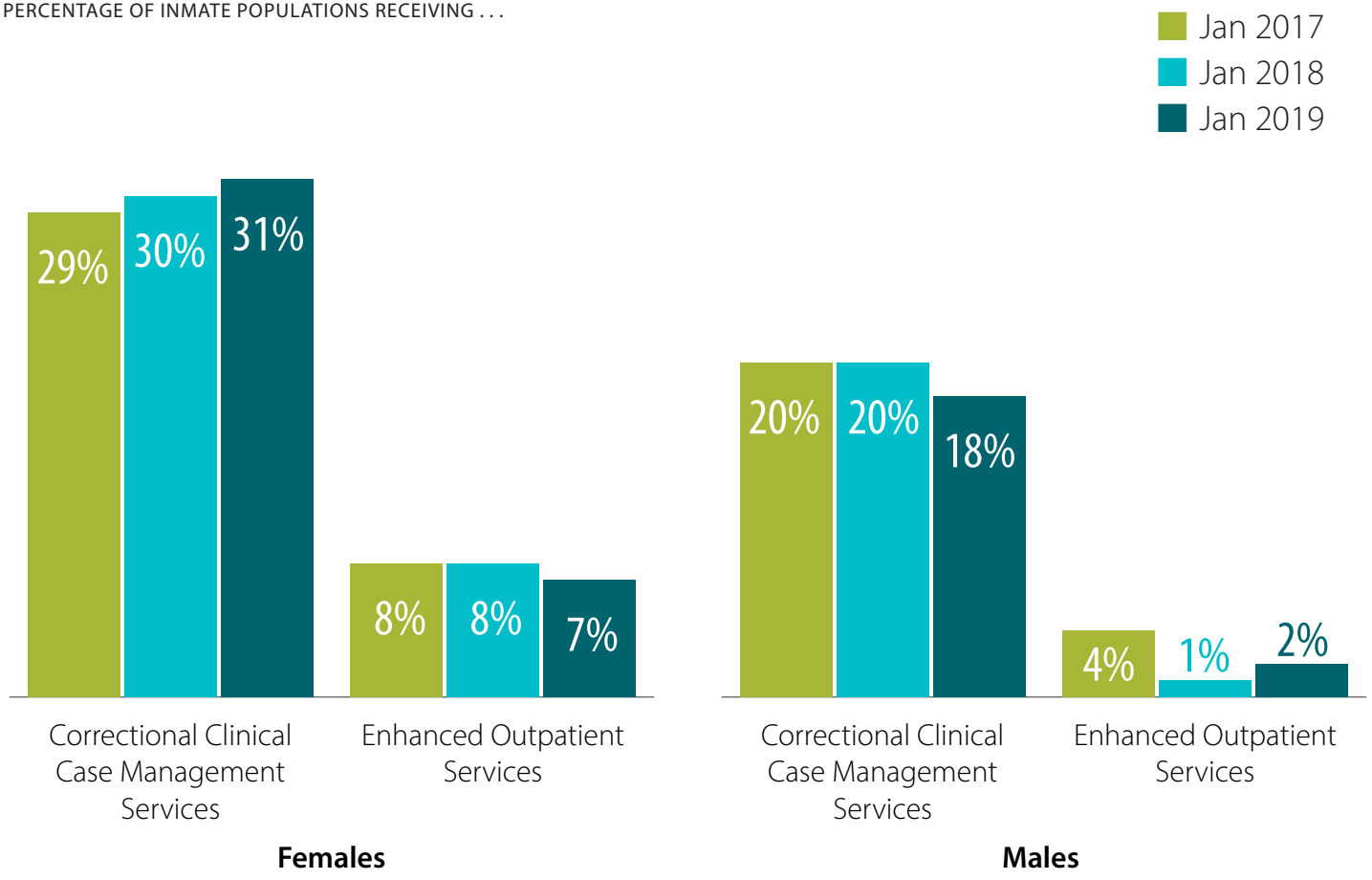
Source: Jail Profile Survey, Board of State and Community Corrections.

As of December 31, 2020, over 18,000 people in California jails — representing 31% of the average daily population for that month — were identified as having a psychological disorder and receiving mental health services. Most of these individuals, 91%, were receiving psychotropic medications, and 26% were assigned to beds designated for people with mental health conditions.

Mental Health Services in Prison, by Gender

California, January 2017 to January 2019

PERCENTAGE OF INMATE POPULATIONS RECEIVING . . .

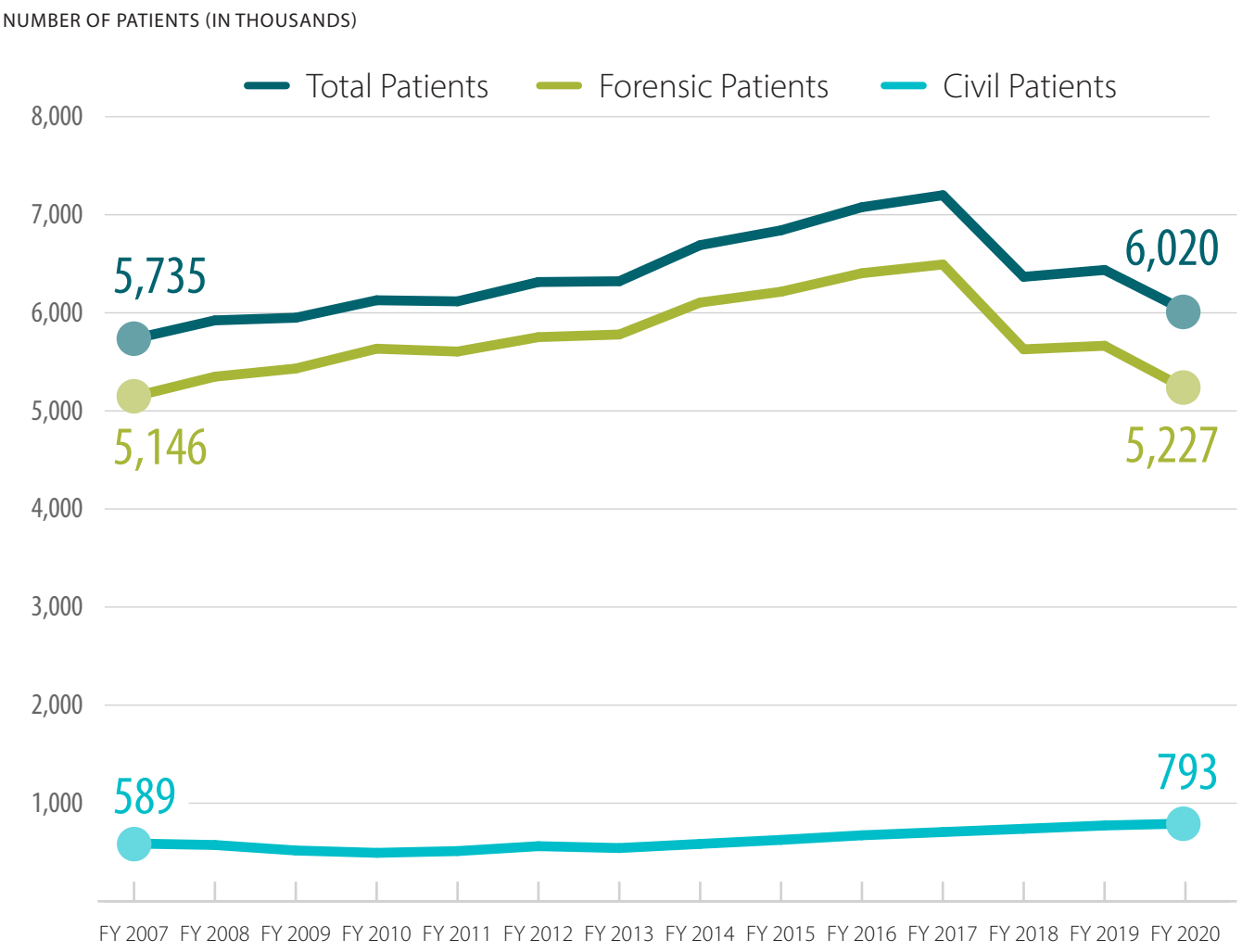


Notes: Source did not include additional gender categories. *Clinical case management* services are provided by a clinician who assists the inmate to access prison services, provides individual and group treatment, and monitors and tracks how the inmate is progressing. *Enhanced outpatient services* are housed in a dedicated unit structured to manage serious mental illness with functional problems. These services often help transition an inmate from a hospital or crisis program. Male inmates include those in the general population, and exclude those in separate high-security and reception facilities. Female inmates include those in the general population or in the single female reception program, which is housed in a facility for the general population.

Source: Special data request, *COMPSTAT DAI Statistical Report - 13 Month*, California Dept. of Corrections and Rehabilitation.

From January 2017 to January 2019, California's general prison population grew to almost 50,000 (not shown). During that period, close to one in three California females and one in five males in general prison settings received clinical case management services. Considerably lower percentages of females and males in these settings received enhanced outpatient treatment in dedicated units for inmates with mental illness.

Patients in State Hospitals, by Type, California,
FY 2007 to FY 2020



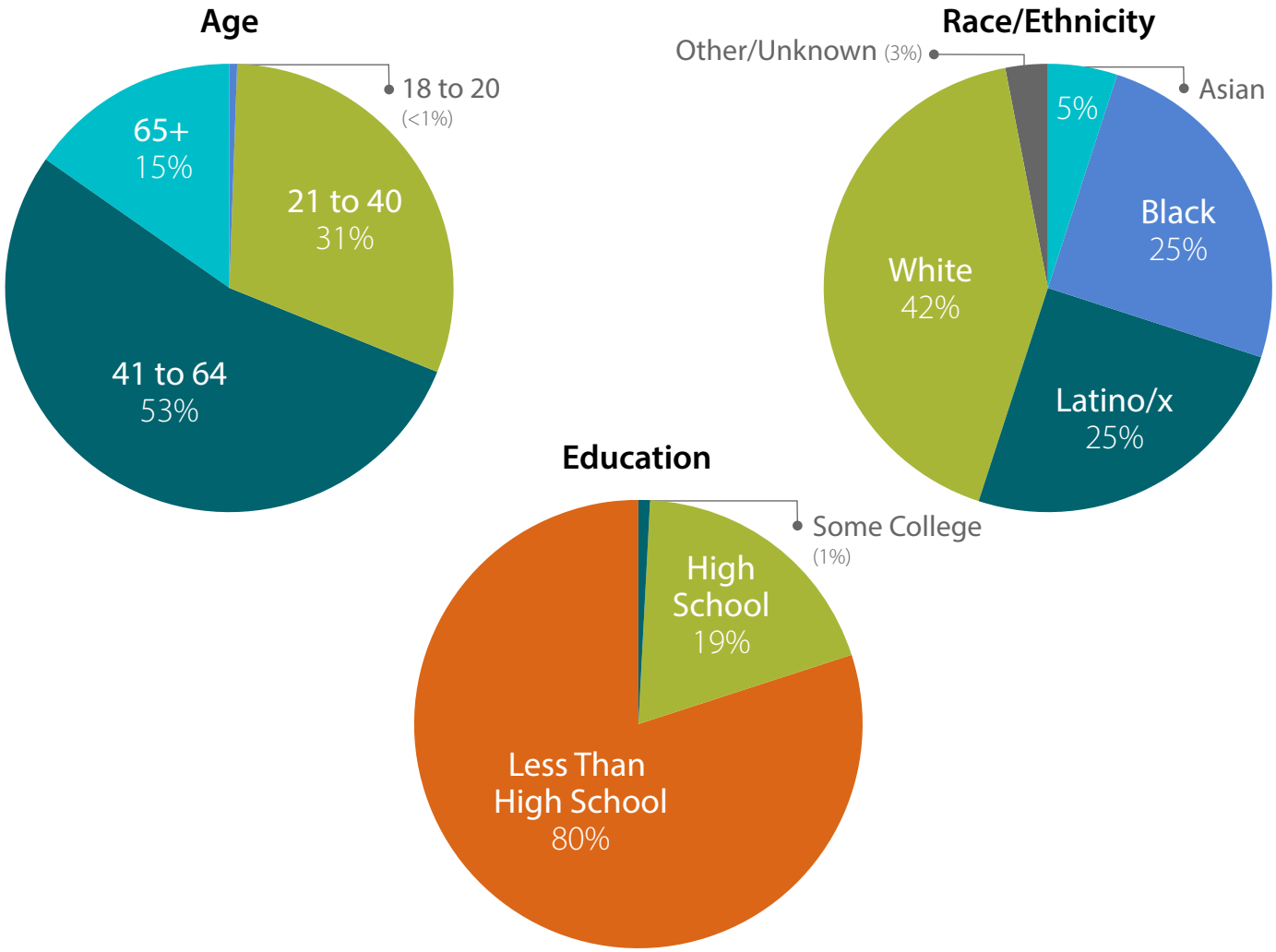
Notes: Data are a count of patients admitted to California state hospitals during fiscal years (FY) 2007 to 2020. *Forensic patients* are those sent to the Department of State Hospitals (DSH) through the criminal court system and have committed or have been accused of committing a crime linked to their mental illness. *Civil patients* are committed to DSH from civil courts because they are a danger to themselves or others.

Source: *Department of State Hospitals Forensic vs. Civil Commitment Population*, California Health and Human Services Open Data Portal, last updated March 25, 2021.

The Department of State Hospitals (DSH) oversees the care of patients mandated for mental health treatment by a civil or criminal court. Those mandated by the criminal court system (forensic patients) accounted for about nine in 10 patients in DSH hospitals.

Patients in State Hospitals, by Demographics

California, FY 2020



In 2020, more than half of state hospital patients were between the ages of 41 and 64. Four out of 10 patients were White. Eighty percent of state hospital patients did not graduate from high school.

Notes: The Department of State Hospitals population consists of patients mandated for treatment by a criminal or civil court. Source uses *Hispanic*.

Source: *Patient Demographics (Age, Education, Ethnicity)*, CHHS Open Data Portal, last updated January 21, 2021.

Methodology for Estimates of Prevalence of Serious Mental Illness, Serious Emotional Disturbance, and Serious Psychological Distress

This publication includes estimates of different measures of the prevalence of mental illness. Dr. Charles Holzer developed prevalence estimates for serious mental illness and serious emotional disturbance using a sociodemographic risk model. Serious psychological distress prevalence estimates were obtained from the UCLA California Health Interview Survey. The method for each is described here.

Serious mental illness was defined as a composite variable including diagnosis of a mental disorder excluding schizophrenia/psychosis and at least 120 days of impairment in the past year. When days of impairment were not available, a score of at least 7 on the Sheehan Disability Scale was used. The SDS measures the extent to which a mental disorder interfered with a person's ability to attend to the home (like cleaning, shopping, and taking care of the house), work or perform schoolwork, and engage in a social life or leisure activities, or by the number of days that activities were limited due to the disorder.

The National Institute of Mental Health's Collaborative Psychiatric Epidemiology Surveys (CPES) were the basis for estimating risk of serious mental illness. CPES combines three nationally representative surveys:

- National Comorbidity Survey Replication (NCS-R)
- National Survey of American Life (NSAL)
- National Latino and Asian American Study (NLAAS)

CPES provided data on the distributions, correlates, and risk factors of mental disorders among the general population, with special emphasis on minority groups. Analyses of these data sets resulted in estimates of the risk of mental disorder associated with seven demographic characteristics: race, ethnicity, age, marital status, education, residential status, and poverty. Resulting risk factors were applied to the demographic characteristics of each California county using American Community Survey (ACS) 2019. An additional adjustment was made to account for population size as estimated by the California Department of Finance.

Serious emotional disturbance (SED) in children was estimated based on studies commissioned by the Substance Abuse and Mental Health Services Administration's Center for Mental Health Services (CMHS) and published in the *Federal Register*. CMHS's definition of SED is "persons from birth up to age 18, who currently or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-IVR that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities. Functional impairment is defined as difficulties that substantially interfere with or limit a child or adolescent from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skill."

ABOUT THIS SERIES

The California Health Care Almanac is an online clearinghouse for data and analysis examining the state's health care system. It focuses on issues of quality, affordability, insurance coverage and the uninsured, and the financial health of the system with the goal of supporting thoughtful planning and effective decisionmaking. Learn more at **www.chcf.org/almanac**.

AUTHOR

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Talia Hahn, MPH, Senior Associate, DMA Health Strategies

FOR MORE INFORMATION

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Methodology for Estimates of Prevalence of Serious Mental Illness, Serious Emotional Disturbance, and Serious Psychological Distress (continued)

Dr. Holzer's estimates were based on estimated rates of SED prevalence for children in families above and below the federal poverty level applied to the poverty and nonpoverty populations in each county using the 2019 ACS adjusted to the population estimates of the California Department of Finance, excluding children living in institutional or group living settings.

Serious psychological distress (SPD) was estimated by the California Health Interview Survey (CHIS) through a mixed method survey administered by a combination of computer-assisted web interviewing and computer-assisted telephone interviewing to a random sample of California adolescents and adults. Responses were weighted according to California population estimates from the California Department of Finance. Based on the one month in the past 12 months where they were at their worst emotionally, respondents who scored 13 or more on the six symptoms of mental illness based on the Kessler 6 scale, according to the table below, were determined to have experienced SPD during the past 12 months.

DURING THE ONE MONTH IN THE PAST 12 MONTHS WHEN YOU WERE AT YOUR WORST EMOTIONALLY, HOW OFTEN DID YOU FEEL...	ALL OF THE TIME	MOST OF THE TIME	SOME OF THE TIME	A LITTLE OF THE TIME	NONE OF THE TIME
1. So depressed that nothing could cheer you up?	4	3	2	1	0
2. Nervous?	4	3	2	1	0
3. Restless or fidgety?	4	3	2	1	0
4. Hopeless?	4	3	2	1	0
5. That everything was an effort?	4	3	2	1	0
6. Worthless?	4	3	2	1	0

Sources: "A New Design for CHIS 2019-2020," UCLA Center for Health Policy Research ("Center"); "AskCHIS," Center; and *CHIS 2019 Questionnaires: Adult*, Center, September 2021.

Appendix: California Counties Included in Regions

REGION	COUNTIES
Central Coast	Monterey, San Benito, San Luis Obispo, Santa Barbara, Santa Cruz, Ventura
Greater Bay Area	Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Solano, Sonoma
Inland Empire	Riverside, San Bernardino
Los Angeles County	Los Angeles
Northern and Sierra	Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Inyo, Lake, Lassen, Mariposa, Mendocino, Modoc, Mono, Nevada, Plumas, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, Yuba
Orange County	Orange
Sacramento Area	El Dorado, Placer, Sacramento, Yolo
San Diego Area	Imperial, San Diego
San Joaquin Valley	Fresno, Kern, Kings, Madera, Merced, San Joaquin, Stanislaus, Tulare

TRANSFORMING MENTAL HEALTH CARE IN THE UNITED STATES

The U.S. mental health system has reached a moment when a historic transformation to address persistent problems appears realistic. These problems include high levels of unmet need for care, underdevelopment of community-based supports that can help avoid unnecessary emergency care or police engagement, and disparities in access and quality of services.

RAND CORPORATION

BRIEF

In recent years,

encouraging trends highlight the growing possibility of addressing these challenges:

Expanded access to coverage. Medicaid expansion in 39 states has extended affordable coverage to millions of Americans. Medicaid is now the leading payer for U.S. mental health care among adults with serious mental illness.

Equitable mental health coverage. Mental health parity, the once-controversial idea that mental health benefits should equal other medical benefits, is now the law of the land.

New evidence-based treatments. Recent research has substantially strengthened the evidence base supporting the effectiveness of new treatments for depression, anxiety, and psychosis, as well as for new models for delivering care.

Political consensus. Reforming the U.S. mental health system has received strong bipartisan support at both the federal and state levels.

Against this background, a RAND research team sought to identify goals for transforming the U.S. mental health care system and to pinpoint opportunities to drive systemic improvements. To develop these recommendations, the team interviewed mental health experts throughout the country—including government officials, public administrators, health system executives, and academicians. In parallel, the team conducted a comprehensive review of the scientific literature to identify best practices and recent innovations in mental health care.

The overarching goals of these recommendations appear in **Figure 1**.

Figure 1. Goals for a Mental Health System Centered on the Patient Journey

WITH THESE THREE GOALS AS A FRAMEWORK,

the team recommends 15 strategies for transforming mental health care in the United States into a patient-centered system

1

Goal 1: Promote Pathways to Care

1. Promote systematic mental health education. Mental health education should be considered a key part of a comprehensive health education curriculum. Schools have the potential to destigmatize mental health and improve attitudes, enhance the knowledge and skills needed for prevention, and promote increased help-seeking.

2. Integrate mental health expertise into general health care settings. Mental health conditions are often unrecognized in general health care settings. Integrated, whole-person care approaches are effective in connecting people to care but are underutilized.

3. Link homeless individuals with mental illness to supportive housing. Supportive housing programs help homeless people with mental health needs begin recovery by starting from a foundation of stable housing. Stable housing not only improves individuals' quality of life and chances for recovery; it can also save the health care system money by reducing the need for recurring care. Administrators at all levels of government should expand supportive housing programs, particularly for individuals with serious mental illness.

4. Develop a mental health diversion strategy centered on community mental health. Correctional facilities are one of the largest providers of mental health care in the United States. Yet, in this setting, many with mental health conditions might not receive the care they need. An evidence-based program that diverts people away from the criminal justice system and into community-based mental health services would benefit this population.

2

Goal 2: Improve Access to Care

5. Strengthen mental health parity regulation and enforcement. Although mandated by law, mental health parity has still not been fully achieved. Governments can institute laws and regulations that set clear standards for assessing parity compliance, require mental health coverage from a broader range of insurance plans, and strengthen enforcement of existing state and federal parity laws.

6. Reimburse evidence-based mental health treatments at their true cost. Establishing Medicaid reimbursement rates that are commensurate with the costs of providing care should encourage providers to offer evidence-based treatments that now are often unavailable. Improving access within Medicaid would particularly benefit Americans with low incomes and those with serious mental illnesses.

7. Establish an evidence-based mental health crisis response system. Many communities lack an adequate mental health crisis response system. Poor crisis care results in missed opportunities to direct individuals into treatment and sometimes ends in suicide that might have been prevented. Building an evidence-based response system that swiftly identifies individual mental health needs and efficiently triages individuals into appropriate care should reduce unnecessary suffering.

8. Establish a national strategy to finance and disseminate evidence-based early interventions for serious mental illness. Growing evidence points to the effectiveness of programs that deliver coordinated clinical and supportive services early in the course of schizophrenia and related disorders. These programs, as well as emerging early interventions for serious mental illnesses, fall outside the Medicaid-based public mental health system and require a national strategy to fund and disseminate them widely.

9. Expand scholarships and loan repayment programs to stimulate workforce growth. Expanding the recruitment pipeline for mental health specialty workers, such as psychiatrists and psychologists, will help meet the needs of underserved areas. Policies for doing this include expanding scholarship, fellowship, and loan forgiveness programs that attract more individuals, support more-diverse students, and require a commitment to practicing in high-need settings.

10. Improve the availability and quality of peer-support services. Peer-support specialists are people who have experienced mental health or substance use problems and have been trained to join teams caring for those struggling with mental health conditions, psychological trauma, or substance use disorders. These specialists have been proven highly effective in improving patient outcomes. Expanding access to training, credentialing, and reimbursement for peer support has the potential to improve access to high-quality peer-support care.

11. Expand access to digital and telehealth services for mental health. Digital and telehealth services can extend access to mental health care throughout the United States, particularly in rural communities that face shortages of providers. Stimulated by the COVID-19 pandemic, state and federal policymakers should codify expansion of these services by ensuring that insurers cover them, that clinicians are adequately reimbursed, and that consumers know how to use the technologies.

12. Include patient-important outcomes in treatment planning and assessments of care quality. The current system is seldom organized to deliver patient-centered care or to provide access to the full range of community supportive services. As a result, provider-based goals often misalign with patient-based goals. Including patient outcomes, such as social functioning and occupational goals, in care planning can improve this alignment and enhance the patient-centeredness of mental health care.

3

Goal 3: Establish a Continuum of Evidence-Based Care

13. Define and institutionalize a continuum of care in states and communities. Individuals with mental health needs often fall through the cracks because of a lack of clarity regarding who should provide care, at what level of intensity, and in what settings over time. Available clinical guidelines provide an explicit framework for resolving these questions about level of care and can help optimize mental health spending within communities. State Medicaid systems should mandate their use.

14. Launch a national care-coordination initiative. Care coordination involves integrating mental health providers, care managers, and other providers into coordinated teams, often in primary care settings. The effectiveness of coordination has been demonstrated in various evidence-based models, but few practices are using it. A national initiative led by the Centers for Medicare & Medicaid Services that provides technical assistance, implementation tools, and learning support for implementing practices would help transition practices to evidence-based models.

15. Form a learning collaborative for Medicaid mental health financing. Collaborations between Medicaid officials, advocates, and state policymakers can help ensure that emerging evidence on innovative financing and service delivery models drive improvement in mental health care systems, especially for Americans with low incomes or serious mental illness.

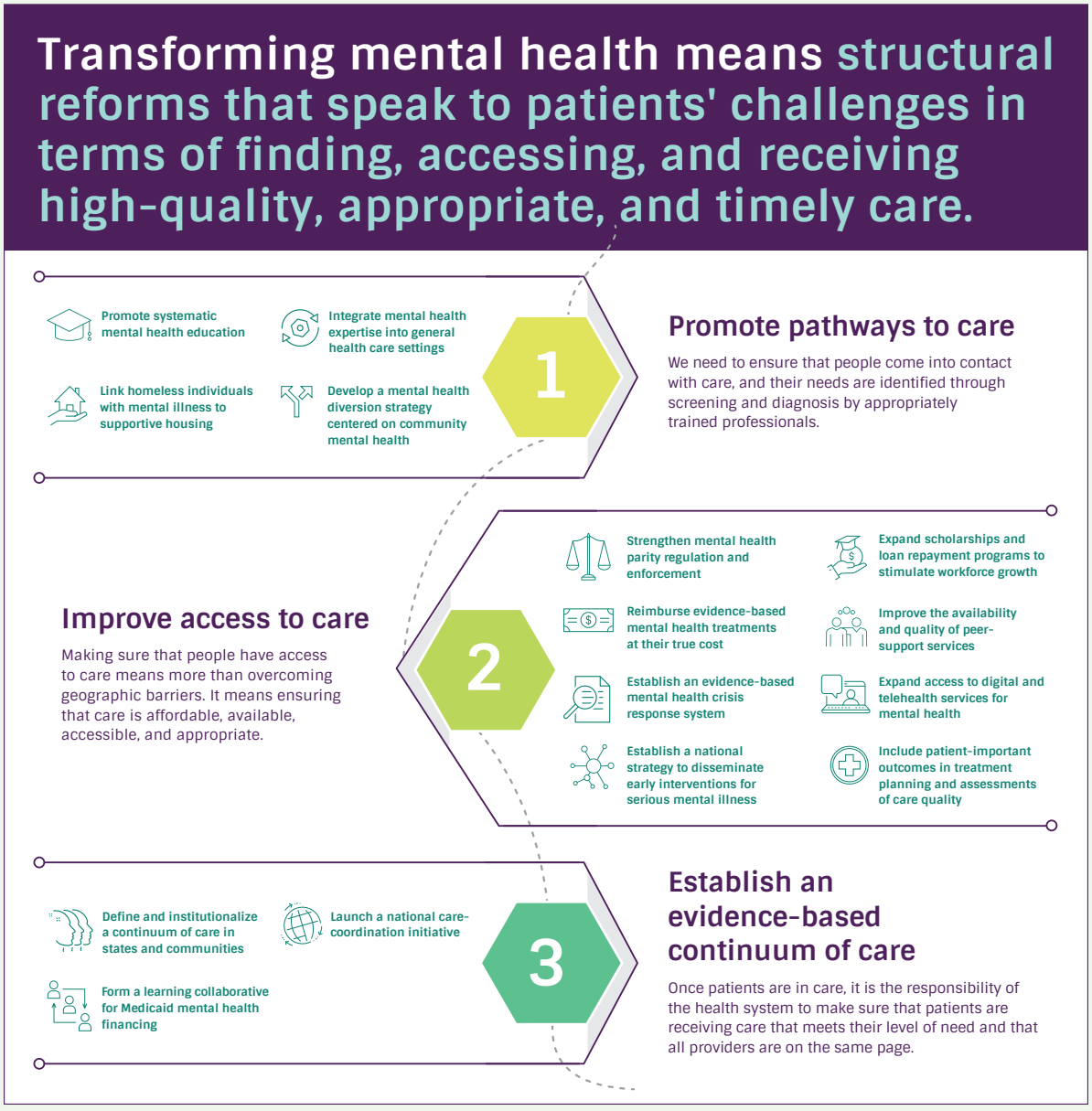
> “We need systems attuned to what people need. People are unique in their needs. Even if they are in congregate settings, it needs to be person-centered to do the assessments, with close coordination of care.”

