Mental Health Services
Oversight & Accountability Commission

Commission Meeting
November 21, 2024
Presentations and Handouts

Agenda Item 6:	**•Presentation:**	**Grant Opportunities: Maternal Mental Health/0-5, K-12 Students, Immigrants and Refugees**
	•Handout:	**California Pan-Ethnic Health Network Report: Improving Mental Health Care for Immigrant and Refugee Communities**
Agenda Item 9:	**•Presentation:**	**Proposition 1 Implementation Update**
	•Handout:	**Proposal: Quarterly Meetings & Committees + Workgroup**
Agenda Item 10:	**•Presentation:**	**Orange County Innovation: Program Improvements for Valued Outpatient Treatment (PIVOT)**
Agenda Item 11:	**•Presentation:**	**Full Service Partnerships Legislative Report**
Agenda Item 12:	**•Presentation:**	**Report to the Legislature on the Mental Health Student Services Act**
Agenda Item 13:	**•Presentation:**	**Counting what Counts: School-based Universal Mental Health Screening Legislative Report**

Grant Opportunities: Maternal Mental Health/0-5 K-12 Students Immigrants and Refugees

November 21, 2024

Tom Orrock, Deputy Director of Operations
Riann Kopchak, Chief of Community Engagement and Grants
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MHSOAC
Mental Health Services Oversight & Accountability Commission

Why this approach?

May 2023: Commission publishes report "Well and Thriving: Advancing Prevention and Early Intervention in Mental Health"

August 2023: Commissioners prioritized opportunities to advance the care and treatment of children ages 0-5

2024-2027 Commission Strategic Plan

What is being done and what can be done?

Factors for Consideration

Components

- Incentivize funding
- Technical assistance
- Data collection and evaluation

Criteria

- Avoid overlap with existing resources
- Immediate impact
- Sustainability
- Scalability
- Population
- Negative outcome of mental illness
- Strategic Plan

Barriers

- Identify potential barriers
- Identify potential solutions

Key Themes from Community Engagement

Whole-family approaches including parents/caregivers

Support that provides resources and care to improve the family unit prior to birth and through infancy

Focus on early detection relative to social emotional maturity and developmental milestones

Systemic improvement relative to culturally responsive providers within this career ladder

Expanded affordable after school or daycare programs

Expansion of Community Pathways programs to prevent child welfare involvement

Grant Opportunities

Landscape analysis, evaluation, and technical assistance

($3 million)

- Contractor(s) would provide technical assistance, analyze current systems, identify gaps and barriers, and provide an evaluation to inform future work.

CBO-led partnership grants

($18 million)

- Two grants for partnerships involving a lead CBO and 3 support CBOs in large counties ($4 million each)
- Two grants for partnerships involving lead CBO and 2 support CBOs in medium counties ($3 million each)
- Two grants for partnerships involving lead CBO and 1 support CBO in small counties ($2 million each)

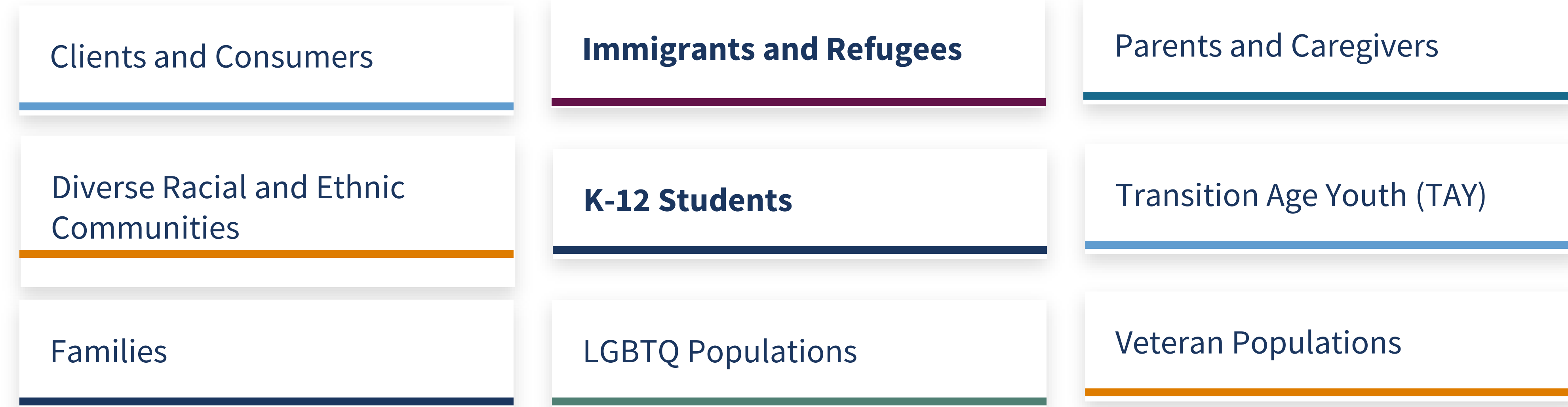
RFA Target Release Date: January 2025

Proposed Motion

That the Commission authorizes staff to release an RFP to award $21 million in Mental Health Wellness Act funding through a competitive bid process designed to support partnerships serving maternal mental health and the 0-5 population, conduct landscape analysis and evaluation, and provide technical assistance to grantees awarded through the competitive bid process.

Advocacy Funding

The Commission funds organizations through competitive bid contracts to conduct state and local advocacy, training and education, and outreach and engagement activities on behalf of nine underserved populations in California.



YOUTH ADVOCACY INITIATIVE

HUMBOLDT
SACRAMENTO
FRESNO
SAN BERNARDINO

MHSOAC
Mental Health Services
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K-12 Student Advocacy Background

- Awarded to 20 community-based organizations and six county offices of education
- Contracted with PRO Youth and Families to form the Youth Advisory initiative
- Engaged approximately 400 youth through virtual meetings and in-person convenings held throughout the state
- Outreached to and engaged with youth from rural areas and diverse backgrounds
- Most recently contracted with Jakara Movement to organize two regional youth advisory boards, and to hold four statewide conferences

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Community Engagement Themes

Youth feel disconnected from decision making

Peer support programs

Additional local and state-level advocacy

Regional efforts can inform statewide focus

Youth voice elevated with use of mentors

K-12 Student Advocacy Grant Opportunity

K-12 Student Advocacy

($2,010,000 million)

- Provide local partners and youth with resources and state level advocacy
- Contractor would subcontract with local partners to form Youth Engagement and Empowerment teams
- Hold three annual conferences where the youth teams will convene to collaborate on statewide advocacy
- Publish a multimedia Final Report to uplift youth voice and inform decision makers

RFA Target Release Date: January 2025

Proposed Motion

That the Commission authorizes staff to release an RFP for K-12 Advocacy in the amount of $2,010,000 to support advocacy, training and education, and outreach and engagement efforts in the K-12 student population.

Immigrant and Refugee Advocacy Background

- From 2019-2022, five local-level CBOs conducted advocacy, training, and outreach in the Superior, Bay Area, Central, Southern, and Los Angeles regions
- From 2021-2024 statewide organization CPEHN convened 8 local CBOs to conduct advocacy across California at local and state levels
- Findings and recommendations from statewide and local partnership are shared in state policy agenda "Improving Mental Health Care for California's Immigrants and Refugees"

Community Engagement Themes

Cultural responsiveness and linguistic competency

Disparities in mental health systems lead to difficulties accessing care

CBOs are the key to connecting with this population

Grant Opportunities

Statewide Contract ($502,500)

- Contractor will advocate at the state level, leverage existing state and local programs to meet population need
- Convene local partners to share information

Local Contracts ($502,500 each)

- Seven contracts in four regions: Superior (1), Central (2), Bay Area (2), Southern/LA (2)
- Contractor will conduct local outreach and engagement, provide training and education that promotes the needs of this population

RFA Target Release Date February 2025

Proposed Motion

That the Commission authorizes staff to release two RFPs totaling $4,020,000 to support the state and local level advocacy, training and education, and outreach and engagement needs in immigrant and refugee populations.

Improving Mental Health Care for Immigrant and Refugee Communities

STATE POLICY AGENDA

AUGUST 2024

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INTRODUCTION

Immigrants and refugees are deeply rooted in California and provide significant cultural, familial and economic contributions to the state. California's immigrant and refugee communities face long-standing barriers to educational attainment, economic opportunities, and access to social services and health care. Many have faced egregious violations of their rights, safety, and mental wellbeing. Traumatic and often violent migratory experiences, coupled with the stigma and misconception of receiving mental health services, put the physical and mental wellbeing of immigrants and refugees at particular risk. In addition, many immigrants and refugees from war-torn countries have experienced trauma, which can lead to mental health conditions such as anxiety, depression, and PTSD.

To better understand the mental health care needs and challenges faced by immigrant and refugee communities, CPEHN partnered with eight community-based organizations that work closely with these communities.

In 2023, the California Pan-Ethnic Health Network (CPEHN), with the support of the Mental Health Oversight and Accountability Commission (MHSOAC) and the California Health Care Foundation, convened community-based organizations who serve immigrant and refugee communities. The goal of this engagement was to strengthen the voice of immigrant and refugee communities in mental health policy and program development.

- Boat People SOS
- Center for Empowering Refugees and Immigrants
- Healthy House Within a MATCH Coalition
- Hmong Cultural Center of Butte County
- Level Up NorCal
- Orange County Asian and Pacific Islander Community Alliance
- The Cambodian Family
- Visión y Compromiso

CPEHN held one on one meetings with each of these partners to better understand their previous experiences and perspectives on barriers to mental health care and community-defined solutions for the immigrant and refugee communities they serve. From these meetings, CPEHN developed an initial outline of barriers and policy recommendations for improving access to culturally and linguistically appropriate mental health services for immigrants and refugee communities. CPEHN held virtual convenings with the partner organizations to further refine these barriers and recommendations to develop a state policy agenda.

This policy brief reports findings from these convenings and represents the collective work of CPEHN and our eight project partners.

BARRIERS

CPEHN and their project partners identified three major barriers currently preventing immigrants and refugees from receiving high quality mental health services.

- Lack of Cultural and Linguistic Competency in Mental Health Services
- Difficulty Accessing Mental Health Services and Information
- Cultural Stigma around Mental Health

LACK OF CULTURAL AND LINGUISTIC COMPETENCY IN MENTAL HEALTH SERVICES

Immigrants and refugees need culturally and linguistically competent services to effectively communicate their mental health needs to healthcare providers. Too often, these services are lacking, resulting in misunderstandings, misdiagnosis, inappropriate treatment, and difficulty in obtaining a proper diagnosis and receiving effective treatment for their mental health conditions. In extreme cases, immigrants and refugees arrive in these spaces without someone they can trust or communicate with, and with their mental health in critical condition due to trauma.

"Often, we see secondary translators (family members or children who act as translators for immigrant parents), but the issue is that they are not fully trained to explain or translate more complex issues. This may cause more miscommunication, misunderstanding, or confusion with both mental health and physical health issues. In addition, this dependence on children causes a lot of pressure on the children who themselves have to learn from the ground up. They may not have a touch point or navigator to help guide them on these issues."

– I&R Project Participant

Specific barriers include:

- **Lack of interpretation and translation.** Immigrants and refugees often wait months to find someone who speaks their language. It is even more difficult to find someone who shares the same cultural background and understands the cultural history and context of their situation. Additionally, there are challenges related to dialects; sometimes interpreters speak a different dialect, which is not understood by the member. Conversations around mental health are difficult, and many seeking care have experienced trauma, therefore there is a critical need for careful interpretation to avoid triggering traumas.
- **Health care and mental health terminology is not commonly used in some languages.** Because there is no direct translation of some words and terms, translation and interpretation becomes a challenging task. In some cases, words related to a mental health diagnosis are translated into native languages as "crazy," which creates stigmas.

DIFFICULTLY ACCESSING MENTAL HEALTH SERVICES AND INFORMATION

Accessing mental health care presents significant challenges for immigrants and refugees, who often work long hours and lack access to childcare services, making it difficult for them to find the time for health care appointments. In addition, the health care system is hard to understand and navigate. Health care clinics and offices can be unwelcoming, especially for those unfamiliar with the language and the standard registration and paperwork processes involved in health care appointments.

> *"Health insurance is hard to navigate. There's a lack of information on what kinds of services are available. Many immigrants and refugees do not know what kind of Medi-Cal they have – it's very complicated. Even providers have a hard time determining what services are covered and what type of health insurance an individual should get based on income."*
>
> *– I&R Project Participant*

Specific barriers include:

- **Lack of insurance.** Many immigrants and refugees do not know if they are eligible for Medi-Cal and may be wary of applying for Medi-Cal due to lack of knowledge and distrust of the government stemming from their traumatic experiences in their home countries. In addition, the paperwork and administrative work required to apply for insurance may deter some from applying.
- **Difficulty navigating health care system.** For those who have insurance, many do not understand what their insurance covers or how to access covered services. Even for CBOs that specialize in these issues, it can be difficult to navigate mental health services, especially trying to determine if a provider is culturally and linguistically appropriate and is accepting new patients.
- **Concerns about out-of-pocket costs of care.** Many immigrants and refugees do not seek care for mental health concerns due to fears about how much this care might cost, and concerns about how this might impact their credit scores or applications for other services.

BARRIERS TO ACCESSING MENTAL HEALTH SERVICES

Lack of Insurance

Difficulty Navigating Health Care Systems

Concerns about Out-of-Pocket Costs of Care

Lack of Education on Mental Health

Transportation Challenges

- **Lack of education around mental health for both patients and providers.** Community members lack access to education around mental health conditions. Primary care physician (PCP) appointments are often rushed, and PCPs may not recognize mental health symptoms or be competent in recognizing cultural symbols or markers that may be masking mental health symptoms.
- **Transportation challenges.** Transportation to mental health appointments can be a barrier, especially in rural areas of the state. Many of the communities where immigrants and refugees live lack reliable public transportation. MHSOAC Project members shared that they often use their own vehicles to take people to appointments.

CULTURAL STIGMA

Cultural stigma can significantly impede immigrants and refugees from seeking mental health care, as mental health is stigmatized in many cultures. Seeking help for mental health issues may be perceived as a sign of weakness or failure, which can deter individuals from seeking the necessary treatment.

Specific barriers include:

- **Fear or shame associated with seeking mental health care.** Stigma related to mental health is different across different cultures and backgrounds. But for many immigrants and refugees, there may be a stigma of looking weak if you seek care for a mental health concern or a stigma of shame for going against your family. These cultural norms can make it difficult for an individual to say that they need help or to seek mental health care.
- Skepticism of Western mental health beliefs and treatments. Some immigrants and refugees may come from cultures that prioritize traditional healing practices over Western medical treatments. Many of these individuals might prefer a mixture of Eastern and Western medicine.

"Stigma to mental health is different across the board - as a mixed-race individual, a partner's African American family might say something like "what happens in the house, stays in the house." For African American men, they are told to man up, that they have to be emotionless, leading them to not be able to express themselves. For those who come from an Asian background, there is a stigma of shame for going against your family, fear of feeling dejected, or mentally abused for doing so. In the Mexican culture, "machismo" culture is real. These are norms among our different cultures, and it's hard to stand up and say they need help on their level when these norms are being perpetuated."

– I&R Project Participant

- Intergenerational differences around mental health. There are persistent intergenerational challenges among refugee and immigrant communities related to mental health. There are different lived experiences across generations – immigrant versus refugees versus first-generation. While some communities are becoming more open about discussing mental health challenges across generations, many younger community members do not feel comfortable discussing their mental health with parents or grandparents.

POLICY RECOMMENDATIONS

Immigrants and refugees are a population with unique and significant mental health needs due to their experiences with trauma, with leaving their homelands and roots, and with challenging and often violent migrations. Yet too many immigrants and refugees are not receiving the mental health care diagnoses and care that they need.

To ensure mental health services for immigrants and refugees, the project partners recommend four key areas for policy and health system investment.

1. Promoting Trauma-Informed Care and Cultural Competency in Mental Health Services
2. Investing in Community-Defined Evidence Practices and Community-Based Organizations and Workers
3. Improving Access to Mental Health Services for Immigrant and Refugee Communities
4. Developing and Retaining a Diverse Mental Health Workforce

PROMOTING TRAUMA-INFORMED CARE AND CULTURAL COMPETENCY IN MENTAL HEALTH SERVICES

Mandating ongoing cultural competency training, requiring the hiring of culturally competent interpreters, and promoting specialized education programs will empower mental health providers to deliver more effective and compassionate care. By acknowledging and addressing the unique trauma histories and cultural contexts of immigrants and refugees, these interventions aim to foster trust, understanding, and positive health outcomes within these communities.

> *"We have to put ourselves in the community member's position, it's important to understand what the community member has been through. It's important to find out what the problem is from THEM, and then provide solutions or treatment based on that."*
>
> *– I&R Project Participant*

Recommended policy and workforce interventions include:

- **Require the hiring of culturally competent interpreters and translators.** Having cultural and historical knowledge of the languages spoken by immigrants and refugees is crucial for providing

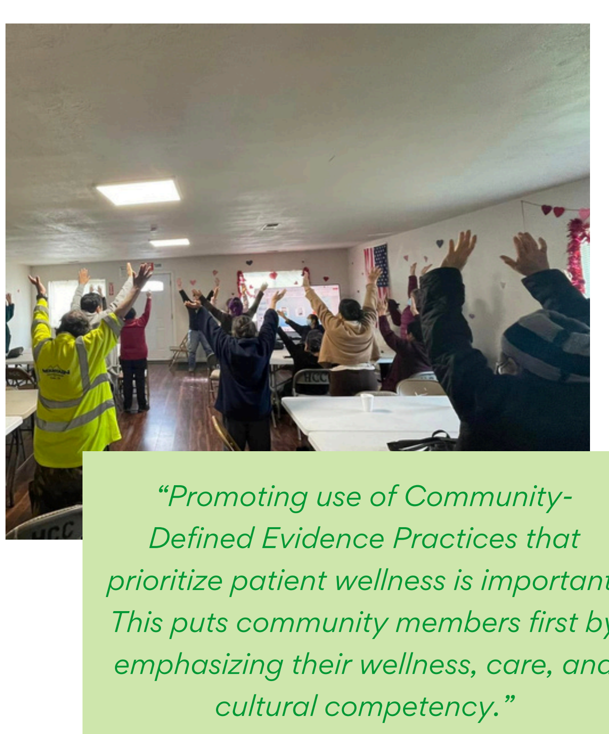
trauma-informed care. Different generations within these communities may respond differently to certain words or phrases due to stigma or past trauma.

- **Mandate ongoing cultural competency training for mental health care providers.** Cultural competency training for all members of the mental health care team, including first responders and law enforcement officers, as well as social workers should be a requirement for licensure and accreditation. Educational programs for providers should incorporate cultural competency into their curriculums. Furthermore, one-time cultural competency training is not sufficient to ensure that mental health workers, providers, and first responders are prepared to work effectively with immigrants and refugees. All mental health care providers should be required to have ongoing training to ensure that they are continuously improving their cultural competency skills and knowledge and are staying up to date on the latest research and best practices.
- **Create community-based training programs that provide specialized education and training for mental health providers working with immigrant and refugee populations.** Beyond the need for mental health providers to develop stronger cultural competencies, the immigrant and refugee populations have specific needs that require specialized knowledge and training. Policymakers can provide funding for the development of such training programs.
- **Advance trauma-informed care through training for mental health providers.** Trauma-informed care is a vital policy solution for improving mental health care for immigrants and refugees, particularly those from war-torn countries, as it acknowledges and addresses the unique effects of trauma on mental health. Many immigrants and refugees have experienced trauma, such as conflict, displacement, persecution, and violence, which can have lasting impacts on their mental health. Policymakers can support the implementation of trauma-informed care by funding training programs for mental health care providers and promoting the use of community defined evidence-based practices that prioritize patient wellness.

