WELLNESS • RECOVERY • RESILIENCE

Mental Health Services
Oversight & Accountability Commission

July 25, 2019
PowerPoint Presentations and Handouts

Tab 4:	• **PowerPoint:**	**MHSOAC Budget Overview**
Tab 6:	• **PowerPoint:**	**Reimagining Behavioral Health for California's Children and Families**
Tab 7:	• **Handout:**	**Prevention and Early Intervention Project Framework**
	• **Handout:**	**Strategic Plan Process Map Summary**

Reducing Criminal Justice Involvement for People with Mental Illness

DOJ-FSP Data Linkage Preliminary Findings

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July 25, 2019

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MHSA & Project Background

- The Mental Health Services Act stipulates that mental health programs shall emphasize strategies to reduce incarceration of people with unmet mental health needs.
- One goal of the Full Service Partnership (FSP) programs is to prevent, serve and divert individuals with mental illness from criminal justice involvement.

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Project Purpose & Key Findings

- The purpose of this project was to better understand the impact of FSP program participation on criminal justice involvement.
- MHSOAC linked arrest records from the Department of Justice (DOJ) to FSP client data from the Department of Health Care Services (DHCS) at the individual level.
- We found a significant reduction in arrest rates associated with FSP program participation.

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Linkage Detail

- Data Sources
  - Arrest records from DOJ for adults
  - FSP data in the Data Collection and Reporting System from DHCS for adults
- Study Period
  - July 1, 2007 – June 30, 2016 (9 fiscal years)
- Study Population
  - 64, 173 partners (18 or older)
  - 58, 907 unique clients
  - Start of program enrollment between 7/1/2007 and 6/30/2016
  - Partners under 18 at enrollment were excluded from this analysis as no minors' arrest records available in the DOJ data.

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Methods

- Three time periods were identified for each FSP partner.
  - Before FSP – one year before an FSP partnership enrollment
  - During FSP – number of days enrolled in FSP
  - After FSP – up to one year after FSP discharge
- Arrest rates were calculated for before, during, and after FSP participation.

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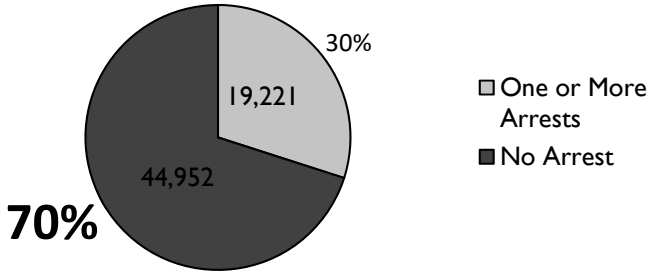
Arrest Statistics

- Total of 80,902 arrests found in one year before, during, or one year after FSP participation.
- Of the 64,173 partners, 70% (44,952) had no observed arrests.



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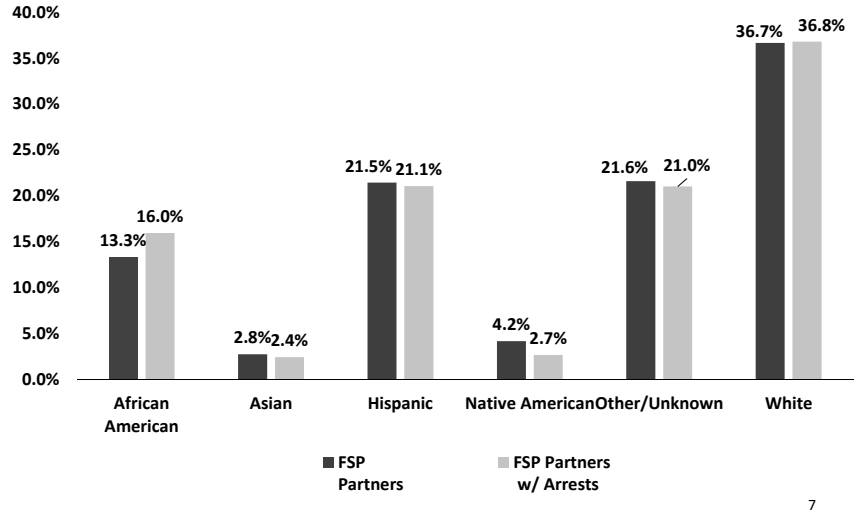
FSP Partners by Race/Ethnicity