—Former federal health policy official

Conclusions

Leaders in government, the private sector, and health care can chart a transformative new course in improving mental health in the United States. RAND's 15 evidence-based recommendations can guide decisionmakers to feasible and effective strategies that support consumers in finding, accessing, and receiving high-quality, appropriate, and timely mental health care (summarized in **Figure 2**). These changes should receive bipartisan political support and catalyze substantial improvements in access, use, and quality of mental health care that in turn would improve the lives and health of tens of millions of Americans.

Figure 2. How to Transform Mental Health Care in the United States



This brief describes research conducted in RAND Health Care and documented in ***How to Transform the U.S. Mental Health System: Evidence-Based Recommendations***, by Ryan K. McBain, Nicole K. Eberhart, Joshua Breslau, Lori Frank, M. Audrey Burnam, Vishnupriya Kareddy, and Molly M. Simmons, RR-A889-1, 2021 (available at www.rand.org/t/RRA889-1). To view this brief online, visit www.rand.org/t/RBA889-1. The RAND Corporation is a research organization that develops solutions to public policy challenges to help make communities throughout the world safer and more secure, healthier and more prosperous. RAND is nonprofit, nonpartisan, and committed to the public interest. RAND's publications do not necessarily reflect the opinions of its research clients and sponsors. RAND is a registered trademark.

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RB-A889-1

www.rand.org

Mental Health Services
Oversight & Accountability Commission

STATE OF CALIFORNIA
GAVIN NEWSOM, Governor

August 14th, 2023

Sameer Chowdhary, Partner
McKinsey & Company

Letter sent via email

Dear Mr. Chowdhary:

Thank you for agreeing to present at the public hearing on data during the Commission's August 24th, 2023 meeting. Panelists have been selected because of their expertise and knowledge of how data can be used for decision making, accountability, and system improvement.

The meeting begins at 9:00 a.m. 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 10 minutes. Please consider the following topics as part of your presentation:

- How do you use data as a tool for transformational change?
- What are the challenges and barriers to establishing core metrics for accountability and transparency?
- What models from other fields can inform how the mental health field uses data for system improvement and policy change?
- Promising models around use of data, data sharing, and collaboration.

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

August 14th, 2023

Serene Olin, Principal
Health Management Associates

Letter sent via email

Dear Ms. Olin:

Thank you for agreeing to present at the public hearing on data during the Commission's August 24th, 2023 meeting. Panelists have been selected because of their expertise and knowledge of how data can be used for decision making, accountability, and system improvement.

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Respectfully,

Toby Ewing, Ph.D.

Executive Director

Mental Health Services
Oversight & Accountability Commission

STATE OF CALIFORNIA
GAVIN NEWSOM, Governor

August 14th, 2023

Marlies Perez, Chief
Behavioral Health Community Services
Department of Health Care Services

Letter sent via email

Dear Ms. Perez:

Thank you for agreeing to present at the public hearing on data during the Commission's August 24th, 2023 meeting. Panelists have been selected because of their expertise and knowledge of how data can be used for decision making, accountability, and system improvement.

The meeting begins at 9:00 a.m. 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 10 minutes. Please consider the following topics as part of your presentation:

- How do you use data as a tool for transformational change?
- What are the challenges and barriers to establishing core metrics for accountability and transparency?
- What models from other fields can inform how the mental health field uses data for system improvement and policy change?
- Promising models around use of data, data sharing, and collaboration.

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

August 14th, 2023

Emily Putnam-Horstein, Co-Director
Children's Data Network

Letter sent via email

Dear Ms. Putnam-Horstein:

Thank you for agreeing to present at the public hearing on data during the Commission's August 24th, 2023 meeting. Panelists have been selected because of their expertise and knowledge of how data can be used for decision making, accountability, and system improvement.

The meeting begins at 9:00 a.m. 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 10 minutes. Please consider the following topics as part of your presentation:

- How do you use data as a tool for transformational change?
- What are the challenges and barriers to establishing core metrics for accountability and transparency?
- What models from other fields can inform how the mental health field uses data for system improvement and policy change?
- Promising models around use of data, data sharing, and collaboration.

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

August 14th, 2023

Daniel Webster, Principal Investigator
California Child Welfare Indicators Project

Letter sent via email

Dear Mr. Webster:

Thank you for agreeing to present at the public hearing on data during the Commission's August 24th, 2023 meeting. Panelists have been selected because of their expertise and knowledge of how data can be used for decision making, accountability, and system improvement.

The meeting begins at 9:00 a.m. 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 10 minutes. Please consider the following topics as part of your presentation:

- How do you use data as a tool for transformational change?
- What are the challenges and barriers to establishing core metrics for accountability and transparency?
- What models from other fields can inform how the mental health field uses data for system improvement and policy change?
- Promising models around use of data, data sharing, and collaboration.

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 7

Information

August 24, 2023 Commission Meeting
Universal Mental Health Screening for Children and Youth Project

Summary: The Commission will hear a presentation and consider approving a proposed process to support the Legislature's request that the Commission report information and make recommendations related to the universal mental health screening for children and youth prior to March 1, 2024. This plan will include how the Commission will use the $200,000 in its proposed budget to support this initiative.

Background: Most mental health challenges begin to emerge at an early age,[1] yet mental health needs of young people are frequently undetected and unsupported. The consequences of such oversight can be dire, even fatal, for youth, as unaddressed mental health challenges increase their risk of suicide and can lead to multiple adverse outcomes later in life. Consistent with the Commission's recently adopted Prevention and Early Intervention Report, providing universal screening in multiple key settings, such as schools, has great potential to assuage the magnitude of unmet mental health needs and their consequences among California's young population.

Universal Screening Initiative

The Legislature requests that the Commission, in consultation with the Department of Health Care Services, report information and make recommendations to the state and Legislature related to universal mental health screening of children and youth, by March 1, 2024. It is the intent of the Legislature that the report informs future budget and policy considerations around expanding mental health screenings to children in California, with the goal of reducing adverse health and life outcomes later in life stemming from unaddressed mental health issues.

Process: The Commission's proposed budget includes $200,000 to fund a process to fulfill the requirements of the Legislature's request. Commission staff have drafted a proposal and timeline of research and engagement activities in support of this initiative.

Enclosure (1): Draft Universal Screening Initiative Proposal

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

[1] Kessler, R. C., Amminger, G. P., Aguilar-Gaxiola, S., Alonso, J., Lee, S., & Ustün, T. B. (2007). Age of onset of mental disorders: A review of recent literature. Current Opinion in Psychiatry, 20(4), 359-364.

Mental Health Services
Oversight & Accountability Commission

Universal Mental Health Screening of Children and Youth

Project Plan Proposal

The Commission has been asked to identify and report information and recommendations to the Legislature related to universal mental health screening for children and youth in California. Below is a background and summary of activities to support this project.

Background

Between 50 and 75 percent of mental health symptoms begin during youth and young adulthood.[i] In California alone, at least one in every three people between the ages of 12 to 17 report having a significant mental health challenge. Yet, the mental health needs of young people are frequently undetected and unsupported. The consequences of such oversight can be dire, even fatal.

A slew of evidence confirms that a young person living with unaddressed mental health needs is more likely to experience social, economic, and health-related challenges later in life – shortening their life expectancy by 10 to 20 years.[ii] In the short term, a lack of mental health support leads to suffering and in the worst case, can result in suicide for young people.[iii] Fortunately, when a person's mental health needs are identified and supported early, their outcomes greatly improve.[iv]

Universal screening, where all children are assessed for risk, is a key strategy for detecting and responding to the earliest signs of mental health needs. Young people spend a large portion of their time in school settings and because of this, schools provide an opportune setting for screening.[v]

Despite its potential, California's schools vary widely in their use of mental health screening tools and practices. Concerns around stigma, capacity limits, and legal considerations further discourage the use of screening in schools. California wants to understand the opportunities and barriers around mental health screening as part of its broader commitment to improve the mental health of young people and to prevent challenges later in life which stem from unaddressed mental health needs.

Project Goal

The Legislature has requested that the Commission, in consultation with the Department of Health Care Services, report information and make recommendations to the state and Legislature related to universal mental health screening of children and youth by March 1, 2024. It is the intent of the Legislature that the report informs future budget and policy

considerations around expanding mental health screenings to children in California, with an emphasis on school settings.

The Legislature requests that the Commission's report include the following:

a. A review of existing research and standards related to universal mental health screening policies and practices for identifying and addressing mental health needs for children and youth.

b. A review of the evidence on the effectiveness and cost of existing screening tools and how they are administered across various setting and populations.

c. Information on existing mental health screening in California including the Sonoma County Office of Education universal screening program, among other screening programs.

d. Recommendations to the Legislature related to tools, best practices, and costs of administering and responding to universal mental health screening for children and youth in California.

Project Activities

Below are proposed activities to support progress towards the Legislatures goals.

Research and review:
The Commission will conduct research to support the development of a foundational knowledge of screening models, tools, and best practices as they are recognized in academia, clinical practice, policy, and government. This may include the following:

a. Summary of evidence to support universal screening for mental health and summary of best practices.
b. Identity universal screening models and standards including those in other states and/or countries.
c. Landscape analysis for mental health screening in California.
d. Cost analysis for implementing universal screening for children and youth.

Outreach and Engagement:
The Commission will engage with a diverse array of experts, stakeholders, people with lived experience and other key partners to better understand opportunities and concerns regarding universal mental health screening for youth. Activities may include:

a. Key informant interviews
b. Site visits to universal screening programs
c. Public meetings

Final Report:
Proposed activities will inform a final report, developed by the Commission, with a summary of findings and recommendations to satisfy the requirements of the Legislature's request outlined above. Staff will present a drafts report to the Commission for review and consideration of adoption.

Funding

The Commission's proposed budget includes $200,000, allocated by the Legislature, to support the Commission in its activities to meet the Legislature's goals for universal mental health screening. Below are considerations for the use of these funds.

Research and Review: Funding for one or more contracts to support literature reviews, landscape analysis, cost analysis, and other research activities.

Consult and Support: Funding to secure ongoing consult, review, and other support from subject matter experts.

Operations: Funding for travel expenses, material development, and communication activities.

Timeline

Following approval of the Commission's budget, staff will develop and execute a formal work plan of activities and milestones, with the goal of delivering a final report to the legislature prior to March 2024.

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[i] Kessler, R. C., Amminger, G. P., Aguilar-Gaxiola, S., Alonso, J., Lee, S., & Ustün, T. B. (2007). Age of onset of mental disorders: A review of recent literature. Current Opinion in Psychiatry, 20(4), 359-364. https://doi.org/10.1097/YCO.0b013e32816ebc8c

[ii] Chesney, E., Goodwin, G. M., & Fazel, S. (2014). Risks of all-cause and suicide mortality in mental disorders: A meta-review. World Psychiatry: Official Journal of the World Psychiatric Association (WPA), 13(2), 153–160. https://doi.org/10.1002/wps.20128

[iii] Ivey-Stephenson, A.Z., Demissie, Z., Crosby, A.E., Stone, D.M., GAylor, E., Wilkis, N., Lowry, R., & Brown, M. (2020). Suicidal ideation and behaviors among high school students — Youth risk behavior survey, United States, 2019. MMWR Supplements, 69(Suppl-1):47–55. http://dx.doi.org/10.15585/mmwr.su6901a6external icon

[iv] Csillag, C., Nordentoft, M., Mizuno, M., Jones, P. B., Killackey, E., Taylor, M., Chen, E., Kane, J., & McDaid, D. (2016). Early intervention services in psychosis: From evidence to wide implementation. Early Intervention in Psychiatry, 10(6), 540–546. https://doi.org/10.1111/eip.12279

[v] Mental Health America Board of Directors. (2016, September 18). Position statement 41: Early identification of mental health issues in young people. Mental Health America. https://www.mhanational.org/issues/ position-statement-41-early-identification-mental-health-issues-young-people

AGENDA ITEM 8

Action

August 24, 2023 Commission Meeting
Commission 2023-2024 Spending Plan

Summary: Each year, the Mental Health Services Oversight and Accountability Commission is presented with a budget update in July at the beginning of the new fiscal year, and again in January which coincides with a presentation on the Governor's proposed budget for the following fiscal year. Staff also provides a budget presentation in May that coincides with the Governor's May Revision. The goal of these presentations is to support fiscal transparency and ensure that Commission expenditures are in line with the Commission's priorities.

Background:
The Commission's budget is organized into three main categories: Operations, Budget Directed, and Local Assistance.

- **Operations:** Includes Personnel and Core Operations. These funds are provided for staff, rent, and other related expenses needed to support the work of the Commission. Funding is usually ongoing with some exceptions such as one-time funding to support Commission directed initiatives.
- **Budget Directed:** Funding provided in the Governor's Budget Act for technical assistance, implementation, and evaluation of grant programs with one-time and ongoing funding that is allocated over multiple fiscal years.
- **Local Assistance:** Includes the majority of Commission's funding that is provided to counties and other local partners. Funding is provided via grants to counties or organizations on an ongoing and/or one-time basis, spread over multiple fiscal years.

Annual funding in the Commission's budget can be authorized for a single fiscal year, or multiple fiscal years. Fluctuations in annual funding reflect the availability of one-time funding, funding authorizations that are available over multiple years and periodic on-going budget decisions that result in either growth or reductions in expenditure authority.

The Commission Staff will present the Commission's proposed 2023-24 budget for consideration.

Presenter: Norma Pate, Deputy Director

Enclosures: None

Handouts: PowerPoint slides will be made available at the Commission Meeting

Proposed Motion: The Commission approves the Fiscal Year 2023-24 spending plan.

Budget by Fiscal Year and Specific Category

	Fiscal Year 2020-21	Fiscal Year 2021-22	Fiscal Year 2022-23	Fiscal Year 2023-24
Operations				
Personnel	$5,528,000	$6,720,000	$8,100,000	$8,968,000
Core Operations	$5,256,000	$3,890,000	$3,168,000	$4,295,000
Total Operations	**$11,063,000**	**$10,610,000**	**$11,268,000**	**$13,263,000**
Budget Directed				
COVID-19 Response*	$2,020,000			
Covid 19/Suicide Prevention*	$2,000,000			
Anti-Bullying Campaign*		$5,000,000		
MHSSA Admin Augmentation*		$15,000,000		
MHSSA Admin/Evaluation*		$10,000,000	$16,646,000	
Fellowship/Transformational Change*			$5,000,000	
Evaluation of FSP Outcomes			$400,000	$400,000
Universal Mental Health Screening Study*				$200,000
EPI Reappropriation*				$1,675,000
Total Budget Directed	**$4,020,000**	**$30,000,000**	**$22,046,000**	**$1,735,000**
Local Assistance				
Children & Youth Behavioral Health Initiative*				$15,000,000
Community Advocacy Partnership	$1,398,000	$5,418,000	$6,700,000	$6,700,000
Mental Health Student Services Act (MHSSA)**	$8,830,000	$188,830,000	$8,830,000	$7,606,000
Mental Health Wellness Act	$20,000,000	$20,000,000	$20,000,000	$20,000,000
Total Local Assistance Funds	**$30,228,000**	**$214,487,000**	**$78,430,000**	**$49,306,000**
Grand Total	**$45,032,000**	**$255,097,000**	**$111,744,000**	**$64,304,000**

*one-time funds

**one-time funds and ongoing funds

AGENDA ITEM 9

Action

August 24, 2023 Commission Meeting
Legislative Priorities for 2023

Summary:
The Commission has prioritized an active role in policymaking related to mental health. Commission staff meets regularly with policy staff from legislative committees and works with leadership, staff members and representatives from the Mental Health Caucus, the Republican Caucus, the Legislative Analyst's Office, and the Administration on legislation related to the Commission's work.

The Commission is routinely asked to consult or provide guidance on legislative proposals under development, proposals that would impact the Commission's operations or that would result in new duties of the Commission. Commission staff also actively promote legislative priorities consistent with the direction of the Commission, typically in the form of recommendations adopted through the Commission's policy projects.

At the August Commission meeting, Commissioners will have the opportunity to discuss new legislation and consider taking positions on existing legislation that will create continuous improvement and transformational change to the mental health system.

Item for Consideration:

- Assembly Bill 599 (Ward)
  This bill, beginning July 1, 2025, no longer allows a student to be suspended or expelled from school for possessing or using tobacco or nicotine. In addition, this bill requires the California Department of Education to develop and make available a model policy for a public health approach to addressing student possession and use of drugs on school property. This bill is sponsored by the California Youth Empowerment Network, California Alliance of Child and Family Services, and Children Now. The California Teachers Association opposes this bill because their members believe an "impaired" student may pose a safety and/or security threat to themselves and others and they assert that effective discipline is unique to each student's situation and all options should be available.
  Location (as of 8/8/23): Senate Appropriations Committee

- Senate Bill 10 (Cortese)
  This bill would require local educational agencies to include protocols for the prevention and treatment of an opioid overdose in their comprehensive school safety plans. This bill would also require the California Department of Education to establish the State Working Group on Fentanyl Education in Schools to promote public education, awareness, and prevention of fentanyl overdoses. This bill is sponsored by the California Consortium of Addiction Programs and Professionals, the County of Santa Clara, and the Santa Clara County Office of Education. It is supported by many organizations and has received no opposition.
  Location (as of 8/8/23): Assembly Appropriations Committee

- Senate Bill 326 (Eggman)
  This bill would modernize and reform the Mental Health Services Act (MHSA), which was passed as Proposition 63 by voters in 2004. This legislation would expand services to include treatment for those with substance use disorders – in addition to care for the most seriously mentally ill – provides more resources for housing and workforce, and continues community support for prevention, early intervention, and innovative pilot programs – all with new and increased accountability for outcomes and through an equity lens. It is sponsored by Governor Newsom, supported by the Steinberg Institute, has received a support if amended from the Children's Partnership, a neutral position from the California Council of Community Behavioral Health Agencies, letters of concerns from Disability Rights California, Cal Voices, Kelechi Ubozoh, Mental Health America of California, the Depression and Bipolar Support Alliance, Communities Voices and the California Alliance of Child and Family Services, and as well as an oppose unless amended from Children Now and the Racial and Ethnic Mental Health Disparities Coalition.
  Location (as of 8/8/23): Assembly Health Committee

Enclosures (7):

(1) 2023 Legislative Calendar
(2) The Life Cycle of Legislation
(3) Assembly Bill 599 (Ward) Fact Sheet
(4) Assembly Bill 599 (Ward)
(5) Senate Bill 10 (Cortese) Fact Sheet
(6) Senate Bill 10 (Cortese)
(7) Senate Bill 326 (Eggman) Fact Sheet
(8) MHSOAC SB 326 Analysis

Proposed Motion:

- The Commission supports AB 599 and directs staff to communicate its position to the Governor and the Legislature; and
- The Commission supports SB 10 and directs staff to communicate its position to the Governor and the Legislature.

2023 TENTATIVE LEGISLATIVE CALENDAR

COMPILED BY THE OFFICE OF THE ASSEMBLY CHIEF CLERK AND THE OFFICE OF THE SECRETARY OF THE SENATE

Revised 11-4-22

JANUARY

	S	M	T	W	TH	F	S
	1	2	3	4	5	6	7
Wk. 1	8	9	10	11	12	13	14
Wk. 2	15	16	17	18	19	20	21
Wk. 3	22	23	24	25	26	27	28
Wk. 4	29	30	31				

FEBRUARY

	S	M	T	W	TH	F	S
Wk. 4				1	2	3	4
Wk. 1	5	6	7	8	9	10	11
Wk. 2	12	13	14	15	16	17	18
Wk. 3	19	20	21	22	23	24	25
Wk. 4	26	27	28				

MARCH

	S	M	T	W	TH	F	S
Wk. 4				1	2	3	4
Wk. 1	5	6	7	8	9	10	11
Wk. 2	12	13	14	15	16	17	18
Wk. 3	19	20	21	22	23	24	25
Wk. 4	26	27	28	29	30	31	

APRIL

	S	M	T	W	TH	F	S
Wk. 4							1
Spring Recess	2	3	4	5	6	7	8
Wk. 1	9	10	11	12	13	14	15
Wk. 2	16	17	18	19	20	21	22
Wk. 3	23	24	25	26	27	28	29
Wk. 4	30						

MAY

	S	M	T	W	TH	F	S
Wk. 4		1	2	3	4	5	6
Wk. 1	7	8	9	10	11	12	13
Wk. 2	14	15	16	17	18	19	20
Wk. 3	21	22	23	24	25	26	27
No Hrgs.	28	29	30	31			

DEADLINES

Jan. 1 Statutes take effect (Art. IV, Sec. 8(c)).

Jan. 4 Legislature reconvenes (J.R. 51(a)(1)).

Jan. 10 Budget must be submitted by Governor (Art. IV, Sec. 12(a)).

Jan. 16 Martin Luther King, Jr. Day.

Jan. 20 Last day to submit **bill requests** to the Office of Legislative Counsel.

Feb. 17 Last day for bills to be **introduced** (J.R. 61(a)(1), J.R. 54(a)).

Feb. 20 Presidents' Day.

Mar. 30 **Spring Recess** begins upon adjournment (J.R. 51(a)(2)).

Mar. 31 Cesar Chavez Day observed.

Apr. 10 Legislature reconvenes from **Spring Recess** (J.R. 51(a)(2)).

Apr. 28 Last day for **policy committees** to hear and report to fiscal committees **fiscal bills** introduced in their house (J.R. 61(a)(2)).

May 5 Last day for **policy committees** to hear and report to the Floor **nonfiscal bills** introduced in their house (J.R. 61(a)(3)).

May 12 Last day for **policy committees** to meet prior to June 5 (J.R. 61(a)(4)).

May 19 Last day for **fiscal committees** to hear and report to the Floor bills introduced in their house (J.R. 61(a)(5)).

Last day for **fiscal committees** to meet prior to June 5 (J.R. 61(a)(6)).

May 29 Memorial Day.

May 30-June 2 **Floor session only**. No committee may meet for any purpose except Rules Committee, bills referred pursuant to A.R. 77.2, and Conference Committees (J.R. 61(a)(7)).

*Holiday schedule subject to final approval by Rules Committee.

OVER

2023 TENTATIVE LEGISLATIVE CALENDAR

COMPILED BY THE OFFICE OF THE ASSEMBLY CHIEF CLERK AND THE OFFICE OF THE SECRETARY OF THE SENATE

Revised 11-4-22

JUNE							
	S	M	T	W	TH	F	S
No Hrgs.					1	2	3
Wk. 4	4	5	6	7	8	9	10
Wk. 1	11	12	13	14	15	16	17
Wk. 2	18	19	20	21	22	23	24
Wk. 3	25	26	27	28	29	30	

June 2 Last day for each house to pass bills introduced in that house (J.R. 61(a)(8)).

June 5 Committee meetings may resume (J.R. 61(a)(9)).

June 15 Budget Bill must be passed by midnight (Art. IV, Sec. 12(c)(3)).

JULY							
	S	M	T	W	TH	F	S
Wk. 3							1
Wk. 4	2	3	4	5	6	7	8
Wk. 1	9	10	11	12	13	14	15
Summer Recess	16	17	18	19	20	21	22
Summer Recess	23	24	25	26	27	28	29
Summer Recess	30	31					

July 4 Independence Day.

July 14 Last day for **policy committees** to meet and report bills (J.R. 61(a)(10)).

Summer Recess begins upon adjournment, provided Budget Bill has been passed (J.R. 51(a)(3)).

AUGUST							
	S	M	T	W	TH	F	S
Summer Recess			1	2	3	4	5
Summer Recess	6	7	8	9	10	11	12
Wk. 2	13	14	15	16	17	18	19
Wk. 3	20	21	22	23	24	25	26
Wk. 4	27	28	29	30	31		

Aug. 14 Legislature reconvenes from Summer Recess (J.R. 51(a)(3)).

SEPTEMBER							
	S	M	T	W	TH	F	S
Wk. 4						1	2
No Hrgs.	3	4	5	6	7	8	9
No Hrgs.	10	11	12	13	14	15	16
Interim Recess	17	18	19	20	21	22	23
Interim Recess	24	25	26	27	28	29	30

Sept. 1 Last day for **fiscal committees** to meet and report bills (J.R. 61(a)(11)).

Sept. 4 Labor Day.

Sept. 5-14 **Floor session only**. No committees may meet for any purpose, except Rules Committee, bills referred pursuant to Assembly Rule 77.2, and Conference Committees (J.R. 61(a)(12)).

Sept. 8 Last day to **amend** on the Floor (J.R. 61(a)(13)).

Sept. 14 Last day for each house to pass bills. (J.R. 61(a)(14)).

Interim Recess begins upon adjournment (J.R. 51(a)(4)).

IMPORTANT DATES OCCURRING DURING INTERIM RECESS

2023

Oct. 14 Last day for Governor to sign or veto bills passed by the Legislature on or before Sept. 14 and in the Governor's possession on or after Sept. 14 (Art. IV, Sec. 10(b)(1)).

2024

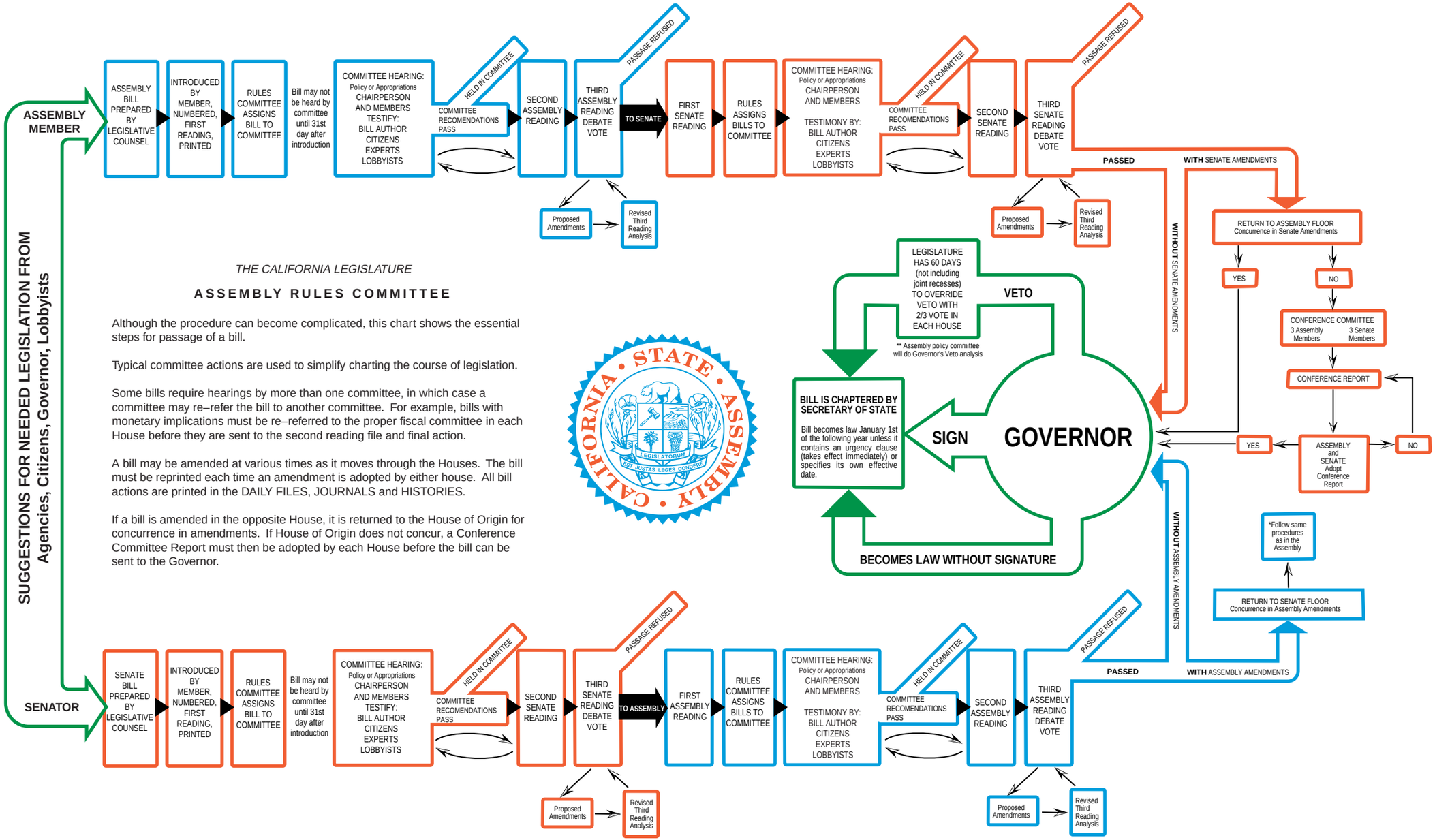
Jan. 1 Statutes take effect (Art. IV, Sec. 8(c)).

Jan. 3 Legislature reconvenes (J.R. 51(a)(4)).