INVESTING IN COMMUNITY-DEFINED EVIDENCE PRACTICES AND COMMUNITY-BASED ORGANIZATIONS AND WORKERS

Community-based services have the potential to improve mental health care for immigrants and refugees by addressing various barriers such as cultural stigma, language barriers, and lack of access to health insurance, yet, too

often, CBOs lack sufficient resources. Community-based organizations can play a critical role in both improving access to mental health services and providing education and outreach about mental health to their communities.



"Promoting use of Community-Defined Evidence Practices that prioritize patient wellness is important. This puts community members first by emphasizing their wellness, care, and cultural competency."

– I&R Project Participant

Recommended policy interventions include:

- **Streamline the Medi-Cal process for credentialing CBO staff to provide mental health care.** Many immigrants and refugees have existing, trusting relationships with CBOs. Creating more opportunities for CBO staff to become credentialed as mental health workers and hiring culturally and linguistically competent providers will make it easier for immigrants and refugees to seek mental health care. Currently, CBOs face many restrictions in providing these services to their members. In addition, CBOs need state funding and resources to offer direct mental health services to their communities.
- **Provide funding and resources to CBOs for outreach and education around mental health.** Building on their trusted relationships with immigrants and refugees, CBOs are in a good position to provide needed culturally and linguistically relevant education about mental health. Immigrant communities are tightknit communities, where efforts to build awareness about mental health and wellness may help to normalize conversations within families and the community about mental health care. CBOs should make a special effort to connect with immigrant and refugee youth around mental health.
- **Partner with Community Health Workers/Promotores/Representatives (CHW/P/Rs).** CHW/P/Rs are well-positioned to serve as trusted health care representatives for immigrants and refugees. CHW/P/Rs can be leveraged to provide information on mental health care and treatment options available to patients.
- **Incorporate traditional healing practices into mental health care delivery.** A blend of Eastern and Western medicine provides an easier entry point to receiving mental health care for many immigrants and refugees. This could also include spiritual guides and remedies, which may be highly valued by some elders. This should include Medi-Cal incorporating traditional healing practices as billable services, allowing immigrants and refugees to receive culturally and linguistically competent mental health care.

IMPROVING ACCESS TO MENTAL HEALTH SERVICES FOR IMMIGRANT AND REFUGEE COMMUNITIES

Improved funding and recognition of the role that community-defined evidence practices and CBOs can play in providing mental health services for immigrant and refugee communities will go a long way towards improving access to mental health services. There are, however, some specific actions that the health care system and state health care agencies need to take to ensure effective access to mental health services.

> *"There are very limited navigation services. Sometimes these services just check a box or do the bare minimum instead of meeting the need. We must start from the ground up, raising awareness, and providing education about mental health. We must also work to include CHW/P/Rs in outreach, and there should not be a separation of this workforce. Raising awareness of benefits is important especially for people who are less familiar with mental health."*
>
> *– I&R Project Participant*

Recommended policy and health system interventions include:

- **Integrate mental health more fully into the health care system, especially primary care offices.** Many immigrants and refugees are more likely to seek primary care than mental health care. Primary care providers can play an important role in screening individuals for mental health issues, providing education around mental health, and connecting patients to mental health resources.
- **Provide mental health services in trusted community spaces.** In addition to supporting CBO staff to become credentialed to provide mental health care, policymakers and mental health providers should leverage existing relationships between CBOs and immigrants and refugees. Mental health providers should be encouraged to provide outreach around mental health and to host mental health clinic days at trusted CBOs, and they should be reimbursed for these activities.
- **Facilitate partnerships between CBOs and mental health providers.** There is a need for a strong pipeline between agencies and organizations that have first touches with immigrants and refugees, CBOs that work with them, and the health care system, including primary care and mental health care providers.
- **Outreach and education about health insurance and mental health resources.** Government agencies need to develop and provide culturally and linguistically relevant information and resources on the benefits available to immigrants, refugees, and asylum seekers. Specifically, there needs to be dedicated outreach and education around Medi-Cal eligibility, how to apply for Medi-Cal, Medi-Cal benefits, and how to access mental health care in Medi-Cal. This outreach should include information about transportation options and benefits that people may not be aware of, such as insurance-covered rides to appointments and clinic-provided shuttles. In some cases, providers need better information on what benefits are covered in which plans and how best to support their patients in ensuring they received the mental health benefits their insurance covers.

DEVELOPING AND RETAINING A DIVERSE MENTAL HEALTH WORKFORCE

Beyond providing additional training to the existing mental health and health care workforce, there is a deep need for growing and diversifying the mental health workforce to better reflect the diversity of California's population.

> *"It's very challenging for a person of color to go into a career for mental health because they have their own trauma. They also have a lack of funding, deterring them from applying for grad school. However, providing opportunities would be incredibly beneficial."*
>
> *– I&R Project Participant*

Recommended policy and workforce interventions include:

- **Develop a workforce pipeline for young people of color to enter the mental health workforce.** To grow the mental health workforce, more educational opportunities and pathways need to be added at the college level, especially at community colleges and programs that are well-attended by people of color.
- **Waive licensing fees and reduce entry requirements for certification programs.** Making jobs in mental health services more accessible and attainable for local applicants by waiving fees and lowering admission restrictions would increase the number of culturally and linguistically concordant providers.
- **Create incentives for established providers of color to remain in the behavioral health workforce.** Unfortunately, many established mental health providers of color experience burnout, and many are leaving the workforce. Policymakers and health care systems should provide funding support to these providers to ensure that salaries and workplace benefits are sufficient. Extending government-like benefits and pensions could attract more people of color to behavioral health jobs and incentivize long-term service. Funding should also be provided for mental health support for behavioral health providers and workers. This will also set a good example for community members, who will see that everyone needs help.

Learning from Community-Based Organizations

INVESTING IN YOUTH

Youth programs play a critical role in shaping the future of our communities. By investing in youth, especially within immigrant and refugee communities, we not only nurture the leaders of tomorrow but also address systemic inequities and promote social justice. Community-based organizations are at the forefront of this work, offering culturally relevant programs that empower young people through leadership development, advocacy, education, health and wellness initiatives, and cultural enrichment activities. By providing culturally relevant support, education, and opportunities for civic engagement, these programs empower youth to become advocates for themselves and their peers, creating a ripple effect of positive change.

In this section, we highlight three exemplary youth programs from our partner organizations that are making significant impacts in their communities. Each of these programs is tailored to the specific cultural and community needs of their participants, fostering leadership, advocacy, and a sense of belonging. From substance use prevention and mental health advocacy to cultural enrichment and intergenerational connection, these programs offer valuable insights into how community-based approaches can make a lasting impact on the lives of young people and a generational impact on the community.

CERI’s Youth Department

Engages over 70 youth and transitional age youth (TAY) from refugee and immigrant communities each year in leadership development, advocacy, academic, health and wellness, and cultural enrichment programs, including programs around environmental justice, green jobs, youth advocacy around harm reduction, and substance use prevention. For example, the youth-led Khmer Dance Group performs traditional Cambodian dances, celebrating their heritage and boosting their confidence and pride. CERI organizes intergenerational activities such as field trips, listening sessions, and advocacy events to bring young people and elders together, helping to bridge generational gaps and build community. In the summer of 2024, CERI launched an intensive 4-week summer leadership and advocacy program to uplift Southeast Asian (SEA) youth and youth from other refugee and immigrant communities (ages 12-24). A key component of the program is the youth-led research project, focusing on understanding how generational trauma affects SEA communities and their relationships to substance use and overall wellness; youth will develop and distribute a safety kit focused on raising awareness around substance use and generational trauma through a harm reduction lens.

The Hmong Cultural Center's Koomtes (Joining Hands) Youth Program

Encourages and empowers youth to build self-esteem, confidence, and leadership skills to support themselves and their peers. The program is led by a Youth Core Group who are trained in advocacy, active listening, facilitation, research, and public speaking techniques. Hmong Cultural Center staff members prepare core members as peer supporters by using real-life scenarios for core members to act out and analyze to learn how to de-escalate or support challenging situations. Core members are given incentives for their leadership in developing and leading program activities such as listening sessions, connecting with stakeholders, advocacy training, and social media campaigns. To date, 43 youths have participated in this program, and 12 have graduated and moved on to find part-time jobs or attend colleges and universities. The youth that have participated have significantly improved their own mental health and their knowledge of mental health systems and have helped peers inside and outside of the program discuss and attend to their own mental health. This program has benefited from an active group of parent volunteers and close collaboration with local government, schools, and community-based organizations.

The Cambodian Family's Empowered Southeast Asian and Latinx Youth Substance Use Disorder Prevention (ESALY) Program

Trains prospective youth leaders in community organizing and civic engagement including introducing them to local community-based organizations, who have collective decades of experience in community organizing, civic engagement, and capacity building. The ESALY has trained a cohort of dedicated, hard-working, and earnest youth leaders from communities of color who have organized, hosted, and co-hosted major agency events, including a Youth Forum and a Youth Leadership Summit (co-hosted with regional EYC partners). These leaders have also met the Santa Ana City Council, Mayor, Youth Commission(ers), and County Board of Supervisors. During a recent youth panel/community forum, youth leaders directly engaged these stakeholders, as well as other community leaders and policymakers in conversation on SUD policy and prevention at the local level. As of 2024, over Southeast Asian and Latinx 110 students have participated in the program. As part of this project, The Cambodian Family published the report and presented at American Public Health Association and Substance Use Disorder Integrated Care Conferences, In Their Eyes: The Causes of Youth Substance Use Disorder & Solutions, which drew from listening sessions with Santa Ana youth, and details youth input on the impact of substance use in their communities and youth-developed policy recommendations.

CONCLUSION

Making real progress in providing mental health care to immigrants and refugees requires a multi-faceted approach that acknowledges the trauma experienced by this population as well their unique cultural backgrounds. Policymakers have an important role to play in ensuring that California's health care system provides easy access to culturally competent mental health services and in supporting existing community-based organizations that work with these populations. In addition, continuing to develop and invest in a diverse mental health workforce that better reflects California's diversity and is trained in working with immigrants and refugees is critical.

This will require the dedicated work and cooperation of many different individuals and entities including mental health workers and providers, CBOs, first responders, health care systems, and governments. These organizations are encouraged to come together and form working groups where they can share successes, challenges, and needs so each organization can support one another.

ABOUT CPEHN

The California Pan-Ethnic Health Network (CPEHN) is a BIPOC-led, multicultural, state policy organization, which seeks to advance health equity by dismantling structural racism and ensuring opportunity and health for all Californians. For 30 years, CPEHN has worked with a diverse network of community-based organizations across the state to identify and elevate community priorities to state policymakers. CPEHN is dedicated to building power with communities of color through policy advocacy, research, network and leadership building, and storytelling.

CPEHN works closely with a network of 8 community-based and statewide organizations as the lead contractor for the MHSOAC's Diverse Racial and Ethnic Communities Stakeholder Advocacy Contract.

PARTNERS

ACKNOWLEDGEMENTS

We would like to thank our partners who contributed to the community stories and quotes in this report:

- Boat People SOS
- The Cambodian Family
- Center for Empowering Refugees and Immigrants
- Healthy House within a MATCH Coalition
- Hmong Cultural Center
- Level Up NorCal
- Orange County Asian and Pacific Islander Community
- Vision y Compromiso

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FUNDED BY

Proposition 1 Implementation Update

Presented by:

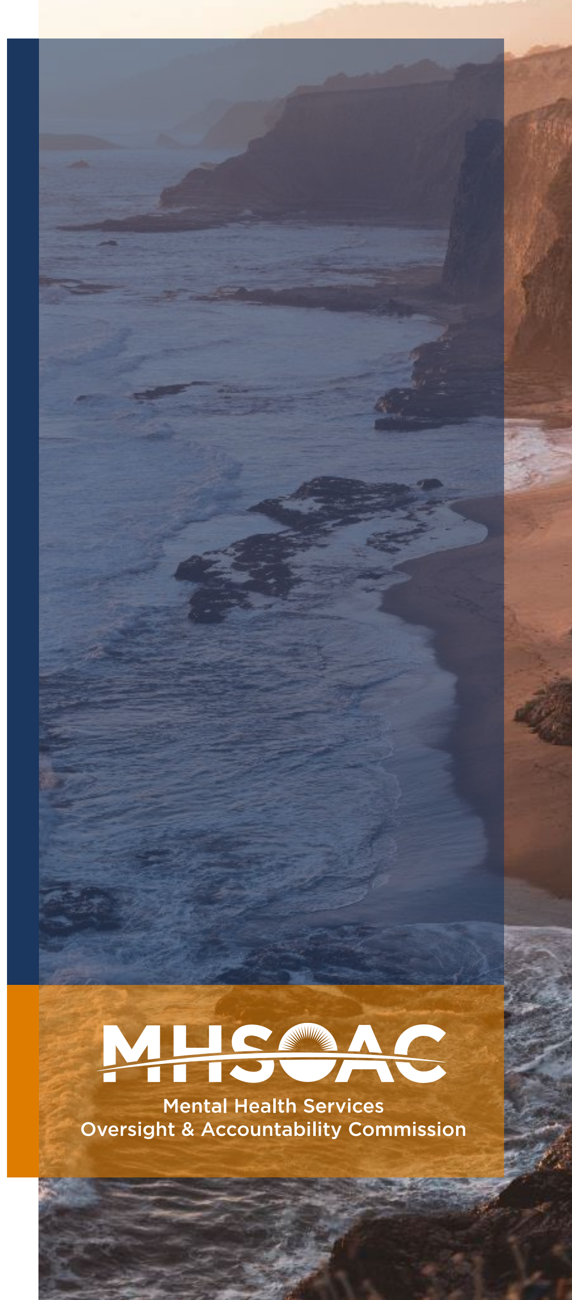
- *Kendra Zoller, Deputy Director of Legislation*
- *Jigna Shah, Chief of Innovation & Program Operations*
- *Andrea Anderson, Chief of Communications*

November 21, 2024

Bagley Keene Reminders

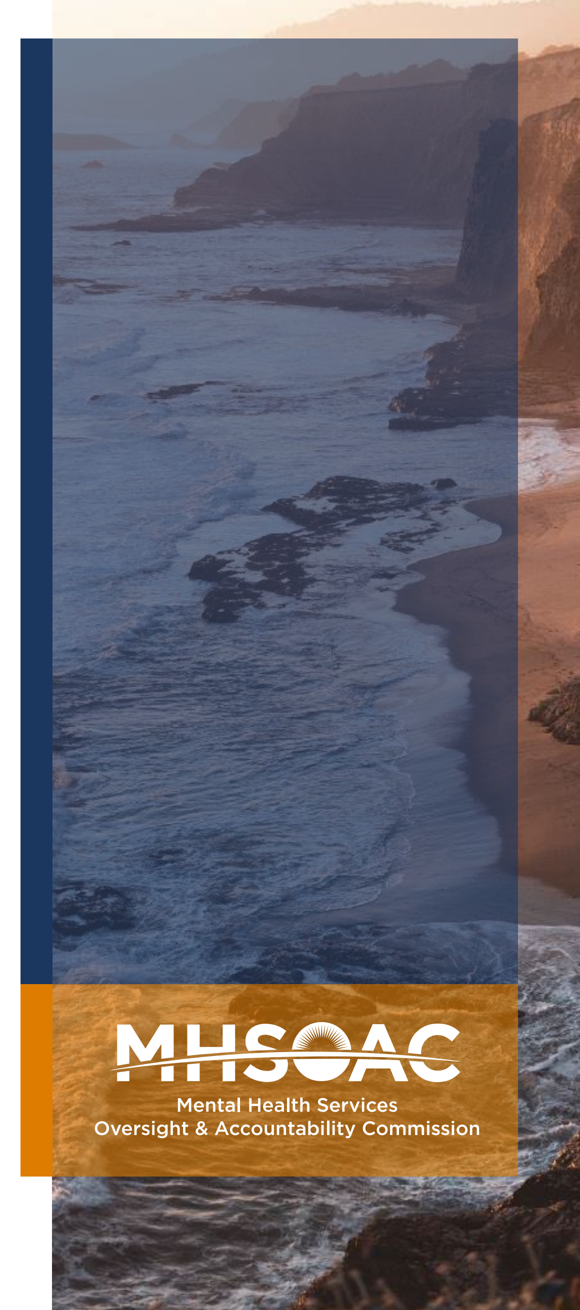
- 27 commissioners: 14 in person for quorum
  - January 1, 2025 – December 31, 2025: Hybrid or satellite
  - January 1, 2026 and beyond: In person or satellite
- Committees/subcommittees:
  - January 1, 2025 – December 31, 2025: Virtual allowed
  - January 1, 2026 and beyond: In person or satellite

Definitions	
In-Person	All in-person; no virtual option
Virtual	Fully virtually, with public room available
Hybrid	In-person quorum; others can be virtual with no restrictions
Satellite	Virtual but all commissioners in public space, publicly noticed 10 days prior, ADA-compliant; cannot make changes once noticed



Full Commission Meetings

- Quarterly: January, April, July, October
- In-person preferred
- Additional orientation/orientation refresher every January
- Additional meetings can be called at any time
- Assigns work to the committees
- Committees will bring recommendations to the meeting for action
- Items can be sent back to the committees for further deliberation or edits



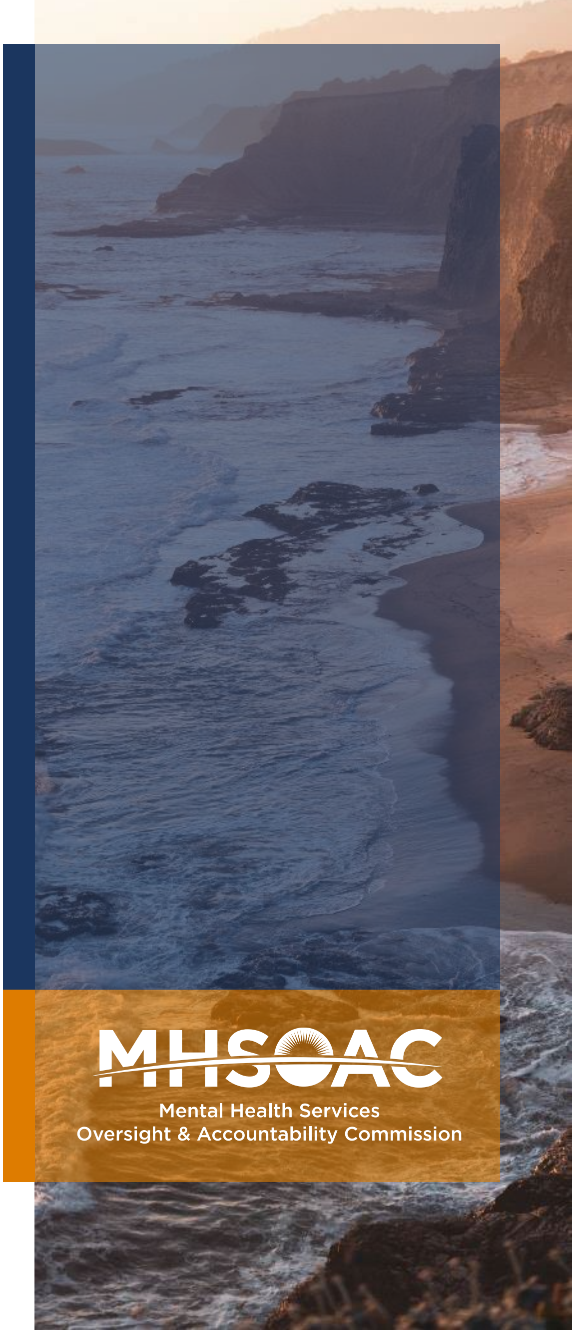
Technical Advisory Committees:

1. **Innovation**
2. **Community Engagement and Grants**
3. **Research and Evaluation**

- Quarterly: March, June, September, October
- One to 13 commissioners per committee
- May meet virtually until January 1, 2026
- Provides evaluations and recommendations to the full Commission, including on related legislation, budget expenditures and contracts, and communication strategies
- Can send projects or discussions to the Community Partnership Bridge Workgroup
- Community Partnership Bridge Workgroup can present to the committees

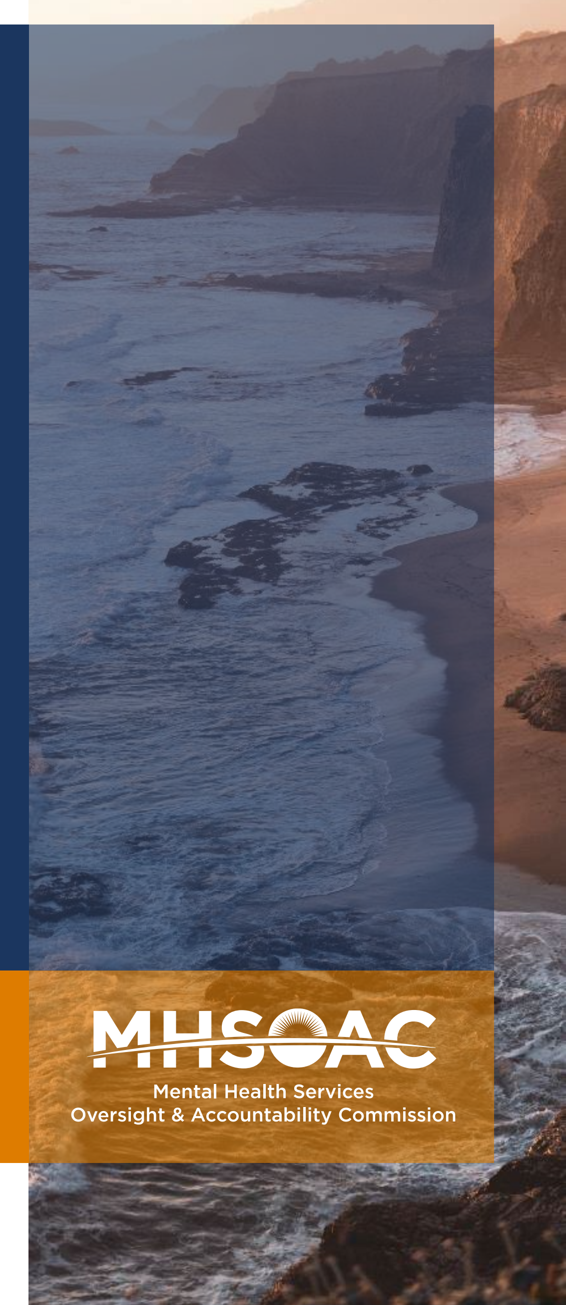
Provides evaluations and recommendations to the full commission on:

Innovation	Community Engagement and Grants	Research and Evaluation
• Approval of county innovation plans and multi-county collaboratives through 7/1/26 • A strategic and operational plan for the Innovation Partnership Fund • Approval of Innovation Partnership Fund grants beginning 7/1/26	• Approval of grants for the: Mental Health Student Services Act; Mental Health Wellness Act; Early Psychosis Intervention; and allcove • Approval of advocacy contracts serving eight populations • The Commission's other community engagement efforts	• Policy projects including implementation • Reports to the Legislature: FSP; MHSSA; Universal Screening • Program evaluations • Metrics • Data dashboards • Development of a Behavioral Health Index
Related legislation, budget expenditures including contracts, and communication strategies.		



Community Partnership Bridge Workgroup

- Quarterly: February, May, August, November
- Can be virtual or in-person, no restrictions
- No members – open public participation
- Up to two commissioners can attend
- Collaborates with community partners and committees to address key issues and projects related to:
    - Reducing health disparities
    - Promoting culturally and linguistically competent care
    - Improving the quality of services
    - Addressing social determinants of health
    - Elevating the voices of peers and those with lived experience
    - Improving access to integrated care options
    - Educating the public about Proposition 1, in coordination with CBHPC, DHCS, CDPH, HCAI, and others



Example Flow Chart

Proposal: Quarterly Meetings & Committees + Workgroup

Hybrid or Satellite through 1/1/26 then In-Person or Satellite

Quarterly Commission Meetings: January, April, July, October*
(Only decision-making body)

Commission: 27 commissioners; 14 in-person for quorum

Technical Advisory Committees: 1 – 13 commissioners; virtual until 1/1/26

Workgroup: Open public participation, option for virtual

**Additional Commission, Committee, and Workgroup meetings can be called at any time*

Innovation Committee

Community Engagement & Grants Committee

Research & Evaluation Committee

Community Partnership Bridge Workgroup

*Quarterly Committee Meetings: March, June, September, December**

*Quarterly Meetings**

Innovation Committee

Provides evaluations and recommendations to the full commission on:

- Approval of county innovation plans and multi-county collaboratives through 7/1/26
- A strategic and operational plan for the Innovation Partnership Fund
- Approval of Innovation Partnership Fund grants beginning 7/1/26

Community Engagement & Grants Committee

Provides evaluations and recommendations to the full commission on:

- Approval of grants for the: Mental Health Student Services Act; Mental Health Wellness Act; Early Psychosis Intervention; and allcove
- Approval of advocacy contracts serving eight populations
- The commission's other community engagement efforts

Research & Evaluation Committee

Provides guidance and recommendations to the full commission on:

- Policy projects including implementation
- Reports to the legislature: FSP; MHSSA; Universal Screening
- Program evaluations
- Metrics
- Data dashboards
- Development of a Behavioral Health Index

Community Partnership Bridge Workgroup

Collaborates with community partners and committees to address key issues and projects related to:

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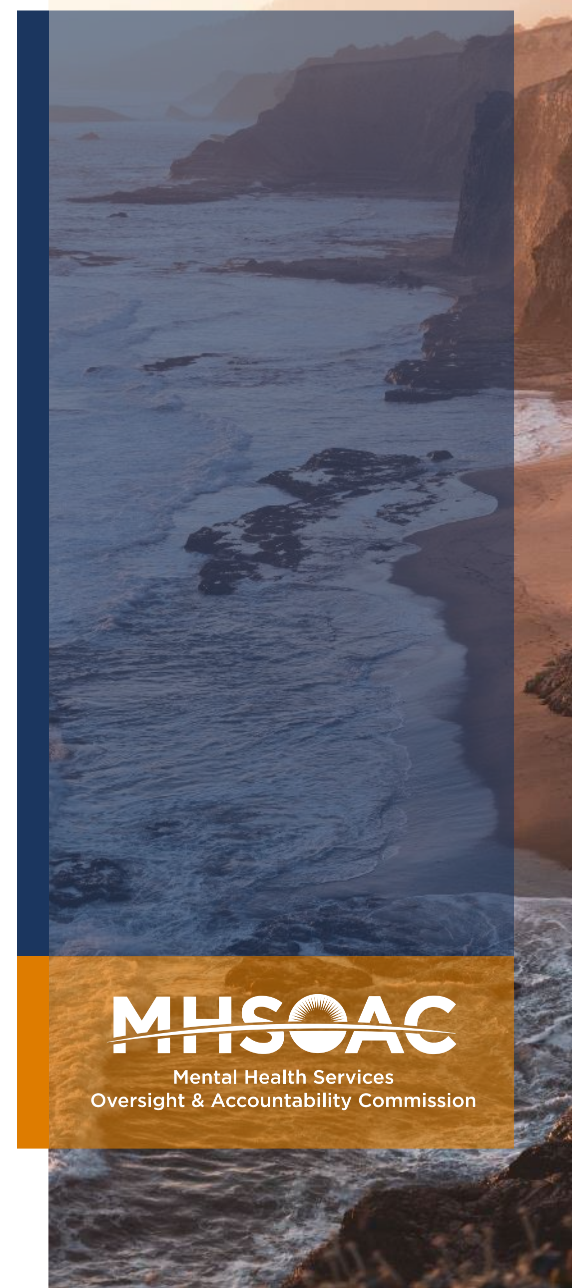
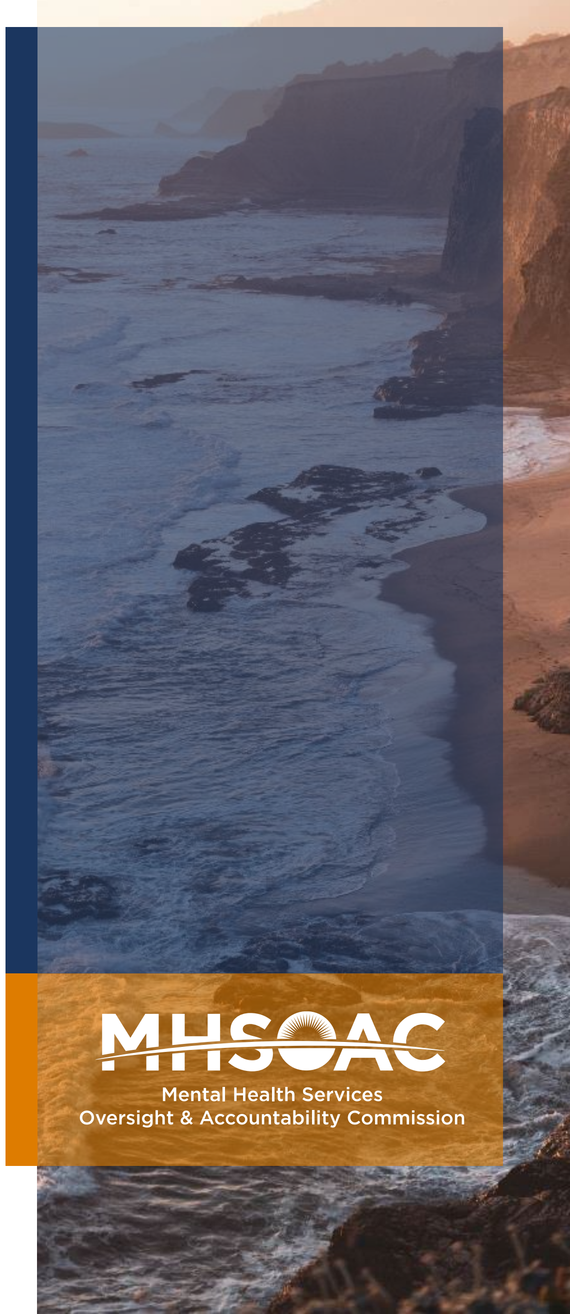
All committees will provide recommendations to the full commission on related legislation, budget expenditures including contracts, and communication strategies.



Reminder: Early Psychosis Intervention + Advisory Committee

- Statutorily required
- Membership: the Chair (or Chair's designee) + 15 commission appointed members
- Frequency: as convened by the Chair
- Required to:
  - Advise on evidence-based approaches for early psychosis and mood disorder detection and intervention.
  - Review and recommend guidelines for program development, awards, and selection processes.
  - Assist in evaluating the competitive selection process for funded programs.
  - Provide guidance as requested by the Chair.
  - Recommend standardized clinical and outcome measures for funded programs, with a data sharing portal.
  - Inform programs about opportunities to participate in clinical research studies.



Example 2025 Calendar

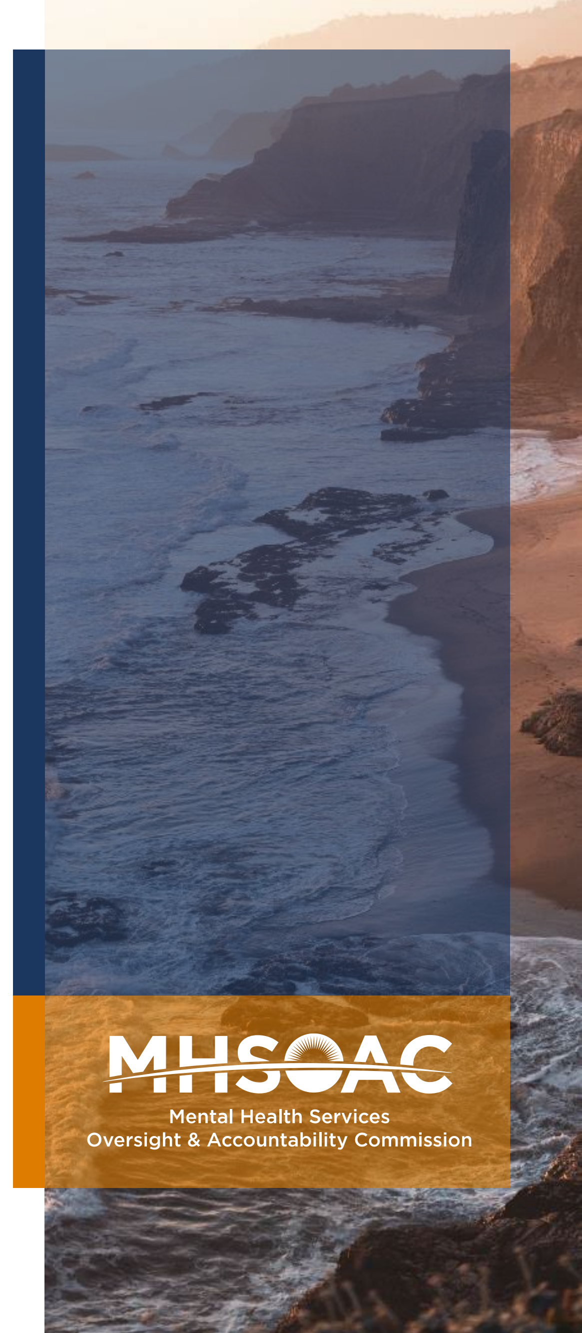
Date	Purpose	Location
January 22-23	**Meeting** + Orientation	*In person*
February 20	**Bridge**	*Virtual or hybrid*
March 18 - 20	**Committees: INN, CEG, RED**	*Virtual*
April 18	**Meeting**	*In person*
May 15	**Bridge**	*Virtual or hybrid*
June 17 - 19	**Committees: INN, CEG, RED**	*Virtual*
July 17	**Meeting**	*In person*
August 21	**Bridge**	*Virtual or hybrid*
September 16 - 18	**Committees: INN, CEG, RED**	*Virtual*
October 17	**Meeting**	*In person*
November 21	**Bridge**	*Virtual or hybrid*
December		

As needed:

EPI+ Advisory Committee

Virtual or Hybrid

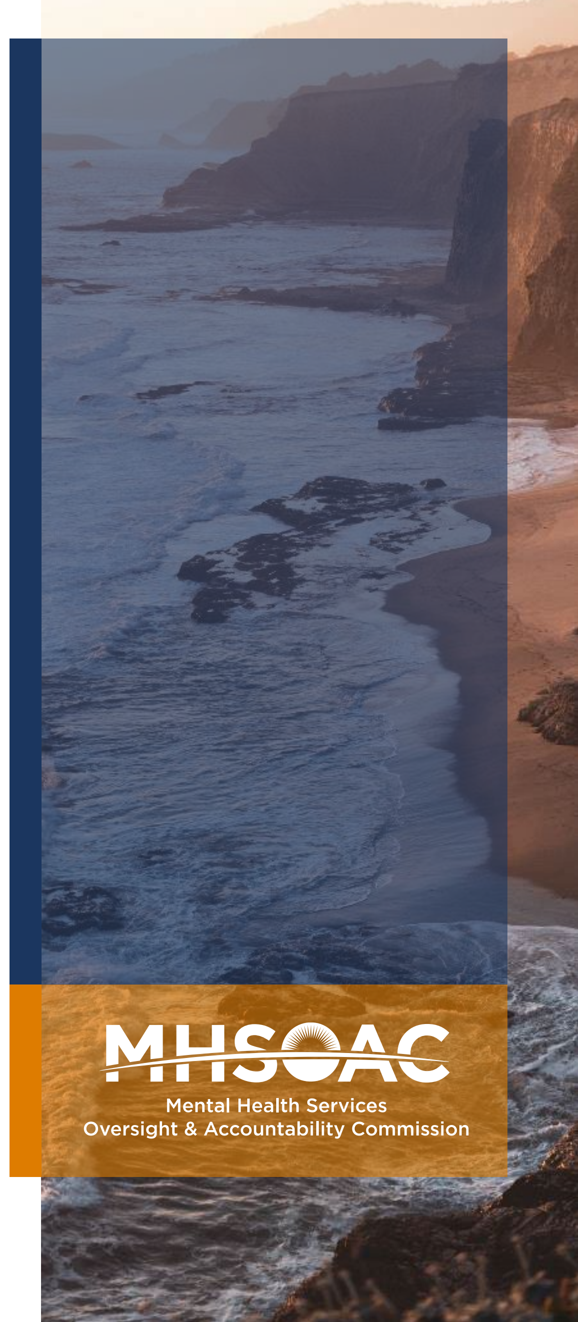
**Keeping the third Thursday (or third week) of the month*



Brand Refresh: How we got to here

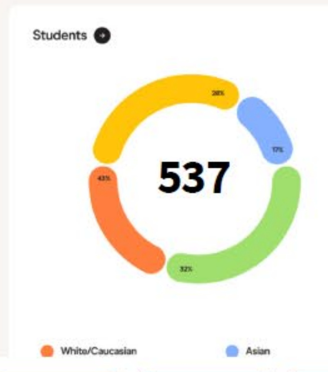
- Statutory requirement to change name to Behavioral Health Services Oversight and Accountability Commission on January 1, 2025
- Representative staff members and commissioners interviewed about the current brand
- Workshop for staff to provide feedback on key interview takeaways: our priorities, who we think we are, who our audiences are, and a naming study
- Staff and Chair agreed: Move forward with nickname option:

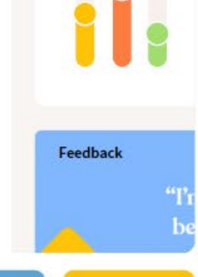
  Commission *for* Behavioral Health
- Ensuing staff and commissioner workshops explored visual direction using this nickname