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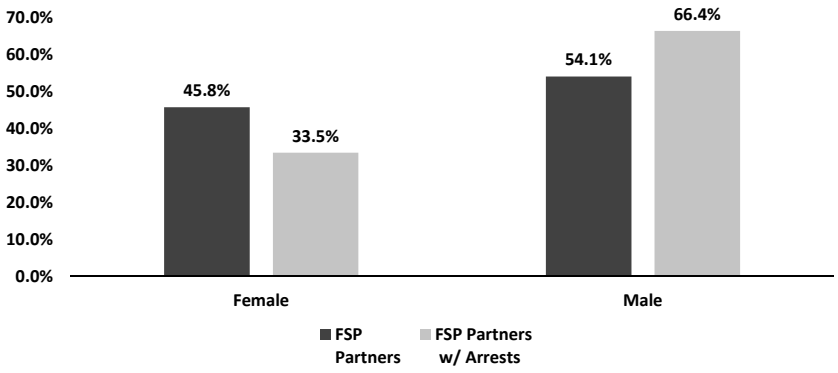
FSP Partners by Gender



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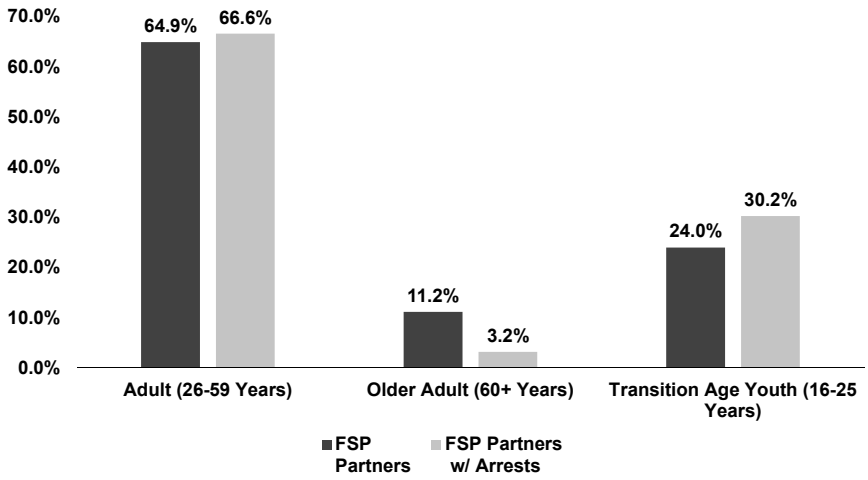
FSP Partners by Age



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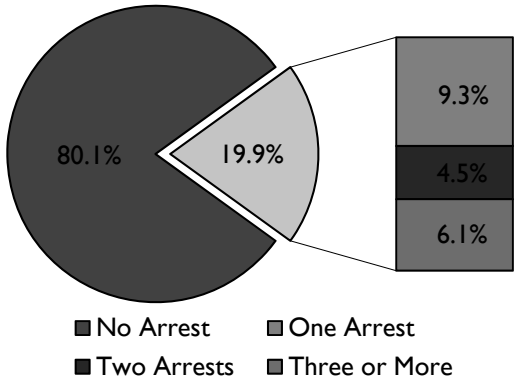
Arrest Before FSP Enrollment

- Of the 64,173 partners, 19.9% (12,791) had one or more arrests before enrollment.
- Do these partners see fewer arrests during and after FSP?