*Holiday schedule subject to final approval by Rules Committee.

THE LIFE CYCLE OF LEGISLATION

From Idea into Law



THE CALIFORNIA LEGISLATURE

ASSEMBLY RULES COMMITTEE

Although the procedure can become complicated, this chart shows the essential steps for passage of a bill.

Typical committee actions are used to simplify charting the course of legislation.

Some bills require hearings by more than one committee, in which case a committee may re–refer the bill to another committee. For example, bills with monetary implications must be re–referred to the proper fiscal committee in each House before they are sent to the second reading file and final action.

A bill may be amended at various times as it moves through the Houses. The bill must be reprinted each time an amendment is adopted by either house. All bill actions are printed in the DAILY FILES, JOURNALS and HISTORIES.

If a bill is amended in the opposite House, it is returned to the House of Origin for concurrence in amendments. If House of Origin does not concur, a Conference Committee Report must then be adopted by each House before the bill can be sent to the Governor.

CHRISTOPHER M. WARD
ASSEMBLYMEMBER FOR THE 78TH DISTRICT
PHONE: (916) 319-2078 WEBSITE: https://a78.asmdc.org/ EMAIL: Assemblymember.Ward@assembly.ca.gov

Fact Sheet: AB 599

School Substance Use Suspension/Expulsion Policies

PROPOSED BILL

Assembly Bill (AB) 599 would revise school suspension and expulsion policies for drug-related infractions by requiring local education agencies, county offices of education, and public schools to create policies using a public health approach in lieu of suspensions and expulsions.

BACKGROUND

Under current law, school policies regarding drugs tend to focus on a punitive approach when dealing with substance possession or intoxication on school campuses. Moreover, suspensions and expulsions do not address the underlying need for support to prevent substance abuse among students.

According to a 2017-2019 survey of California public school students, 7% of 7th graders, 15% of 9th graders, 23% of 11th graders, and 29% of students in non-traditional programs used alcohol or drugs in the previous 30 days.[1] Youth alcohol, tobacco, and other drug use is a significant public health concern linked to a wide range of academic, social, and health problems. Adolescent substance use is highly predictive of adult substance abuse because the adolescent brain is still developing, making it more susceptible to addiction.

In addition, over 60% of drug-related suspensions and expulsions are of boys, over 80% are of socioeconomically disadvantaged students and 80% are of youth of color.[2,3]

Education Code §48900 allows school officials discretion in deciding whether to suspend or expel a pupil that unlawfully possessed, used, furnished, or been under the influence of a controlled substance, alcoholic beverage, or intoxicant or possessed or used tobacco or tobacco products. However, this discretion is not evenly exercised by school districts throughout the state.

Under current law, school districts can use community resources when responding to issues of student substance use and possession: however, the Education Code is vague in this area and requires administrators to make significant treatment decisions for the affected student that many do not feel comfortable making. Additionally, many school districts do not currently recognize community based treatment centers for student drug infractions, which leaves only punitive options for administrators.

SOLUTION

AB 599 would require a school district or county office of education to establish a public health framework for identifying and referring youth with substance use needs to community-based services, including mechanisms for screening/referral, education on overdose risk, training of school staff, and connecting with local community-based providers.

By requiring school districts to create a public health framework for administrators assisting students with substance possession and use infractions, the administrators will have identified resources and the ability to

[1] WestEd, California Healthy Kids Survey (CHKS) & Biennial State CHKS. California Dept. of Education (Aug. 2020)

[2] California Department of Education. Expulsion Data. 2021-22.
[3] California Department of Education. Suspension Data. 2021-22.

make referral based decisions for students. In addition, this allows administrators greater flexibility beyond using suspensions and expulsions as a response, while addressing the health needs of students to reduce the likelihood of future substance abuse and addiction.

SUPPORT

CALIFORNIA YOUTH EMPOWERMENT NETWORK (Co-Sponsor)

CALIFORNIA ALLIANCE OF CHILD AND FAMILY SERVICES (Co-Sponsor)

CHILDREN NOW (Co-Sponsor)

GREATER HOPE FOUNDATION FOR CHILDREN INC

MENTAL HEALTH AMERICA OF CALIFORNIA

PACIFIC CLINICS

PENNY LANE CENTERS

OPPOSITION

None at this time.

FOR MORE INFORMATION

Contact: Caleb Beaver
Phone: (916) 319-2078
Email: Caleb.Beaver@asm.ca.gov

Bill Version : Introduced February 9, 2023

AMENDED IN ASSEMBLY MARCH 28, 2023

CALIFORNIA LEGISLATURE—2023–24 REGULAR SESSION

ASSEMBLY BILL No. 599

Introduced by Assembly Member Ward
(Coauthor: Assembly Member Lee)

February 9, 2023

An act to amend, repeal, and add Sections 48900, 48901.1, 48915, and 49079 of, and to add Section 48901.2 to, the Education Code, relating to pupil discipline.

LEGISLATIVE COUNSEL'S DIGEST

AB 599, as amended, Ward. Suspensions and expulsions: ~~controlled substances:~~ tobacco.

Existing law prohibits a pupil from being suspended from school or recommended for expulsion, unless the superintendent of the school district or the principal of the school in which the pupil is enrolled determines that the pupil has committed a specified act, including, among other acts, that the pupil ~~(1) unlawfully possessed, used, sold, or otherwise furnished, or had been under the influence of, a controlled substance, an alcoholic beverage, or an intoxicant of any kind, or (2)~~ possessed or used tobacco, or products containing tobacco or nicotine products, including, but not limited to, cigarettes, cigars, miniature cigars, clove cigarettes, smokeless tobacco, snuff, chew packets, *vaping products,* and betel.

~~This bill would, commencing July 1, 2025, remove unlawfully possessing, using, or being under the influence of a controlled substance, an alcoholic beverage, or an intoxicant of any kind from the list of acts for which a pupil, regardless of their grade of enrollment, may be suspended or recommended for expulsion for. The bill would,~~

~~commencing July 1, 2025, prohibit a charter school pupil in kindergarten or any of grades 1 to 12, inclusive, from being suspended or recommended for expulsion solely on the basis of those acts.~~

This bill would, commencing July 1, 2025, remove having possessed or used tobacco, or products containing tobacco or nicotine products, including, but not limited to, cigarettes, cigars, miniature cigars, clove cigarettes, smokeless tobacco, snuff, chew packets, *vaping products,* and betel from the list of acts for which a pupil, regardless of their grade of enrollment, may be suspended or recommended for expulsion for. The bill would, commencing July 1, 2025, prohibit a charter school pupil in kindergarten or any of grades 1 to 12, inclusive, from being suspended or recommended for expulsion solely on the basis of those acts.

Existing law requires the principal or superintendent of schools to recommend the expulsion of a pupil for certain acts committed at school or at a school activity off school grounds, including, among others, the unlawful possession of certain controlled substances, unless the principal or superintendent determines that expulsion should not be recommended under the circumstances or that an alternative means of correction would address the conduct.

This bill, commencing July 1, 2025, would instead no longer require the principal or superintendent of schools to recommend the expulsion of a pupil for the unlawful possession of certain controlled substances under any circumstance.

This bill would require the State Department of Education, on or before July 1, 2025, to develop and make available a model policy for a public health approach to addressing pupil possession and use of illicit drugs on school property, as specified. The bill would require the department to collaborate with stakeholders, including treatment providers, local educational agencies, and community-based organizations in the development of the model policy. The bill would require local educational agencies, as defined, to adopt, on or before July 1, 2025, a plan to address pupils who possess or use drugs on school property. The bill would require the plan to be ~~youth informed~~ *youth-informed, reduce criminalization,* and to include specific information on where on campus and in the community pupils can receive education, treatment, or support for substance ~~use.~~ *abuse.* By imposing additional duties on local educational agencies, the bill would impose a state-mandated local program.

This bill would also make Legislative findings and declarations relating to these provisions, make conforming changes, and delete obsolete provisions.

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.

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

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

SECTION 1. (a) The Legislature finds and declares all of the following:

(1) According to a 2017–2019 survey of California public school pupils, 7 percent of 7th graders, 15 percent of 9th graders, 23 percent of 11th graders, and 29 percent of pupils in nontraditional programs used alcohol or drugs in the previous 30 days.

(2) Youth alcohol, tobacco, and other drug use is a significant public health concern linked to a wide range of academic, social, and health problems.

(3) Fentanyl was responsible for one in five deaths among Californians 15 to 24 years of age, inclusive, in 2021.

(4) Adolescent substance use is highly predictive of adult substance use disorders because the adolescent brain is still developing making it more susceptible to addiction.

(5) Research notes that high feelings of school connectedness can decrease drug use, and data indicates that pupils who reported low levels of school connectedness were more likely to use drugs or alcohol.

(6) Over 60 percent of drug-related suspensions are of boys, over 75 percent are of socioeconomically disadvantaged pupils, and 59 percent are of youth of color.

(b) Therefore, it is the intent of the Legislature to do all of the following:

(1) Provide teachers and school administrators with the means to foster safe and supportive learning environments for all children in California.

(2) Reduce the number of suspensions and expulsions experienced by pupils due to illicit drug use and possession in schools.

(3) Require local educational agencies to take a public health approach when dealing with pupils who use or possess drugs on campus.

(4) Ensure that pupils who transfer between multiple classrooms, taught by multiple teachers, be allowed to attend all remaining classes from which they have not been removed for disciplinary reasons.

SEC. 2. Section 48900 of the Education Code is amended to read:

48900. A pupil shall not be suspended from school or recommended for expulsion, unless the superintendent of the school district or the principal of the school in which the pupil is enrolled determines that the pupil has committed an act as defined pursuant to any of subdivisions (a) to (r), inclusive:

(a) (1) Caused, attempted to cause, or threatened to cause physical injury to another person.

(2) Willfully used force or violence upon the person of another, except in self-defense.

(b) Possessed, sold, or otherwise furnished a firearm, knife, explosive, or other dangerous object, unless, in the case of possession of an object of this type, the pupil had obtained written permission to possess the item from a certificated school employee, which is concurred in by the principal or the designee of the principal.

(c) Unlawfully possessed, used, sold, or otherwise furnished, or been under the influence of, a controlled substance listed in Chapter 2 (commencing with Section 11053) of Division 10 of the Health and Safety Code, an alcoholic beverage, or an intoxicant of any kind.

(d) Unlawfully offered, arranged, or negotiated to sell a controlled substance listed in Chapter 2 (commencing with Section 11053) of Division 10 of the Health and Safety Code, an alcoholic beverage, or an intoxicant of any kind, and either sold, delivered, or otherwise furnished to a person another liquid, substance, or

material and represented the liquid, substance, or material as a controlled substance, alcoholic beverage, or intoxicant.

(e) Committed or attempted to commit robbery or extortion.

(f) Caused or attempted to cause damage to school property or private property.

(g) Stole or attempted to steal school property or private property.

(h) Possessed or used tobacco, or products containing tobacco or nicotine products, including, but not limited to, cigarettes, cigars, miniature cigars, clove cigarettes, smokeless tobacco, snuff, chew packets, and betel. However, this section does not prohibit the use or possession by a pupil of the pupil's own prescription products.

(i) Committed an obscene act or engaged in habitual profanity or vulgarity.

(j) Unlawfully possessed or unlawfully offered, arranged, or negotiated to sell drug paraphernalia, as defined in Section 11014.5 of the Health and Safety Code.

(k) (1) Disrupted school activities or otherwise willfully defied the valid authority of supervisors, teachers, administrators, school officials, or other school personnel engaged in the performance of their duties.

(2) Except as provided in Section 48910, a pupil enrolled in kindergarten or any of grades 1 to 3, inclusive, shall not be suspended for any of the acts enumerated in paragraph (1), and those acts shall not constitute grounds for a pupil enrolled in kindergarten or any of grades 1 to 12, inclusive, to be recommended for expulsion. This paragraph is inoperative on July 1, 2020.

(3) Except as provided in Section 48910, commencing July 1, 2020, a pupil enrolled in kindergarten or any of grades 1 to 5, inclusive, shall not be suspended for any of the acts specified in paragraph (1), and those acts shall not constitute grounds for a pupil enrolled in kindergarten or any of grades 1 to 12, inclusive, to be recommended for expulsion.

(4) Except as provided in Section 48910, commencing July 1, 2020, a pupil enrolled in any of grades 6 to 8, inclusive, shall not be suspended for any of the acts specified in paragraph (1). This paragraph is inoperative on July 1, 2025.

(*l*) Knowingly received stolen school property or private property.

(m) Possessed an imitation firearm. As used in this section, "imitation firearm" means a replica of a firearm that is so substantially similar in physical properties to an existing firearm as to lead a reasonable person to conclude that the replica is a firearm.

(n) Committed or attempted to commit a sexual assault as defined in Section 261, 266c, 286, 287, 288, or 289 of, or former Section 288a of, the Penal Code or committed a sexual battery as defined in Section 243.4 of the Penal Code.

(o) Harassed, threatened, or intimidated a pupil who is a complaining witness or a witness in a school disciplinary proceeding for purposes of either preventing that pupil from being a witness or retaliating against that pupil for being a witness, or both.

(p) Unlawfully offered, arranged to sell, negotiated to sell, or sold the prescription drug Soma.

(q) Engaged in, or attempted to engage in, hazing. For purposes of this subdivision, "hazing" means a method of initiation or preinitiation into a pupil organization or body, whether or not the organization or body is officially recognized by an educational institution, that is likely to cause serious bodily injury or personal degradation or disgrace resulting in physical or mental harm to a former, current, or prospective pupil. For purposes of this subdivision, "hazing" does not include athletic events or school-sanctioned events.

(r) Engaged in an act of bullying. For purposes of this subdivision, the following terms have the following meanings:

(1) "Bullying" means any severe or pervasive physical or verbal act or conduct, including communications made in writing or by means of an electronic act, and including one or more acts committed by a pupil or group of pupils as defined in Section 48900.2, 48900.3, or 48900.4, directed toward one or more pupils that has or can be reasonably predicted to have the effect of one or more of the following:

(A) Placing a reasonable pupil or pupils in fear of harm to that pupil's or those pupils' person or property.

(B) Causing a reasonable pupil to experience a substantially detrimental effect on the pupil's physical or mental health.

(C) Causing a reasonable pupil to experience substantial interference with the pupil's academic performance.

(D) Causing a reasonable pupil to experience substantial interference with the pupil's ability to participate in or benefit from the services, activities, or privileges provided by a school.

(2) (A) "Electronic act" means the creation or transmission originated on or off the schoolsite, by means of an electronic device, including, but not limited to, a telephone, wireless telephone, or other wireless communication device, computer, or pager, of a communication, including, but not limited to, any of the following:

(i) A message, text, sound, video, or image.

(ii) A post on a social network internet website, including, but not limited to:

(I) Posting to or creating a burn page. "Burn page" means an internet website created for the purpose of having one or more of the effects listed in paragraph (1).

(II) Creating a credible impersonation of another actual pupil for the purpose of having one or more of the effects listed in paragraph (1). "Credible impersonation" means to knowingly and without consent impersonate a pupil for the purpose of bullying the pupil and such that another pupil would reasonably believe, or has reasonably believed, that the pupil was or is the pupil who was impersonated.

(III) Creating a false profile for the purpose of having one or more of the effects listed in paragraph (1). "False profile" means a profile of a fictitious pupil or a profile using the likeness or attributes of an actual pupil other than the pupil who created the false profile.

(iii) (I) An act of cyber sexual bullying.

(II) For purposes of this clause, "cyber sexual bullying" means the dissemination of, or the solicitation or incitement to disseminate, a photograph or other visual recording by a pupil to another pupil or to school personnel by means of an electronic act that has or can be reasonably predicted to have one or more of the effects described in subparagraphs (A) to (D), inclusive, of paragraph (1). A photograph or other visual recording, as described in this subclause, shall include the depiction of a nude, semi-nude, or sexually explicit photograph or other visual recording of a minor where the minor is identifiable from the photograph, visual recording, or other electronic act.

(III) For purposes of this clause, "cyber sexual bullying" does not include a depiction, portrayal, or image that has any serious literary, artistic, educational, political, or scientific value or that involves athletic events or school-sanctioned activities.

(B) Notwithstanding paragraph (1) and subparagraph (A), an electronic act shall not constitute pervasive conduct solely on the basis that it has been transmitted on the internet or is currently posted on the internet.

(3) "Reasonable pupil" means a pupil, including, but not limited to, a pupil with exceptional needs, who exercises average care, skill, and judgment in conduct for a person of that age, or for a person of that age with the pupil's exceptional needs.

(s) A pupil shall not be suspended or expelled for any of the acts enumerated in this section unless the act is related to a school activity or school attendance occurring within a school under the jurisdiction of the superintendent of the school district or principal or occurring within any other school district. A pupil may be suspended or expelled for acts that are enumerated in this section and related to a school activity or school attendance that occur at any time, including, but not limited to, any of the following:

(1) While on school grounds.

(2) While going to or coming from school.

(3) During the lunch period whether on or off the campus.

(4) During, or while going to or coming from, a school-sponsored activity.

(t) A pupil who aids or abets, as defined in Section 31 of the Penal Code, the infliction or attempted infliction of physical injury to another person may be subject to suspension, but not expulsion, pursuant to this section, except that a pupil who has been adjudged by a juvenile court to have committed, as an aider and abettor, a crime of physical violence in which the victim suffered great bodily injury or serious bodily injury shall be subject to discipline pursuant to subdivision (a).

(u) As used in this section, "school property" includes, but is not limited to, electronic files and databases.

(v) For a pupil subject to discipline under this section, a superintendent of the school district or principal is encouraged to provide alternatives to suspension or expulsion, using a research-based framework with strategies that improve behavioral and academic outcomes, that are age appropriate and designed to

address and correct the pupil's specific misbehavior as specified in Section 48900.5.

(w) (1) It is the intent of the Legislature that alternatives to suspension or expulsion be imposed against a pupil who is truant, tardy, or otherwise absent from school activities.

(2) It is further the intent of the Legislature that the Multi-Tiered System of Supports, which includes restorative justice practices, trauma-informed practices, social and emotional learning, and schoolwide positive behavior interventions and support, may be used to help pupils gain critical social and emotional skills, receive support to help transform trauma-related responses, understand the impact of their actions, and develop meaningful methods for repairing harm to the school community.

(x) This section shall become inoperative on July 1, 2025, and, as of January 1, 2026, is repealed.

SEC. 3. Section 48900 is added to the Education Code, to read:

48900. A pupil shall not be suspended from school or recommended for expulsion, unless the superintendent of the school district or the principal of the school in which the pupil is enrolled determines that the pupil has committed an act as defined pursuant to any of subdivisions (a) to (r), inclusive:

(a) (1) Caused, attempted to cause, or threatened to cause physical injury to another person.

(2) Willfully used force or violence upon the person of another, except in self-defense.

(b) Possessed, sold, or otherwise furnished a firearm, knife, explosive, or other dangerous object, unless, in the case of possession of an object of this type, the pupil had obtained written permission to possess the item from a certificated school employee, which is concurred in by the principal or the designee of the principal.

(c) Unlawfully ~~sold or otherwise furnished~~ *possessed, used, sold, or otherwise furnished, or been under the influence of* a controlled substance listed in Chapter 2 (commencing with Section 11053) of Division 10 of the Health and Safety Code, an alcoholic beverage, or an intoxicant of any kind. *This section does not prohibit the use or possession by a pupil of the pupil's own prescription products.*

(d) Unlawfully offered, arranged, or negotiated to sell a controlled substance listed in Chapter 2 (commencing with Section

11053) of Division 10 of the Health and Safety Code, an alcoholic beverage, or an intoxicant of any kind, and either sold, delivered, or otherwise furnished to a person another liquid, substance, or material and represented the liquid, substance, or material as a controlled substance, alcoholic beverage, or intoxicant.

(e) Committed or attempted to commit robbery or extortion.

(f) Caused or attempted to cause damage to school property or private property.

(g) Stole or attempted to steal school property or private property.

(h) [Reserved]

(i) Committed an obscene act or engaged in habitual profanity or vulgarity.

(j) Unlawfully possessed or unlawfully offered, arranged, or negotiated to sell drug paraphernalia, as defined in Section 11014.5 of the Health and Safety Code.

(k) (1) Disrupted school activities or otherwise willfully defied the valid authority of supervisors, teachers, administrators, school officials, or other school personnel engaged in the performance of their duties.

(2) Except as provided in Section 48910, a pupil enrolled in kindergarten or any of grades 1 to 3, inclusive, shall not be suspended for any of the acts enumerated in paragraph (1), and those acts shall not constitute grounds for a pupil enrolled in kindergarten or any of grades 1 to 12, inclusive, to be recommended for expulsion. This paragraph is inoperative on July 1, 2020.

(3) Except as provided in Section 48910, commencing July 1, 2020, a pupil enrolled in kindergarten or any of grades 1 to 5, inclusive, shall not be suspended for any of the acts specified in paragraph (1), and those acts shall not constitute grounds for a pupil enrolled in kindergarten or any of grades 1 to 12, inclusive, to be recommended for expulsion.

(4) Except as provided in Section 48910, commencing July 1, 2020, a pupil enrolled in any of grades 6 to 8, inclusive, shall not be suspended for any of the acts specified in paragraph (1). This paragraph is inoperative on July 1, 2025.

(*l*) Knowingly received stolen school property or private property.

(m) Possessed an imitation firearm. As used in this section, "imitation firearm" means a replica of a firearm that is so substantially similar in physical properties to an existing firearm as to lead a reasonable person to conclude that the replica is a firearm.

(n) Committed or attempted to commit a sexual assault as defined in Section 261, 266c, 286, 287, 288, or 289 of, or former Section 288a of, the Penal Code or committed a sexual battery as defined in Section 243.4 of the Penal Code.

(o) Harassed, threatened, or intimidated a pupil who is a complaining witness or a witness in a school disciplinary proceeding for purposes of either preventing that pupil from being a witness or retaliating against that pupil for being a witness, or both.

(p) Unlawfully offered, arranged to sell, negotiated to sell, or sold the prescription drug Soma.

(q) Engaged in, or attempted to engage in, hazing. For purposes of this subdivision, "hazing" means a method of initiation or preinitiation into a pupil organization or body, whether or not the organization or body is officially recognized by an educational institution, that is likely to cause serious bodily injury or personal degradation or disgrace resulting in physical or mental harm to a former, current, or prospective pupil. For purposes of this subdivision, "hazing" does not include athletic events or school-sanctioned events.

(r) Engaged in an act of bullying. For purposes of this subdivision, the following terms have the following meanings:

(1) "Bullying" means any severe or pervasive physical or verbal act or conduct, including communications made in writing or by means of an electronic act, and including one or more acts committed by a pupil or group of pupils as defined in Section 48900.2, 48900.3, or 48900.4, directed toward one or more pupils that has or can be reasonably predicted to have the effect of one or more of the following:

(A) Placing a reasonable pupil or pupils in fear of harm to that pupil's or those pupils' person or property.

(B) Causing a reasonable pupil to experience a substantially detrimental effect on the pupil's physical or mental health.

(C) Causing a reasonable pupil to experience substantial interference with the pupil's academic performance.

(D) Causing a reasonable pupil to experience substantial interference with the pupil's ability to participate in or benefit from the services, activities, or privileges provided by a school.

(2) (A) "Electronic act" means the creation or transmission originated on or off the schoolsite, by means of an electronic device, including, but not limited to, a telephone, wireless telephone, or other wireless communication device, computer, or pager, of a communication, including, but not limited to, any of the following:

(i) A message, text, sound, video, or image.

(ii) A post on a social network internet website, including, but not limited to:

(I) Posting to or creating a burn page. "Burn page" means an internet website created for the purpose of having one or more of the effects listed in paragraph (1).

(II) Creating a credible impersonation of another actual pupil for the purpose of having one or more of the effects listed in paragraph (1). "Credible impersonation" means to knowingly and without consent impersonate a pupil for the purpose of bullying the pupil and such that another pupil would reasonably believe, or has reasonably believed, that the pupil was or is the pupil who was impersonated.

(III) Creating a false profile for the purpose of having one or more of the effects listed in paragraph (1). "False profile" means a profile of a fictitious pupil or a profile using the likeness or attributes of an actual pupil other than the pupil who created the false profile.

(iii) (I) An act of cyber sexual bullying.

(II) For purposes of this clause, "cyber sexual bullying" means the dissemination of, or the solicitation or incitement to disseminate, a photograph or other visual recording by a pupil to another pupil or to school personnel by means of an electronic act that has or can be reasonably predicted to have one or more of the effects described in subparagraphs (A) to (D), inclusive, of paragraph (1). A photograph or other visual recording, as described in this subclause, shall include the depiction of a nude, semi-nude, or sexually explicit photograph or other visual recording of a minor where the minor is identifiable from the photograph, visual recording, or other electronic act.

(III) For purposes of this clause, "cyber sexual bullying" does not include a depiction, portrayal, or image that has any serious literary, artistic, educational, political, or scientific value or that involves athletic events or school-sanctioned activities.

(B) Notwithstanding paragraph (1) and subparagraph (A), an electronic act shall not constitute pervasive conduct solely on the basis that it has been transmitted on the internet or is currently posted on the internet.

(3) "Reasonable pupil" means a pupil, including, but not limited to, a pupil with exceptional needs, who exercises average care, skill, and judgment in conduct for a person of that age, or for a person of that age with the pupil's exceptional needs.

(s) A pupil shall not be suspended or expelled for any of the acts enumerated in this section unless the act is related to a school activity or school attendance occurring within a school under the jurisdiction of the superintendent of the school district or principal or occurring within any other school district. A pupil may be suspended or expelled for acts that are enumerated in this section and related to a school activity or school attendance that occur at any time, including, but not limited to, any of the following:

(1) While on school grounds.

(2) While going to or coming from school.

(3) During the lunch period whether on or off the campus.

(4) During, or while going to or coming from, a school-sponsored activity.

(t) A pupil who aids or abets, as defined in Section 31 of the Penal Code, the infliction or attempted infliction of physical injury to another person may be subject to suspension, but not expulsion, pursuant to this section, except that a pupil who has been adjudged by a juvenile court to have committed, as an aider and abettor, a crime of physical violence in which the victim suffered great bodily injury or serious bodily injury shall be subject to discipline pursuant to subdivision (a).

(u) As used in this section, "school property" includes, but is not limited to, electronic files and databases.

(v) For a pupil subject to discipline under this section, a superintendent of the school district or principal is encouraged to provide alternatives to suspension or expulsion, using a research-based framework with strategies that improve behavioral and academic outcomes, that are age appropriate and designed to

address and correct the pupil's specific misbehavior as specified in Section 48900.5.

(w) (1) It is the intent of the Legislature that alternatives to suspension or expulsion be imposed against a pupil who is truant, tardy, or otherwise absent from school activities.

(2) It is further the intent of the Legislature that the Multi-Tiered System of Supports, which includes restorative justice practices, trauma-informed practices, social and emotional learning, and schoolwide positive behavior interventions and support, may be used to help pupils gain critical social and emotional skills, receive support to help transform trauma-related responses, understand the impact of their actions, and develop meaningful methods for repairing harm to the school community.

(x) This section shall become operative on July 1, 2025.

SEC. 4. Section 48901.1 of the Education Code is amended to read:

48901.1. Notwithstanding Section 47610 or any other law, commencing July 1, 2020, the following provisions apply to charter schools:

(a) A pupil enrolled in a charter school in kindergarten or any of grades 1 to 5, inclusive, shall not be suspended on the basis of having disrupted school activities or otherwise willfully defied the valid authority of supervisors, teachers, administrators, school officials, or other school personnel engaged in the performance of their duties, and those acts shall not constitute grounds for a pupil enrolled in a charter school in kindergarten or any of grades 1 to 12, inclusive, to be recommended for expulsion.

(b) A pupil enrolled in a charter school in any of grades 6 to 8, inclusive, shall not be suspended on the basis of having disrupted school activities or otherwise willfully defied the valid authority of supervisors, teachers, administrators, school officials, or other school personnel engaged in the performance of their duties. This subdivision is inoperative on July 1, 2025.

(c) This section shall become inoperative on July 1, 2025, and, as of January 1, 2026, is repealed.

SEC. 5. Section 48901.1 is added to the Education Code, to read:

48901.1. Notwithstanding Section 47610 or any other law, the following provisions apply to charter schools:

(a) A pupil enrolled in a charter school in kindergarten or any of grades 1 to 5, inclusive, shall not be suspended on the basis of having disrupted school activities or otherwise willfully defied the valid authority of supervisors, teachers, administrators, school officials, or other school personnel engaged in the performance of their duties, and those acts shall not constitute grounds for a pupil enrolled in a charter school in kindergarten or any of grades 1 to 12, inclusive, to be recommended for expulsion.

(b) A pupil enrolled in a charter school in any of grades 6 to 8, inclusive, shall not be suspended on the basis of having disrupted school activities or otherwise willfully defied the valid authority of supervisors, teachers, administrators, school officials, or other school personnel engaged in the performance of their duties. This subdivision is inoperative on July 1, 2025.