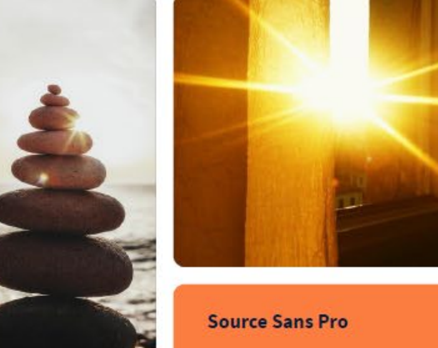


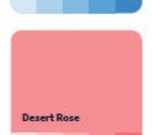
Brand Refresh: Updated logo

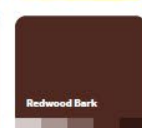
Brand Refresh: Visual direction





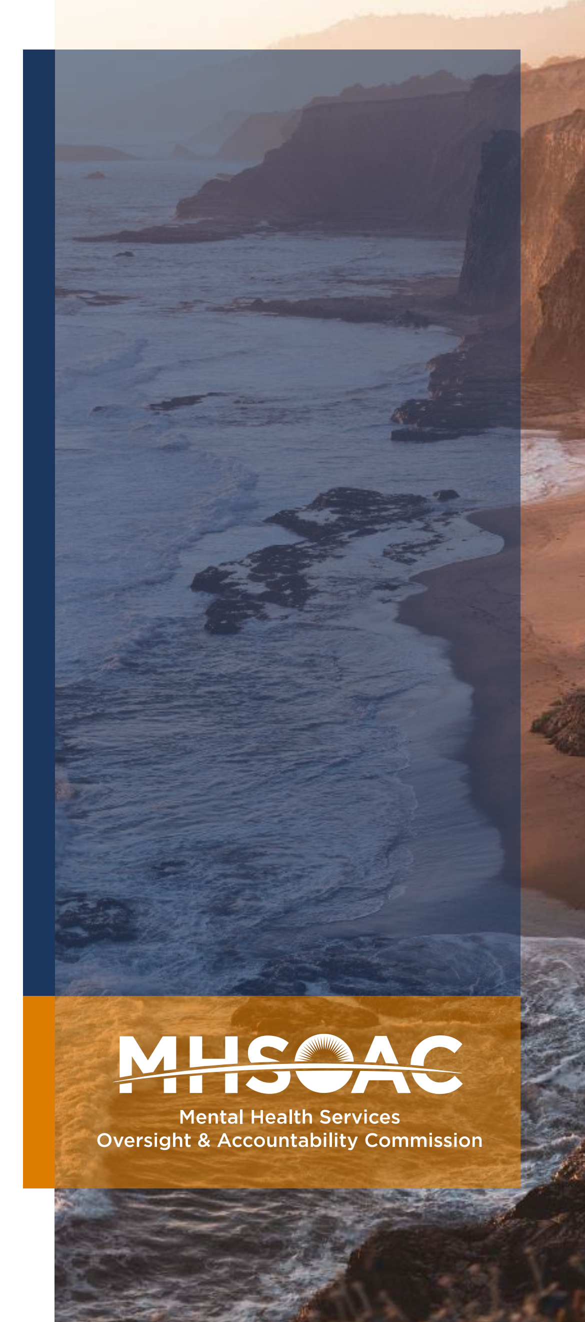






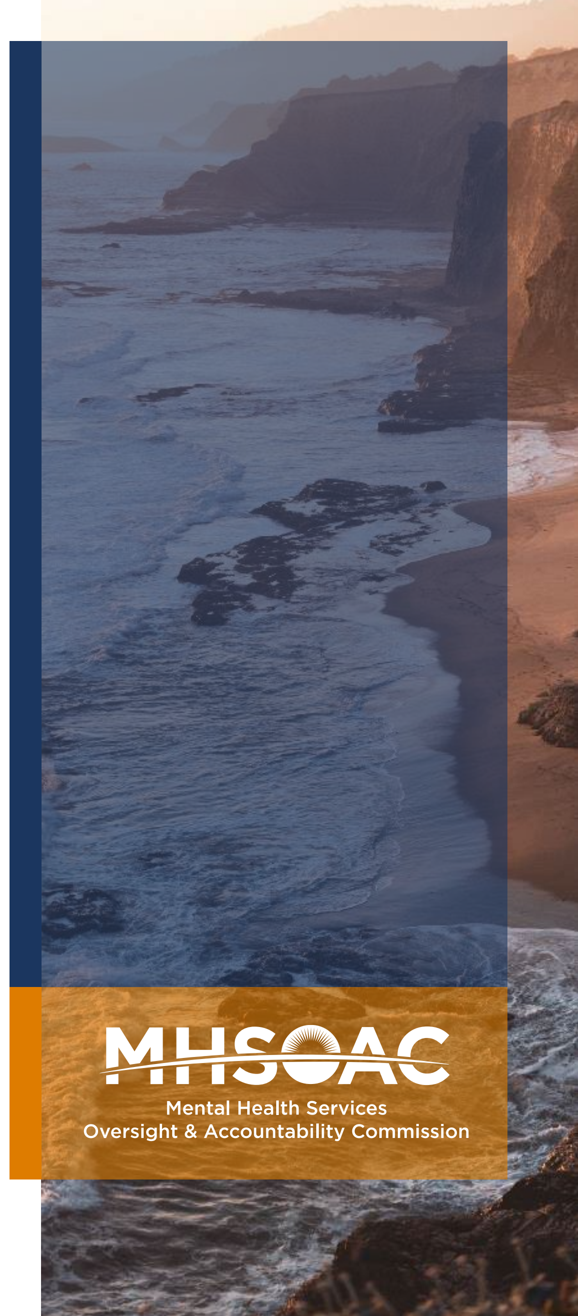
Next Steps

- Today: Discussion and feedback
- Approve Brand Refresh Design Direction
- January: Vote on meetings and committees
- Update the rules and procedures accordingly



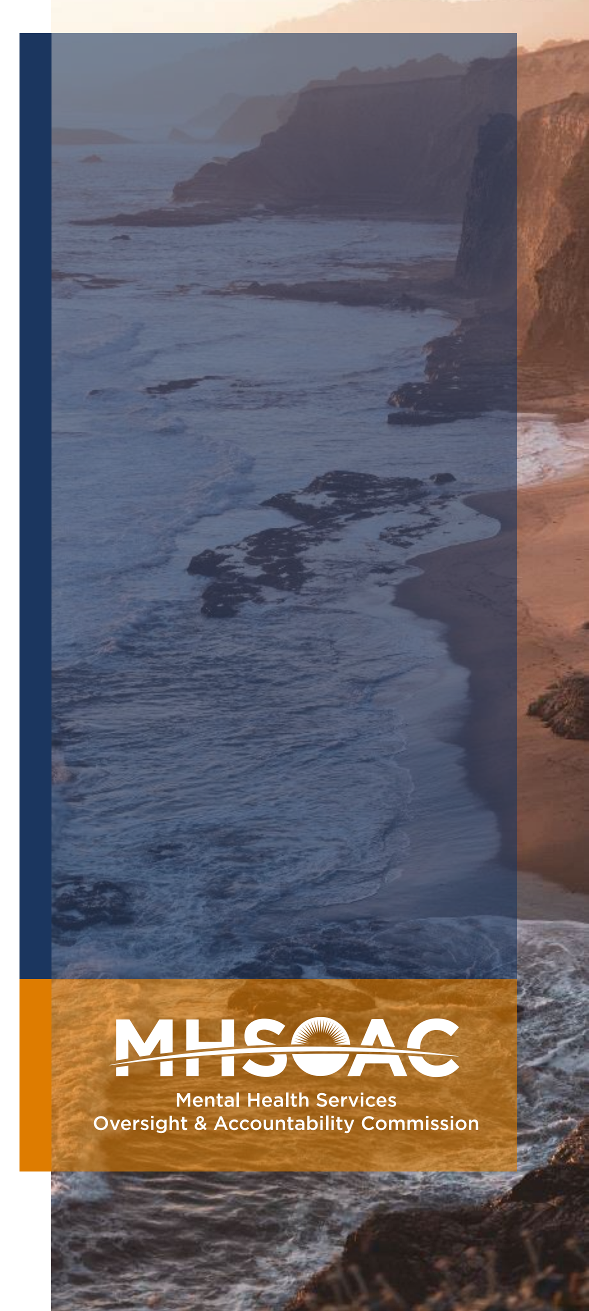
Proposed Motion

- That the Commission adopt the 2025 Commission Calendar and the creation of the following Committees:
    1. Innovation
    2. Community Engagement and Grants, and
    3. Research and Evaluation



Proposed Motion

That the Commission adopt the Brand Refresh Design Direction including the nickname, logo and color palate.



Proposal: Quarterly Meetings & Committees + Workgroup

Hybrid or Satellite through 12/31/2025 then In-Person or Satellite

***Commission**: 27 commissioners; 14 in-person for quorum*

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Quarterly Commission Meetings: January, April, July, October*
(Only decision-making body)

Innovation Committee | **Community Engagement & Grants Committee** | **Research & Evaluation Committee** | **Community Partnership Bridge Workgroup**

*Quarterly Committee Meetings: March, June, September, December**

Innovation Committee

Provides evaluations and recommendations to the full commission on:

- Approval of county innovation plans and multi-county collaboratives through 7/1/26
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Provides evaluations and recommendations to the full commission on:

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- Policy projects including implementation
- Reports to the legislature: FSP; MHSSA; Universal Screening
- Program evaluations
- Metrics
- Data dashboards
- Development of a Behavioral Health Index

All committees will provide recommendations to the full commission on related legislation, budget expenditures including contracts, and communication strategies.

Community Partnership Bridge Workgroup

*Quarterly Meetings**

Collaborates with community partners and committees to address key issues and projects related to:

- Reducing health disparities
- Promoting culturally and linguistically competent care
- Improving the quality of services
- Addressing social determinants of health
- Elevating the voices of peers and those with lived experience
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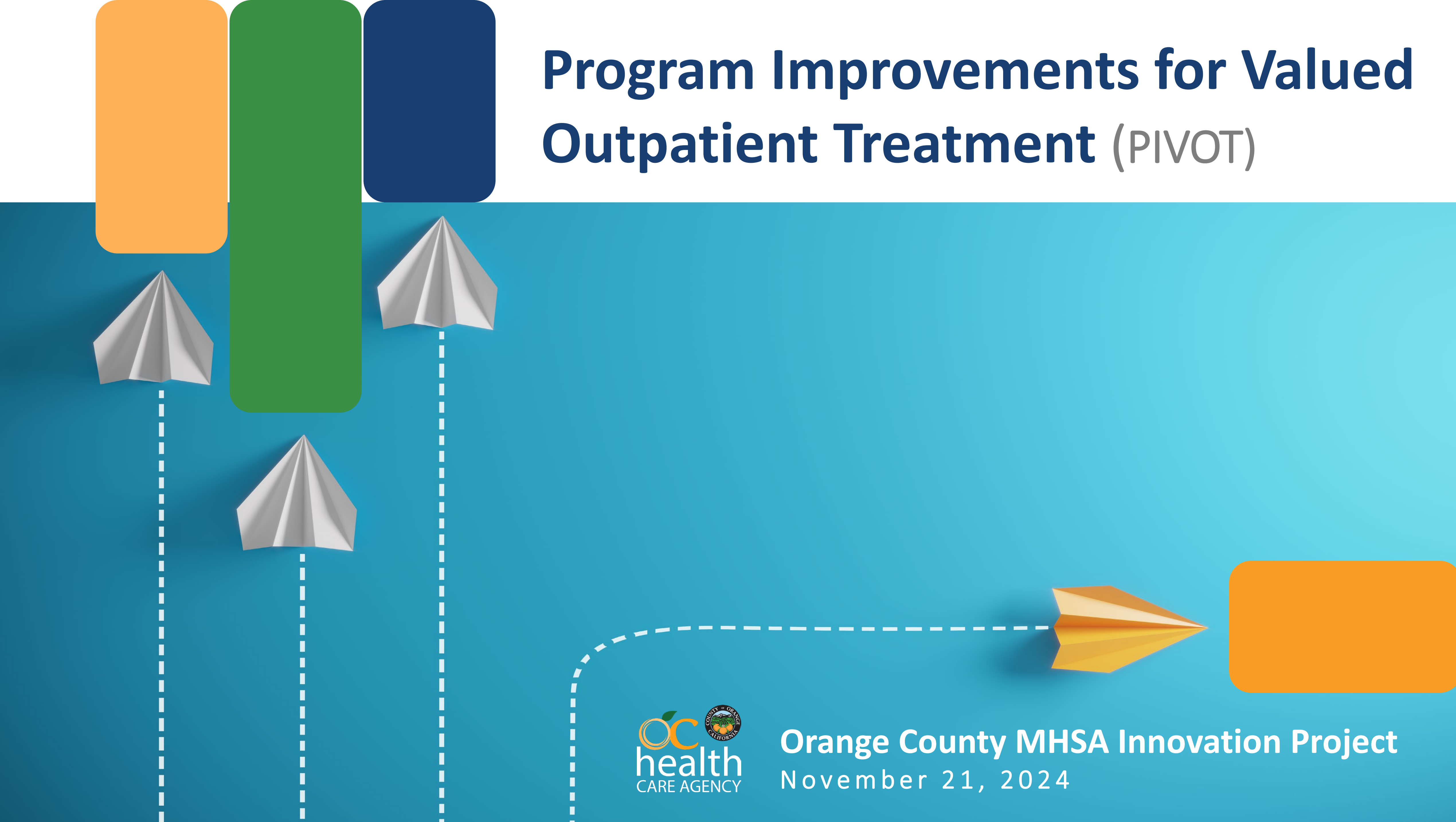
- Educating the public about Prop 1, in coordination with CBHPC, DHCS, CDPH, HCAI, and others


Program Improvements for Valued Outpatient Treatment (PIVOT)
OC health CARE AGENCY
Orange County MHSA Innovation Project
November 21, 2024

Project Description

Primary Problem

- Behavioral Health Transformation initiatives, including BHSA, will require changes in behavioral health operations and programs.
- Several areas within the system of care require administrative and/or program changes to improve access to and quality of services.

Response to Need

Create an overarching proposal that:

- Identifies successful strategies and administrative changes needed to prepare for the transition to BHSA and share lessons learned.
- Proposes innovative strategies to address local areas of need identified through stakeholder feedback.
- Offers counties with similar challenges the opportunity to participate in PIVOT components that best align with their local needs.

PIVOT

1 — Full-Service Partnership Reboot

Establish the local administrative processes and data infrastructure needed to prepare the county for changes to FSP programs under BHSA.

2 — Integrated Complex Care Management for Older Adults

Develop a system of care for older adults living with co-occurring mental health and neurocognitive conditions, who may also be homeless or at risk of homelessness.

3 — Developing Capacity for Specialty MH Plan Services with Diverse Communities

Identify the minimum capacity of a community-based organization to be able to become a specialty mental health plan/DMC-ODS contracted provider.

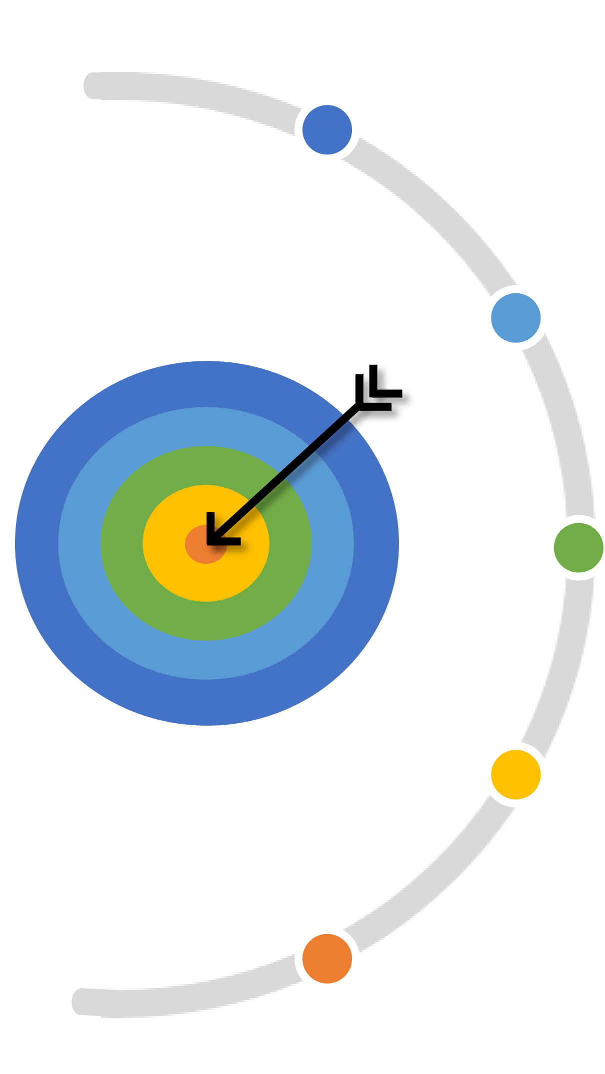
4 — Innovative Countywide Workforce Initiatives

Explore an alternative strategy to build a culturally competent and well-trained behavioral health workforce of professionals and paraprofessionals.

5 — Innovative Approaches to Delivery of Care

Identify a more culturally responsive, inclusive and efficient delivery of care, utilizing a User Experience model to gather input from consumers and their family members.

Behavioral Health Transformation Alignment



1

Full-Service Partnership Reboot
Focuses on changing administrative processes and building the data infrastructure necessary to align with the new funding and program requirements under BHSA

2

Innovative Countywide Workforce Initiatives
Proposes to address workforce shortage and increase access to services, which aligns with workforce infrastructure proposed under BHSA.

3

Developing Capacity for Specialty MH Plan Services with Diverse Communities
Strives to develop capacity of CBOs to become specialty mental heath providers to ensure equitable access, and advance CDEPs, which aligns with efforts under BHSA.

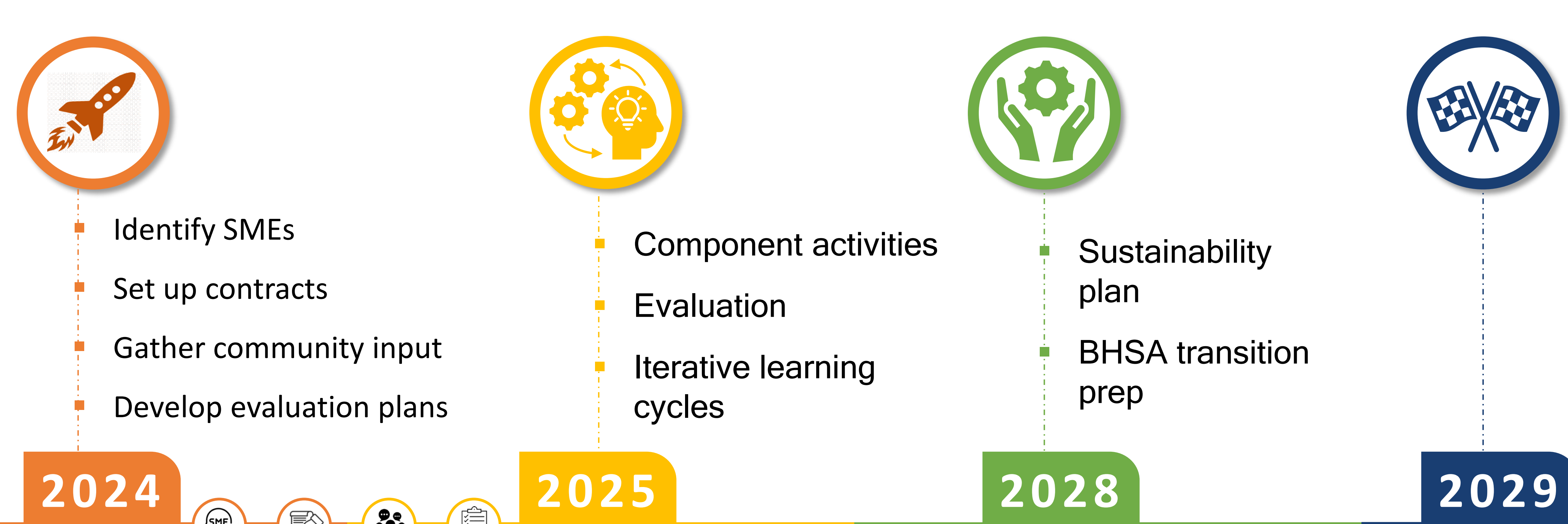
4

Integrated Complex Care Management for Older Adults
Strives to provide culturally responsive care and create pathways for equitable access to housing and care to reduce disparities, which aligns with several goals under BHSA.