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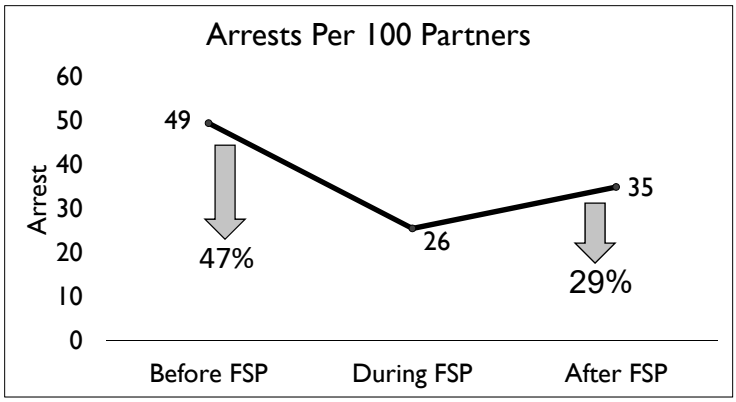
Change in Arrest Rate for All FSP

- Arrest rate declined by 47% from before to during FSP.
- Arrest rate declined by 29% from before to after FSP.



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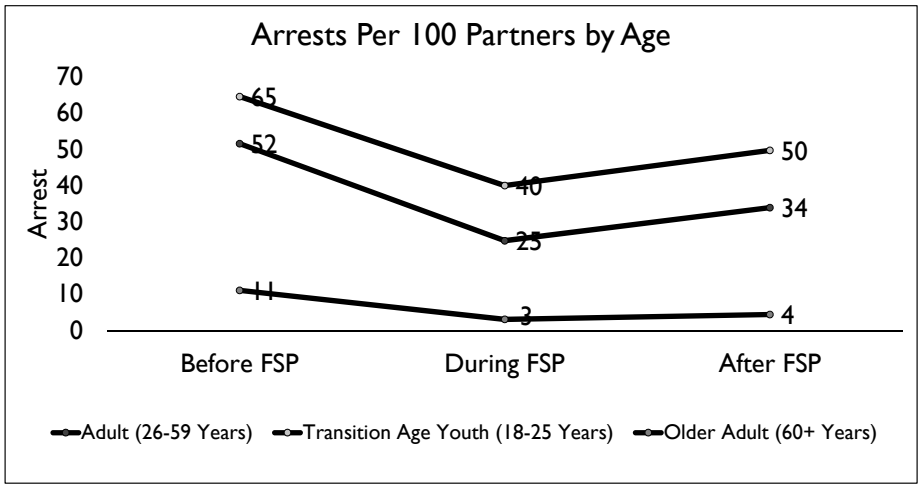
Arrest Rates by Age

- Similar patterns of arrest rate reductions were found across the three age groups.



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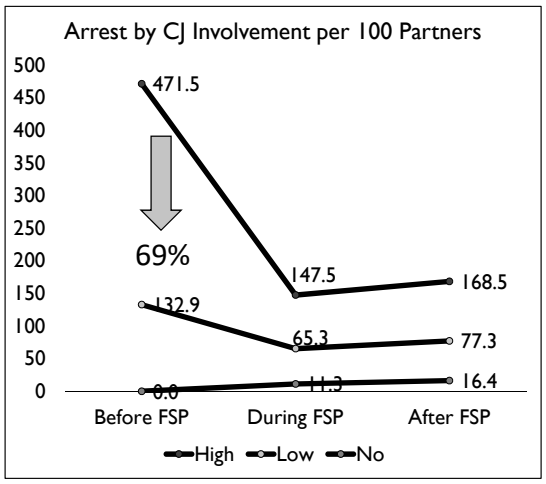
Arrest Rates by Criminal Justice Involvement



- Each of the 64,173 partners were classified as No (0 arrest), Low (1-2 arrests) or High CJ Involvement (3+ arrests) according their before enrollment arrest history.
- High CJ Involvement
  - Arrest rate ⇩ by 69% from before to during FSP.
  - Arrest rate ⇩ by 64% from before to After FSP.
- Low CJ Involvement
  - Arrest rate ⇩ by 51% from before to during FSP.
  - Arrest rate ⇩ by 42% from before to After FSP.