(c) A pupil enrolled in a charter school in kindergarten or any of grades 1 to 12, inclusive, shall not be suspended or recommended for expulsion solely on the basis ~~of either of the following:~~

~~(1) Having~~ *of having* possessed or used tobacco, or products containing tobacco or nicotine products, including, but not limited to, cigarettes, cigars, miniature cigars, clove cigarettes, smokeless tobacco, snuff, chew packets, *vaping products,* and betel.

~~(2) Having unlawfully possessed, used, or been under the influence of, a controlled substance listed in Chapter 2 (commencing with Section 11053) of Division 10 of the Health and Safety Code, an alcoholic beverage, or an intoxicant of any kind.~~

(d) This section shall become operative on July 1, 2025.

SEC. 6. Section 48901.2 is added to the Education Code, to read:

48901.2. (a) On or *before* July 1, 2025, the department shall develop and make available a model policy, consistent with the requirements of subdivision (b), for a public health approach to addressing pupil possession and use of illicit drugs on school property. The department shall collaborate with stakeholders, including treatment providers, local educational agencies, and community-based organizations in the development of the model policy.

(b) (1) On or before July 1, 2025, local educational agencies shall adopt a plan to address pupils who possess or use drugs on

school property. The plan shall, consistent with paragraph (2), be ~~youth-informed~~ *youth-informed, reduce criminalization,* and include specific information on where on campus and in the community pupils can receive education, treatment, or support for substance ~~use.~~ *abuse.*

(2) Local educational agencies shall make a good faith effort to adopt a plan that is youth informed.

(c) For purposes of this section, local educational agencies include school districts, county offices of education, and charter schools.

SEC. 7. Section 48915 of the Education Code is amended to read:

48915. (a) (1) Except as provided in subdivisions (c) and (e), the principal or the superintendent of schools shall recommend the expulsion of a pupil for any of the following acts committed at school or at a school activity off school grounds, unless the principal or superintendent determines that expulsion should not be recommended under the circumstances or that an alternative means of correction would address the conduct:

(A) Causing serious physical injury to another person, except in self-defense.

(B) Possession of any knife or other dangerous object of no reasonable use to the pupil.

(C) Unlawful possession of any controlled substance listed in Chapter 2 (commencing with Section 11053) of Division 10 of the Health and Safety Code, except for either of the following:

(i) The first offense for the possession of not more than one avoirdupois ounce of marijuana, other than concentrated cannabis.

(ii) The possession of over-the-counter medication for use by the pupil for medical purposes or medication prescribed for the pupil by a physician.

(D) Robbery or extortion.

(E) Assault or battery, as defined in Sections 240 and 242 of the Penal Code, upon any school employee.

(2) If the principal or the superintendent of schools makes a determination as described in paragraph (1), the principal or superintendent is encouraged to do so as quickly as possible to ensure that the pupil does not lose instructional time.

(b) Upon recommendation by the principal or the superintendent of schools, or by a hearing officer or administrative panel appointed

pursuant to subdivision (d) of Section 48918, the governing board of a school district may order a pupil expelled upon finding that the pupil committed an act listed in paragraph (1) of subdivision (a) or in subdivision (a), (b), (c), (d), or (e) of Section 48900. A decision to expel a pupil for any of those acts shall be based on a finding of one or both of the following:

(1) Other means of correction are not feasible or have repeatedly failed to bring about proper conduct.

(2) Due to the nature of the act, the presence of the pupil causes a continuing danger to the physical safety of the pupil or others.

(c) The principal or superintendent of schools shall immediately suspend, pursuant to Section 48911, and shall recommend expulsion of a pupil that the principal or superintendent determines has committed any of the following acts at school or at a school activity off school grounds:

(1) Possessing, selling, or otherwise furnishing a firearm. This subdivision does not apply to an act of possessing a firearm if the pupil had obtained prior written permission to possess the firearm from a certificated school employee, which is concurred in by the principal or the designee of the principal. This subdivision applies to an act of possessing a firearm only if the possession is verified by an employee of a school district. The act of possessing an imitation firearm, as defined in subdivision (m) of Section 48900, is not an offense for which suspension or expulsion is mandatory pursuant to this subdivision and subdivision (d), but it is an offense for which suspension, or expulsion pursuant to subdivision (e), may be imposed.

(2) Brandishing a knife at another person.

(3) Unlawfully selling a controlled substance listed in Chapter 2 (commencing with Section 11053) of Division 10 of the Health and Safety Code.

(4) Committing or attempting to commit a sexual assault as defined in subdivision (n) of Section 48900 or committing a sexual battery as defined in subdivision (n) of Section 48900.

(5) Possession of an explosive.

(d) The governing board of a school district shall order a pupil expelled upon finding that the pupil committed an act listed in subdivision (c), and shall refer that pupil to a program of study that meets all of the following conditions:

(1) Is appropriately prepared to accommodate pupils who exhibit discipline problems.

(2) Is not provided at a comprehensive middle, junior, or senior high school, or at any elementary school.

(3) Is not housed at the schoolsite attended by the pupil at the time of suspension.

(e) Upon recommendation by the principal or the superintendent of schools, or by a hearing officer or administrative panel appointed pursuant to subdivision (d) of Section 48918, the governing board of a school district may order a pupil expelled upon finding that the pupil, at school or at a school activity off of school grounds violated subdivision (f), (g), (h), (i), (j), (k), (*l*), or (m) of Section 48900, or Section 48900.2, 48900.3, or 48900.4, and either of the following:

(1) That other means of correction are not feasible or have repeatedly failed to bring about proper conduct.

(2) That due to the nature of the violation, the presence of the pupil causes a continuing danger to the physical safety of the pupil or others.

(f) The governing board of a school district shall refer a pupil who has been expelled pursuant to subdivision (b) or (e) to a program of study that meets all of the conditions specified in subdivision (d). Notwithstanding this subdivision, with respect to a pupil expelled pursuant to subdivision (e), if the county superintendent of schools certifies that an alternative program of study is not available at a site away from a comprehensive middle, junior, or senior high school, or an elementary school, and that the only option for placement is at another comprehensive middle, junior, or senior high school, or another elementary school, the pupil may be referred to a program of study that is provided at a comprehensive middle, junior, or senior high school, or at an elementary school.

(g) As used in this section, "knife" means any dirk, dagger, or other weapon with a fixed, sharpened blade fitted primarily for stabbing, a weapon with a blade fitted primarily for stabbing, a weapon with a blade longer than ~~3½~~ *three and one-half* inches, a folding knife with a blade that locks into place, or a razor with an unguarded blade.

(h) As used in this section, the term "explosive" means "destructive device" as described in Section 921 of Title 18 of the United States Code.

(i) This section shall become inoperative on July 1, 2025, and, as of January 1, 2026, is repealed.

SEC. 8. Section 48915 is added to the Education Code, to read:

48915. (a) (1) Except as provided in subdivisions (c) and (e), the principal or the superintendent of schools shall recommend the expulsion of a pupil for any of the following acts committed at school or at a school activity off school grounds, unless the principal or superintendent determines that expulsion should not be recommended under the circumstances or that an alternative means of correction would address the conduct:

(A) Causing serious physical injury to another person, except in self-defense.

(B) Possession of any knife or other dangerous object of no reasonable use to the pupil.

(C) Robbery or extortion.

(D) Assault or battery, as defined in Sections 240 and 242 of the Penal Code, upon any school employee.

(2) If the principal or the superintendent of schools makes a determination as described in paragraph (1), the principal or superintendent is encouraged to do so as quickly as possible to ensure that the pupil does not lose instructional time.

(b) Upon recommendation by the principal or the superintendent of schools, or by a hearing officer or administrative panel appointed pursuant to subdivision (d) of Section 48918, the governing board of a school district may order a pupil expelled upon finding that the pupil committed an act listed in paragraph (1) of subdivision (a) or in subdivision (a), (b), (c), (d), or (e) of Section 48900. A decision to expel a pupil for any of those acts shall be based on a finding of one or both of the following:

(1) Other means of correction are not feasible or have repeatedly failed to bring about proper conduct.

(2) Due to the nature of the act, the presence of the pupil causes a continuing danger to the physical safety of the pupil or others.

(c) The principal or superintendent of schools shall immediately suspend, pursuant to Section 48911, and shall recommend expulsion of a pupil that the principal or superintendent determines

has committed any of the following acts at school or at a school activity off school grounds:

(1) Possessing, selling, or otherwise furnishing a firearm. This subdivision does not apply to an act of possessing a firearm if the pupil had obtained prior written permission to possess the firearm from a certificated school employee, which is concurred in by the principal or the designee of the principal. This subdivision applies to an act of possessing a firearm only if the possession is verified by an employee of a school district. The act of possessing an imitation firearm, as defined in subdivision (m) of Section 48900, is not an offense for which suspension or expulsion is mandatory pursuant to this subdivision and subdivision (d), but it is an offense for which suspension, or expulsion pursuant to subdivision (e), may be imposed.

(2) Brandishing a knife at another person.

(3) Unlawfully selling a controlled substance listed in Chapter 2 (commencing with Section 11053) of Division 10 of the Health and Safety Code.

(4) Committing or attempting to commit a sexual assault as defined in subdivision (n) of Section 48900 or committing a sexual battery as defined in subdivision (n) of Section 48900.

(5) Possession of an explosive.

(d) The governing board of a school district shall order a pupil expelled upon finding that the pupil committed an act listed in subdivision (c), and shall refer that pupil to a program of study that meets all of the following conditions:

(1) Is appropriately prepared to accommodate pupils who exhibit discipline problems.

(2) Is not provided at a comprehensive middle, junior, or senior high school, or at any elementary school.

(3) Is not housed at the schoolsite attended by the pupil at the time of suspension.

(e) Upon recommendation by the principal or the superintendent of schools, or by a hearing officer or administrative panel appointed pursuant to subdivision (d) of Section 48918, the governing board of a school district may order a pupil expelled upon finding that the pupil, at school or at a school activity off of school grounds violated subdivision (f), (g), (i), (j), (k), (*l*), or (m) of Section 48900, or Section 48900.2, 48900.3, or 48900.4, and either of the following:

(1) That other means of correction are not feasible or have repeatedly failed to bring about proper conduct.

(2) That due to the nature of the violation, the presence of the pupil causes a continuing danger to the physical safety of the pupil or others.

(f) The governing board of a school district shall refer a pupil who has been expelled pursuant to subdivision (b) or (e) to a program of study that meets all of the conditions specified in subdivision (d). Notwithstanding this subdivision, with respect to a pupil expelled pursuant to subdivision (e), if the county superintendent of schools certifies that an alternative program of study is not available at a site away from a comprehensive middle, junior, or senior high school, or an elementary school, and that the only option for placement is at another comprehensive middle, junior, or senior high school, or another elementary school, the pupil may be referred to a program of study that is provided at a comprehensive middle, junior, or senior high school, or at an elementary school.

(g) As used in this section, "knife" means any dirk, dagger, or other weapon with a fixed, sharpened blade fitted primarily for stabbing, a weapon with a blade fitted primarily for stabbing, a weapon with a blade longer than ~~3½~~ *three and one-half* inches, a folding knife with a blade that locks into place, or a razor with an unguarded blade.

(h) As used in this section, the term "explosive" means "destructive device" as described in Section 921 of Title 18 of the United States Code.

(i) This section shall become operative on July 1, 2025.

SEC. 9. Section 49079 of the Education Code is amended to read:

49079. (a) A school district shall inform the teacher of each pupil who has engaged in, or is reasonably suspected to have engaged in, any of the acts described in any of the subdivisions, except subdivision (h), of Section 48900 or in Section 48900.2, 48900.3, 48900.4, or 48900.7 that the pupil engaged in, or is reasonably suspected to have engaged in, those acts. The district shall provide the information to the teacher based upon any records that the district maintains in its ordinary course of business, or receives from a law enforcement agency, regarding a pupil described in this section.

(b) A school district, or school district officer or employee, is not civilly or criminally liable for providing information under this section unless it is proven that the information was false and that the district or district officer or employee knew or should have known that the information was false, or the information was provided with a reckless disregard for its truth or falsity.

(c) An officer or employee of a school district who knowingly fails to provide information about a pupil who has engaged in, or who is reasonably suspected to have engaged in, the acts referred to in subdivision (a) is guilty of a misdemeanor, which is punishable by confinement in the county jail for a period not to exceed six months, or by a fine not to exceed one thousand dollars ($1,000), or both.

(d) The information provided shall be from the previous three school years.

(e) Any information received by a teacher pursuant to this section shall be received in confidence for the limited purpose for which it was provided and shall not be further disseminated by the teacher.

(f) This section shall become inoperative on July 1, 2025, and, as of January 1, 2026, is repealed.

SEC. 10. Section 49079 is added to the Education Code, to read:

49079. (a) A school district shall inform the teacher of each pupil who has engaged in, or is reasonably suspected to have engaged in, any of the acts described in Section 48900, 48900.2, 48900.3, 48900.4, or 48900.7 that the pupil engaged in, or is reasonably suspected to have engaged in, those acts. The district shall provide the information to the teacher based upon any records that the district maintains in its ordinary course of business, or receives from a law enforcement agency, regarding a pupil described in this section.

(b) A school district, or school district officer or employee, is not civilly or criminally liable for providing information under this section unless it is proven that the information was false and that the district or district officer or employee knew or should have known that the information was false, or the information was provided with a reckless disregard for its truth or falsity.

(c) An officer or employee of a school district who knowingly fails to provide information about a pupil who has engaged in, or

who is reasonably suspected to have engaged in, the acts referred to in subdivision (a) is guilty of a misdemeanor, which is punishable by confinement in the county jail for a period not to exceed six months, or by a fine not to exceed one thousand dollars ($1,000), or both.

(d) The information provided shall be from the previous three school years.

(e) Any information received by a teacher pursuant to this section shall be received in confidence for the limited purpose for which it was provided and shall not be further disseminated by the teacher.

(f) This section shall become operative on July 1, 2025.

SEC. 11. 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.

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SENATOR DAVE CORTESE
SB 10
"Melanie's Law" - Opioid & Fentanyl Overdose Prevention Among Youth

Principal coauthors: Senators Hurtado and Umberg
Coauthors: Senators Archuleta, Ashby, Caballero, Nguyen, Portantino, and Wilk
Coauthors: Assembly Members Haney, Jackson, Low, Quirk-Silva, Rodriguez, and Santiago

SUMMARY

SB 10 will expand statewide prevention and education efforts to combat the skyrocketing overdoses and fentanyl-related deaths that have plagued youth statewide.

ISSUE

As reported recently by The Mercury News, fentanyl was responsible for an astounding one in five youth deaths (ages 15-to-24) in California last year. In one year alone (2019-2020), fentanyl overdoses among youth nearly doubled and we have seen that trend continue to increase.

Fentanyl and other synthetic opioids were responsible for more than 105,000 deaths in America from October 2020 to October 2021, with 69,000 deaths being caused by fentanyl.

Fentanyl, in particular, is responsible for more deaths among youth than all other drugs combined. This drug can be found in fake and counterfeit pills that are sold through social media or e-commerce platforms, making them available to youth.

Across America, the Drug Enforcement Agency has noted a considerable rise in the amount of fake and counterfeit pills containing a deadly dose of fentanyl – nearly a 502 percent increase since 2019.

BACKGROUND

Pursuant to Education Code Section 49414.3, school nurses or trained personnel who have volunteered may provide emergency medical aid through naloxone hydrochloride or another opioid antagonist.

Through the statewide standing order issued by the State Public Health Officer pursuant to Section 1714.22 of the Civil Code, local education agencies may apply to receive opioid antagonists such as naloxone. The State Department of Health Care Services is currently administering the Naloxone Distribution Project to provide entities, including local education agencies, opioid antagonists, such as naloxone.

THIS BILL

SB 10 seeks to provide necessary intervention, increase accessibility to resources and provide valuable education and training services to protect our youth from fentanyl poising and overdoses. SB XX does the following:

- Requires local education agencies to embed opioid overdose prevention and treatment in their **School Safety Plans**, including synthetic opioids, such as fentanyl; and
- Requires the California Department of Education to work with California Health and Human Services Agency to develop and distribute an **Opioid Antagonist Training & School Resource Guide** to all local education agencies regarding the emergency use of opioid antagonists, such as naloxone, on school campuses; and
- Requires local education agencies **distribute safety advice** to families regarding opioid overdose prevention including through student orientation materials and through posting online information; and
- Establishes a **State Working Group on Fentanyl Overdose/Abuse Prevention** focused on public

education, awareness, prevention and minimizing overdoses; and
- Encourages the establishment of **County Working Groups on Fentanyl Overdose/Abuse Prevention** through a new state grant program.

SUPPORT (PARTIAL LIST)

- The County of Santa Clara **(Co-Sponsor)**
- The Santa Clara County Office of Education **(Co-Sponsor)**
- The California Association of Student Councils **(Co-Sponsor)**
- The California Consortium of Addiction Programs & Professionals **(Co-Sponsor)**
- The Santa Clara County School Boards Association
- The Los Angeles County Office of Education
- The Alameda County Office of Education
- The California Teachers Association
- The California Federation of Teachers
- ACLU California Action
- California Psychological Association
- California Society of Addiction Medicine
- California Alliance for State Advocacy
- Govern for California
- The Steinberg Institute
- The California School Nurses Organization

OPPOSITION

NONE

FOR MORE INFORMATION

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AMENDED IN ASSEMBLY JUNE 30, 2023

AMENDED IN SENATE MAY 18, 2023

AMENDED IN SENATE APRIL 10, 2023

AMENDED IN SENATE MARCH 23, 2023

SENATE BILL No. 10

Introduced by Senator Cortese
(Principal coauthors: Senators Hurtado and Umberg)
(Coauthors: Senators Archuleta, Ashby, Caballero, Nguyen, Portantino, and Wilk)
(Coauthors: Assembly Members Haney, Jackson, Low, Quirk-Silva, Rodriguez, and Santiago)

December 5, 2022

An act to amend Sections 32282, 47605, and 47605.6 of, and to add Sections 49414.4 and 49428.16 to, the Education Code, relating to pupil health.

LEGISLATIVE COUNSEL'S DIGEST

SB 10, as amended, Cortese. Pupil health: opioid overdose prevention and treatment: Melanie's Law.

(1) Existing law authorizes a public or private elementary or secondary school to determine whether or not to make emergency naloxone hydrochloride or another opioid antagonist and trained personnel available at its school, and to designate one or more volunteers to receive related training to address an opioid overdose, as specified.

This bill would require the State Department of Education, in collaboration with the California Health and Human Services Agency, to establish the State Working Group on Fentanyl Education in Schools, for the purpose of promoting public education, awareness, and

prevention of fentanyl overdoses, with the outreach aimed at staff and pupils in schools. The bill would state the Legislature's encouragement of county offices of education to establish similar county working groups.

The bill would require the State Working Group on Fentanyl Education in Schools, in collaboration with specified relevant entities, to develop a School Resource Guide on Opioids, serving as a toolkit that may be accessed by school staff. The bill would require that certain information be included in the ~~guide, that~~ *guide and would require the guide to be completed and provided to the department on or before July 1, 2024. The bill would require* the department ~~distribute~~ *to make* the guide *available* to all county offices of education, school districts, state special schools, and charter schools serving pupils in any of grades 7 to 12, inclusive, and that each of those local educational agencies ~~distribute it~~ *make the guide available* to their school campuses, as specified.

The bill would also require the department and the agency to collaborate to develop informational materials containing safety advice, for pupils and parents or guardians of pupils, on how to prevent an opioid overdose. The bill would require the department to ~~distribute~~ *make* the informational materials *available* to ~~the~~ *all* local educational agencies, and would require the local educational agencies to ~~distribute~~ *make* the informational materials *available* to *their* school ~~campuses.~~ *campuses, as provided.* The bill would require a school to *annually* notify pupils and parents or guardians of pupils of the informational materials, as specified.

The bill would condition implementation of these provisions on an appropriation. By creating new duties for local educational agencies, the bill would impose a state-mandated local program.

(2) Under existing law, each school district and county office of education is responsible for the overall development of a comprehensive school safety plan for each of its schools operating kindergarten or any of grades 1 to 12, inclusive, in cooperation with certain local entities. Existing law requires that the plan identify appropriate strategies and programs that will provide or maintain a high level of school safety and address the school's procedures for complying with existing laws related to school safety. Existing law requires a petition to establish a charter school to include, among other things, a reasonably comprehensive description of the procedures that the charter school will follow to ensure the health and safety of pupils and staff, including requiring the

development and annual update of a school safety plan that includes certain safety topics and procedures.

This bill would additionally require a comprehensive school safety plan, and the school safety plan of a charter school, *for a school serving pupils in any of grades 7 to 12, inclusive,* to include the development of a protocol in the event a pupil is suffering or is reasonably believed to be suffering from an opioid overdose. By creating new duties for local educational agencies, the bill would impose a state-mandated local program.

(3) Existing law states the intent of the Legislature that alternatives to suspension or expulsion be imposed against a pupil who is truant, tardy, or otherwise absent from school activities. Existing law further states legislative intent that the Multi-Tiered System of Supports, which includes restorative justice practices, among other things, may be used to help pupils, as specified.

This bill would state the intent of the Legislature that a school use alternatives to a referral of a pupil to a law enforcement agency in response to an incident involving the pupil's misuse of an opioid, to the extent not in conflict with any other law requiring that referral. The bill would state legislative intent that the above-described Multi-Tiered System of Supports may be used to achieve these alternatives.

(4) 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.

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

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

SECTION 1. This act shall be known, and may be cited, as Melanie's Law.

SEC. 2. Section 32282 of the Education Code is amended to read:

32282. (a) The comprehensive school safety plan shall include, but not be limited to, both of the following:

(1) Assessing the current status of school crime committed on school campuses and at school-related functions.

(2) Identifying appropriate strategies and programs that will provide or maintain a high level of school safety and address the school's procedures for complying with existing laws related to school safety, which shall include the development of all of the following:

(A) Child abuse reporting procedures consistent with Article 2.5 (commencing with Section 11164) of Chapter 2 of Title 1 of Part 4 of the Penal Code.

(B) Disaster procedures, routine and emergency, including adaptations for pupils with disabilities in accordance with the federal Americans with Disabilities Act of 1990 (42 U.S.C. Sec. 12101 et seq.). The disaster procedures shall also include, but not be limited to, both of the following:

(i) Establishing an earthquake emergency procedure system in every public school building having an occupant capacity of 50 or more pupils or more than one classroom. A school district or county office of education may work with the Office of Emergency Services and the Alfred E. Alquist Seismic Safety Commission to develop and establish the earthquake emergency procedure system. The system shall include, but not be limited to, all of the following:

(I) A school building disaster plan, ready for implementation at any time, for maintaining the safety and care of pupils and staff. The department shall provide general direction to school districts and county offices of education on what to include in the school building disaster plan.

(II) A drop procedure whereby each pupil and staff member takes cover under a table or desk, dropping to the pupil's or staff member's knees, with the head protected by the arms, and the back to the windows. A drop procedure practice shall be held at least once a school quarter in elementary schools and at least once a semester in secondary schools.

(III) Protective measures to be taken before, during, and following an earthquake.

(IV) A program to ensure that pupils and both the certificated and classified staff are aware of, and properly trained in, the earthquake emergency procedure system.

(ii) Establishing a procedure to allow a public agency, including the American Red Cross, to use school buildings, grounds, and

equipment for mass care and welfare shelters during disasters or other emergencies affecting the public health and welfare. The school district or county office of education shall cooperate with the public agency in furnishing and maintaining the services as the school district or county office of education may deem necessary to meet the needs of the community.

(C) Policies pursuant to subdivision (d) of Section 48915 for pupils who committed an act listed in subdivision (c) of Section 48915 and other school-designated serious acts that would lead to suspension, expulsion, or mandatory expulsion recommendations pursuant to Article 1 (commencing with Section 48900) of Chapter 6 of Part 27 of Division 4 of Title 2.

(D) Procedures to notify teachers of dangerous pupils pursuant to Section 49079.

(E) A discrimination and harassment policy consistent with the prohibition against discrimination contained in Chapter 2 (commencing with Section 200) of Part 1.

(F) The provisions of any schoolwide dress code, pursuant to Section 35183, that prohibits pupils from wearing "gang-related apparel," if the school has adopted that type of a dress code. For those purposes, the comprehensive school safety plan shall define "gang-related apparel." The definition shall be limited to apparel that, if worn or displayed on a school campus, reasonably could be determined to threaten the health and safety of the school environment. A schoolwide dress code established pursuant to this section and Section 35183 shall be enforced on the school campus and at any school-sponsored activity by the principal of the school or the person designated by the principal. For purposes of this subparagraph, "gang-related apparel" shall not be considered a protected form of speech pursuant to Section 48950.

(G) Procedures for safe ingress and egress of pupils, parents, and school employees to and from school.

(H) A safe and orderly environment conducive to learning at the school.

(I) The rules and procedures on school discipline adopted pursuant to Sections 35291, 35291.5, 47605, and 47605.6.

(J) Procedures for conducting tactical responses to criminal incidents, including procedures related to individuals with guns on school campuses and at school-related functions. The procedures to prepare for active shooters or other armed assailants shall be

based on the specific needs and context of each school and community.

(K) ~~A~~ *For schools that serve pupils in any of grades 7 to 12, inclusive, a* protocol in the event a pupil is suffering or is reasonably believed to be suffering from an opioid overdose.

(b) It is the intent of the Legislature that schools develop comprehensive school safety plans using existing resources, including the materials and services of the partnership, pursuant to this chapter. It is also the intent of the Legislature that schools use the handbook developed and distributed in partnership by the State Department of Education's Safe Schools and Violence Prevention Center and the Attorney General's Crime and Violence Prevention Center entitled "Safe Schools: A Planning Guide for Action" in conjunction with developing their plan for school safety.

(c) Each schoolsite council or school safety planning committee, in developing and updating a comprehensive school safety plan, shall, where practical, consult, cooperate, and coordinate with other schoolsite councils or school safety planning committees.

(d) The comprehensive school safety plan may be evaluated and amended, as needed, by the school safety planning committee, but shall be evaluated at least once a year, to ensure that the comprehensive school safety plan is properly implemented. An updated file of all safety-related plans and materials shall be readily available for inspection by the public.

(e) As comprehensive school safety plans are reviewed and updated, the Legislature encourages all plans, to the extent that resources are available, to include policies and procedures aimed at the prevention of bullying.

(f) The comprehensive school safety plan, as written and updated by the schoolsite council or school safety planning committee, shall be submitted for approval pursuant to subdivision (a) of Section 32288.

(g) The department shall maintain and conspicuously post on its internet website a compliance checklist for developing a comprehensive school safety plan, and shall update the checklist when necessary.

SEC. 3. Section 47605 of the Education Code is amended to read:

47605. (a) (1) Except as set forth in paragraph (2), a petition for the establishment of a charter school within a school district

may be circulated by one or more persons seeking to establish the charter school. A petition for the establishment of a charter school shall identify a single charter school that will operate within the geographic boundaries of that school district. A charter school may propose to operate at multiple sites within the school district if each location is identified in the charter school petition. The petition may be submitted to the governing board of the school district for review after either of the following conditions is met:

(A) The petition is signed by a number of parents or legal guardians of pupils that is equivalent to at least one-half of the number of pupils that the charter school estimates will enroll in the charter school for its first year of operation.

(B) The petition is signed by a number of teachers that is equivalent to at least one-half of the number of teachers that the charter school estimates will be employed at the charter school during its first year of operation.

(2) A petition that proposes to convert an existing public school to a charter school that would not be eligible for a loan pursuant to subdivision (c) of Section 41365 may be circulated by one or more persons seeking to establish the charter school. The petition may be submitted to the governing board of the school district for review after the petition is signed by not less than 50 percent of the permanent status teachers currently employed at the public school to be converted.

(3) A petition shall include a prominent statement that a signature on the petition means that the parent or legal guardian is meaningfully interested in having their child or ward attend the charter school, or in the case of a teacher's signature, means that the teacher is meaningfully interested in teaching at the charter school. The proposed charter shall be attached to the petition.

(4) After receiving approval of its petition, a charter school that proposes to expand operations to one or more additional sites or grade levels shall request a material revision to its charter and shall notify the chartering authority of those additional locations or grade levels. The chartering authority shall consider whether to approve those additional locations or grade levels at an open, public meeting. If the additional locations or grade levels are approved pursuant to the standards and criteria described in subdivision (c), they shall be a material revision to the charter school's charter.

(5) (A) A charter school that established one site outside the boundaries of the school district, but within the county in which that school district is located before January 1, 2020, may continue to operate that site until the charter school submits a request for the renewal of its charter petition. To continue operating the site, the charter school shall do either of the following:

(i) First, before submitting the request for the renewal of the charter petition, obtain approval in writing from the school district where the site is operating.