5

Innovative Approaches to Delivery of Care
Seeks to create a more efficient clinic experience for clients, and provide access to wholistic, integrated services, which aligns with BHSA's goal of providing culturally responsive services.

5-Year Project Timeline



Sustainability

Developing Capacity for Specialty MH Plan Services with Diverse Communities

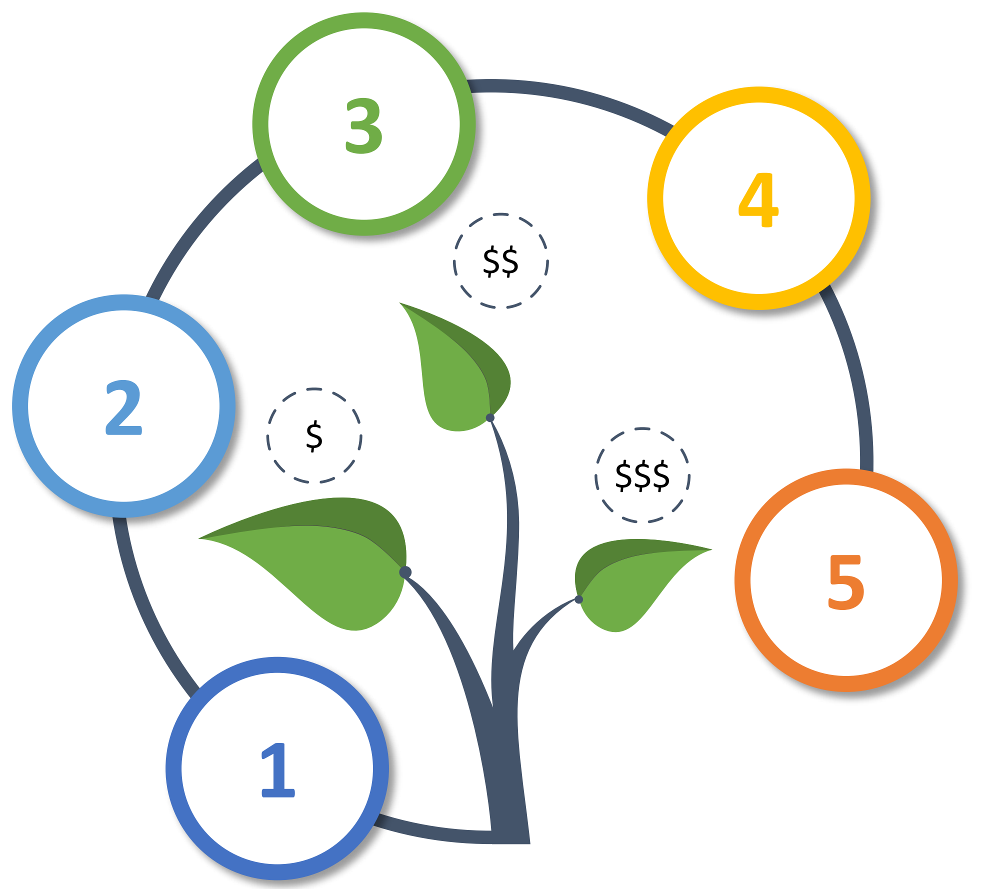
Provide CBOs with minimum steps to become Medi-Cal providers. CBOs will sustain services through Medi-Cal billing.

Integrated Complex Care Management for Older Adults

Sustain through proposed blend of funding structure.

Full-Service Partnership Reboot

Implement new changes into FSP programs to support ongoing operations and sustain service delivery under BHSA.



Innovative Countywide Workforce Initiatives

Embed successful strategies into administrative policies; apply for additional workforce development grants and opportunities with partners; collaboration with Managed Care Plans and explore ability to maintain through the BHSS component.

Innovative Approaches to Delivery of Care

Integrate successful approaches into daily program operations, where possible. Infuse culture of change to normalize piloting different approaches to care to establish a culture of continued learning.

Integrate successful approaches and strategies into administrative processes or program operations.

Identify and/or set up alternative sources of funding (Medi-Cal, grants).

Explore ability to sustain through BHSS funding component.

Project Budget

Category	Includes
Contractors $27,500,000	• Project Managers • Evaluators • Subject Matter Experts
Staffing $4,825,000	• County Staff time • Component Champions • Peer Support Specialists
Program $2,500,000	• Program Supplies • Translation/ Interpretation • Travel
Indirect $125,000	• 5%

Total 5-Yr Requested Budget
$34,950,000

ochealth
CARE AGENCY
COUNTY OF ORANGE
CALIFORNIA

Thank you!

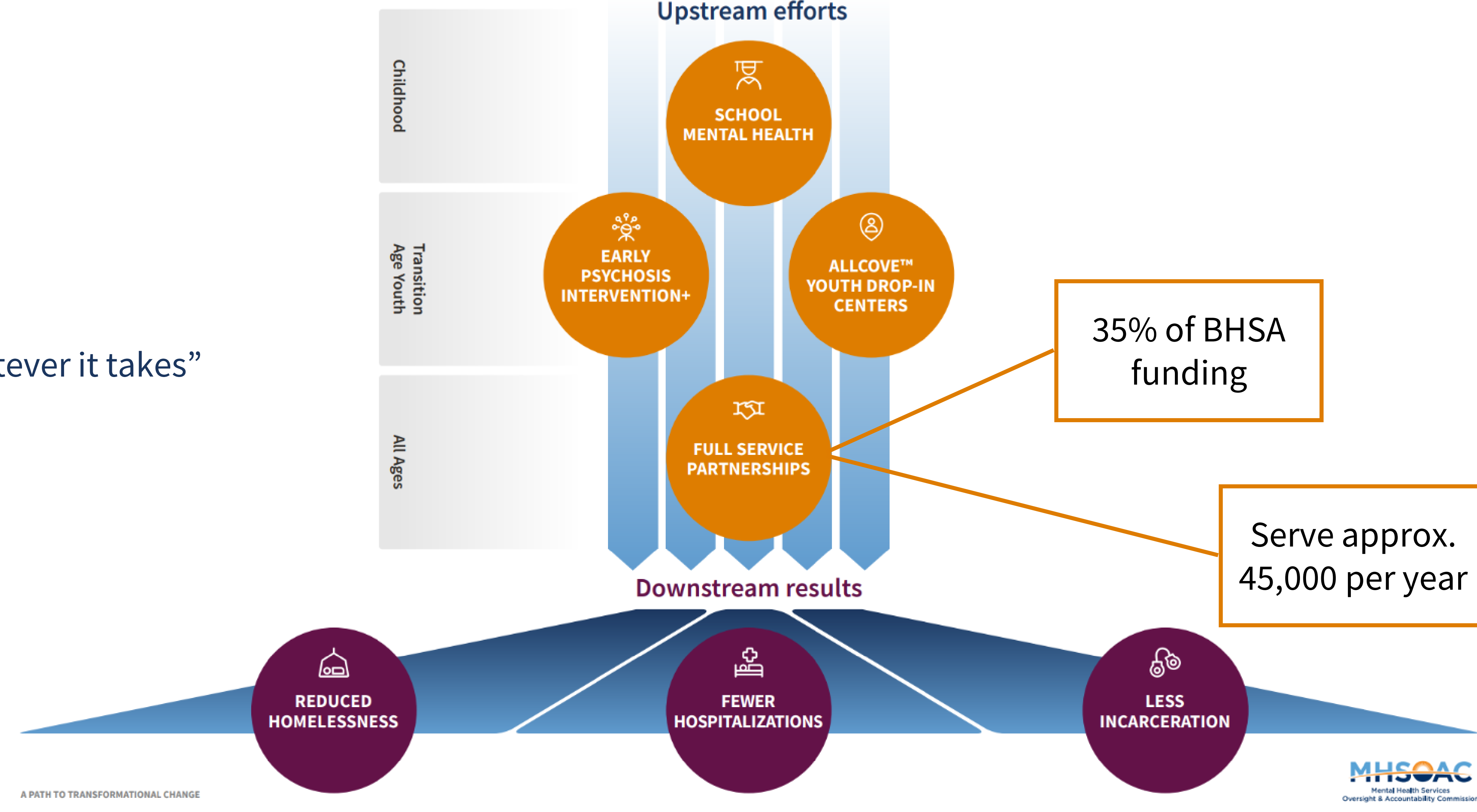
Proposed Motion:

That the Commission approve Orange County's Program Improvements for Valued Outpatient Treatment (PIVOT) Innovation Project for up to $34,950,000 over five (5) years

Full Service Partnerships Legislative Report

November 2024

“whatever it takes”

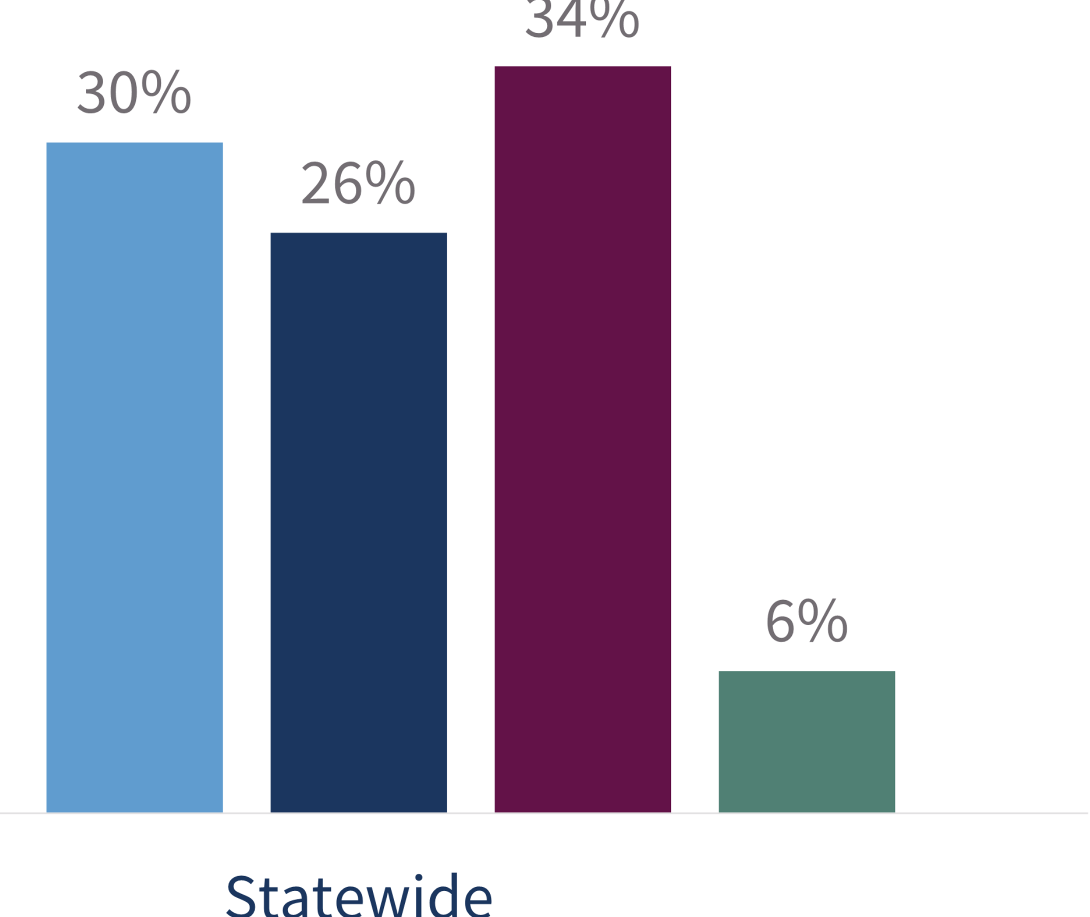


Senate Bill 465 directs the Commission to report on:

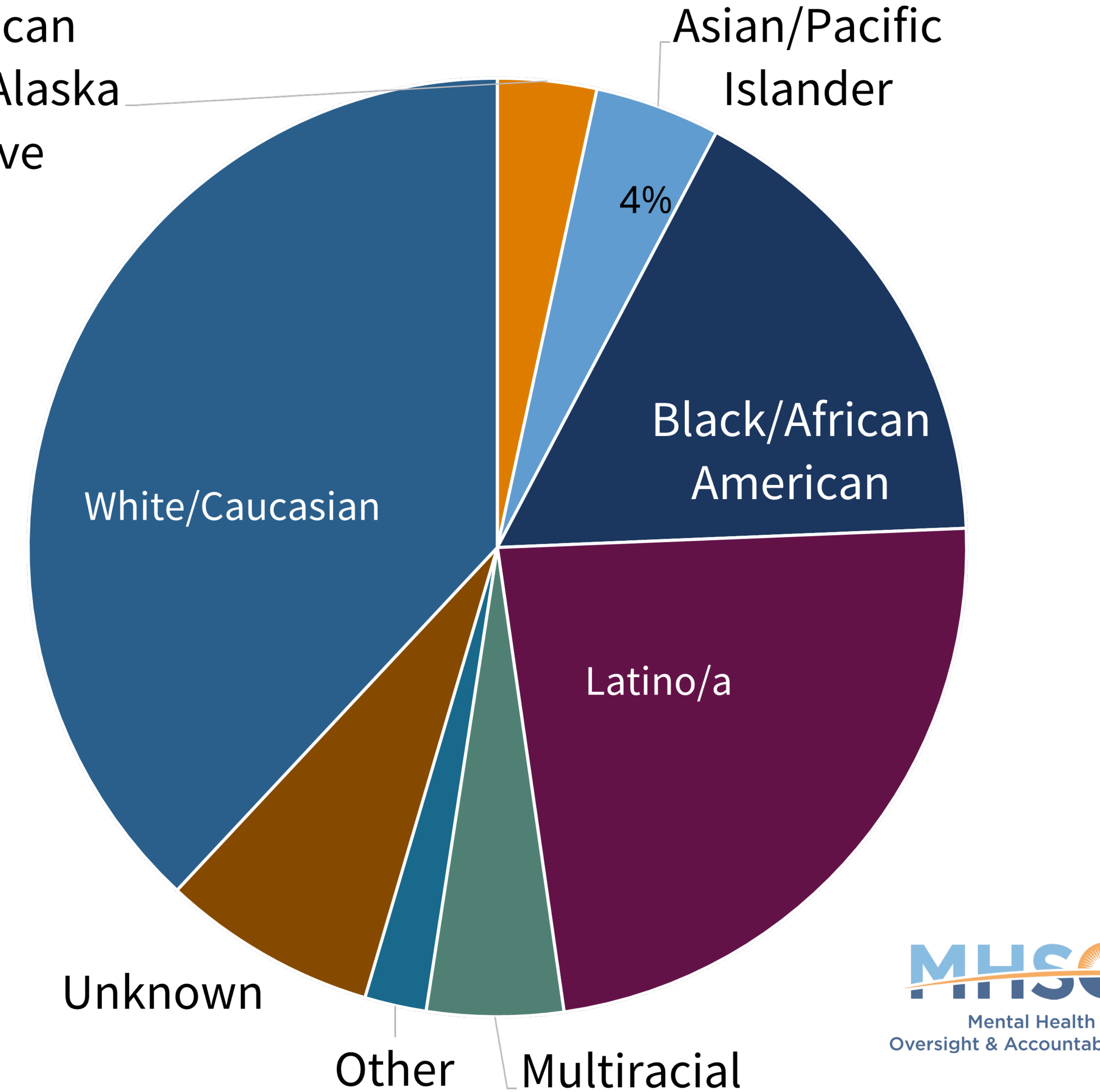
- Status of individuals eligible for FSPs: criminal justice involvement; housing status or homelessness; hospitalization, emergency room use, and crisis service use.
- Separation from an FSP: outcomes for the 12 months following separation.
- Are those most in need are accessing and maintaining in an FSP?
- Identification of barriers to receiving data
- Recommendations to strengthen California's use of FSPs to reduce incarceration, hospitalization, and homelessness.

Client overview

Adults are the largest age group served by FSPs.