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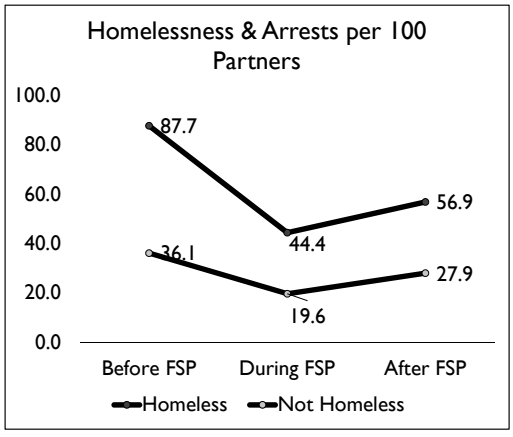
Arrest Rates By Prior Homelessness



- Homeless partners are defined as partners who reported any number of days of being homeless in the past 12 months prior to enrollment.
- Partners with prior homelessness had a much higher pre-FSP arrest rate than the partners with no history of homelessness.
- Arrest rates of the prior-homeless partners declined by 49.4% from before to during and 35% from before to after FSP.

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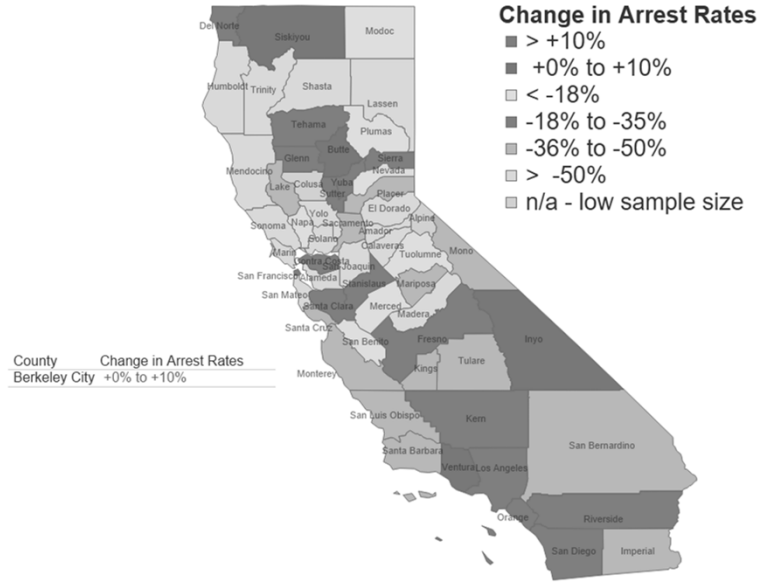
Changes in County Arrest Rates



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Summary

- There is a significant reduction of arrest rates associated with the FSP program participation.
  - ⇩ of 47% from before to during FSP
  - ⇩ of 29% from before to after FSP
- Reduction of arrest rates is consistent across various subgroups
  - Strongest for “High CJ Involvement”
    - ⇩ of 47% from before to during FSP
    - ⇩ of 29% from before to after FSP
- Next Steps
  - What drives these results?
    - Link FSP clients to individual FSP programs
    - Investigate characteristics of FSP programs associated with the greatest reductions in the criminal justice involvement for the FSP population
    - Additional data health care data linkages

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Thank you!

Additional questions?

Please contact
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at dawnte.early@mhsoac.ca.gov.

Mental Health Services Oversight and Accountability Commission | www.mhsoac.ca.gov

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MHSOAC
Mental Health Services
Oversight & Accountability Commission

MHSOAC Budget Overview

Norma Pate, Deputy Director, MHSOAC

WELLNESS • RECOVERY • RESILIENCE

1

MHSOAC Expenditures for Fiscal Year 2018-19

FY 2018-19 **Total Budget: $36,566,000**	**$36,566,000**
Personnel Services	$4,586,126.32
Operations (OE&E)	$1,350,015.29
Information Technology	$529,910.91
Communications	$675,894.00
Evaluation	$876,204.01
Research Policy Projects	$319,891.54
Innovation	$2,595,000.00
Innovation Youth Event	$155,585.00
Stakeholders	$5,387,909.46
Triage	$20,000,000.00
Remaining Balance	**$89,463.47**