(ii) Submit a request for the renewal of the charter petition pursuant to Section 47607 to the school district in which the charter school is located.

(B) If a Presidential declaration of a major disaster or emergency is issued in accordance with the federal Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. Sec. 5121 et seq.) for an area in which a charter schoolsite is located and operating, the charter school, for not more than five years, may relocate that site outside the area subject to the Presidential declaration if the charter school first obtains the written approval of the school district where the site is being relocated to.

(C) Notwithstanding subparagraph (A), if a charter school was relocated from December 31, 2016, to December 31, 2019, inclusive, due to a Presidential declaration of a major disaster or emergency in accordance with the federal Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. Sec. 5121 et seq.), that charter school shall be allowed to return to its original campus location in perpetuity.

(D) (i) A charter school in operation and providing educational services to pupils before October 1, 2019, located on a federally recognized California Indian reservation or rancheria or operated by a federally recognized California Indian tribe shall be exempt from the geographic restrictions of paragraph (1) and subparagraph (A) of this paragraph and the geographic restrictions of subdivision (a) of Section 47605.1.

(ii) The exemption to the geographic restrictions of subdivision (a) of Section 47605.1 in clause (i) does not apply to nonclassroom-based charter schools operating pursuant to Section 47612.5.

(E) The department shall regard as a continuing charter school for all purposes a charter school that was granted approval of its

petition, that was providing educational services to pupils before October 1, 2019, and is authorized by a different chartering authority due to changes to this paragraph that took effect January 1, 2020. This paragraph shall be implemented only to the extent it does not conflict with federal law. In order to prevent any potential conflict with federal law, this paragraph does not apply to covered programs as identified in Section 8101(11) of the federal Elementary and Secondary Education Act of 1965 (20 U.S.C. Sec. 7801) to the extent the affected charter school is the restructured portion of a divided charter school pursuant to Section 47654.

(6) Commencing January 1, 2003, a petition to establish a charter school shall not be approved to serve pupils in a grade level that is not served by the school district of the governing board considering the petition, unless the petition proposes to serve pupils in all of the grade levels served by that school district.

(b) No later than 60 days after receiving a petition, in accordance with subdivision (a), the governing board of the school district shall hold a public hearing on the provisions of the charter, at which time the governing board of the school district shall consider the level of support for the petition by teachers employed by the school district, other employees of the school district, and parents. Following review of the petition and the public hearing, the governing board of the school district shall either grant or deny the charter within 90 days of receipt of the petition, provided, however, that the date may be extended by an additional 30 days if both parties agree to the extension. A petition is deemed received by the governing board of the school district for purposes of commencing the timelines described in this subdivision on the day the petitioner submits a petition to the district office, along with a signed certification that the petitioner deems the petition to be complete. The governing board of the school district shall publish all staff recommendations, including the recommended findings and, if applicable, the certification from the county superintendent of schools prepared pursuant to paragraph (8) of subdivision (c), regarding the petition at least 15 days before the public hearing at which the governing board of the school district will either grant or deny the charter. At the public hearing at which the governing board of the school district will either grant or deny the charter, petitioners shall have equivalent time and procedures to present

evidence and testimony to respond to the staff recommendations and findings.

(c) In reviewing petitions for the establishment of charter schools pursuant to this section, the chartering authority shall be guided by the intent of the Legislature that charter schools are and should become an integral part of the California educational system and that the establishment of charter schools should be encouraged. The governing board of the school district shall grant a charter for the operation of a school under this part if it is satisfied that granting the charter is consistent with sound educational practice and with the interests of the community in which the school is proposing to locate. The governing board of the school district shall consider the academic needs of the pupils the school proposes to serve. The governing board of the school district shall not deny a petition for the establishment of a charter school unless it makes written factual findings, specific to the particular petition, setting forth specific facts to support one or more of the following findings:

(1) The charter school presents an unsound educational program for the pupils to be enrolled in the charter school.

(2) The petitioners are demonstrably unlikely to successfully implement the program set forth in the petition.

(3) The petition does not contain the number of signatures required by subdivision (a).

(4) The petition does not contain an affirmation of each of the conditions described in subdivision (e).

(5) The petition does not contain reasonably comprehensive descriptions of all of the following:

(A) (i) The educational program of the charter school, designed, among other things, to identify those whom the charter school is attempting to educate, what it means to be an "educated person" in the 21st century, and how learning best occurs. The goals identified in that program shall include the objective of enabling pupils to become self-motivated, competent, and lifelong learners.

(ii) The annual goals for the charter school for all pupils and for each subgroup of pupils identified pursuant to Section 52052, to be achieved in the state priorities, as described in subdivision (d) of Section 52060, that apply for the grade levels served, and specific annual actions to achieve those goals. A charter petition

may identify additional school priorities, the goals for the school priorities, and the specific annual actions to achieve those goals.

(iii) If the proposed charter school will serve high school pupils, the manner in which the charter school will inform parents about the transferability of courses to other public high schools and the eligibility of courses to meet college entrance requirements. Courses offered by the charter school that are accredited by the Western Association of Schools and Colleges may be considered transferable and courses approved by the University of California or the California State University as creditable under the "A to G" admissions criteria may be considered to meet college entrance requirements.

(B) The measurable pupil outcomes identified for use by the charter school. "Pupil outcomes," for purposes of this part, means the extent to which all pupils of the charter school demonstrate that they have attained the skills, knowledge, and attitudes specified as goals in the charter school's educational program. Pupil outcomes shall include outcomes that address increases in pupil academic achievement both schoolwide and for all pupil subgroups served by the charter school, as that term is defined in subdivision (a) of Section 52052. The pupil outcomes shall align with the state priorities, as described in subdivision (d) of Section 52060, that apply for the grade levels served by the charter school.

(C) The method by which pupil progress in meeting those pupil outcomes is to be measured. To the extent practicable, the method for measuring pupil outcomes for state priorities shall be consistent with the way information is reported on a school accountability report card.

(D) The governance structure of the charter school, including, but not limited to, the process to be followed by the charter school to ensure parental involvement.

(E) The qualifications to be met by individuals to be employed by the charter school.

(F) The procedures that the charter school will follow to ensure the health and safety of pupils and staff. These procedures shall require all of the following:

(i) That each employee of the charter school furnish the charter school with a criminal record summary as described in Section 44237.

(ii) ~~The~~ *For all schools, the* development of a school safety plan, which shall include the safety topics listed in subparagraphs (A) to ~~(K),~~ *(J),* inclusive, of paragraph (2) of subdivision (a) of Section 32282. *For schools serving pupils in any of grades 7 to 12, inclusive, the development of a school safety plan shall also include the safety topic listed in subparagraph (K) of paragraph (2) of subdivision (a) of Section 32282.*

(iii) That the school safety plan be reviewed and updated by March 1 of every year by the charter school.

(G) The means by which the charter school will achieve a balance of racial and ethnic pupils, special education pupils, and English learner pupils, including redesignated fluent English proficient pupils, as defined by the evaluation rubrics in Section 52064.5, that is reflective of the general population residing within the territorial jurisdiction of the school district to which the charter petition is submitted. Upon renewal, for a charter school not deemed to be a local educational agency for purposes of special education pursuant to Section 47641, the chartering authority may consider the effect of school placements made by the chartering authority in providing a free and appropriate public education as required by the federal Individuals with Disabilities Education Act (Public Law 101-476), on the balance of pupils with disabilities at the charter school.

(H) Admission policies and procedures, consistent with subdivision (e).

(I) The manner in which annual, independent financial audits shall be conducted, which shall employ generally accepted accounting principles, and the manner in which audit exceptions and deficiencies shall be resolved to the satisfaction of the chartering authority.

(J) The procedures by which pupils can be suspended or expelled from the charter school for disciplinary reasons or otherwise involuntarily removed from the charter school for any reason. These procedures, at a minimum, shall include an explanation of how the charter school will comply with federal and state constitutional procedural and substantive due process requirements that is consistent with all of the following:

(i) For suspensions of fewer than 10 days, provide oral or written notice of the charges against the pupil and, if the pupil denies the charges, an explanation of the evidence that supports the charges

and an opportunity for the pupil to present the pupil's side of the story.

(ii) For suspensions of 10 days or more and all other expulsions for disciplinary reasons, both of the following:

(I) Provide timely, written notice of the charges against the pupil and an explanation of the pupil's basic rights.

(II) Provide a hearing adjudicated by a neutral officer within a reasonable number of days at which the pupil has a fair opportunity to present testimony, evidence, and witnesses and confront and cross-examine adverse witnesses, and at which the pupil has the right to bring legal counsel or an advocate.

(iii) Contain a clear statement that no pupil shall be involuntarily removed by the charter school for any reason unless the parent or guardian of the pupil has been provided written notice of intent to remove the pupil no less than five schooldays before the effective date of the action. The written notice shall be in the native language of the pupil or the pupil's parent or guardian, or, if the pupil is a homeless child or youth, or a foster child or youth, in the native language of the homeless or foster child's educational rights holder. In the case of a foster child or youth, the written notice shall also be provided to the foster child's attorney and county social worker. If the pupil is an Indian child, as defined in Section 224.1 of the Welfare and Institutions Code, the written notice shall also be provided to the Indian child's tribal social worker and, if applicable, county social worker. The written notice shall inform the pupil, the pupil's parent or guardian, the homeless child's educational rights holder, the foster child's educational rights holder, attorney, and county social worker, or the Indian child's tribal social worker and, if applicable, county social worker of the right to initiate the procedures specified in clause (ii) before the effective date of the action. If the pupil's parent or guardian, the homeless child's educational rights holder, the foster child's educational rights holder, attorney, or county social worker, or the Indian child's tribal social worker or, if applicable, county social worker initiates the procedures specified in clause (ii), the pupil shall remain enrolled and shall not be removed until the charter school issues a final decision. For purposes of this clause, "involuntarily removed" includes disenrolled, dismissed, transferred, or terminated, but does not include suspensions specified in clauses (i) and (ii).

(iv) A foster child's educational rights holder, attorney, and county social worker and an Indian child's tribal social worker and, if applicable, county social worker shall have the same rights a parent or guardian of a child has to receive a suspension notice, expulsion notice, manifestation determination notice, involuntary transfer notice, and other documents and related information.

(K) The manner by which staff members of the charter schools will be covered by the State Teachers' Retirement System, the Public Employees' Retirement System, or federal social security.

(L) The public school attendance alternatives for pupils residing within the school district who choose not to attend charter schools.

(M) The rights of an employee of the school district upon leaving the employment of the school district to work in a charter school, and of any rights of return to the school district after employment at a charter school.

(N) The procedures to be followed by the charter school and the chartering authority to resolve disputes relating to provisions of the charter.

(O) The procedures to be used if the charter school closes. The procedures shall ensure a final audit of the charter school to determine the disposition of all assets and liabilities of the charter school, including plans for disposing of any net assets and for the maintenance and transfer of pupil records.

(6) The petition does not contain a declaration of whether or not the charter school shall be deemed the exclusive public employer of the employees of the charter school for purposes of Chapter 10.7 (commencing with Section 3540) of Division 4 of Title 1 of the Government Code.

(7) The charter school is demonstrably unlikely to serve the interests of the entire community in which the school is proposing to locate. Analysis of this finding shall include consideration of the fiscal impact of the proposed charter school. A written factual finding under this paragraph shall detail specific facts and circumstances that analyze and consider the following factors:

(A) The extent to which the proposed charter school would substantially undermine existing services, academic offerings, or programmatic offerings.

(B) Whether the proposed charter school would duplicate a program currently offered within the school district and the existing program has sufficient capacity for the pupils proposed to be served

within reasonable proximity to where the charter school intends to locate.

(8) The school district is not positioned to absorb the fiscal impact of the proposed charter school. A school district satisfies this paragraph if it has a qualified interim certification pursuant to Section 42131 and the county superintendent of schools, in consultation with the County Office Fiscal Crisis and Management Assistance Team, certifies that approving the charter school would result in the school district having a negative interim certification pursuant to Section 42131, has a negative interim certification pursuant to Section 42131, or is under state receivership. Charter schools proposed in a school district satisfying one of these conditions shall be subject to a rebuttable presumption of denial.

(d) (1) Charter schools shall meet all statewide standards and conduct the pupil assessments required pursuant to Section 60605 and any other statewide standards authorized in statute or pupil assessments applicable to pupils in noncharter public schools.

(2) Charter schools shall, on a regular basis, consult with their parents, legal guardians, and teachers regarding the charter school's educational programs.

(e) (1) In addition to any other requirement imposed under this part, a charter school shall be nonsectarian in its programs, admission policies, employment practices, and all other operations, shall not charge tuition, and shall not discriminate against a pupil on the basis of the characteristics listed in Section 220. Except as provided in paragraph (2), admission to a charter school shall not be determined according to the place of residence of the pupil, or of that pupil's parent or legal guardian, within this state, except that an existing public school converting partially or entirely to a charter school under this part shall adopt and maintain a policy giving admission preference to pupils who reside within the former attendance area of that public school.

(2) (A) A charter school shall admit all pupils who wish to attend the charter school.

(B) If the number of pupils who wish to attend the charter school exceeds the charter school's capacity, attendance, except for existing pupils of the charter school, shall be determined by a public random drawing. Preference shall be extended to pupils currently attending the charter school and pupils who reside in the school district except as provided for in Section 47614.5.

Preferences, including, but not limited to, siblings of pupils admitted or attending the charter school and children of the charter school's teachers, staff, and founders identified in the initial charter, may also be permitted by the chartering authority on an individual charter school basis. Priority order for any preference shall be determined in the charter petition in accordance with all of the following:

(i) Each type of preference shall be approved by the chartering authority at a public hearing.

(ii) Preferences shall be consistent with federal law, the California Constitution, and Section 200.

(iii) Preferences shall not result in limiting enrollment access for pupils with disabilities, academically low-achieving pupils, English learners, neglected or delinquent pupils, homeless pupils, or pupils who are economically disadvantaged, as determined by eligibility for any free or reduced-price meal program, foster youth, or pupils based on nationality, race, ethnicity, or sexual orientation.

(iv) In accordance with Section 49011, preferences shall not require mandatory parental volunteer hours as a criterion for admission or continued enrollment.

(C) In the event of a drawing, the chartering authority shall make reasonable efforts to accommodate the growth of the charter school and shall not take any action to impede the charter school from expanding enrollment to meet pupil demand.

(3) If a pupil is expelled or leaves the charter school without graduating or completing the school year for any reason, the charter school shall notify the superintendent of the school district of the pupil's last known address within 30 days, and shall, upon request, provide that school district with a copy of the cumulative record of the pupil, including report cards or a transcript of grades, and health information. If the pupil is subsequently expelled or leaves the school district without graduating or completing the school year for any reason, the school district shall provide this information to the charter school within 30 days if the charter school demonstrates that the pupil had been enrolled in the charter school. This paragraph applies only to pupils subject to compulsory full-time education pursuant to Section 48200.

(4) (A) A charter school shall not discourage a pupil from enrolling or seeking to enroll in the charter school for any reason, including, but not limited to, academic performance of the pupil

or because the pupil exhibits any of the characteristics described in clause (iii) of subparagraph (B) of paragraph (2).

(B) A charter school shall not request a pupil's records or require a parent, guardian, or pupil to submit the pupil's records to the charter school before enrollment.

(C) A charter school shall not encourage a pupil currently attending the charter school to disenroll from the charter school or transfer to another school for any reason, including, but not limited to, academic performance of the pupil or because the pupil exhibits any of the characteristics described in clause (iii) of subparagraph (B) of paragraph (2). This subparagraph shall not apply to actions taken by a charter school pursuant to the procedures described in subparagraph (J) of paragraph (5) of subdivision (c).

(D) The department shall develop a notice of the requirements of this paragraph. This notice shall be posted on a charter school's internet website. A charter school shall provide a parent or guardian, or a pupil if the pupil is 18 years of age or older, a copy of this notice at all of the following times:

(i) When a parent, guardian, or pupil inquires about enrollment.

(ii) Before conducting an enrollment lottery.

(iii) Before disenrollment of a pupil.

(E) (i) A person who suspects that a charter school has violated this paragraph may file a complaint with the chartering authority.

(ii) The department shall develop a template to be used for filing complaints pursuant to clause (i).

(5) Notwithstanding any other law, a charter school in operation as of July 1, 2019, that operates in partnership with the California National Guard may dismiss a pupil from the charter school for failing to maintain the minimum standards of conduct required by the Military Department.

(f) The governing board of a school district shall not require an employee of the school district to be employed in a charter school.

(g) The governing board of a school district shall not require a pupil enrolled in the school district to attend a charter school.

(h) The governing board of a school district shall require that the petitioner or petitioners provide information regarding the proposed operation and potential effects of the charter school, including, but not limited to, the facilities to be used by the charter school, the manner in which administrative services of the charter

school are to be provided, and potential civil liability effects, if any, upon the charter school and upon the school district. The description of the facilities to be used by the charter school shall specify where the charter school intends to locate. The petitioner or petitioners also shall be required to provide financial statements that include a proposed first-year operational budget, including startup costs, and cashflow and financial projections for the first three years of operation. If the school is to be operated by, or as, a nonprofit public benefit corporation, the petitioner shall provide the names and relevant qualifications of all persons whom the petitioner nominates to serve on the governing body of the charter school.

(i) In reviewing petitions for the establishment of charter schools within the school district, the governing board of the school district shall give preference to petitions that demonstrate the capability to provide comprehensive learning experiences to pupils identified by the petitioner or petitioners as academically low achieving pursuant to the standards established by the department under Section 54032, as that section read before July 19, 2006.

(j) Upon the approval of the petition by the governing board of the school district, the petitioner or petitioners shall provide written notice of that approval, including a copy of the petition, to the applicable county superintendent of schools, the department, and the state board.

(k) (1) (A) (i) If the governing board of a school district denies a petition, the petitioner may elect to submit the petition for the establishment of a charter school to the county board of education. The petitioner shall submit the petition to the county board of education within 30 days of a denial by the governing board of the school district. At the same time the petition is submitted to the county board of education, the petitioner shall also provide a copy of the petition to the school district. The county board of education shall review the petition pursuant to subdivisions (b) and (c). If the petition submitted on appeal contains new or different material terms, the county board of education shall immediately remand the petition to the governing board of the school district for reconsideration, which shall grant or deny the petition within 30 days. If the governing board of the school district denies a petition after reconsideration, the petitioner may elect to resubmit the

petition for the establishment of a charter school to the county board of education.

(ii) The county board of education shall review the appeal petition pursuant to subdivision (c). If the denial of the petition was made pursuant to paragraph (8) of subdivision (c), the county board of education shall also review the school district's findings pursuant to paragraph (8) of subdivision (c).

(iii) As used in this subdivision, "material terms" of the petition means the signatures, affirmations, disclosures, documents, and descriptions described in subdivisions (a), (b), (c), and (h), but shall not include minor administrative updates to the petition or related documents due to changes in circumstances based on the passage of time related to fiscal affairs, facilities arrangements, or state law, or to reflect the county board of education as the chartering authority.

(B) If the governing board of a school district denies a petition and the county board of education has jurisdiction over a single school district, the petitioner may elect to submit the petition for the establishment of a charter school to the state board. The state board shall review a petition submitted pursuant to this subparagraph pursuant to subdivision (c). If the denial of a charter petition is reversed by the state board pursuant to this subparagraph, the state board shall designate the governing board of the school district in which the charter school is located as the chartering authority.

(2) If the county board of education denies a petition, the petitioner may appeal that denial to the state board.

(A) The petitioner shall submit the petition to the state board within 30 days of a denial by the county board of education. The petitioner shall include the findings and documentary record from the governing board of the school district and the county board of education and a written submission detailing, with specific citations to the documentary record, how the governing board of the school district or the county board of education, or both, abused their discretion. The governing board of the school district and county board of education shall prepare the documentary record, including transcripts of the public hearing at which the governing board of the school district and county board of education denied the charter, at the request of the petitioner. The documentary record shall be prepared by the governing board of the school district and county

board of education no later than 10 business days after the request of the petitioner is made. At the same time the petition and supporting documentation is submitted to the state board, the petitioner shall also provide a copy of the petition and supporting documentation to the school district and the county board of education.

(B) If the appeal contains new or different material terms, as defined in clause (iii) of subparagraph (A) of paragraph (1), the state board shall immediately remand the petition to the governing board of the school district to which the petition was submitted for reconsideration. The governing board of the school district shall grant or deny the petition within 30 days. If the governing board of the school district denies a petition after reconsideration, the petitioner may elect to resubmit the petition to the state board.

(C) Within 30 days of receipt of the appeal submitted to the state board, the governing board of the school district or county board of education may submit a written opposition to the state board detailing, with specific citations to the documentary record, how the governing board of the school district or the county board of education did not abuse its discretion in denying the petition. The governing board of the school district or the county board of education may submit supporting documentation or evidence from the documentary record that was considered by the governing board of the school district or the county board of education.

(D) The state board's Advisory Commission on Charter Schools shall hold a public hearing to review the appeal and documentary record. Based on its review, the Advisory Commission on Charter Schools shall submit a recommendation to the state board whether there is sufficient evidence to hear the appeal or to summarily deny review of the appeal based on the documentary record. If the Advisory Commission on Charter Schools does not submit a recommendation to the state board, the state board shall consider the appeal, and shall either hear the appeal or summarily deny review of the appeal based on the documentary record at a regular public meeting of the state board.

(E) The state board shall either hear the appeal or summarily deny review of the appeal based on the documentary record. If the state board hears the appeal, the state board may affirm the determination of the governing board of the school district or the county board of education, or both of those determinations, or may

reverse only upon a determination that there was an abuse of discretion. If the denial of a charter petition is reversed by the state board, the state board shall designate, in consultation with the petitioner, either the governing board of the school district or the county board of education in which the charter school is located as the chartering authority.

(3) A charter school for which a charter is granted by either the county board of education or the state board based on an appeal pursuant to this subdivision shall qualify fully as a charter school for all funding and other purposes of this part.

(4) A charter school that receives approval of its petition from a county board of education or from the state board on appeal shall be subject to the same requirements concerning geographic location to which it would otherwise be subject if it received approval from the chartering authority to which it originally submitted its petition. A charter petition that is submitted to either a county board of education or to the state board shall meet all otherwise applicable petition requirements, including the identification of the proposed site or sites where the charter school will operate.

(5) Upon the approval of the petition by the county board of education, the petition or petitioners shall provide written notice of that approval, including a copy of the petition, to the governing board of the school district in which the charter school is located, the department, and the state board.

(6) If either the county board of education or the state board fails to act on a petition within 180 days of receipt, the decision of the governing board of the school district to deny the petition shall be subject to judicial review.

(*l*) (1) Teachers in charter schools shall hold the Commission on Teacher Credentialing certificate, permit, or other document required for the teacher's certificated assignment. These documents shall be maintained on file at the charter school and are subject to periodic inspection by the chartering authority. A governing body of a direct-funded charter school may use local assignment options authorized in statute and regulations for the purpose of legally assigning certificated teachers, in accordance with all of the requirements of the applicable statutes or regulations in the same manner as a governing board of a school district. A charter school shall have authority to request an emergency permit or a waiver

from the Commission on Teacher Credentialing for individuals in the same manner as a school district.

(2) By July 1, 2020, all teachers in charter schools shall obtain a certificate of clearance and satisfy the requirements for professional fitness pursuant to Sections 44339, 44340, and 44341.

(3) The Commission on Teacher Credentialing shall include in the bulletins it issues pursuant to subdivision (k) of Section 44237 to provide notification to local educational agencies of any adverse actions taken against the holders of any commission documents, notice of any adverse actions taken against teachers employed by charter schools, and shall make this bulletin available to all chartering authorities and charter schools in the same manner in which it is made available to local educational agencies.

(m) A charter school shall transmit a copy of its annual, independent financial audit report for the preceding fiscal year, as described in subparagraph (I) of paragraph (5) of subdivision (c), to its chartering authority, the Controller, the county superintendent of schools of the county in which the charter school is sited, unless the county board of education of the county in which the charter school is sited is the chartering authority, and the department by December 15 of each year. This subdivision does not apply if the audit of the charter school is encompassed in the audit of the chartering authority pursuant to Section 41020.

(n) A charter school may encourage parental involvement, but shall notify the parents and guardians of applicant pupils and currently enrolled pupils that parental involvement is not a requirement for acceptance to, or continued enrollment at, the charter school.

(o) The requirements of this section shall not be waived by the state board pursuant to Section 33050 or any other law.

SEC. 4. Section 47605.6 of the Education Code is amended to read:

47605.6. (a) (1) In addition to the authority provided by Section 47605.5, a county board of education may also approve a petition for the operation of a charter school that operates at one or more sites within the geographic boundaries of the county and that provides instructional services that are not generally provided by a county office of education. A county board of education may approve a countywide charter only if it finds, in addition to the other requirements of this section, that the educational services to

be provided by the charter school will offer services to a pupil population that will benefit from those services and that cannot be served as well by a charter school that operates in only one school district in the county. A petition for the establishment of a countywide charter school pursuant to this subdivision may be circulated throughout the county by any one or more persons seeking to establish the charter school. The petition may be submitted to the county board of education for review after either of the following conditions is met:

(A) The petition is signed by a number of parents or guardians of pupils residing within the county that is equivalent to at least one-half of the number of pupils that the charter school estimates will enroll in the school for its first year of operation and each of the school districts where the charter school petitioner proposes to operate a facility has received at least 30 days' notice of the petitioner's intent to operate a charter school pursuant to this section.

(B) The petition is signed by a number of teachers that is equivalent to at least one-half of the number of teachers that the charter school estimates will be employed at the school during its first year of operation and each of the school districts where the charter school petitioner proposes to operate a facility has received at least 30 days' notice of the petitioner's intent to operate a charter school pursuant to this section.

(2) An existing public school shall not be converted to a charter school in accordance with this section.

(3) After receiving approval of its petition, a charter school that proposes to establish operations at additional sites within the geographic boundaries of the county board of education shall notify the school districts where those sites will be located. The charter school shall also request a material revision of its charter by the county board of education that approved its charter and the county board of education shall consider whether to approve those additional locations at an open, public meeting, held no sooner than 30 days following notification of the school districts where the sites will be located. If approved, the location of the approved sites shall be a material revision of the charter school's approved charter.

(4) A petition shall include a prominent statement indicating that a signature on the petition means that the parent or guardian

is meaningfully interested in having their child or ward attend the charter school, or in the case of a teacher's signature, means that the teacher is meaningfully interested in teaching at the charter school. The proposed charter shall be attached to the petition.

(b) No later than 60 days after receiving a petition, in accordance with subdivision (a), the county board of education shall hold a public hearing on the provisions of the charter, at which time the county board of education shall consider the level of support for the petition by teachers, parents or guardians, and the school districts where the charter school petitioner proposes to place school facilities. Following review of the petition and the public hearing, the county board of education shall either grant or deny the charter within 90 days of receipt of the petition. However, this date may be extended by an additional 30 days if both parties agree to the extension. A petition is deemed received by the county board of education for purposes of commencing the timelines described in this subdivision when the petitioner submits a petition, in accordance with subparagraph (A) or (B) of paragraph (1) of subdivision (a), to the county office of education. The county board of education shall publish all staff recommendations, including the recommended findings, regarding the petition at least 15 days before the public hearing at which the county board of education will either grant or deny the charter. At the public hearing at which the county board of education will either grant or deny the charter, petitioners shall have equivalent time and procedures to present evidence and testimony to respond to the staff recommendations and findings. A county board of education may impose any additional requirements beyond those required by this section that it considers necessary for the sound operation of a countywide charter school. A county board of education may grant a charter for the operation of a charter school under this part only if it is satisfied that granting the charter is consistent with sound educational practice and that the charter school has reasonable justification for why it could not be established by petition to a school district pursuant to Section 47605. The county board of education shall deny a petition for the establishment of a charter school if it finds one or more of the following:

(1) The charter school presents an unsound educational program for the pupils to be enrolled in the charter school.

(2) The petitioners are demonstrably unlikely to successfully implement the program set forth in the petition.

(3) The petition does not contain the number of signatures required by subdivision (a).

(4) The petition does not contain an affirmation of each of the conditions described in subdivision (e).

(5) The petition does not contain reasonably comprehensive descriptions of all of the following:

(A) (i) The educational program of the charter school, designed, among other things, to identify those pupils whom the charter school is attempting to educate, what it means to be an "educated person" in the 21st century, and how learning best occurs. The goals identified in that program shall include the objective of enabling pupils to become self-motivated, competent, and lifelong learners.

(ii) The annual goals for the charter school for all pupils and for each subgroup of pupils identified pursuant to Section 52052, to be achieved in the state priorities, as described in subdivision (d) of Section 52060, that apply for the grade levels served by the charter school, and specific annual actions to achieve those goals. A charter petition may identify additional school priorities, the goals for the school priorities, and the specific annual actions to achieve those goals.