Race and ethnicity of FSP clients varies by age



Adults N=98,099

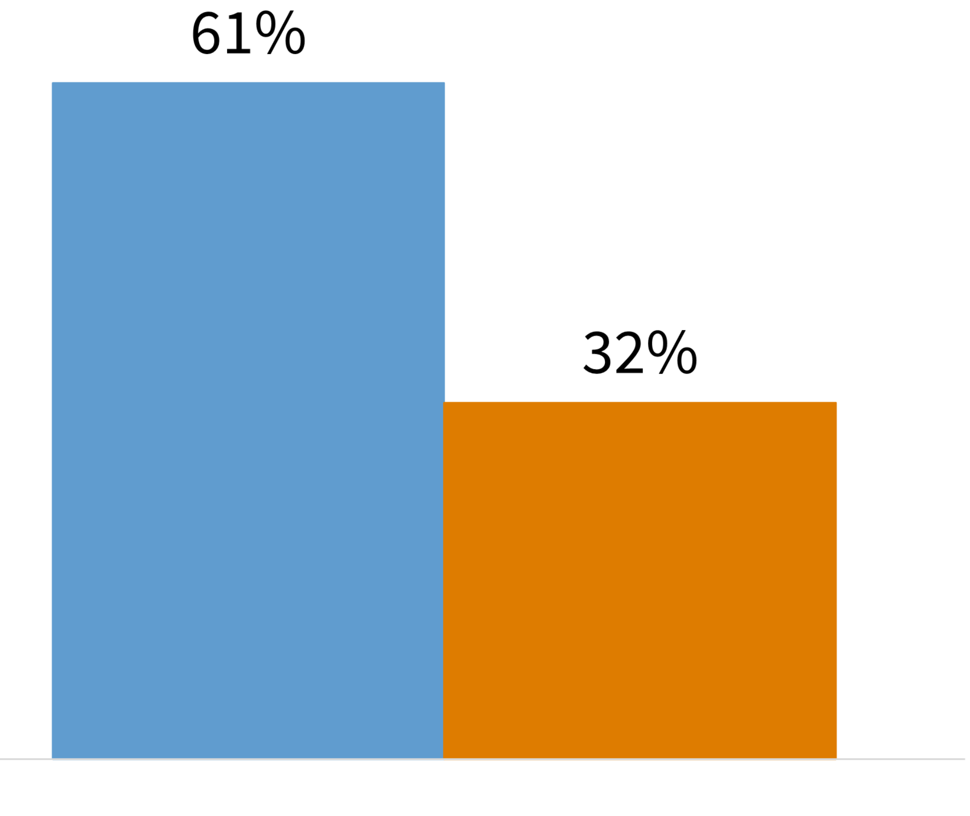
MHSOAC
Mental Health Services Oversight & Accountability Commission

Race and ethnicity of FSP clients varies by age

American Indian/Alaska Native
Asian/Pacific Islander
Black/African American
Latino/a
Multiracial
Other
Unknown
White/Caucasian

Child/TAY
N=98,099

About 60% of adult and 30% child/TAY clients have reported homelessness



Most prevalent diagnoses experienced by clients

Adults

- Schizophrenia/ psychotic disorders (69%)
- Depressive disorders (63%)
- Substance use/addictive disorders (41%)

Children/TAY

- Depressive disorders (61%)
- Trauma/stressor-related disorders (26%)
- Disruptive/ impulse control/ conduct disorders (33%)
- Neurodevelopmental disorders (31%)
- Anxiety disorders (27%)

Service use

Child/TAY clients tend to exit partnerships faster than adult and older adult clients

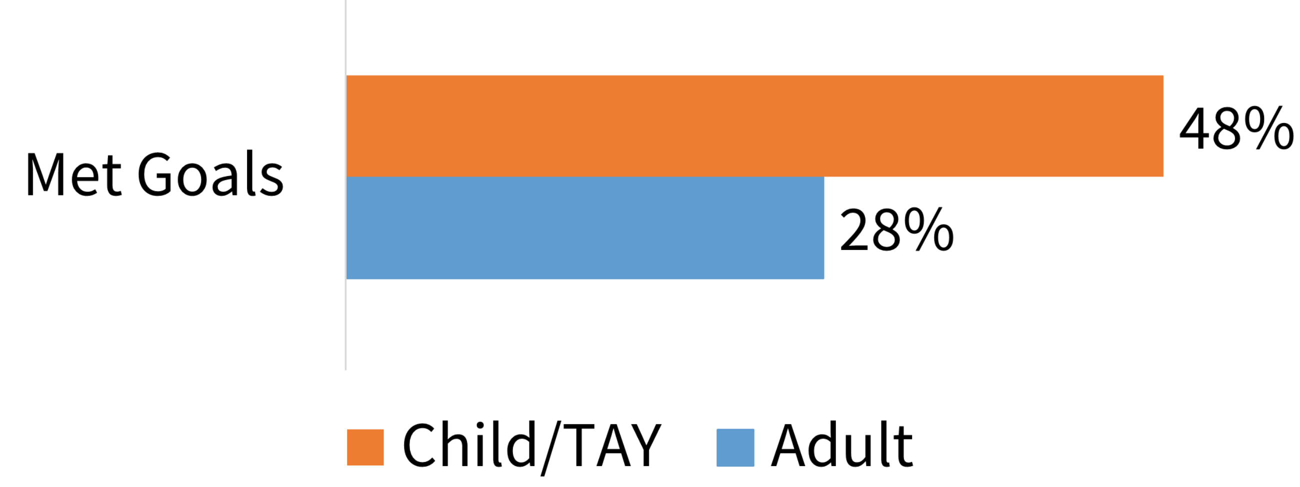
Discharged

100%
80%
60%
40%
20%
0%

0 6 12 18 24 30 36

Months After Enrollment

Meeting their goals was the most common reason for exiting an FSP



In most regions crisis service use went Down after joining an FSP

	CRISIS SERVICES		
Region	Pre	Post	Percent Change
California	80,581	73,266	**-0.09**
Bay Area	7,067	8,894	0.26
Central	19,137	16,624	**-0.13**
Los Angeles	17,006	19,612	0.15
Southern	30,129	22,442	**-0.26**
Superior	7,242	5,694	**-0.21**

Psychiatric hospital admissions went down after joining an FSP

	PRE	POST
Admissions (x 1,000)	86	59
Days (x 10,000)	82	57

Commission learning efforts

Targeted Outreach

- **87** participants
- **40** organizations
- **22** counties
- **28%** identified as people of color
- **24%** shared they had personal or family experience of behavioral health challenges

Community Forums

- **145** participants
- **76** organizations
- **29** counties
- **43%** identified as people of color
- **44%** shared they had personal or family experience of behavioral health challenges

Statewide Survey

- **228** participants
- **35** counties
- **57%** identified as people of color
- **46%** shared they had personal or family experience of behavioral health challenges
- Average of **10 years** of experience in FSPs

Research

- **3** deep dives on county contract practices
- **2** case studies on data collection and reporting
- **2** pilot projects on performance management
- **4** site visits (3 adult and 1 child/TAY)

Data collection

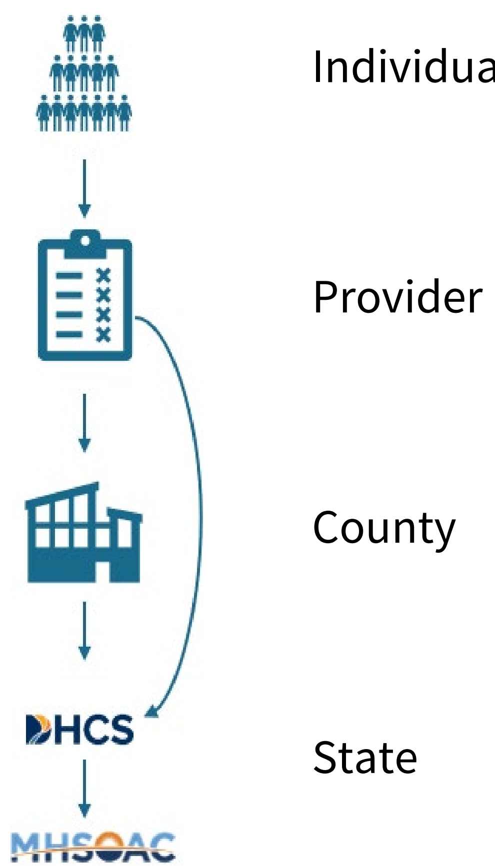
Required Forms

PAF The Partner Assessment Form (PAF)

! KET The Key Event Tracking (KET)

3M Quarterly reports

Reporting



Individual

Provider

County

State

Findings – data collection and reporting

Domain	Category
Data collection and entry	Lack of clarity
	Inefficiency
	Redundancy
	Administrative burden
Data reporting and monitoring	Inability to pull data
	Lack of good data
Aspirations	Make it useable
	IT solutions to data system

Recommendations

Data Infrastructure

- The Commission's findings suggest the existing DCR system is not sufficient for capturing accurate, high-quality data necessary for statewide accountability and transparency of FSPs. The Commission recommends that the existing DCR system be overhauled or replaced with a more flexible, adaptive, provider-centered system.

Findings: Beyond the data

Staffing and workforce

Finding

The ongoing workforce crisis significantly affects all aspects of FSP programs. FSP providers repeatedly called for solutions to address persistent staff shortages and guidance on how to better leverage current staff resources. Training and capacity building alone will not be sufficient to alleviate the current strain on FSP providers or alleviate the resulting turnover.

Recommendations

The Commission suggests the State invest significant resources in identifying scalable solutions that can:

- Widen the pipeline
- Increase incentives/benefits
- Reduce provider stress
- Utilize peers

Outcomes contracting

Finding

The current contracting practices between counties and providers does not place a strong enough focus on outcomes. Not enough incentives are awarded to providers for reaching client goals.

Recommendations

- The Commission recommends counties include performance metrics into their future contracts with service providers, thus incentivizing improved client outcomes.
- Outcome based contracting should be thoroughly vetted and an evaluation should be conducted.

Funding

Finding

- There remains substantial confusion around what services are billable and to whom under payment reform and in anticipation of BHSA implementation.

Recommendations

- Strong technical assistance and training on:
  - Braiding funding and sustainability
  - Clarity around Medi-Cal billable services
  - Impacts of CalAIM
  - Impacts of BHSA

Service models

Finding

Counties and providers both need support and clarity around BHSA requirements and technical assistance and training to get staff prepared to meet mandates.

Recommendations

The Commission recommends California develop and disseminate clear service model guidelines for FSP programs statewide, including:

- A clear definition of what an FSP is, and what the shared goals of FSPs are.
- Clear and specific eligibility requirements for FSP clients to reduce wait times and ensure individuals are connected to the correct resources from day one.
- Recommended evidence-based practices for treatment models specified in BHSA.
- Guidance on selecting an appropriate treatment model.

Performance management

Finding

- Most providers don’t have systematic goal setting and tracking or the resources to support staff in meeting performance goals.

Recommendations

- The Commission recommends the launch of a statewide learning community where county behavioral health staff and providers can gain greater knowledge of the potential benefits of performance management for their teams and better understand the resources necessary to undertake performance management with fidelity.
- Furthermore, the Commission suggests an evaluation of the plausible impact and resources needed to create scalable performance management statewide.

Next steps

Evaluation of child/TAY FSPs including:

- Client overview
- Service delivery models
- Referral sources
- Service delivery site/embedded services
- Outcomes

Pilot projects in Sacramento and Nevada Counties on performance management. Results will be brought to the Commission in Summer 2025.

Technical assistance and capacity building focused on:

- Value-based contracting and performance management
- Improved service delivery

Next steps

Best practices toolkit

The toolkit will focus on the following five topics and is expected to be available in summer of 2025:

- Peer and paraprofessional supports in the workforce
- Services and treatment for individuals with substance use disorders
- Collaboration with community and cultural partners
- Step-down levels of support
- Outreach and engagement

Thank You
MHSOAC
Mental Health Services
Oversight & Accountability Commission

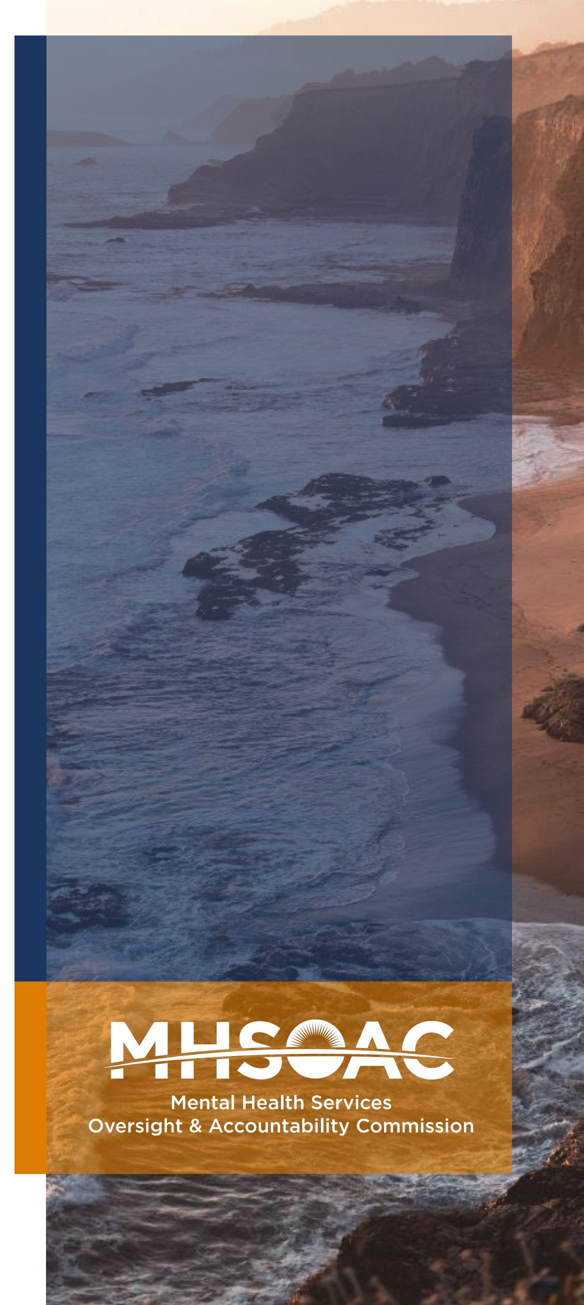
Report to the Legislature on the Mental Health Student Services Act

Dr. Melissa Martin-Mollard, Chief of Research and Evaluation

November 21, 2024

Mental Health Student Services Act

- $255 million investment, prioritizing highest needs K-12 school districts and schools.
- Reaches approximately 45% of school districts and almost 1 in 4 schools.
- Services are tailored to meet local needs.

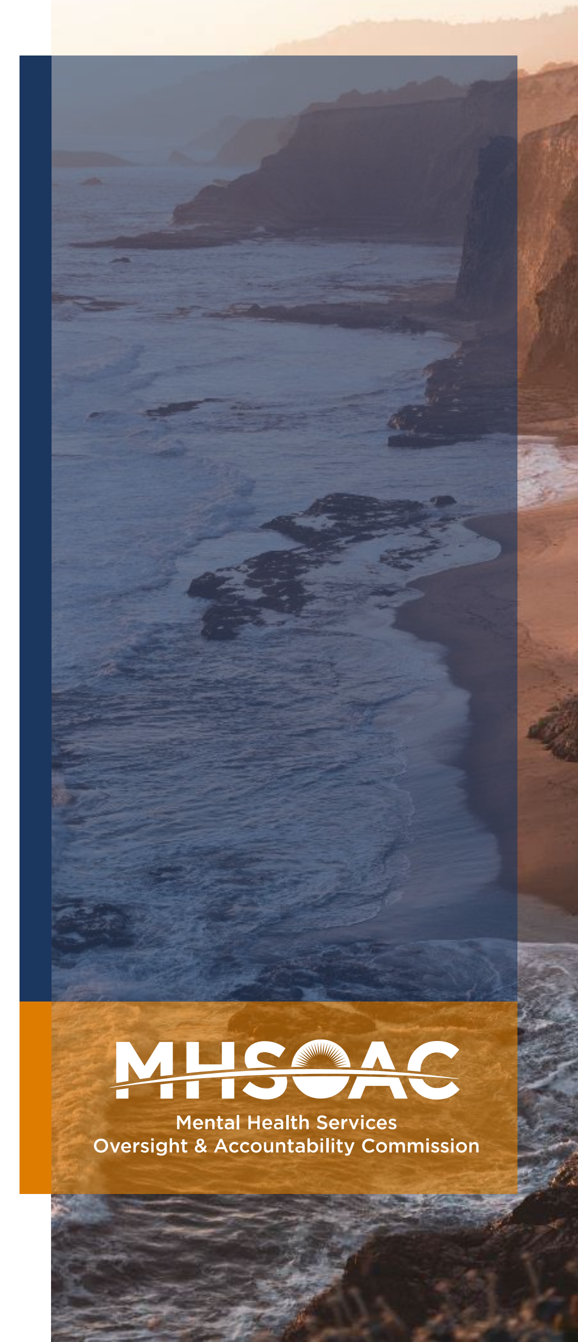


Report to the Legislature on the Mental Health Student Services Act

by the Mental Health Services Oversight and Accountability Commission

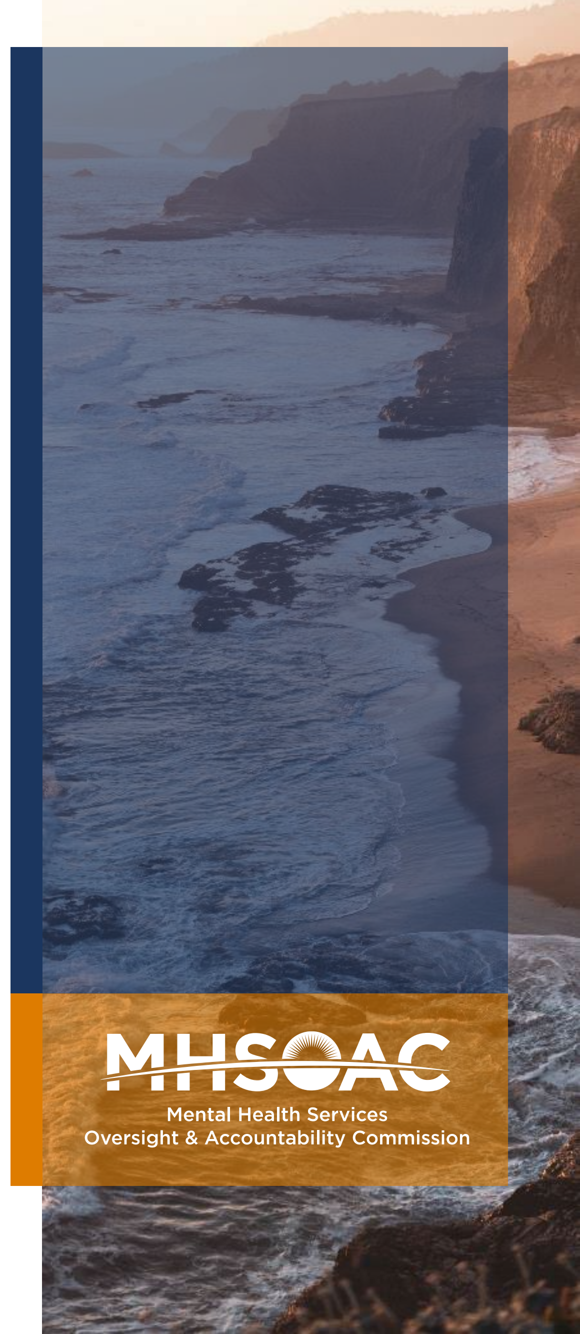
Submitted to the Fiscal and Policy Committees of the Legislature

DRAFT



Lessons Learned

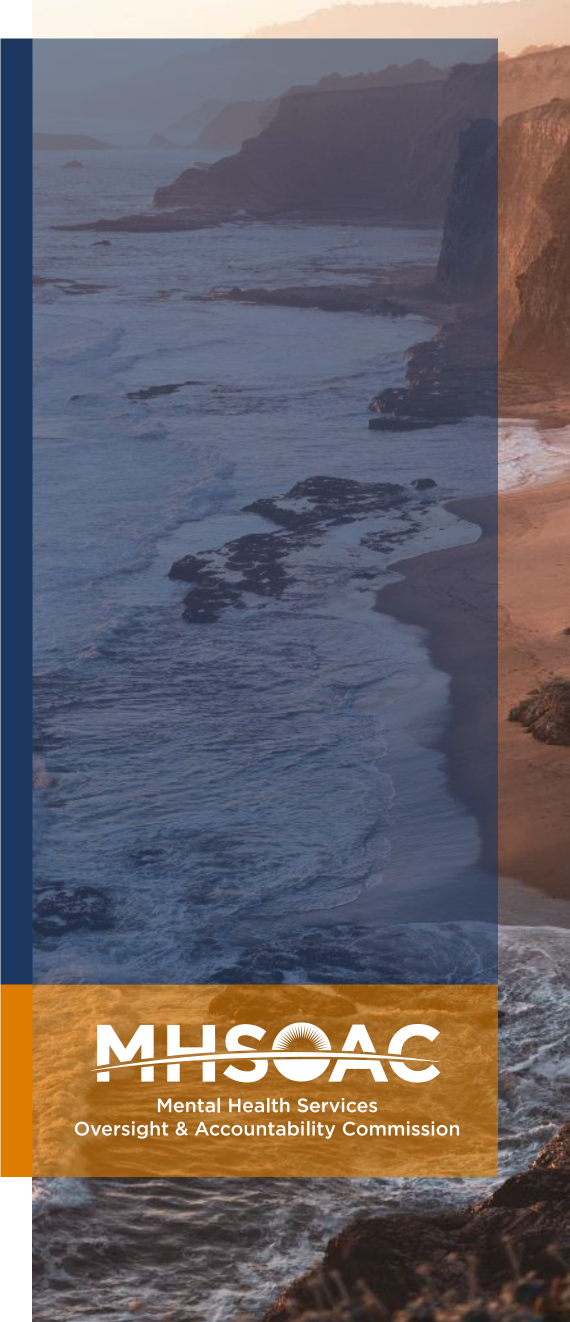
1. Local MHSSA activities and services are **heterogenous and tailored** to meet local needs and gaps in services.
2. MHSSA partners have **built and strengthened partnerships** but need additional guidance to support local success.
3. The **need** for school mental health services often **exceeds** local capacity.
4. **School mental health standards** are needed in California to drive quality improvement.
5. **Alignment** of California's school mental health initiatives is important for local success.



Recommendations

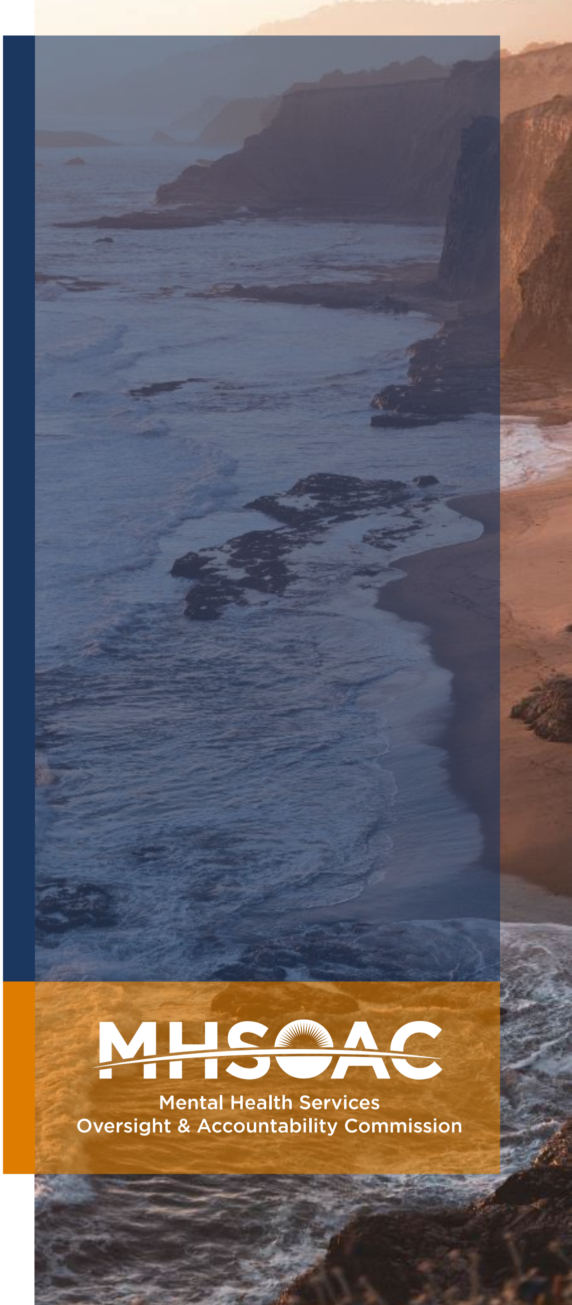
The State should:

- Establish a **leadership** structure for youth behavioral health to coordinate and align school mental health initiatives and develop a strategy for building sustainable, comprehensive school mental health systems in every K-12 school in California.
- Make additional **investments** that are adequate, consistent, aligned, and incentivized to achieve desired outcomes.
- Develop an **accountability** structure including school mental health standards and metrics that show progress toward established goals.



Next Steps: WestEd Evaluation

- WestEd completed planning phase of evaluation
  - Extensive document review
  - Community engagement
  - Listening sessions with grantees
  - Youth Advisory Board
  - Collaboration with Commission staff



Next Steps: WestEd Evaluation

State-Level School Mental Health System

Other School Mental Health Initiatives

County-Level School Mental Health System

School-Level Mental Health System

MHSSA

Grantee Partnerships

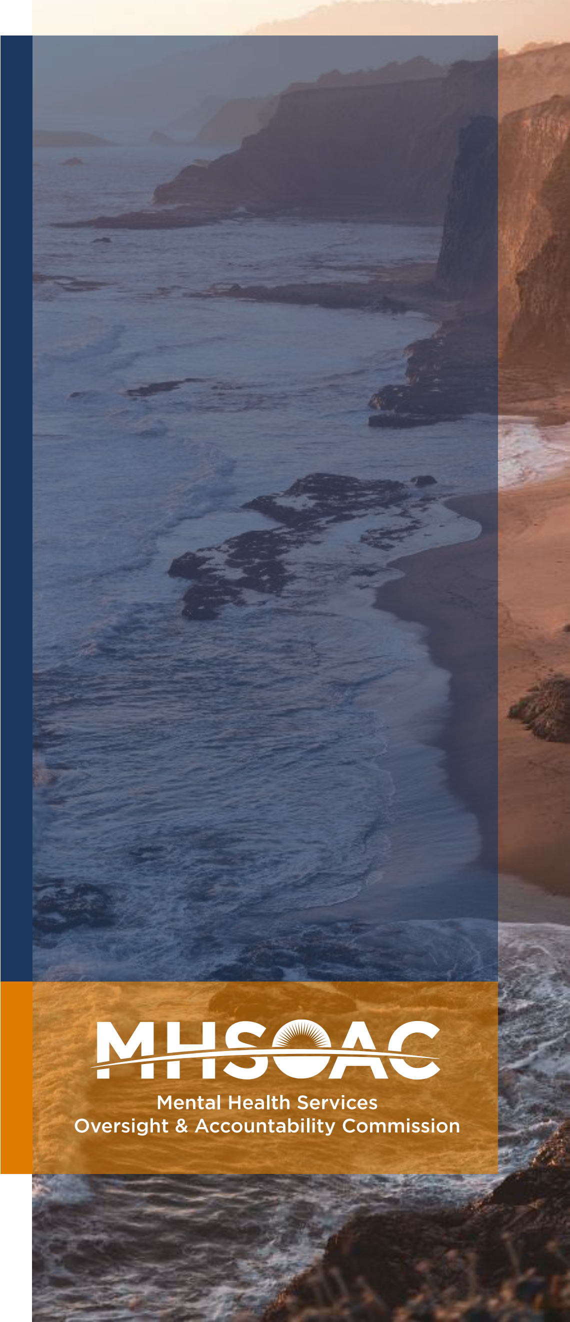
Existing

New & Emerging

MHSSA-Funded Activities and Services

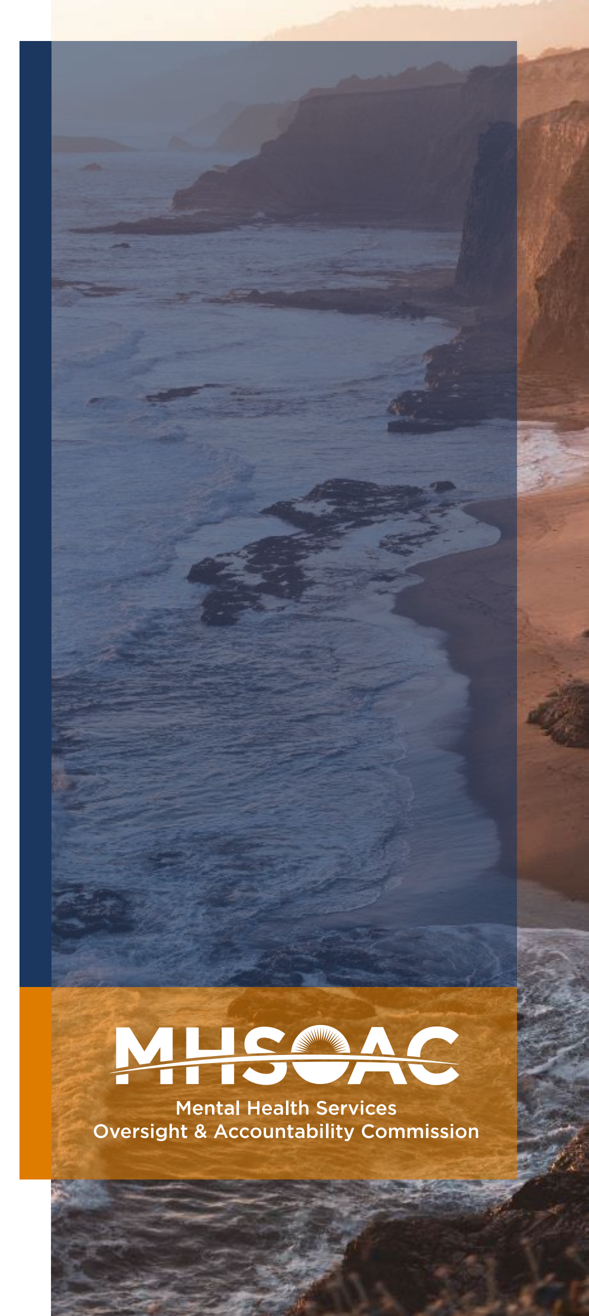
Student Mental Health

Community Factors/Social Determinants



Next Steps: WestEd Evaluation

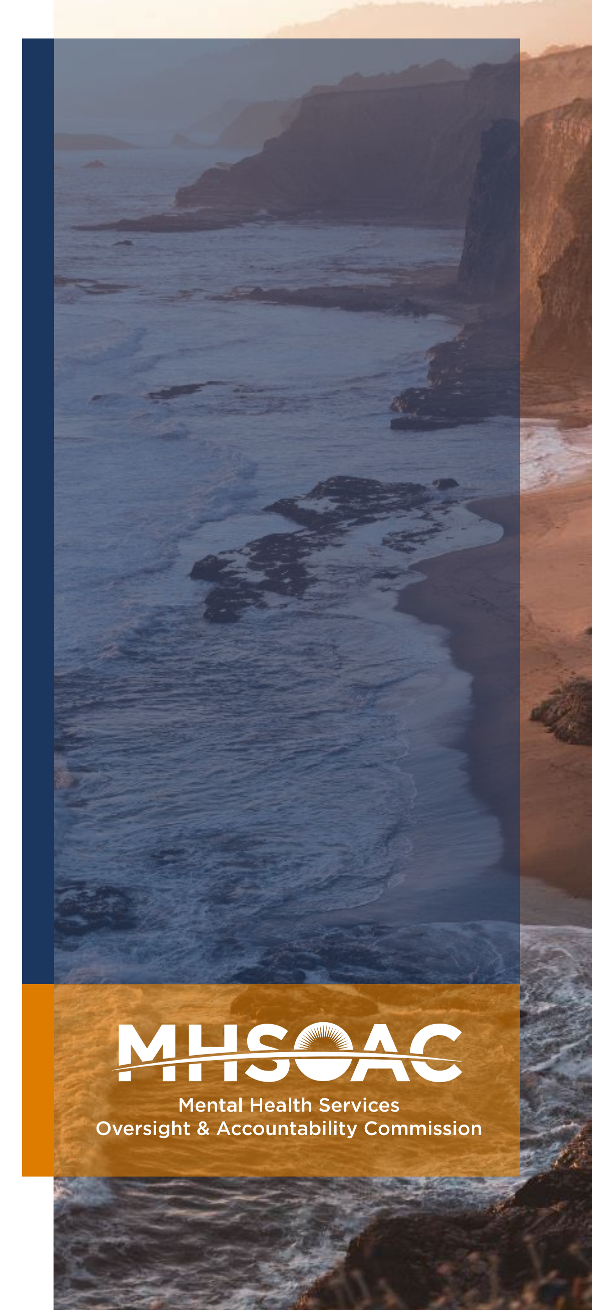
- **1.** Community Engagement
- **2.** Contextual Descriptive Analyses
- **3.** Process and Systems Change Evaluation
- **4.** Grantee Partnership Case Study
- **5.** Implementation and Impact School Case Study
- **6.** Dissemination and Strategic Communication



Proposed Motions

1) That the Commission approve the biennial progress report to the legislature on the Mental Health Students Service Act (MHSSA)

2) That the Commission approve a contract for up to $4 million for WestEd to begin Phase 2 of the MHSSA evaluation.



THANK YOU

Counting what Counts
School-based Universal Mental Health Screening
Legislative Report
Presented by Kali Patterson
November 21, 2021
MHSOAC
Mental Health Services
Oversight & Accountability Commission

The Youth Mental Health Crisis and Role of Schools

Rising mental health challenges
1 million K-12 students in California are at risk for mental health issues, with 42% of 11th graders reporting chronic sadness.

Impact on student outcomes
Unaddressed mental health needs are linked to lower academic performance, chronic absenteeism, and overuse of disciplinary interventions.

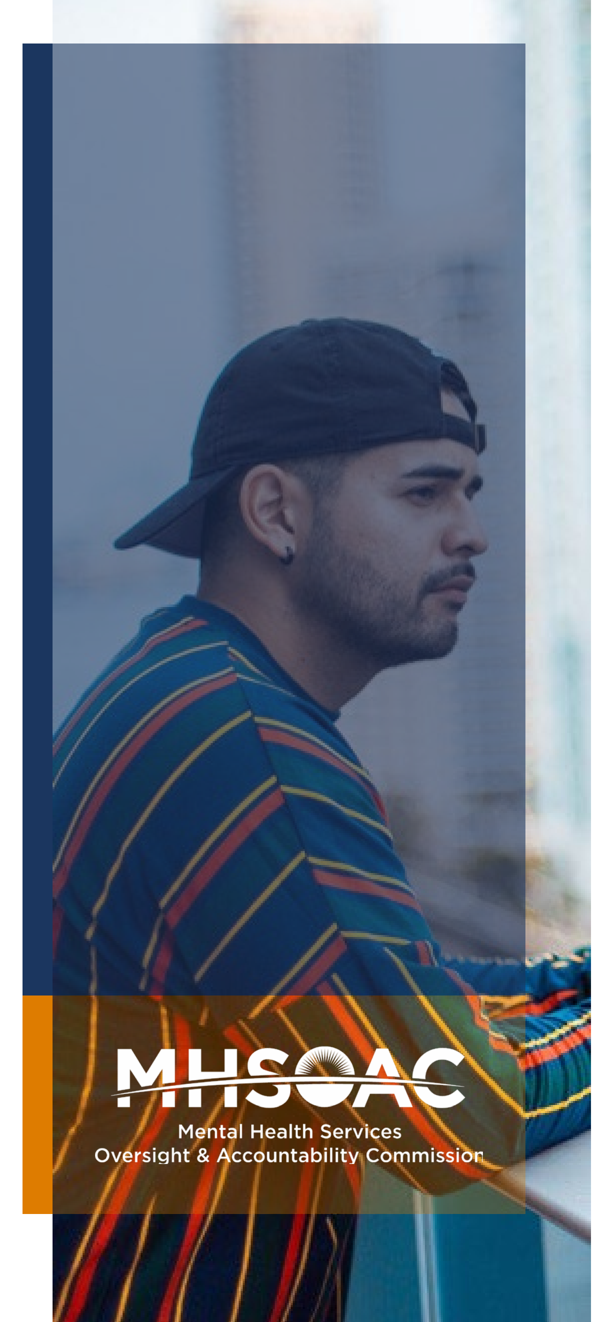
Increased demand for school-based support
Educators face higher demands to address student mental health; 73% report job-related stress from these needs.

The Universal Mental Health Screening Project

The 2023-24 Budget Act requires the Commission to deliver a report on universal mental health screening for children and youth, with an emphasis on California K-12 settings.

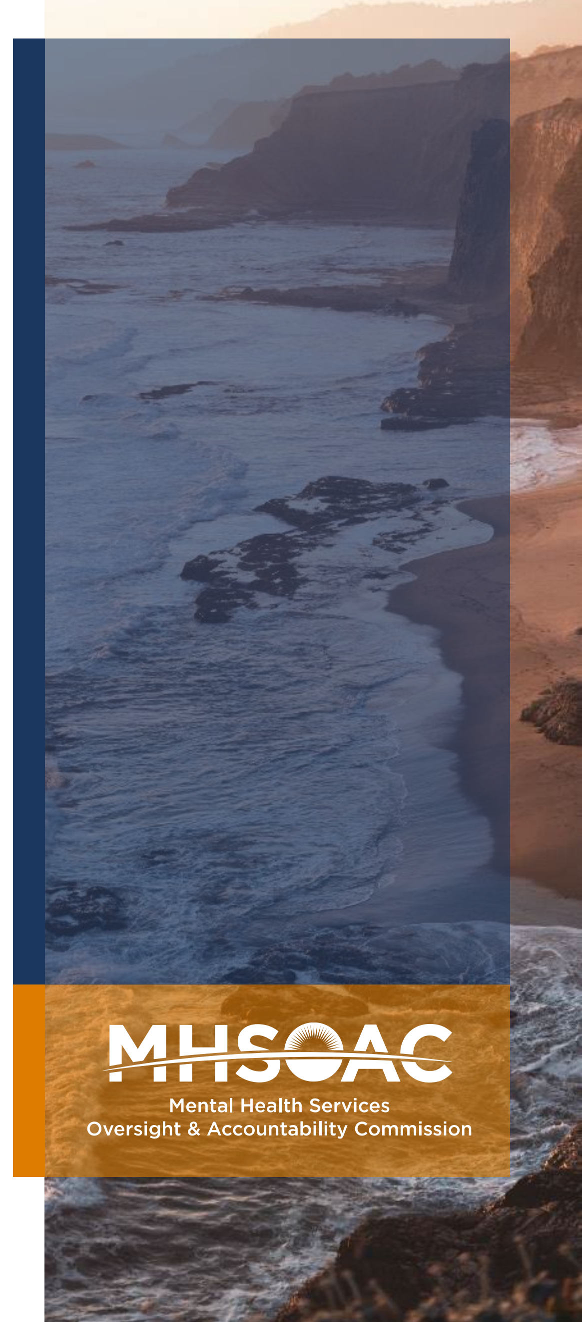
The present report aims to:

- Present findings from a landscape analysis on SUMHS practices, perceptions, and barriers.
- Deliver a set of recommendations for implementing SUMHS in support of California's broader goals and investments for youth mental and behavioral health.



School-based Universal Mental Health Screening (SUMHS) Defined

- Proactive assessment of all students' mental and behavioral health risks and strengths.
  - Indicators of wellbeing and resiliency
  - Stress and trauma exposure
  - Signs of anxiety, depression, substance use, or other behavioral health challenges
- Provides individual AND school wide data to inform a range of services and supports within MTSS.
- Implemented as part of a comprehensive school mental health system.