(iii) If the proposed charter school will enroll high school pupils, the manner in which the charter school will inform parents regarding the transferability of courses to other public high schools. Courses offered by the charter school that are accredited by the Western Association of Schools and Colleges may be considered to be transferable to other public high schools.

(iv) If the proposed charter school will enroll high school pupils, information as to the manner in which the charter school will inform parents as to whether each individual course offered by the charter school meets college entrance requirements. Courses approved by the University of California or the California State University as satisfying their prerequisites for admission may be considered as meeting college entrance requirements for purposes of this clause.

(B) The measurable pupil outcomes identified for use by the charter school. "Pupil outcomes," for purposes of this part, means the extent to which all pupils of the charter school demonstrate

that they have attained the skills, knowledge, and aptitudes specified as goals in the charter school's educational program. Pupil outcomes shall include outcomes that address increases in pupil academic achievement both schoolwide and for all pupil subgroups served by the charter school, as that term is defined in subdivision (a) of Section 52052. The pupil outcomes shall align with the state priorities, as described in subdivision (d) of Section 52060, that apply for the grade levels served by the charter school.

(C) The method by which pupil progress in meeting those pupil outcomes is to be measured. To the extent practicable, the method for measuring pupil outcomes for state priorities shall be consistent with the way information is reported on a school accountability report card.

(D) The location of each charter school facility that the petitioner proposes to operate.

(E) The governance structure of the charter school, including, but not limited to, the process to be followed by the charter school to ensure parental involvement.

(F) The qualifications to be met by individuals to be employed by the charter school.

(G) The procedures that the charter school will follow to ensure the health and safety of pupils and staff. These procedures shall require all of the following:

(i) That each employee of the charter school furnish the charter school with a criminal record summary as described in Section 44237.

(ii) ~~The~~ *For all schools, the* development of a school safety plan, which shall include the safety topics listed in subparagraphs (A) to ~~(K),~~ *(J),* inclusive, of paragraph (2) of subdivision (a) of Section 32282. *For schools serving pupils in any of grades 7 to 12, inclusive, the development of a school safety plan shall also include the safety topic listed in subparagraph (K) of paragraph (2) of subdivision (a) of Section 32282.*

(iii) That the school safety plan be reviewed and updated by March 1 of every year by the charter school.

(H) The means by which the charter school will achieve a balance of racial and ethnic pupils, special education pupils, and English learner pupils, including redesignated fluent English proficient pupils as defined by the evaluation rubrics in Section 52064.5, that is reflective of the general population residing within

the territorial jurisdiction of the county board of education to which the charter petition is submitted. Upon renewal, for a charter school not deemed to be a local educational agency for purposes of special education pursuant to Section 47641, the chartering authority may consider the effect of school placements made by the chartering authority in providing a free and appropriate public education as required by the federal Individuals with Disabilities Education Act (Public Law 101-476), on the balance of pupils with disabilities at the charter school.

(I) The manner in which annual, independent financial audits shall be conducted, in accordance with regulations established by the state board, and the manner in which audit exceptions and deficiencies shall be resolved.

(J) The procedures by which pupils can be suspended or expelled from the charter school for disciplinary reasons or otherwise involuntarily removed from the charter school for any reason. These procedures, at a minimum, shall include an explanation of how the charter school will comply with federal and state constitutional procedural and substantive due process requirements that is consistent with all of the following:

(i) For suspensions of fewer than 10 days, provide oral or written notice of the charges against the pupil and, if the pupil denies the charges, an explanation of the evidence that supports the charges and an opportunity for the pupil to present the pupil's side of the story.

(ii) For suspensions of 10 days or more and all other expulsions for disciplinary reasons, both of the following:

(I) Provide timely, written notice of the charges against the pupil and an explanation of the pupil's basic rights.

(II) Provide a hearing adjudicated by a neutral officer within a reasonable number of days at which the pupil has a fair opportunity to present testimony, evidence, and witnesses and confront and cross-examine adverse witnesses, and at which the pupil has the right to bring legal counsel or an advocate.

(iii) Contain a clear statement that no pupil shall be involuntarily removed by the charter school for any reason unless the parent or guardian of the pupil has been provided written notice of intent to remove the pupil no less than five schooldays before the effective date of the action. The written notice shall be in the native language of the pupil or the pupil's parent or guardian, or, if the pupil is a

homeless child or youth, or a foster child or youth, in the native language of the homeless or foster child's educational rights holder. In the case of a foster child or youth, the written notice shall also be provided to the foster child's attorney and county social worker. If the pupil is an Indian child, as defined in Section 224.1 of the Welfare and Institutions Code, the written notice shall also be provided to the Indian child's tribal social worker and, if applicable, county social worker. The written notice shall inform the pupil, the pupil's parent or guardian, the homeless child's educational rights holder, the foster child's educational rights holder, attorney, and county social worker, or the Indian child's tribal social worker and, if applicable, county social worker of the right to initiate the procedures specified in clause (ii) before the effective date of the action. If the pupil's parent or guardian, the homeless child's educational rights holder, the foster child's educational rights holder, attorney, or county social worker, or the Indian child's tribal social worker or, if applicable, county social worker initiates the procedures specified in clause (ii), the pupil shall remain enrolled and shall not be removed until the charter school issues a final decision. For purposes of this clause, "involuntarily removed" includes disenrolled, dismissed, transferred, or terminated, but does not include suspensions specified in clauses (i) and (ii).

(iv) A foster child's educational rights holder, attorney, and county social worker and an Indian child's tribal social worker and, if applicable, county social worker shall have the same rights a parent or guardian of a child has to receive a suspension notice, expulsion notice, manifestation determination notice, involuntary transfer notice, and other documents and related information.

(K) The manner by which staff members of the charter school will be covered by the State Teachers' Retirement System, the Public Employees' Retirement System, or federal social security.

(L) The procedures to be followed by the charter school and the county board of education to resolve disputes relating to provisions of the charter.

(M) Admission policy and procedures, consistent with subdivision (e).

(N) The public school attendance alternatives for pupils residing within the county who choose not to attend the charter school.

(O) The rights of an employee of the county office of education, upon leaving the employment of the county office of education, to be employed by the charter school, and any rights of return to the county office of education that an employee may have upon leaving the employment of the charter school.

(P) The procedures to be used if the charter school closes. The procedures shall ensure a final audit of the charter school to determine the disposition of all assets and liabilities of the charter school, including plans for disposing of any net assets and for the maintenance and transfer of public records.

(6) A declaration of whether or not the charter school shall be deemed the exclusive public school employer of the employees of the charter school for purposes of the Educational Employment Relations Act (Chapter 10.7 (commencing with Section 3540) of Division 4 of Title 1 of the Government Code).

(7) Any other basis that the county board of education finds justifies the denial of the petition.

(c) A county board of education that approves a petition for the operation of a countywide charter may, as a condition of charter approval, enter into an agreement with a third party, at the expense of the charter school, to oversee, monitor, and report to the county board of education on the operations of the charter school. The county board of education may prescribe the aspects of the charter school's operations to be monitored by the third party and may prescribe appropriate requirements regarding the reporting of information concerning the operations of the charter school to the county board of education.

(d) (1) Charter schools shall meet all statewide standards and conduct the pupil assessments required pursuant to Section 60605 and any other statewide standards authorized in statute or pupil assessments applicable to pupils in noncharter public schools.

(2) Charter schools shall on a regular basis consult with their parents and teachers regarding the charter school's educational programs.

(e) (1) In addition to any other requirement imposed under this part, a charter school shall be nonsectarian in its programs, admission policies, employment practices, and all other operations, shall not charge tuition, and shall not discriminate against any pupil on the basis of ethnicity, national origin, gender, gender identity, gender expression, or disability. Except as provided in

paragraph (2), admission to a charter school shall not be determined according to the place of residence of the pupil, or of the pupil's parent or guardian, within this state.

(2) (A) A charter school shall admit all pupils who wish to attend the charter school.

(B) If the number of pupils who wish to attend the charter school exceeds the charter school's capacity, attendance, except for existing pupils of the charter school, shall be determined by a public random drawing. Preference shall be extended to pupils currently attending the charter school and pupils who reside in the county except as provided for in Section 47614.5. Preferences, including, but not limited to, siblings of pupils admitted or attending the charter school and children of the charter school's teachers, staff, and founders identified in the initial charter, may also be permitted by the chartering authority on an individual charter school basis. Priority order for any preference shall be determined in the charter petition in accordance with all of the following:

(i) Each type of preference shall be approved by the chartering authority at a public hearing.

(ii) Preferences shall be consistent with federal law, the California Constitution, and Section 200.

(iii) Preferences shall not result in limiting enrollment access for pupils with disabilities, academically low-achieving pupils, English learners, neglected or delinquent pupils, homeless pupils, or pupils who are economically disadvantaged, as determined by eligibility for any free or reduced-price meal program, foster youth, or pupils based on nationality, race, ethnicity, or sexual orientation.

(iv) In accordance with Section 49011, preferences shall not require mandatory parental volunteer hours as a criterion for admission or continued enrollment.

(C) In the event of a drawing, the county board of education shall make reasonable efforts to accommodate the growth of the charter school and in no event shall take any action to impede the charter school from expanding enrollment to meet pupil demand.

(3) If a pupil is expelled or leaves the charter school without graduating or completing the school year for any reason, the charter school shall notify the superintendent of the school district of the pupil's last known address within 30 days and shall, upon request, provide that school district with a copy of the cumulative record

of the pupil, including report cards or a transcript of grades, and health information. If the pupil is subsequently expelled or leaves the school district without graduating or completing the school year for any reason, the school district shall provide this information to the charter school within 30 days if the charter school demonstrates that the pupil had been enrolled in the charter school. This paragraph applies only to pupils subject to compulsory full-time education pursuant to Section 48200.

(4) (A) A charter school shall not discourage a pupil from enrolling or seeking to enroll in the charter school for any reason, including, but not limited to, academic performance of the pupil or because the pupil exhibits any of the characteristics described in clause (iii) of subparagraph (B) of paragraph (2).

(B) A charter school shall not request a pupil's records or require a parent, guardian, or pupil to submit the pupil's records to the charter school before enrollment.

(C) A charter school shall not encourage a pupil currently attending the charter school to disenroll from the charter school or transfer to another school for any reason, including, but not limited to, academic performance of the pupil or because the pupil exhibits any of the characteristics described in clause (iii) of subparagraph (B) of paragraph (2). This subparagraph shall not apply to actions taken by a charter school pursuant to the procedures described in subparagraph (J) of paragraph (5) of subdivision (b).

(D) The department shall develop a notice of the requirements of this paragraph. This notice shall be posted on a charter school's internet website. A charter school shall provide a parent or guardian, or a pupil if the pupil is 18 years of age or older, a copy of this notice at all of the following times:

(i) When a parent, guardian, or pupil inquires about enrollment.

(ii) Before conducting an enrollment lottery.

(iii) Before disenrollment of a pupil.

(E) (i) A person who suspects that a charter school has violated this paragraph may file a complaint with the chartering authority.

(ii) The department shall develop a template to be used for filing complaints pursuant to clause (i).

(5) Notwithstanding any other law, a charter school in operation as of July 1, 2019, that operates in partnership with the California National Guard may dismiss a pupil from the charter school for

failing to maintain the minimum standards of conduct required by the Military Department.

(f) The county board of education shall not require an employee of the county or a school district to be employed in a charter school.

(g) The county board of education shall not require a pupil enrolled in a county program to attend a charter school.

(h) The county board of education shall require that the petitioner or petitioners provide information regarding the proposed operation and potential effects of the charter school, including, but not limited to, the facilities to be used by the charter school, the manner in which administrative services of the charter school are to be provided, and potential civil liability effects, if any, upon the charter school, any school district where the charter school may operate, and upon the county board of education. The petitioner or petitioners shall also be required to provide financial statements that include a proposed first-year operational budget, including startup costs, and cashflow and financial projections for the first three years of operation. If the charter school is to be operated by, or as, a nonprofit public benefit corporation, the petitioner shall provide the names and relevant qualifications of all persons whom the petitioner nominates to serve on the governing body of the charter school.

(i) In reviewing petitions for the establishment of charter schools within the county, the county board of education shall give preference to petitions that demonstrate the capability to provide comprehensive learning experiences to pupils identified by the petitioner or petitioners as academically low achieving pursuant to the standards established by the department under Section 54032, as that section read before July 19, 2006.

(j) Upon the approval of the petition by the county board of education, the petitioner or petitioners shall provide written notice of that approval, including a copy of the petition, to the school districts within the county, the Superintendent, and the state board.

(k) If a county board of education denies a petition, the petitioner shall not elect to submit the petition for the establishment of the charter school to the state board.

(*l*) (1) Teachers in charter schools shall be required to hold the Commission on Teacher Credentialing certificate, permit, or other document required for the teacher's certificated assignment. These documents shall be maintained on file at the charter school and

shall be subject to periodic inspection by the chartering authority. A governing body of a direct-funded charter school may use local assignment options authorized in statute and regulations for the purpose of legally assigning certificated teachers, in accordance with all of the requirements of the applicable statutes or regulations in the same manner as a governing board of a school district. A charter school shall have authority to request an emergency permit or a waiver from the Commission on Teacher Credentialing for individuals in the same manner as a school district.

(2) The Commission on Teacher Credentialing shall include in the bulletins it issues pursuant to subdivision (k) of Section 44237 to provide notification to local educational agencies of any adverse actions taken against the holders of any commission documents, notice of any adverse actions taken against teachers employed by charter schools. The Commission on Teacher Credentialing shall make this bulletin available to all chartering authorities and charter schools in the same manner in which it is made available to local educational agencies.

(m) A charter school shall transmit a copy of its annual, independent, financial audit report for the preceding fiscal year, as described in subparagraph (I) of paragraph (5) of subdivision (b), to the county office of education, the Controller, and the department by December 15 of each year. This subdivision does not apply if the audit of the charter school is encompassed in the audit of the chartering authority pursuant to Section 41020.

(n) A charter school may encourage parental involvement but shall notify the parents and guardians of applicant pupils and currently enrolled pupils that parental involvement is not a requirement for acceptance to, or continued enrollment at, the charter school.

(o) The requirements of this section shall not be waived by the state board pursuant to Section 33050 or any other law.

SEC. 5. Section 49414.4 is added to the Education Code, to read:

49414.4. (a) It is the intent of the Legislature that, as part of a restorative justice framework, a school use alternatives to a referral of a pupil to a law enforcement agency in response to an incident involving the pupil's misuse of an opioid, to the extent not in conflict with any other law requiring that referral.

(b) It is further the intent of the Legislature that the Multi-Tiered System of Supports, which includes restorative justice practices, trauma-informed practices, social and emotional learning, and schoolwide positive behavior interventions and support, may be used to achieve the alternatives described in subdivision (a), in order to help pupils gain critical social and emotional skills, receive support to help transform trauma-related responses, understand the impact of their actions, and develop meaningful methods for repairing harm to the school community.

SEC. 6. Section 49428.16 is added to the Education Code, to read:

49428.16. (a) It is the intent of the Legislature to assist local educational agencies in developing strategies for preventing pupil opioid overdoses, including synthetic opioids.

(b) (1) The State Department of Education, in collaboration with the California Health and Human Services Agency, shall establish the State Working Group on Fentanyl Education in Schools. The purpose of the working group shall be the promotion of public education, awareness, and prevention of fentanyl overdoses, with the outreach aimed at staff and pupils in schools.

(2) The Legislature encourages county offices of education to establish their own respective County Working Group on Fentanyl Education in Schools, in accordance with the purpose and outreach described in paragraph (1). The County Working Group on Fentanyl Education in Schools shall include, but is not limited to, representatives of local educational agencies within the county and the county public health department.

(c) (1) The State Working Group on Fentanyl Education in Schools shall collaborate with relevant entities, ~~including,~~ *which may include,* but not *be* limited to, ~~all of~~ the following, to develop a School Resource Guide on Opioids, serving as a toolkit that may be accessed by school staff:

(A) The California Society of Addiction Medicine.

(B) The Emergency Medical Services Authority.

(C) The California School Nurses Organization.

(D) The California Medical Association.

(E) The American Academy of Pediatrics.

(F) The California AfterSchool Network.

(2) The guide shall include, but not be limited to, all of the following information:

(A) Resource information on an entity's application process for the statewide standing order issued by the State Public Health Officer pursuant to Section 1714.22 of the Civil Code, and resource information on an entity's participation in the Naloxone Distribution Project administered by the State Department of Health Care Services.

(B) Resource information on the provision of emergency naloxone hydrochloride or another opioid antagonist, as described in Section 49414.3.

(3) The guide shall be completed and provided to the State Department of Education on or before July 1, 2024.

~~(3)~~

(4) The State Department of Education shall ~~distribute~~ *make* the guide *available* to all local educational ~~agencies.~~ *agencies by posting the guide on the State Department of Education's internet website.* Each local educational agency shall ~~distribute~~ *make* the guide *available* to its school ~~campuses,~~ *campuses by posting the guide on the local educational agency's internet website,* making sure that the guide is available to school staff.

(d) (1) The State Department of Education and the California Health and Human Services Agency shall collaborate to develop informational materials containing safety advice, for pupils and parents or guardians of pupils, on how to prevent an opioid overdose. The ~~department~~ *State Department of Education* shall ~~distribute~~ *make* the informational materials *available* to all local educational ~~agencies.~~ *agencies by posting the guide on the State Department of Education's internet website.* Each local educational agency shall ~~distribute~~ *make* the informational materials *available* to its school ~~campuses.~~ *campuses by posting the guide on the local educational agency's internet website.*

(2) A school of a local educational agency shall *annually* notify pupils and parents or guardians of pupils of the informational materials described in paragraph (1), in accordance with the ~~methodology and frequency~~ requirements described in *subdivision (a) of* Section ~~49428.~~ *48980.*

(e) For purposes of this section, the following definitions apply:

(1) "Local educational agency" ~~has the same meaning as set forth in Section 49428.15.~~ *means a county office of education, school district, state special school, or charter school that serves pupils in any of grades 7 to 12, inclusive.*

(2) "Opioid antagonist" ~~has the same meaning as set forth in Section 49414.3.~~ *means naloxone hydrochloride or another drug approved by the federal Food and Drug Administration that, when administered, negates or neutralizes in whole or in part the pharmacological effects of an opioid in the body, and has been approved for the treatment of an opioid overdose.*

(f) Any provision of this section shall be implemented only to the extent that an appropriation is made in the annual Budget Act or another statute for the respective purpose of the provision.

SEC. 7. 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.

O

GOVERNOR NEWSOM'S TRANSFORMATION OF BEHAVIORAL HEALTH SERVICES

Housing with Accountability. Reform with Results.

- Major effort to pass a bond for 10,000 new clinic placements and homes.
- First reform in nearly two decades since voters passed the Mental Health Services Act in 2004.
- Focus on housing with accountability for people with mental health needs, including veterans and unhoused people.

Together with the Legislature, local officials, labor leaders, community organizations, and more, Governor Gavin Newsom is proposing a major transformation of the State's behavioral health care system – making good on decades-old promises. This effort will **build 10,000 new beds with $4.68 billion funded by a bond on the March 2024 ballot** to provide the resources needed to care and house those with the most severe mental health needs and substance use disorders.

The package focuses on **five solutions** to transform California's behavioral health system through **housing with accountability and reform with results:**

1. Reforming the Mental Health Services Act to provide services to the most seriously ill and to treat substance use disorders
2. Building a workforce to reflect and connect with California's diversity
3. Focusing on outcomes, accountability, and equity
4. Housing and behavioral health treatment in unlocked, community-based settings
5. Housing for veterans with behavioral health challenges

LEGISLATIVE PACKAGE

- **SB 326: REFORM –** After nearly 20 years, this bill would **modernize and reform the Mental Health Services Act (MHSA),** which was passed as Proposition 63 by voters in 2004. This legislation would expand services to include treatment for those with substance use disorders – in addition to care for the most seriously mentally ill – provides more resources for housing and workforce, and continues community support for prevention, early intervention, and innovative pilot programs – all with new and increased accountability for outcomes and through an equity lens.

- **AB 531: BUILD – A $4.68 billion general obligation bond** to build 10,000 new clinic beds and homes that would be on the March 2024 ballot. This would be the single largest expansion of California's continuum of behavioral health treatment and residential settings. It will create new, dedicated housing for people experiencing homelessness who have behavioral health needs, with a dedicated investment to serve veterans, allowing Californians experiencing behavioral health conditions to have a place to stay while safely stabilizing and healing.

Combined, these two bills will build out the State's capacity to provide behavioral health care and housing with **strengthened accountability for results**, while creating good jobs. These reforms will complement and build upon Governor Newsom's Behavioral Health Expansion and Reform efforts to provide care - from prevention and early intervention to outpatient, crisis, inpatient, and supportive care and supplements the work currently underway with the implementation of CARE Court.

The behavioral health legislative package will go to the **voters for approval in March 2024**, after consideration and approval by Legislature and Governor Newsom's signature in 2023.

SB 326: REFORM

REFORMING BEHAVIORAL HEALTH CARE FUNDING TO PROVIDE SERVICES TO THE MOST SERIOUSLY ILL AND TO TREAT SUBSTANCE USE DISORDERS.

- Expands services to include treatment for substance use disorders (SUDs) alone and allows counties to use funds in combination with federal funds to expand SUD services. Because of this expansion to cover SUD, the bill updates the name of the MHSA to the Behavioral Health Services Act (BHSA).
- Recognizes the need for housing to address a variety of serious behavioral health disorders.
- Modernizes county allocations **(92%)** to require the following priorities and encourage innovation in each area:
    - 30% for Housing Interventions for children and families, youth, adults, and older adults living with serious mental illness/serious emotional disturbance (SMI/SED) and/or SUD who are experiencing homelessness or are at risk of homelessness.
        - Authorizes housing interventions to include rental subsidies, operating subsidies, shared housing, family housing for children and youth who meet criteria, and the non-federal share for certain transitional rent.

        - Half of this amount (50%) is prioritized for housing interventions for the chronically homeless. Up to 25% may be used for capital development.
    - 35% for Full Service Partnership (FSP) programs, which are the most effective model of comprehensive and intensive care for people at any age with the most complex needs. These funds will be used to expand the number of FSP slots available across the state and are key to CARE Court being successfully implemented.
    - 30% for Behavioral Health Services and Supports, including early intervention, workforce education and training, capital facilities and technological needs, and innovative pilots and projects, to strengthen the range of services individuals, families, and communities need. A majority of this amount must be used for Early Intervention.
    - 5% for Prevention through population-based programming on behavioral health and wellness. For example, in school-linked settings, this prevention funding must focus on school-wide or classroom-based mental health and substance use disorder programs, not individual services.
- Creates a **new total state-directed funding (3%)** to workforce investments, leveraging existing federal funding, and benefitting the entire state system.
- Continues the **funding for state implementation (5%)** of the policy, including development of statewide outcomes, oversight of county outcomes, training and technical assistance to counties, research and evaluation, and policy administration.

EXPANDS THE BEHAVIORAL HEALTH WORKFORCE TO REFLECT AND CONNECT WITH CALIFORNIA'S DIVERSE POPULATION.

The proposal recognizes and supports the critical need to expand a culturally-competent and well-trained behavioral health workforce to address behavioral health capacity shortages and expand access to services.

- Provides up to 3% of annual BHSA funds for the California Health and Human Services Agency (CHHS) to implement a statewide behavioral health workforce initiative, including leveraging federal dollars through a workforce initiative under BH-CONNECT; a proposed Medicaid demonstration waiver that will draw down significant additional federal matching dollars for this purpose.
- Authorizes counties to also fund additional, local workforce initiatives using resources from their local BHSA allocation prioritized for Behavioral Health Services and Supports.

FOCUSING ON OUTCOMES, ACCOUNTABILITY, AND EQUITY.

OUTCOMES: The proposal replaces the existing plan with a new <u>County Integrated Plan for Behavioral Health Services and Outcomes</u>, including all local behavioral health funding and services.

- Requires counties to demonstrate coordinated behavioral health planning using all services and sources of behavioral health funding (e.g., BHSA, opioid settlement funds, realignment funding, federal financial participation), in order to provide increased transparency and stakeholder engagement on all local services.
- Requires stratified local data analysis to identify behavioral health disparities and consider approaches to eliminate those disparities.
- Requires the Department of Health Care Services (DHCS) to work with counties and stakeholders to establish outcome metrics for state and county behavioral health services and programs.

ACCOUNTABILITY: The proposal establishes a new, annual <u>County Behavioral Health Outcomes, Accountability, and Transparency Report</u> to provide public visibility into county results, disparities, spending, and longitudinal impact on homelessness.

- Requires counties to report annual service utilization data and expenditures of state and federal behavioral health funds, unspent dollars, and other information. Authorizes DHCS to impose corrective action plans on counties that fail to meet the requirements established by this section.
- Authorizes up to 2% of local BHSA revenue to be used for local 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, on top of the existing 5% county administrative costs.
- Reduces authorized local prudent reserve amounts in the BHSA to allow for needed investments while still saving for an economic downturn.

EQUITY: The proposal connects the Behavioral Health System statewide for all Californians.

- For those with Medi-Cal health insurance: Authorizes DHCS to align the terms of the county behavioral health plan contracts regarding administration, infrastructure, and organization with Medi-Cal managed care plan contracts.
- For those with commercial health insurance: Directs the Department of Managed Health Care (DMHC) and DHCS to develop a plan with stakeholder engagement for achieving parity between commercial and Medi-Cal mental health and substance use disorder benefit. This may include, but is not limited to, phasing in alignment of utilization management, benefit standardization, and covered services.

AB 531: HOUSING

HOUSING AND BEHAVIORAL HEALTH TREATMENT IN COMMUNITY-BASED UNLOCKED SETTINGS.

The proposal places a General Obligation Bond on the March 2024 ballot for construction of unlocked community-based behavioral health treatment & residential care settings.

- A recent RAND study indicates the state has a shortage of at least 6,000 behavioral health beds. This lack of sufficient capacity leads not only to unnecessary long lengths of stays in locked settings and hospitals, but contributes to the growing crisis of homelessness and incarceration among those with severe mental illness and substance use disorders.
- To address this long-standing challenge, the Governor is proposing to use a general obligation bond to build up settings that will help ensure those with the greatest needs have access to high quality, unlocked, community-based residential care, including "step-down" community-based facilities, where people can reside short-term after a behavioral health crisis hospitalization and then transition to lower levels of care that can better support long-term success.
- Bond funding would be used to construct, acquire, and rehabilitate unlocked, voluntary, community-based residential care settings for individuals with behavioral health needs, increasing the availability of care settings that support rehabilitation and recovery.
- Among Californians experiencing homelessness, nearly 40,000 have a severe mental illness and over 36,000 have a chronic substance use disorder.

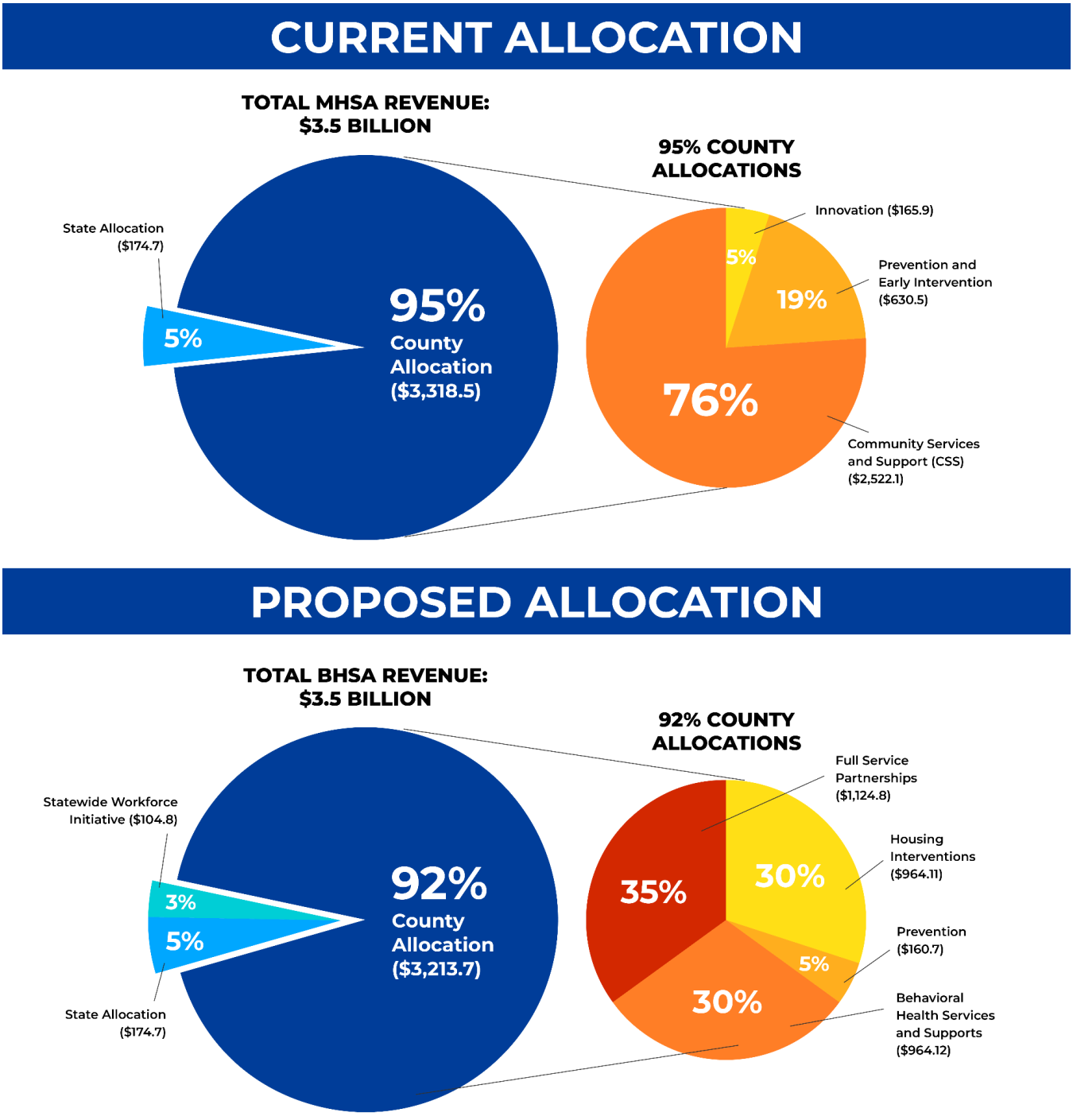
HOUSING FOR VETERANS WITH BEHAVIORAL HEALTH CHALLENGES.