Core Features of a Comprehensive School Mental Health System

MENTAL HEALTH SCREENING
Proactive universal and targeted assessment of risks, strengths, and needs

EVIDENCE-BASED AND EMERGING BEST PRACTICES

WORKFORCE
Well-trained educators and specialized support personnel

SUSTAINABLE FUNDING
Leverage and apply various financial and nonfinancial resources

LEADERSHIP, CAPACITY BUILDING, AND INFRASTRUCTURE

DATA CAPABILITIES
Data systems, data outcomes, and data-driven decision-making

THOUGHTFUL PLANNING
Needs assessment and resource mapping

COLLABORATION AND TEAMING
Student, family, school, community

MULTI-TIERED SYSTEM OF SUPPORT
Wellness promotion, prevention, early intervention, and crisis response

Adapted from www.schoolmentalhealth.org/AdvancingCSMHS

Benefits

- **Preventive**: Promotes student wellbeing and improves behavioral, social, and educational outcomes.
- **Unbiased**: Uses objective and contextual data rather than relying on staff referral.
- **Destigmatizing**: Helps normalize mental health needs and support-seeking behavior.
- **Confidential**: Adheres to strict data privacy laws and policies.
- **Equitable**: Reduces mental health and educational disparities, especially for historically underserved students and their families.
- **Cost effective**: Universal screening requires investments in planning and resources, but results in cost savings by improving student outcomes and driving systems level change.

Landscape Analysis

Literature Review: Existing research and guidelines on SUMHS implementation.

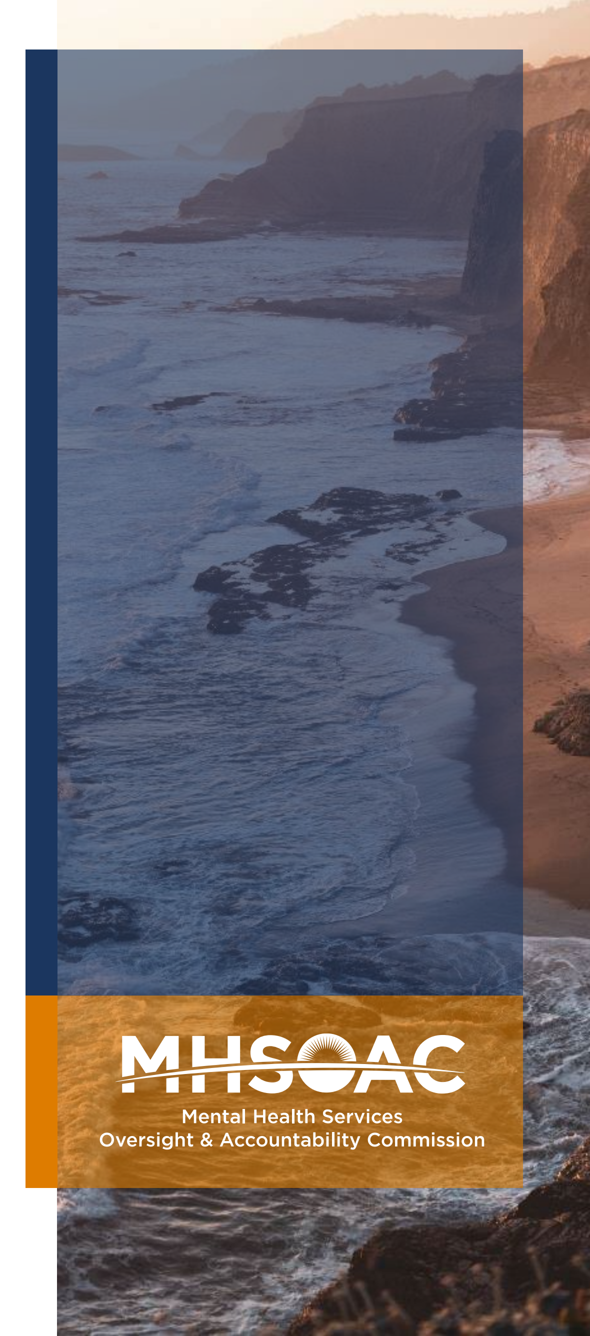
Statewide School Survey: Completed by 443 LEAs representing schools/districts in 55 counties.

Site Visits: Universal screening programs in San Diego, Sonoma, Yolo, and Riverside counties.

Qualitative analysis: Interviews and virtual listening sessions to gather student, parent, school, and community perspectives.

Findings

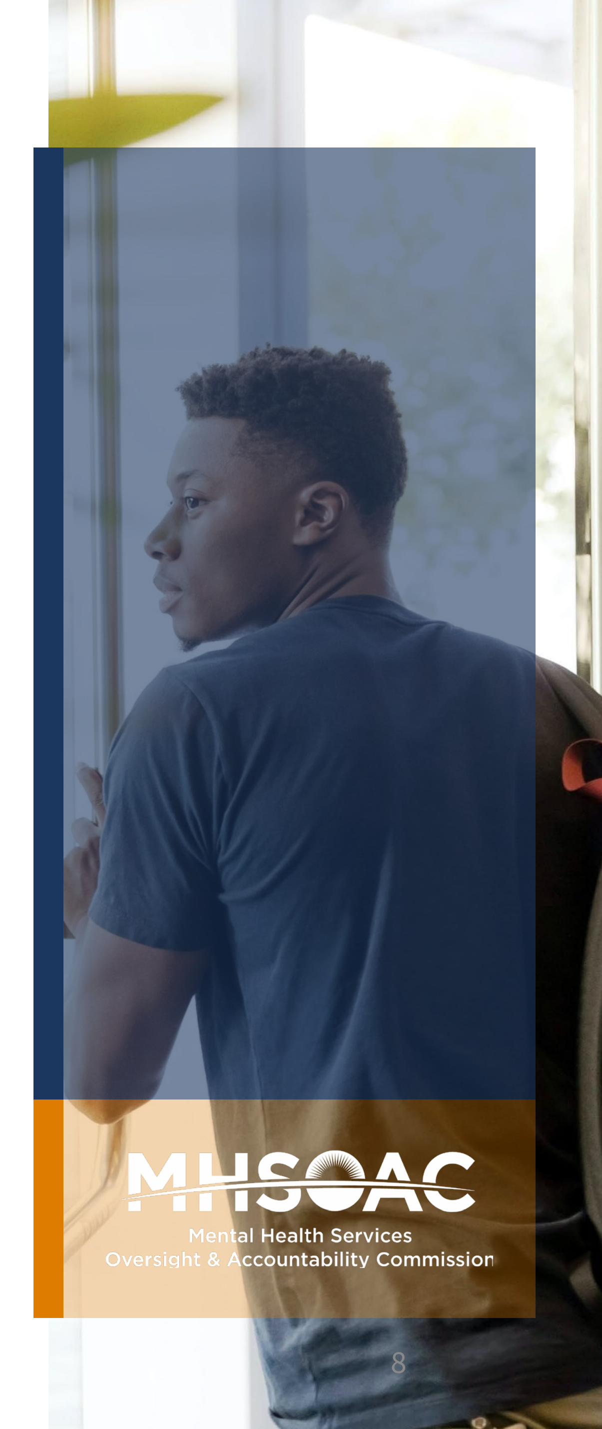
1. Current policies and practices
2. Awareness, perceptions, and buy-in
3. Capacity barriers and resource needs
4. Opportunities within California's youth behavioral health ecosystem



1. Current Policies and Practices

Evidence supports the use of SUMHS to improve students' wellbeing and ability to learn, yet without leadership, guidance, and standards, implementation varies in California and elsewhere.

- 43% of schools/districts surveyed are implementing SUMHS
  - Consistent across grade level, region, and reason for screening.
  - Wide variation in implementation.
- 43% of schools/districts surveyed are not implementing SUMHS
  - Among these, 79% percent report using staff referral strategies which were considered inadequate by most LEAs.
- 14% were unsure if SUMHS had been implemented in their schools/districts.



2. Awareness, Perceptions, and Buy-in

Myths are driving the narrative around SUMHS, reinforcing stigma, fears, and mistrust that hinder progress for school-based mental health.

- 92% of survey respondents agree that implementing SUMHS would benefit students, staff, and school communities.
- Lack of awareness and buy-in from communities affect a school's ability to implement SUMHS effectively.
- Common concerns about SUMHS
  - School liability
  - Stigma and labeling
  - Privacy and consent
  - Trust and transparency

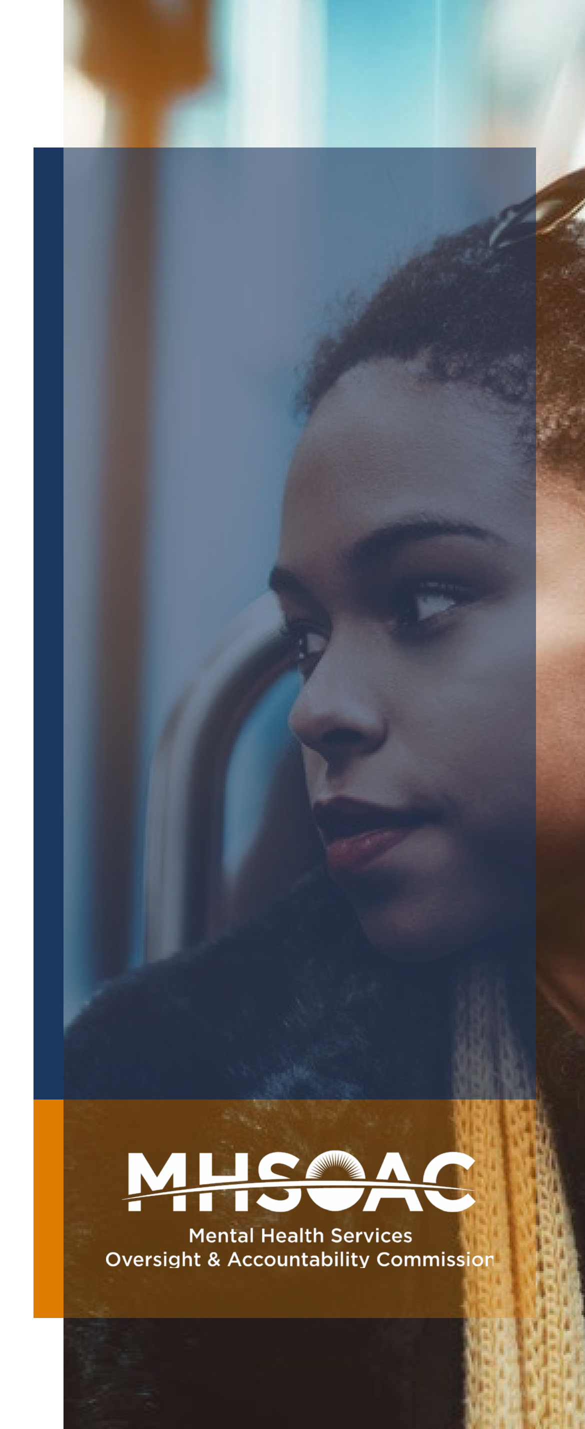
3. Capacity Barriers and Resource Needs

Capacity barriers are outweighing the benefits of SUMHS. Schools need resources and technical support to use SUMHS effectively.

School Survey Finding: Barriers to Implementing SUMHS

Barrier	Survey Respondents Who Were NOT Conducting UMHS	Survey Respondents Who Were Conducting UMHS
Lack of post-screening community resources	57%	44%
Lack of post-screening school resources	66%	38%
Survey/assessment fatigue	31%	31%
Equity/cultural responsiveness	46%	22%
Lack of staff	60%	15%
Ethical/legal concerns	61%	15%
Lack of knowledge about how to implement	58%	12%
Cost to conduct screening	54%	8%

0% 10% 20% 30% 40% 50% 60% 70%

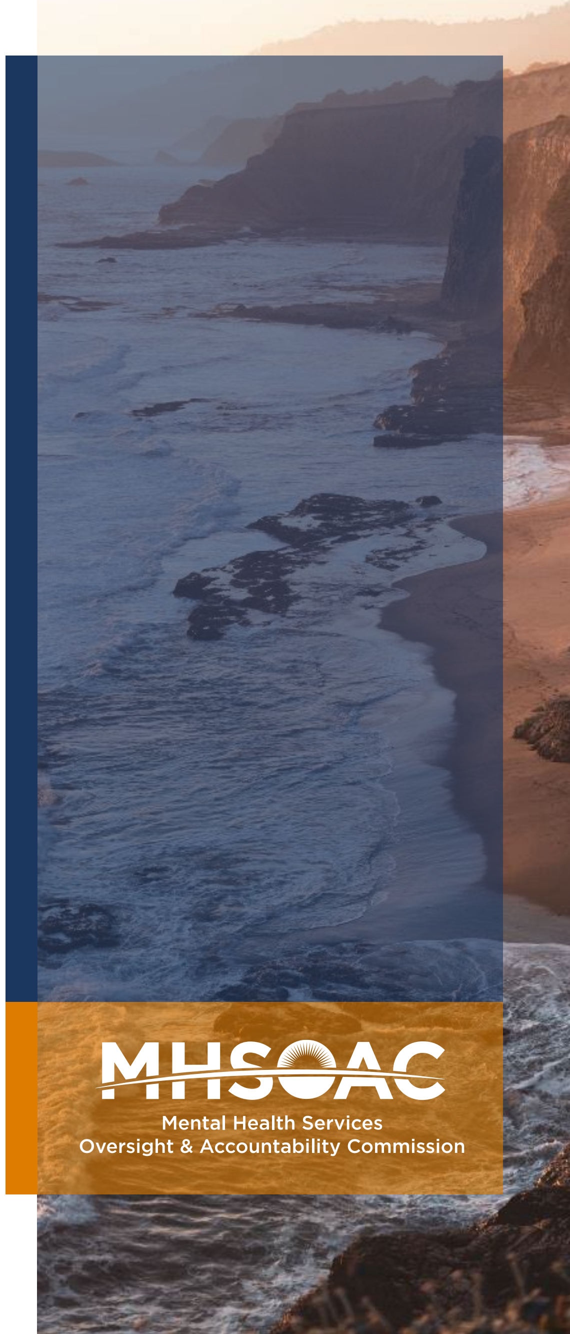


4. Opportunities within California's Youth Behavioral Health Ecosystem

California's youth behavioral health investments lay the groundwork for implementing comprehensive school mental health systems, including SUMHS, in K-12 schools.

State-level Initiatives

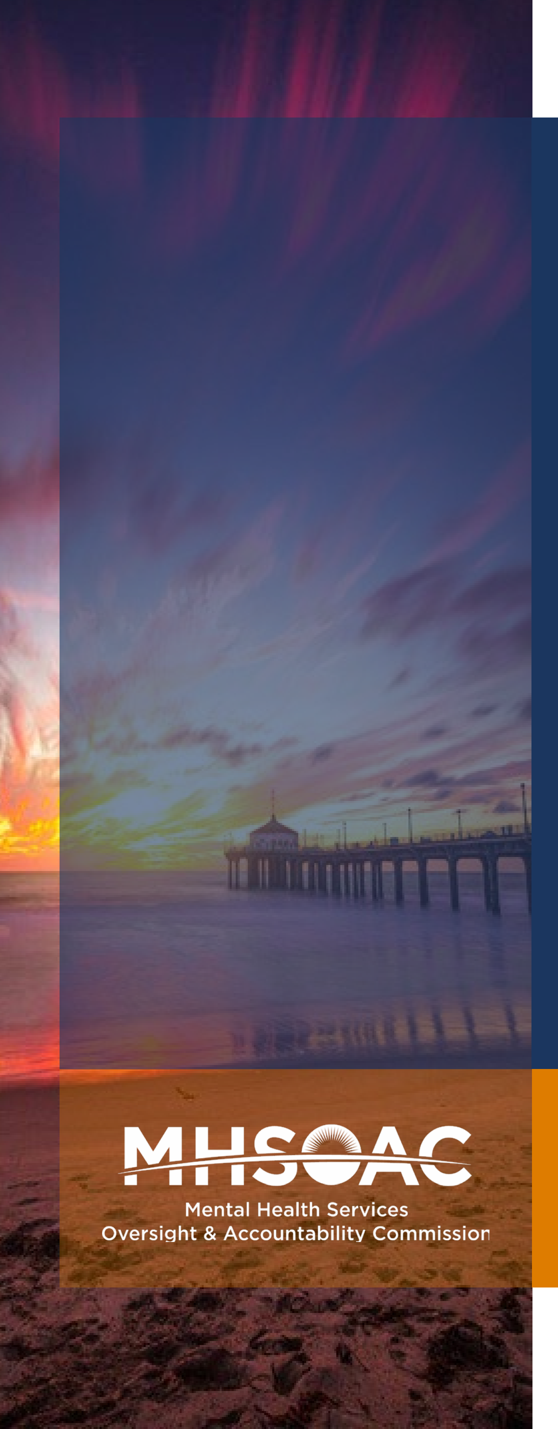
- CYBHI
- MHSSA
- CalAIM
- CDE Initiatives
- Prop 1 - BHSA



Components of a Comprehensive School Mental Health System	California Initiative
Sustainable Funding	• School Behavioral Health Incentive Program (SBHIP) • CYBHI School-Linked Partnership and Capacity Grants • CYBHI Multi-Payer Fee Schedule
Workforce	• Youth Mental Health Academy • CYBHI Certified Wellness Coaches • Healthcare Provider Training and eConsult • CYBHI Safe Spaces Trauma-informed training
Family-School-Community Collaboration and Teaming	• MHSSA Partnership Grants • Community Schools Partnership Program
Comprehensive Planning	• School-Linked Partnerships and Capacity Grants • MHSSA Universal Screening Planning Incentive Grant
Multi-Tiered System of Support	• CalHOPE Student Support and Schools Initiative • CYBHI Mindfulness, Resilience, and Well-being Supports • CDE Mental Health Instruction Expansion (SB 224) • Project Cal-Well • California School-Based Wellness Centers
Evidence Based and Emerging Best Practices	• CYBHI Evidence-Based and CDEP Grants • CYBHI Youth Suicide Crisis Response Pilots • Youth Peer-to-Peer Support Program Pilots
Mental Health Screening	• EPSDT Medi-Cal benefit • MHSSA Universal Screening Planning Grant • CYBHI Multi-Payer Fee Schedule (screening and assessment reimbursement)
Data Systems	• CYBHI Data Sharing and Privacy Workgroup and Guidelines • California’s Data Exchange Framework • Semi-Statewide Electronic Health Record (CalMHSA)

A Path Forward: Recommendations for Implementing SUMHS in California

1. **Establish leadership and guidance for school-based mental and behavioral health, including SUMHS practices.**
    - Standards for SUMHS implementation with metrics tied to a broader accountability framework for statewide comprehensive school-based mental health systems.
    - Guidance, tools, and technical assistance to help LEAs plan for and implement SUMHS with fidelity to established standards.
2. **Improve awareness, trust, and participation of students, parents, and educators**
    - Support the mental health and wellbeing of teachers and staff.
    - Consultation, training, and curriculum requirements to improve mental health literacy among teachers and staff.
    - Strengthen student, family, and community awareness of and participation in school-based behavioral health services.
3. **Build capacity for comprehensive school mental health systems and SUMHS through incentives, resources, and by meeting schools where they are.**
    - Fund the planning, staffing, and piloting of equity-centered SUMHS practices.
    - Implement multi-county learning models to refine and scale SUMHS best practices.
    - Invest in universal data systems that support responsive and responsible cross-system data sharing.
    - Expand Tier 1 and Tier 2 supports in schools.



Recognition

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Motion

That the Commission approve the School-based Universal Mental Health Screening Legislative Report.