The proposal dedicates a portion of the bond to housing for veterans at risk of, or experiencing, homelessness with behavioral health needs.

- Upwards of 50% or more of homeless veterans suffer from mental health issues and upwards of 70% or more are affected by SUD.
- Bond funding would be disbursed as grants for new construction, acquisition, rehabilitation, or preservation of affordable multifamily housing to provide interim, transitional, and permanent supportive housing for veterans who are homeless, or at risk of homelessness, and living with behavioral health challenges.

Figure 1. Comparison of Existing MHSA Allocations and Proposed BHSA Allocations

(Dollars in Millions)



Mental Health Services
Oversight & Accountability Commission

July 25, 2023

Governor Newsom's Behavioral Health Modernization Proposal

Introduction

California's mental health system is among the most comprehensive and outcome-driven in the nation, yet it falls short of public expectations. The challenges of our mental health system drive feelings of hopelessness for the clients and families seeking services and deep frustration among the public who witness its outcomes and taxpayers who fund public programs.

The challenges are many:

- Increasing numbers of unhoused residents – many with unmet mental health and substance use needs.
- Gaps in access to care, particularly for Californians in the early stages of psychosis or other mental health and substance use needs.
- Over-reliance on law enforcement to respond to mental health needs.
- Large and ongoing annual increases in spending on institutional care, particularly for justice involved individuals.
- Persistent and pernicious disparities that expand the health, economic and life expectancy gaps that adversely impact California's communities of color, LGBTQ+, and others.

These and other challenges have prompted Governor Newsom to propose reforms to California's landmark Mental Health Services Act and to propose broad reaching reforms to California's behavioral health system, which encompasses mental health and substance use disorder (SUD) needs.

The Governor's Behavioral Health Modernization Proposal has several components. This analysis focuses on the reforms proposed in Senate Bill 326 (Eggman), which does the following:

- Renames the Mental Health Services Act (MHSA) to the Behavioral Health Services Act (BHSA) and clarifies that BHSA funding can be used to support substance use disorder services in addition to traditional mental health care.

- Modifies how BHSA funding can be used by counties, with the following funding allocations:

    - Thirty percent for housing interventions for children and adults with serious mental health needs, including substance use disorders. Existing fiscal rules allow but do not require funding for housing interventions.

    - Thirty-five percent for Full-Service Partnerships (FSPs) which provide a range of recovery-oriented services targeted to individuals with severe and persistent mental health needs who are unhoused, at risk of becoming unhoused, justice involved or hospitalized. Under current MHSA requirements, a minimum 38 percent of MHSA funds must be dedicated to FSPs, with the option to spend more.

    - Thirty percent for Behavioral Health Services and Supports, which include non-FSP services, Early Intervention, Capital Facilities and Technological Needs, Workforce Education and Training, innovative, and funding to support a prudent reserve. A majority of these funds – a minimum of 15 percent of total funding - must be spent on early intervention strategies. Under current law 19 percent of MHSA must be used for prevention or early intervention.

    - Five percent for Population-Based Prevention for mental health and substance use disorder prevention programming. As noted above, under current law 19 percent of MHSA funding must be spent on prevention and early intervention with counties having the authority to determine how those funds are distributed between prevention and early intervention.

- Proposes a more comprehensive community planning process to reflect all public behavioral health spending and the development of an Integrated Plan for Behavioral Health Services and Outcomes that reflects uses of the newly renamed BHSA funding, as well as other funding.

- Enhances county reporting of behavioral health spending, regardless of source of funding.

- Enhances county reporting on mental health and substance use outcomes.

- Sets aside three percent of total revenues to support state-directed initiatives to expand California's behavioral health workforce. Under existing MHSA rules, counties have the option to use their MHSA funds to support workforce, education, and training programs as part of their three-year MHSA expenditure plan, but there is no specific funding set aside for that purpose. The Governor's proposal would shift three percent of total funds from counties to the state for workforce purposes.

- Reforms to the MHSA are intended to be integrated with a range of related initiatives designed to draw down more federal funding for mental health and substance use disorder services, improve crisis response and enhance prevention and early intervention strategies.

  The Governor also is proposing a $4.7 billion bond to build more behavioral health treatment settings, including residential programs, and to build an estimated 1,800 supportive housing units and 1,800 interim, transitional, and supportive housing units for veterans.

  These reforms would be subject to voter approval through a ballot measure scheduled for a public vote in March 2024.

Issues for Consideration

The Governor's Behavioral Health reform proposal is aligned with the Commission's work in several areas, and it creates opportunities the Commission may wish to consider that would strengthen the proposal.

1. Recognizing Complexity – Reserve the Ability to Modify Provisions Over Time

Background. The Governor's proposed reforms are complex and will take considerable time to implement, particularly as reforms established through the ballot interact with new waivers under Medicaid, other statutory changes, and new operational approaches.

Concerns. The proposed reforms will have unintended consequences and unanticipated challenges. The Commission may wish to encourage the Governor and Legislature to:

- Use the ballot only for those reforms that require a public vote, and

- Affirm the ability of the Governor and Legislature to modify the language adopted at the ballot on an as needed basis without returning to the ballot.

The initial MHSA includes a provision allowing legislative modifications consistent with the Act. That provision is in place because the MHSA was established as an initiative measure, not a legislative ballot measure. The proposed reforms are being put on the ballot by the Legislature. The Commission may wish to encourage the Governor and Legislature to retain reform authority for ballot language, even when reforms are not consistent with the initial intent of the ballot, ensuring their ability to act when additional reforms are needed.

2. Substance Use Disorder – Enhancing Access to Services

Background. The Governor's proposal is intended to improve the integration of mental health and substance use disorder services, consistent with the concept of behavioral health. The proposal would clarify that BHSA funding can be used to support SUD services and

require counties to include substance use disorder services in their three-year comprehensive planning. Substance use disorders are mental health disorders but California's mental health system has not integrated SUD services into mental health care. Recognizing that SUD needs are mental health needs, the Commission has sponsored and supported legislation to clarify that MHSA funding can be used to support SUD needs, including for prevention and early intervention. While substance use disorder services are included under established definitions of mental health needs, the Governor's proposal would clarify that funding established under the BHSA can be used for the full range of SUD services and calls for more integrated planning and service delivery.

Concerns. The state and local behavioral health partners have struggled to fully integrate mental health and substance use services. While the proposal would clarify that BHSA funds could be used to support SUD services, and the reform proposal requires integrated planning, the proposal is unclear on how it would improve the integration of mental health care with substance use programs at the local level. The State is working through a range of initiatives, including administrative integration under the California Advancing and Innovating Medi-Cal (CalAIM) initiative, yet it is not clear that community providers are positioned to integrate services and the reform proposal does not include an implementation plan to ensure that care delivery is integrated in alignment with the proposed policy changes.

Mental health advocates have suggested that the proposed reforms would place greater demands on limited mental health funding, with existing dollars being newly tasked to address workforce and housing needs related to substance use disorders where there is no co-occurring mental health need. It is unclear if the proposal envisions the integration of current SUD funding along with BHSA funding, which could result in improved efficiencies through stronger care integration.

While the proposal calls for robust community engagement, planning, transparency and accountability at the local level, the Commission may wish to explore whether statutory reforms authorizing expanded use of BHSA funding for SUD services will be accompanied by a robust community engagement and strategic planning process at the state level to promote the full integration of mental health and SUD services over time, including fiscal, workforce, licensing, technical assistance, data collection, research, oversight, and outcome reporting.

The behavioral health integration vision of the proposal is consistent with the Commission's priorities and the Commission may wish to encourage a robust state-level planning process – with substantial technical assistance and support for mandatory local integrated planning efforts – and offer to support those efforts.

3. Full Service Partnerships– Increasing Emphasis

Background. Full-Service Partnerships (FSP) were initially designed to support mental health clients who were served in state hospitals under civil commitments. The "whatever it takes" approach that characterizes FSPs has been demonstrated to be an effective model for

reducing homelessness, justice involvement and hospitalizations. The MHSA currently requires 76 percent of MHSA funding to be dedicated to Community Services and Supports, with state regulations requiring a "majority" of those funds, or a minimum of 38 percent of overall MHSA funding, to support Full-Service Partnerships.

The Governor's proposal requires counties to dedicate 35 percent of ongoing BHSA revenues for FSPs, which amounts to a minimum three percent reduction in FSP investments. As outlined in the box below, almost all counties fall short of meeting the majority threshold for FSP investments today. As a result, for some counties, the new spending rules would result in additional investments in FSPs, for others it may result in lower FSP spending.*

The Commission has sponsored legislation to strengthen state attention on the operations and impact that FSPs have on state-level outcomes, namely homelessness among persons with serious and persistent mental health needs, justice involvement and hospitalizations.

State hospitalization trends are of particular concern, as the state has seen dramatic increases in the clients served and state spending on programs for persons deemed Incompetent to Stand Trail (IST). In Fiscal Year (FY) 2017-18, there were 1,827 persons deemed incompetent to stand trial; it is estimated that in FY 2023-24, there will be 4,298. Generally, persons deemed IST with felony charges are directed to state hospitals for competency restoration before their felony charges are pursued through the judicial system. Research from the Department of State Hospitals indicates that nearly half of mental health clients have an average of 16 arrests before the felony charge that led to their placement in a state hospital. The Department also reports that fewer than half of those clients received community based mental health care in the six months prior to their state hospital placement.

The Commission's work to fortify Full Service Programs began with the state's $5 million investment in an Innovation Incubator, that focused on reducing Justice involvement, and

*As outlined in the Commission's 2023 report on Full-Service Partnerships, in 2012 the then Department of Mental Health issued an Information Notice allowing counties to reduce their MHSA allocation for FSPs as long as they met the "majority" funding threshold with other sources of funding, namely federal Medicaid reimbursements. The Information Notice stated that the exemption from the minimum funding standard applies only to the 2011/12 Fiscal Year. In 2021 the Commission notified the Department of Health Care Services that counties were not meeting minimum funding thresholds as required by state regulations. The counties countered that the exemption in the Information Notice remained in effect because the Department of Health Care Services never issued a subsequent Information Notice ending the exemption, despite the clear language in the original Notice. Additionally, counties have expressed confusion over whether the "majority" threshold reflects a majority of revenues or expenditures, which can vary widely in some counties.

reducing state hospital utilization and costs. Nine counties participated in that work and the Commission continues its work to strengthen FSPs in partnership with diverse counties.

Concerns. While the Governor's proposal elevates the significance of FSPs, the fiscal set-aside for these programs will be reduced in some counties. Additionally, although the reform proposal calls for the Department of Health Care Services to ensure a minimum set of standards for FSP programs, the Department has not consistently enforced mandatory minimum spending requirements or developed the technical assistance and training capacity to support local FSP providers. The Commission has alerted the Department to deficiencies in county spending on FSPs, without substantive response. It is unclear how the Department intends to enforce both spending and service requirements for FSPs under the Governor's proposed reforms.

Given the extraordinary investment the state is making in Full Service Partnerships, which would be approximately $1-$2 billion annually under current MHSA revenue projections, the Commission may wish to explore with the Governor and Legislature whether the state should invest in sustained technical assistance, training, return on investment analyses, and related evaluations to ensure that the mandatory investments in FSPs have the desired results. Increased state attention on the operations and impact of Full Service Partnerships should be intended to result in improved client outcomes, reductions in homelessness, incarceration, and hospitalizations, with the long-term goal of reducing state and local costs in these arenas. The most ambitious goals for FSP programs are to move mental health clients into independent employment that generates sufficient income to achieve self-reliance, avoid homelessness and secure health insurance.

The Commission may wish to consider how best to fortify the Governor's proposal to strengthen the capacity of the state and local behavioral health agencies and their community partners to ensure FSPs achieve their intended outcomes: 1) reduce homelessness, 2) reduce justice involvement, and 3) reduce hospitalizations, with a secondary goal of supporting client employment.

4. Homelessness – Establishing Mandatory Spending

Background. The Governor's proposal will require counties to dedicate thirty percent of BHSA spending on homelessness, including rental subsidies, and related strategies. The MHSA currently authorizes counties to use existing revenues to address housing needs, with a specific mandate to reduce homelessness. Under the MHSA, counties have considerable discretion in how to use these funds, including supporting a range of housing strategies, particularly for, but not exclusively for, those served through FSPs.

Despite the statutory goal of preventing homelessness, county behavioral health agencies may be ill equipped to address the factors that result in mental health clients being unhoused.

A recent survey by UC San Francisco reported high housing costs, more than addiction and unmet mental health needs, as the primary driver of California's homelessness crisis: https://homelessness.ucsf.edu/sites/default/files/2023-06/CASPEH_Report_62023.pdf

Concerns. Inadequate access to mental health and SUD services, combined with frequent justice involvement clearly contributes to homelessness, while a large percentage of unhoused people say they face repeated barriers to care.
It is unclear how the Governor's proposal will result in improved interventions for unhoused persons outside of the expansion of Full-Service Partnerships or direct housing supports, and more significantly for the prevention of homelessness.

For example, the Governor's proposal includes 30 percent of MHSA revenues for Behavioral Health Supports, with a majority of those funds supporting early intervention. It is unclear if those funds would be used to support early interventions to address risks for homelessness, particularly for vulnerable populations such as youth and young adults exiting from the child welfare system.

The recent UCSF report indicates that few people experiencing homelessness are able to access prevention services before they lose their housing, and many leaving institutional settings, such as jails or prisons, should be receiving housing support as they transition out of institutional settings. It is unclear whether the funds set aside for housing can be used for prevention strategies.

Additionally, the state has not invested in understanding the link between improved access to behavioral health services and housing access and housing stability. As a result, it is unclear if establishing mandatory funding levels for housing supports will result in measurable and sustained reductions in the number of mental health clients who are unhoused. One challenge to that analysis is limited data on how counties are using MHSA funds today to support housing, and how the shift of these funds from existing programs to housing supports may undermine the success of the initiative as fewer funds are available to support the services needed to support clients to retain their housing.

It also is unclear how the new funding mandates will impact the ability of counties to sustain their long-term commitments to supportive services associated with the state's No Place Like Home (NPLH) program. In 2018, California voters passed a ballot measure authorizing the sale of $2 billion in bonds to enact a supportive housing program for mental health consumers, with MHSA revenues repaying those bonds at an annual cost of approximately $140 million.

According to the most recent NPLH Annual Report issued by the California Department of Housing and Community Development (HCD), the state has distributed approximately $1.9 billion in NPLH bond funds, has housed 523 Individuals in 498 housing units. HCD estimates that NPLH will result in 7,852 NPLH-assisted units.

It is unclear if HCD has calculated the ongoing fiscal commitment the counties have made to offer supportive services for those units when fully built and whether counties will have sufficient funding or fiscal flexibility to maintain their NPLH commitments and meet the fiscal requirements of the proposed BHSA.

It also is unclear what impact counties will face when they are required to shift 30 percent of their existing expenditures from current uses toward housing. Such a fundamental change could be disruptive to their ability to not only respond to this new mandate, but also to continue to provide the other services called for under the MHSA/BHSA. A more gradual implementation of this commitment to spending on homelessness could make it much more manageable for local communities.

The Commission may wish to consider:

- Whether the Administration has developed an operational plan to guide county use of the 30 percent housing set-aside being proposed.
- Whether the state will provide technical assistance and support to counties to ensure the best use of those funds and how anticipated reporting requirements will allow the state, counties, and service providers to understand the most cost-effective approaches to housing, resulting in long-term sustainable housing stability.
- How the state can best support homelessness prevention and early intervention strategies, such as direct cash assistance, for both transition age youth at high risk, and older adults who face similar risks for being unhoused, but also for Californians leaving institutional settings, such as hospitals, jails, and prisons.
- Whether the state is exploring the use of fiscal incentives for prevention and intervention strategies that reduce the number of unhoused persons, such as improved child welfare investments, childcare, and job training to improve income opportunities or income supports, such as universal basic income initiatives for high-risk groups.
- Whether the state is exploring enhanced access to early psychosis interventions, improved criminal justice diversion and related strategies that reduce barriers to employment – paired with greater investments in affordable housing – as a way to reduce costs and improve housing outcomes.

The Commission may wish to explore opportunities to strengthen the Governor's proposal by recommending the development of an operational strategy to ensure the proposed statutory reforms are matched with technical assistance, research, evaluation, collaborative learning opportunities and outcome reporting to support sustained success.

The Commission also may wish to explore the following approaches to easing the transition to the new housing requirements:

- Establish a baseline for MHSA/BHSA spending (not funding) beginning with the 2021-22 fiscal year and require counties to dedicate a majority of revenue growth above that spending base to address housing needs for clients with serious and persistent behavioral health needs. Based on Department of Finance estimates, this proposal would generate $1.5 billion - $3 billion in immediate funding to support housing. The state could support that investment with robust research and technical assistance on best practices and outcome reporting.

- Establish a 3-year transition approach to shift 30 percent of existing mental health funding to support housing. The first year following enactment of the BHSA, counties could be required to increase their housing investments by a minimum of 10 percent to support housing, 20 percent in the second year, with the goal of reaching the 30 percent funding level within three years – and maintain that investment until such time as the county has substantially met the housing needs of mental health clients, at which point investments could be reduced.

These two approaches would enable the state to accelerate new investments in housing while allowing counties three years to learn how to best invest limited funds to address housing needs and how to evolve their spending programs to adhere to the new fiscal requirements.

5. Early Intervention – Elevation

Background. Consistent with the comments above, the Governor's reform proposal calls for the "majority" of the 30 percent set aside for Behavioral Health Services and Supports funding to be dedicated to early intervention efforts. The Commission has been working to promote early intervention, namely for persons in the early stages of psychosis, through youth drop-in programs and through the development of robust school mental health partnerships between local education agencies and county behavioral health agencies. The Governor's proposal is consistent with the Commission's work in these areas.

Concerns. It is unclear how the establishment of new fiscal requirements will result in greater attention on early intervention strategies. Under existing fiscal rules, counties are required to invest 19 percent of MHSA funds in prevention and early intervention strategies with half of those funds supporting programs for children and youth. The state requires the counties to invest in stigma reduction activities, access to care services and care linkages programs to better connect people to services. Despite those limited requirements, fiscal rules allow counties to invest based on the priorities determined through a local community planning process, including what portion of the 19 percent is used for population or individual prevention efforts and what portion is used for early intervention. It also is important to recognize that the distinctions between prevention and early intervention are not always clear.

The Governor's reform proposal would require counties to invest a minimum of 15 percent of BHSA funds in early prevention and 5 percent in population level prevention. The reform proposal, from a fiscal perspective is substantially similar to existing law – 20 percent under the reform versus 19 percent currently.

For some counties, depending on how they are using existing funding, there may be no difference between existing uses of MHSA funding and funding uses under the proposed BHSA. Under current reporting rules, counties are not required to differentiate between prevention and early intervention spending, and as above, the distinction between those two efforts is not always clear, so we are unable to document whether the reform will result in the establishment of new funding priorities.

The behavioral health reform proposal also highlights the potential for counties to invest in best practices for early intervention for psychosis, but it does not make it a requirement. Research suggests that California has the capacity to support just 10 percent of the residents who develop psychosis within 12 months of their first psychotic episode. Despite evidence that unmet needs associated with psychosis are fueling dramatic state cost increases, the state has not consistently leveraged its available funding, including federal block grants dedicated to early psychosis and publicly funded premiums for health coverage, to promote the expansion of best practices in responding to early psychosis needs.

Through the CYBHI, the Department of Health Care Services and the Commission are partnering to release Evidence Based Practice and Community Defined Evidence Practice funding for early interventions, including for early psychosis and youth drop-in programs.

The state's investment in the allcove™ youth drop-in program is intended to improve access to care during the vulnerable "transition age" period when research suggests mental health needs are mostly likely to develop. Allcove™ youth drop-in centers may be a loss-leader, and should be considered as such. Although the programs may not be fully supported with reimbursement funding, as youth-centric programs they can address stigma, meet immediate needs, engage youth in program planning and build a foundation of understanding and trust to support access to services during the early stages of mental health needs. Currently, a limited range of allcove™ services can be billed under MediCal. The reform proposal, because of its emphasis on MediCal billing, may undermine efforts to expand the adoption of this globally recognized early intervention program – as well as others.

Although the Governor's reform proposal highlights the opportunity for early intervention, it is unclear if the administration is planning to provide guidance on which early intervention opportunities offer the greatest potential for return on investment, how best to align population-based prevention opportunities with early intervention strategies, how to develop a research, evaluation and data analysis strategy to identify new early intervention approaches that target vulnerable populations such as veterans, child welfare participants,

older adults, persons exiting from correctional institutions, state hospitals or other locked settings, or others.

The Commission may wish to explore these opportunities with the Administration, as well as whether the state is proposing to expand technical assistance and training programs, capacity-building investments, the availability of incentive funds to encourage counties to put greater emphasis on early intervention using local funds and how the state will document the impact of these policy changes. For example, the state has an opportunity to replicate the Child and Youth Behavioral Health Initiative – with its emphasis on digital strategies, improved program integration and incentive funding –yet with a focus on reducing disparities and/or adults and older adults.

The Commission may also wish to explore with the administration whether the BHSA would retain the requirement to invest a majority of early intervention funding in children and youth, as is currently required. Children's advocates have raised alarms that the proposed reforms may undermine the progress that has been made in child and youth focused initiatives, especially when recognizing that the majority of mental health needs occur early in life.

6. Prevention – A Core Behavioral Health Strategy

Background. As mentioned above, the Governor's proposal would set aside five percent of BHSA revenues for population-based prevention strategies that focus prevention efforts on an entire population or sub-population within a community. Under current law counties are required to dedicate 19 percent of their MHSA revenues for prevention and early intervention, including support for stigma reduction, outreach, and awareness. As with early intervention funds, current law does not determine how counties should allocate funding across prevention or early intervention strategies. The proposed legislation indicates that prevention funds could not be used for individual level prevention efforts, although it is unclear in the legislation what constitutes an individual prevention effort as compared to a population-level prevention effort.

Under current law, the Commission is authorized to issue regulations on the uses of prevention and early intervention funding under the MHSA and the Commission and the Department of Health Care Services each have a role in promoting effective strategies. Recognizing the Commission's authority, and building upon robust community engagement efforts, the Commission has issued Prevention and Early Intervention regulations that call for improved data reporting and monitoring of disparities and has recommended that the Department implement those reporting standards across the entire mental health system.

The Commission also has long championed stronger prevention and early intervention efforts and recently released a report on leveraging a public health model to support prevention and early intervention. The Commission has issued reports and policy recommendations on criminal justice prevention, suicide prevention, school mental health, and workplace mental

health. Each of these efforts provides a foundation, strategies, and priorities for population-based prevention strategies.

As the Governor's proposal moves prevention strategies from county-driven, local initiatives, to population-only initiatives, it is unclear how individual county investments will differ from existing efforts. The Commission may wish to explore if population-level strategies are better suited to state-level investment and leadership instead of 59 unique county-level, population-based prevention strategies.

For example, at the start of the COVID pandemic, the Department of Health Care Services and the Commission partnered to develop the CalHOPE initiative and the Wellness Together component that focuses on mental health. In the current budget year, state MHSA funds are dedicated to sustaining the CalHOPE program and the Children and Youth Behavioral Health Initiative includes funding to support an on-line mental health information and screening platform and stigma reduction efforts.

These initiatives suggest that population-level prevention opportunities may be better suited to state-level investments.

Under the Governor's reform proposal, regulatory authority over prevention and early intervention would shift from the Commission to the Department. The Legislative Analyst has raised concerns that limiting the Commission's role in this way will, in effect, undermine its independence and value.

The Commission may wish to consider ways to strengthen the Governor's proposal, including:

- Whether to encourage the state to develop a strategic approach to population-based prevention, that leverages federal, state and county investments, taps into the private sector, leverages education, workplace, and related venues, and is integrated into similar public health-informed prevention campaigns, such as smoking cessation, addiction, healthy eating, healthy sleep habits and other related health and mental health prevention initiatives.
- Whether to delay one or more components of the reform to allow time to analyze how the changes in fiscal support for prevention and early intervention will be implemented by counties, the services that will be reduced or eliminated, how population-based prevention efforts will be defined and implemented and the anticipated improved outcomes.
- How the state can best support population based prevention strategies, including the respective roles of the Department of Health Care Services, with its expertise and staff dedicated to mental health finance and oversight, and the Department of Public Health, which currently administers a range of prevention-oriented programs that target many of the communities at risk for mental health needs, and the Commission,

recognizing its independence, ability to engage diverse communities, distribute grant funds and monitor outcomes.

- Exploring the value of allowing flexibility across the proposed BHSA components, including prevention and early intervention, particularly for small and medium-sized counties, to maximize resources and meet the diverse needs of communities across the state.

7. Fiscal Rigidity – New Challenges

Background. The Governor's proposal establishes new, discrete funding allocations that call for very specific levels of funding based on percentages of revenue received. Under existing law, the MHSA has three primary funding components, Community Services and Supports, Prevention and Early Intervention, and Innovation, with the option of moving funds into components for workforce, capital needs and a prudent reserve.

Overlap between the existing MHSA components allows counties to make funding decisions based on local needs with guidance from a community planning process. Counties have considerable discretion in how existing MHSA funds are used because there is functional overlap between the three core components of the Act. For example, Prevention and Early Intervention funds can be used to provide treatment for up to four years, in some instances, including services that also can be funded with Community Services and Support dollars. While this flexibility makes it difficult to track spending in each component, it supports dynamic decision-making and allows counties to determine how to best use limited funds based on diverse and evolving needs.

Concerns. While the proposed reforms suggest the California Department of Health Care Services will have discretion to allow counties to propose alternative funding allocations in limited instances, it is unclear how the four discrete spending categories under the BHSA will work for the state's diverse counties. For example, it is unclear how California's smallest counties, which may have no FSP providers, or in the case of Alpine, do not have clients qualifying for FSP services, will be disparately impacted by these new rules. It also is unclear to what extent the Department will be able to exempt individual counties from a mandatory expenditure percentage.

To strengthen the Governor's reform proposal, the Commission may wish to explore an alternative approach that would provide counties with greater flexibility on how they use BHSA funding. The Commission may wish to explore ways to authorize the Department of Health Care Services to grant an exemption from the mandatory BHSA funding allocations. Exemptions could be limited to counties that can demonstrate that deviation from the statutory funding levels is more likely to result in improved outcomes, with an emphasis on reducing homelessness among mental health clients.

Alternatively, the Commission might explore the value of authorizing counties to spend BHSA funds across a range of percentages for each component, such as 20-30 percent for housing,

25-35 percent for Full Service Partnerships, 20-40 percent for Behavioral Health Services and Supports and 5-10 percent for Population-level Prevention.

8. Accountability – Focus

Background. The Governor's reform proposal re-establishes existing law in Welfare and Institutions Code (WIC) Sections 5610-5613, and Section 14707.5, that require the Department of Health Care Services to establish performance measures, data systems, quality improvement strategies and ensure that county mental health programs are meeting minimum standards. These reporting strategies were supposed to be developed in consultation with diverse communities, work to reduce disparities and be updated as needed. County mental health programs also are required to submit data to the state as required by the Department of Health Care Services to support public accountability (WIC § 5610).

Under current law, state agencies also are required to provide data to the Commission upon request. Under proposed reforms, state agencies would not be required to submit such data to the Commission but would have the discretion to determine whether the Commission should receive this data.

Similarly, under current law, the Commission is charged with overseeing California's children's system of care, the adult system of care, and the older adult system of care, which collectively make up the entire California public mental health system (WIC § 5845(a)). The Commission also has regulatory and oversight authority for prevention, early intervention, and innovation (WIC § 5845(a)). Moreover, the prevention and early intervention language of the MHSA calls for reducing school failure, criminal justice involvement, unemployment, suicide, child welfare involvement, homelessness, and prolonged suffering.

Those broad goals extend beyond the traditional roles of local behavioral health departments and have authorized the Commission to explore school mental health, workplace mental health, the impacts of firearm violence, criminal justice diversion, suicide prevention and other topics that are key to supporting broad individual and community wellbeing, consistent with the language of the MHSA.

The Governor's reform proposal would remove statutory references to the Commission's oversight of California's three systems of care, it would eliminate the Commission's direct role in supporting prevention and early innovation initiatives, and it would eliminate the mandate for innovation spending and thus the need for Commission review and approval of innovation projects.

Concerns. Despite clear and compelling statutory requirements, the Commission and other mental health partners have raised concerns that the Department has not assertively pursued its accountability mandate. In 2017, the Commission alerted the Department of Health Care Services that counties are not consistently reporting MHSA revenues, expenditures, and

unspent funds, were not utilizing MHSA funds under statutory deadlines, and that reversion requirements were not being enforced. A subsequent audit revealed more than $2.5 billion in unspent and unreverted MHSA funding.

While the Department has strengthened its monitoring of funding reversion requirements, it has not improved its attention to other fiscal concerns. In 2022 the Commission alerted the Department that counties are not consistently meeting expenditure requirements for Full Service Partnerships. The Department also has failed to enforce county spending rules that require Commission approval for the use of MHSA innovation funds. Similarly, the Department has not consistently made data available on county mental health outcomes, such as disparities. Despite its statutory authority to receive data from the Department of Health Care Services, the Commission faces significant delays in receiving data or data are incomplete, despite state laws requiring counties to report such data. It is not clear that the Department has consistently updated its data reporting requirements and systems as envisioned in the Welfare and Institutions Code, undermining the value of existing accountability systems.

The reform proposal calls for the Commission to administer grants, identify key policy issues and emerging best practices, and promote high-quality programs implemented through the examination of data and outcomes, leaving it unclear what the role of the Commission would be as an independent "oversight and accountability" entity.

The proposal calls for the Commission to advise the Department and Agency on their accountability initiatives, but it is unclear if the reform proposal would result in fundamental changes to Commission staffing, research and evaluation functions, its authority to sustain its fiscal, programmatic and outcome transparency work and other strategies for fortifying broad public accountability for transformational change in our mental health system.

It also is unclear if the proposal would result in expanded investments in the Department of Health Care Services and its capacity to stand up more robust accountability systems.

The changes proposed by the Administration have raised concerns among some mental health partners that the reforms would weaken existing accountability efforts, particularly independent accountability and hinder the ability of the public and policy makers to understand how well California's mental health system is working and what investments or reforms may be warranted.

The Commission may wish to consider strategies to fortify the Governor's reform proposal, consistent with his calls for improved accountability, including:

- How the Commission can best support the Administration to outline explicit steps to strengthen the Department's oversight of mental health spending, uses of unspent funds, including investments to address homelessness, child welfare involvement, criminal justice involvement, educational failure and the other key outcomes that are the target of prevention and early intervention initiatives as outlined in the BHSA.

- How the Commission, and other entities such as local behavioral boards and the California Behavioral Health Planning Council, the Council on Criminal Justice and Behavioral Health, the Child Welfare Council, external quality review organizations, and other entities can fortify the oversight and accountability championed by the Department of Health Care Services, while emphasizing the work of independent oversight entities.
- How the Administration is proposing to support community engagement – and how the Commission can support that work – to develop new and relevant outcome reporting strategies, the replacement of legacy data systems and improve transparency strategies to ensure that performance and outcome data are relevant, timely, responsive to community needs and used to inform fiscal, programmatic, and related decisions at the state and local levels.
- Why the Administration is proposing to reduce the Commission's access to relevant mental health related data and what policies and procedures the Administration is proposing to ensure the Commission can continue to play an essential advisory and oversight role.
- How the reform proposal could be modified to enhance the oversight opportunities of the Commission and of local behavioral health boards to encourage public understanding of mental health outcomes and enhance public trust that limited behavioral health dollars are being well spent.

9. Minimum Standards – to be Established

Background. The Governor's reform proposal calls for minimum standards for Full-Service Partnerships, MediCal and commercial insurance billing, and may result in new minimum standards under new authorities granted to the Department of Health Care Services to establish program responsibilities or priorities. As stated above, under current law, counties have considerable discretion on how to organize services and where to prioritize investments. For example, fiscal rules require counties to spend a "majority" of community services and support funds on FSPs, and to spend at least 51 percent of prevention and early intervention funding on children and youth. But counties retain authority to spend more than the minimum in these areas and they are also required to pursue a robust community planning process to determine spending priorities.

Concerns. The reform proposal may result in conflict between statewide requirements for specific programs – at the discretion of the Department of Health Care Services – and county needs and priorities as determined by community members. The reform proposal is intended to ensure that counties respond more effectively to unmet mental health needs, but it is not clear how new fiscal mandates – with minimum standards – will result in better outcomes, particularly in response to diverse needs across 59 local behavioral health agencies.

Prior to the MHSA, state fiscal rules often resulted in what became known as "one size fits all" decisions that were difficult to implement across diverse counties, poorly aligned with the

needs of diverse communities, and undermined efforts to both integrate care and tailor responses to individuals.

Critics also have raised concerns that minimum standards create incentives for compliance, rather than creating support for continuous improvement and annual enhancement of outcomes.

To strengthen the Governor's proposal, the Commission may wish to explore whether establishing minimum standards is the most effective strategy for promoting system improvement and achieving better outcomes. The Commission may wish to explore if there are other strategies, particularly creating fiscal incentives, establishing multi-county learning collaboratives, enhancing data analysis and the calculation of returns on investment or cost avoidance for specific programs, or expanding investments such as the child and youth behavioral health initiative with a focus on disparities and/or adults and older adults, or other approaches that can improve outcomes, in addition to or in place of minimum standards.

10. Workforce – Opportunity Prioritization

Background. The behavioral health reform proposal would expand investments in workforce opportunities by setting aside three percent of total revenues for workforce to be administered by the state. Under current requirements, the state allocates funding for workforce on an annual basis using the state's portion of MHSA revenues or other funding. Counties also are allowed to fund workforce, education, and training efforts with local resources and can shift up to 20 percent of their MHSA community services and supports funding those and other efforts.

The reform proposal would establish an ongoing revenue stream for workforce needs, shifting three percent of annual funding from the counties to the state. Based on recent MHSA revenue reports for the 2021-22 fiscal year the three percent set aside for workforce would generate approximately $163 million per year in funding. MHSA revenue projections for the 2022-23 and 2023-34 fiscal years would reduce that estimate to some $103 million each year.

Concerns. California is facing a dramatic workforce shortage. It is unclear how those funds would be used and how quickly they would result in improved access to care. The public sector competes with the private sector for mental health professionals. Some research suggests that reimbursement rates under MediCal and burdensome paperwork requirements are significant barriers to existing professionals responding to public sector needs, remaining in the field, or expanding the hours they commit to the profession. In recent years mental health innovators have developed strategies to address these and other challenges.

It also is not clear what impact a $100-$175 million fiscal shift from the counties to the state will have on the ability of counties to sustain their existing behavioral health programs.

The Commission may wish to explore how the newly established workforce funding would be used, the timeframe for developing a proposal for the use of these funds, how the state might leverage private sector investments, and if there is a role for workforce and technology innovation to address workforce needs.

The Commission also might explore how state-level workforce investments differ from existing local workforce investments as currently allowed under the MHSA, if local behavioral health agencies will guide the uses of state workforce funds and if the newly established state funds can be used to sustain efforts that are currently receiving local workforce funding.

11. Department of Healthcare Services – Fortification

Background. In 2013, the state eliminated the California Department of Mental Health and the California Department of Alcohol and Drug Programs and transferred the functions of those departments to other entities, including the Department of Health Care Services, the Department of Social Services, and the Mental Health Commission. Those organizational changes included establishing the new Department of State Hospitals to oversee the operations of California's mental health hospitals which previously had been administered by the Department of Mental Health.

At the time, mental health advocates raised concerns that California would lose statewide leadership and visibility on the issues of mental health and substance use disorders that had been provided by those standalone departments. The reform moved forward with the intent of better integrating mental health and substance use disorder services into the broader purview of the Department of Health Care Services, particularly with regard to Medi-Cal financing of health care services, something that was previously distributed across the three departments.

The BHSA reform proposal transfers a limited number of functions from the Commission to the Department. As mentioned above, under current law, the Commission issues regulations and oversees county use of Prevention and Early Intervention funding, and reviews and approves county innovation spending. The reform proposal transfers the Commission's PEI regulatory function to the Department, and as discussed below, eliminates innovation regulations and approvals as innovation spending is no longer required.

The proposed reforms would enhance the authority of the Department of Health Care Services to promote improved integration of county supported mental health services with services offered through MediCal managed care plans, as well as supporting improved alignment between state-level prevention and early intervention programs and county strategies. The reform proposal also highlights opportunities to enhance the draw-down of federal Medicaid funding and calls for the Department to support improved billing with the inclusion of a Medi-Cal billing mandate for county behavioral health departments.

Concerns. In recent years the Commission has raised concerns regarding where leadership, technical assistance, and administrative oversight would reside on mental health matters, including school mental health, suicide prevention, workplace mental health, prevention and early intervention, criminal justice diversion, and related opportunities. The reform proposal does not address the operational needs of the Department of Health Care Services or offer a transition or change management plan to ensure the Department has the staff, training, tools, and other resources needed to succeed under its enhanced responsibilities.

The Commission may wish to explore opportunities to strengthen the Governor's proposal, including:

- How the Department of Health Care Services intends to expand its technical assistance and other roles to support local behavioral health departments and improve outcomes consistent with the enhanced authorities outlined in the reform proposal.
- Whether the reforms will promote greater clarity on the appropriate state-level leadership on school mental health, workplace mental health, criminal justice diversion, behavioral health innovation, and targeted strategies to prevent homelessness.
- How the Department will work with the Departments of Aging, Education, Housing and Community Development, Rehabilitation, Social Services, Public Health, and Employment Development to support the early intervention goals outlined in the reform and whether the Department envisions establishing a leadership council or related body to undertake that work.
- How the Department will ensure that the concerns and perspectives of clients, family members, child and youth advocates, including youth and underserved populations, such as communities of color, current and former foster youth, immigrants and refugees, veterans, older adults and others who bring essential perspectives on how to effectively respond to behavioral health needs will be engaged in all aspects of the Department's work.
- Whether the proposal will include an implementation plan that outlines needs for staffing, data infrastructure, technical assistance and incentive funding, as well as strategies around collaborative learning, program integration and capacity building across the range of mental health partners who support California, including county behavioral health leaders, managed care and commercial insurance plans, health and hospital systems, county and community based providers, public safety and emergency responders, and most importantly community organizations, client, peer and family organizations that are key to ensuring that public sector strategies are aligned with individual, family and community needs, particularly around the essential work of addressing disparities.
- The impacts these reforms are intended to achieve, what harms or risks these reforms may create and how those harms and risks can be mitigated or minimized.

12. Innovation – Funding Mandate Elimination

Background. Under the existing MHSA, county behavioral health departments are required to invest 5 percent of their funding toward innovative approaches to support transformational change. Recognizing uncertainty in what constitutes innovation, state law requires Commission approval for innovation projects before spending can occur.

In the last six years, the Commission has approved more than $1 billion in innovation spending that supports more than 200 innovation projects. The Commission has partnered with counties to support a range of multi-county learning collaboratives, with the Commission often funding initial planning costs on behalf of partnering counties, with counties then electing to opt-in and use their innovation funds to join these collaborative projects based on their relevance to individual county priorities.

The Commission has supported multi-county innovation collaboratives to reduce justice involvement, strengthen approaches to responding to psychosis, fortifying Full-Service Partnership programs, deploying Psychiatric Advanced Directives to accelerate recovery and prevent the escalation of mental health crises, enhancing access to care through robust community engagement, and more.

The MHSA Innovation component was established in response to recommendations from the Little Hoover Commission in 2000 that recognized that California's mental health system did not have a built-in strategy for continuous improvement. Organizers of the initiative elected to require each county to invest their innovation funds in county-level projects so that all counties would benefit from the opportunity for innovation, rather than utilizing a state-level innovation fund that may not be equitably distributed across California's 59 local mental health agencies.

Concerns. The language of the reform proposal is unclear on whether counties are encouraged or required to innovate and how or whether innovation will be implemented or supported, if there is a role for the state in supporting innovations, and how innovations developed in one county can be scaled to additional counties.

The Commission has increasingly recognized that innovation is happening in the behavioral health sector, often in the private sector, but that those innovations are not consistently benefiting public sector clients, nor are they consistently designed and implemented with public sector needs in mind.

The Commission may wish to explore ways to embrace innovation to meet statewide goals, including:

- Whether the proposed reforms should be modified to retain the innovation component and whether to leverage innovation funding to address statewide priories, consistent with the Commission's support for multi-county innovation projects and learning collaboratives. The Commission has informally discussed limiting approval

for county spending of innovation unless projects would reduce homelessness and justice involvement. The Commission has not, as of yet, pursued these proposals.

- In the absence of an innovation mandate and a funding set-aside to support that work, the Commission may wish to seek clarification on what resources would be available under the reform proposal to support the ability of counties to innovate.
- Whether the Department of Health Care Services is proposing to support innovation as allowed under the BHSA, taking over the guidance and technical assistance role for innovation currently performed by the Commission.
- How counties will be asked to wind down innovations as new fiscal requirements take effect, while taking into consideration the need for continuity of service for those participating in those projects.
- How the state can leverage private sector innovation investments, including elevating community voice to support private sector innovation decisions.
- Whether in the absence of local innovation funding, the state should set aside a percentage of state BHSA funding to support statewide innovation investments that can accelerate the transformation of California's mental health system, including public-private partnerships, better understanding of the emerging fields of brain health and brain capital, and leverage the expertise of California's diverse communities, research institutions, communications, technology, and related sectors.

13. The Commission's Role should Guide its Membership

Background. California's mental health Commission was formed to elevate visibility on the need for mental health investments and reforms and to ensure fiscal, programmatic, and outcome-based accountability to the taxpayers. The composition of the Commission reflects the goals of bringing together clients, family members and providers, with leaders in business, labor, public safety, education, and the Legislature to guide policy and build public support for the recovery vision of the MSHA.

As mentioned above, the proposed reforms would retain the Commission's independence and shift some responsibilities from the Commission to the Department of Health Care Services. The proposed reforms state that the Commission:

> "Is established to administer grants, identify key policy issues and emerging best practices, and promote high-quality programs…through the examination of data and outcomes."

Commission membership also is proposed to be modified. The existing 16-member Commission has two mental health consumers, two mental health family members, two business representatives, a physician specializing in addiction medicine, a county Sheriff, a local superintendent, a labor union representative, a representative of a health plan or insurer, a mental health professional, a State Senator, and a State Assembly member. The

California Attorney General and the Superintendent of Public Instruction each serve on the Commission and have the authority to appoint a designee.

Under the proposed reforms, the Commission would increase from 16 members to 20 members, with the addition to two family members of persons with substance use disorders, an expert on housing and homelessness, and a county behavioral health director. Additionally, the Commission's mental health peer membership would be reduced to one member and replaced with a peer who has or has had a substance use disorder.

Concerns. Advocates have pointed out the benefit of adding members with SUD experience, both as peers and family members, but have expressed concerns that the Commission would have two peers and four family members, with just one mental health peer. Additionally, they have expressed concern that county behavioral health directors are in charge of the mental health system, and it is unclear why a seat is being added for a county director.

Similarly, they have pointed out that reforms are not proposing to add youth, a seat for an expert on disparities, one or more veterans, an MHSA taxpayer, persons who have experienced homelessness, or others who would bring robust lived experience to the work of the Commission.

The existing makeup of the Commission is reflective of its mission. The Commission may wish to explore with the Administration:

- The rationale for expanding the membership.
- The rationale for the additional members in the proposed reform and the exclusion of other potential contributors.

The Governor's behavioral health reform proposal, with emphasis on Senate Bill 326 (Eggman), would make substantial and lasting changes to California's behavioral health system.

AGENDA ITEM 10

Action

August 24, 2023 Commission Meeting
2024-2027 Strategic Plan Outline

Background: In January, the Commission reviewed progress made under the 2020-23 strategic plan, discussed challenges in accomplishing some of the goals, and identified four priorities for the 2023: Data, Full-Services Partnerships, Impact of Firearm Violence, and development of the 2024-27 Strategic Plan. Commissioner Carnevale was appointed as the lead Commissioner for the 2024-2027 strategic planning efforts and approval was given for a consultant to be selected to support the development of the 2024-27 plan.

In May, Boston Consulting Group (BCG) engaged internal and external community partners to collect perspectives on the Commission's projects, to assess the Commission's model for catalyzing transformational change, to develop a decision-making framework to guide the transformation of mental health care and provide an outline for the new strategic plan.

The Commission in June was briefed on the internal and external engagements and on a preliminary decision-making framework intended to improve the Commission's influence and impact.

Based on considerable public and Commissioner input, a preliminary draft of the strategic plan was developed to enable more focused engagement over the next few months with community partners. Similarly, the Commission will be consulted and briefed as the draft plan is further developed.

This month, the Commission will review the next iteration of the draft analytical framework and the positioning of key themes based on the feedback received from Commissioners, staff and community partners. The Commission also will discuss the value of and potential protocols for explicitly establishing priorities, as recommended by various partners in the first phase of this project. BCG also has prepared preliminary goals and objectives to inform and focus the next phase of the engagement process. The Commission will be briefed on subsequent public outreach activities and specific audiences that are being invited to provide feedback on the draft plan.

Presenters: Norma Pate, Deputy Director; Anna Naify, Consulting Psychologist; Boston Consulting Group

Enclosures: None

Handouts: PowerPoints will be presented at the meeting

Proposed Motion: None

AGENDA ITEM 11

Information

August 24, 2023 Commission Meeting

Anti-Bullying Social Media Report

Summary: The Commission will hear a report out on the youth-driven social media strategy to address race-based bullying. Media Cause, the contractors who developed and executed this strategy, will share some of the digital features that provide peer-to-peer support for youth and discuss outcomes and impacts of the strategy, and future opportunities for youth-designed digital platforms; presented by Media Cause Staff.

Background: In July 2021, the Asian Pacific Islander (API) Equity Budget authorized the Commission to allocate $5 million to create and support a peer social media network project for children and youth, with an emphasis on students in kindergarten and grades 1 to 12 who have experienced bullying, or who are at risk of bullying based on race, ethnicity, language, or country of origin, or perceived race, ethnicity, or country of origin.

In August 2021, an advisory Committee that included 20 youth and adult ally members, chaired by Commissioner Shuo Chen, was formed to provide insight and recommendations on the needs of the youth, the types of support they would seek, and the places and people whom youth trust. This Committee included of a combination of youth and adult leaders across multiple organizations, including those with expertise in outreach to Asian communities, anti-bullying and anti-hate research, youth and media, public health and violence prevention programs and policies, mental health providers, and more. During its public meetings on August 31, 2021, September 30, 2021, and October 29, 2021, the Committee reviewed data about bullying, social media strategies, and peer-networks from interviews and surveys with Committee members. To facilitate these conversations, the Commission contracted with Youth Leadership Institute (YLI) who helped engage committee members using icebreakers, Jamboards, and other tools to encourage creative conversations.

After these Committee meetings, Commission staff worked to establish a contract with Media Cause and YLI continued to engage the Youth Advisors to gather information about social media strategy.

On November 18, 2021, based on recommendations from the Committee, the Commission approved contracting for the following three strategies:

1. Peer-to-Peer Support
2. Social Media Strategy

3. Youth-Designed Content, Resources, and Cultural Ambassadors

Media Cause was chosen as a general contractor for the initiative based on demonstrated experience with similar social media campaigns and strategies, skills and professional services, and their mission to “help those doing good do more.” They are working with YLI and other cultural ambassadors as subcontractors to incorporate youth and cultural voices into the social media strategy.

The purpose of this item is to share the social media strategy, provide an update on impact/outcomes, and consider opportunities to sustain this social media strategy.

Enclosures: None

Handout (1): PowerPoint presentation

MISCELLANEOUS ENCLOSURES

August 24, 2023 Commission Meeting

Enclosures (4):

(1) Evaluation Dashboard
(2) Innovation Dashboard
(3) Department of Health Care Services Revenue and Expenditure Reports Status Update
(4) Rolling Calendar

Mental Health Services
Oversight & Accountability Commission

Summary of Updates

Contracts

New Contracts: 0

Total Contracts: 5

Funds Spent Since the June Commission Meeting

Contract Number	Amount
17MHSOAC073	$ 0.00
17MHSOAC074	$ 0.00
21MHSOAC023	$ 0.00
22MHSOAC025	$ 0.00
22MHSOAC050	$ 0.00
TOTAL	**$ 0.00**

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: $2,089,594.40

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 Updated Formative/Process Evaluation Plan	Complete Complete	1/24/20 1/15/21	No 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 Progress Reports (10 quarterly reports)	Complete	1/15/21- 3/15/23	No

Deliverable	Status	Due Date	Change
Formative/Process Evaluation Plan Implementation and Preliminary Findings (11 quarterly reports)	Complete	1/15/21-3/15/23	No
Co-host Statewide Conference and Workplan (a and b)	In Progress	9/15/21 Fall 2022	No
Midpoint Progress Report for Formative/Process Evaluation Plan	Complete	7/15/21	No
Draft**s** Formative/Process Evaluation Final Report (a and b)	Complete In Progress	3/30/23 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: $2,089,594.40

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 Updated Formative/Process Evaluation Plan	Complete Complete	1/24/20 1/15/21	No 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 Progress Reports (10 quarterly reports)	Complete	1/15/21- 6/15/23	No
Formative/Process Evaluation Plan Implementation and Preliminary Findings (11 quarterly reports)	Complete	1/15/21- 6/15/23	No

Deliverable	Status	Due Date	Change
Co-host Statewide Conference and Workplan (a and b)	In Progress	9/15/21 TBD	No
Midpoint Progress Report for Formative/Process Evaluation Plan	Complete	7/15/21	No
Draft**s** Formative/Process Evaluation Final Report (a and b)	Complete In Progress	3/30/23 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: $5,414,545.00
Total Spent:$ 2,475,870.88

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	No
Quarterly Progress Reports	Complete	03/31/2023	Yes
Quarterly Progress Reports	In Progress	06/30/2023	No
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

Deliverable	Status	Due Date	Change
Quarterly Progress Reports	Not Started	06/30/2024	No

MHSOAC
Mental Health Services
Oversight & Accountability Commission

WestEd: MHSSA Evaluation Planning (22MHSOAC025)

MHSOAC Staff: Kai LeMasson
Active Dates: 06/26/23 - 12/31/24
Total Contract Amount: $1,500,000.00
Total Spent: $0.00

This project will result in a plan for evaluating the Mental Health Student Services Act (MHSSA) partnerships, activities and services, and student outcomes. The MHSSA Evaluation Plan will be informed by community engagement and include an evaluation framework, research questions, viable school mental health metrics, and an analytic and methodological approach to evaluating the MHSSA.

Deliverable	Status	Due Date	Change
Project Management Plan	Complete	August 1, 2023	No
Community Engagement Plan	In Progress	September 1, 2023	No
Community Engagement Plan Implementation (a, b and c)	Not Started	December 15, 2023 January 15, 2024 October 30, 2024	No
Evaluation Framework and Research Questions	Not Started	December 15, 2023	No
School Mental Health Metrics	Not Started	June 15, 2024	No
Evaluation Plan (draft and final)	Not Started	September 1, 2024 October 30, 2024	No
Consultation on Report to the California Legislature	Not Started	March 1, 2024	No
Progress Reports (a, b, and c)	In Progress	September 15, 2023 January 15, 2024 June 15, 2024	No

Mental Health Services
Oversight & Accountability Commission

Third Sector: FSP Evaluation (22MHSOAC050)

MHSOAC Staff: Melissa Martin Mollard
Active Dates: 06/28/23 – 6/30/24
Total Contract Amount: $450,000.00
Total Spent: $0.00

This project will evaluate the effectiveness of FSPs through community engagement, outreach and survey activities culminating in a final report to the Commission with specific recommendations for strengthening the implementation and outcomes of FSP programs throughout the State.

Deliverable	Status	Due Date	Change
Community Engagement Plan (draft and final)	In Progress	August 31, 2023 September 30, 2023	No
Statewide Survey (draft and final)	Not Started	October 31, 2023 December 31, 2023	No
Progress Reports (#1 and #2)	Not Started	October 31, 2023 March 31, 2024	No
Final Report (draft and final	Not Started	March 31, 2024 May 31, 2024	No

Mental Health Services
Oversight & Accountability Commission

INNOVATION DASHBOARD

AUGUST 2023

UNDER REVIEW	Final Proposals Received	Draft Proposals Received	TOTALS
Number of Projects	1	5	**6**
Participating Counties (unduplicated)	1	5	**6**
Dollars Requested	$1,995,129	$118,773,261	**$120,768,390**

PREVIOUS PROJECTS	Reviewed	Approved	Total INN Dollars Approved	Participating Counties
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%)
FY 2022-2023	31	31	$354,562,908.86	26 (44%)

TO DATE	Reviewed	Approved	Total INN Dollars Approved	Participating Counties
2023-2024	1	1	$11,938,639	1

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	San Luis Obispo	Embracing Mental & Behavioral Health for Residential Adult Care & Education (EMBRACE)	$859,996	4 Years	3/24/2023	Pending
Under Review	Santa Cruz	Crisis Now Multi-County Innovation Plan	$4,544,656	3 Years	7/14/2023	Pending
Under Review	Los Angeles	Kedren Children and Family Restorative Care Village	$109,109,252	5 Years	6/2/2023	Pending
Under Review	Tri-City	Community Planning Process	$675,000	3 Years	7/5/2023	Pending
Under Review	Yolo	Crisis Now	$3,584,357	3 Years	6/1/2022	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	Amador	Workforce Retention Strategies	$1,995,129	5 Years	6/19/2023	8/2/2023

APPROVED PROJECTS (FY 23-24)

County	Project Name	Funding Amount	Approval Date
Santa Clara	TGE Center	$11,938,639	7/27/2023

DHCS Status Chart of County RERs Received
August 24, 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 June 27, 2023. This Status Report covers FY 2020 -2021 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
August 24,2023 Commission Meeting

DCHS MHSA Annual Revenue and Expenditure Report Status Update

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	4/14/2023		4/17/2023
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	5/11/2023
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	5/19/2023			
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	4/19/2023	4/20/2023	4/21/2023

DHCS Status Chart of County RERs Received
August 24,2023 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	5/10/2023	5/11/2023	5/25/2023
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	4/14/2023	
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
August 24,2023 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	4/12/2023	4/12/2023	4/13/2023			
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	**59**	**56**	**59**	**55**	**40**	**54**

MHSOAC
Mental Health Services
Oversight & Accountability Commission

Rolling Commission Meeting Calendar (Tentative)

At its January 2023 meeting the Commission identified four priorities: Data/Metrics, Full-Service Partnerships, the Impact of Firearm Violence, and Strategic Planning. The draft calendar below reflects efforts to align the Commission meeting schedule with those priorities. **All topics and locations subject to change**.

Dates	Locations	Priority*
August 24	Sacramento	Data Discussion
September 28	Los Angeles	**9/27** – SUD Site Visit to Street Medicine Program **9/28 -** Substance Use Disorder Discussion
October 25-26	San Francisco	**10/25**-UCSF Neuropsychiatry Site Visit **10/26**-Impact of Firearm Violence Panel
November 16	Virtual	Strategic Plan- DRAFT Election of Chair and Vice Chair FSP Panel Presentation
December	(no meeting)	
January 25, 2024	Santa Barbara	2024-2027 Strategic Plan Adoption Impact of Firearm Violence Report-DRAFT
February 21-22	Napa	**2/21** – Site Visit to Napa State Hospital **2/22** - Priority agenda items for February 2024 through June 2024 will be determined after adoption of the 2024-2027 Strategic Plan
March 28	TBD	TBD: Pending New Strategic Priorities
April 25	TBD	TBD: Pending New Strategic Priorities
May 23	TBD	TBD: Pending New Strategic Priorities
June	TBD	TBD: Pending New Strategic Priorities

*NOTE: The Priorities listed are not the only agenda items under consideration for each month.