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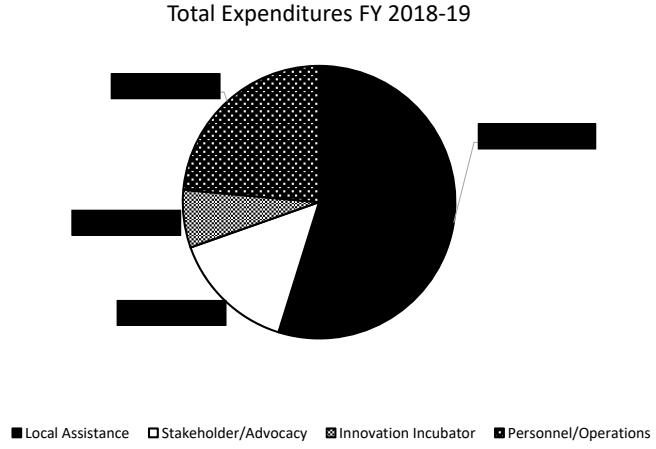
MHSOAC Expenditures FY 2018-19



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MHSOAC Budget Fiscal Year 2019-20

FY 2019-20 Total Budget: $121,852,000	**$121,306,554.79**	**Future Approval**
Personnel Services	$4,960,589.79	
Operations (OE&E)	$1,531,631.00	
Information Technology	$923,500.00	
Communications	$298,990.00	
Evaluation	$676,344.00	
Innovation Incubator	$2,500,000.00	X
Stakeholders	$5,415,500.00	
Triage	$20,000,000.00	
Mental Health Student Services Act	$50,000,000.00	X
Youth Drop-In Centers	$15,000,000.00	X
Early Psychosis Research and Treatment	$20,000,000.00	X
Remaining Balance	**$545,445.21**	X

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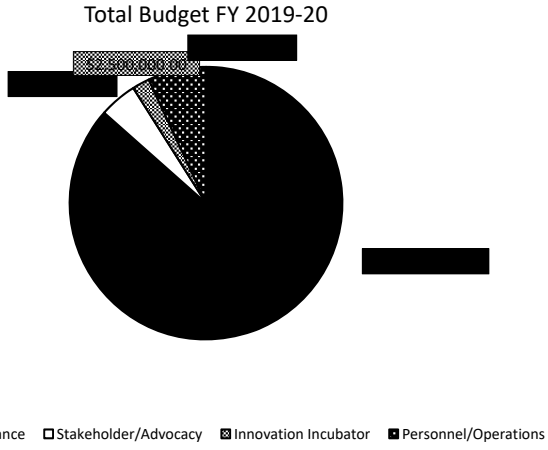
MHSOAC Proposed Budget FY 2019-20



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Proposed Motion

The Commission approves the final FY 2018-19 expenditures and the proposed FY 2019-20 budget as presented.

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Reimagining Behavioral Health for California's Children and Families

MHSA OAC, July 25th 2019

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Behavioral health is not simply a response to pathology

2

California Children's Trust

It is a strategy to achieve equity and support healthy development for all children

3

California Children's Trust

The Crisis is Real

So is the Opportunity

4

THERE HAS BEEN STRIKING INCREASES IN MENTAL HEALTH NEEDS AND ACUITY AMONG YOUTH

Inpatient visits for suicide, suicidal ideation and self-injury **increased by 104% for children ages 1 to 17 years, and by 151% for children ages 10 to 14** between 2006 and 2011.

ED visits increased by 71% for impulse control disorders for children ages 1 to 17 years.

A total of **$11.6 billion was spent on hospital visits** for mental health between 2006 and 2011.

In California, **There has been a 50% increase in mental health hospital days** for children between 2006 and 2014

5

THE MEDICAL MODEL ISN'T THE ANSWER

- Approximately 75% of mental illness manifests between the ages of 10 and 24. Since adolescents have the lowest rate of primary care utilization of any demographic group, it makes early warning signs difficult to detect.
- Provider shortages at the PCP and mental health practitioner level compound the challenge.
- Diagnosis-driven models are only appropriate for some children. Early identification and intervention is essential to any recovery framework.

How did we get here?

We have not found a way to center equity and justice.

We have no common framework for defining and understanding behavioral health among and between public systems and clinical care providers.

A lack of clarity over whether youth mental health care is an essential benefit or a public utility prevents commercial payers from fully engaging.

Our definition of medical necessity is outdated and inconsistent with emerging trends and evidence regarding the impact of trauma and adversity on social and emotional health.

The field is young. Many clinical modalities with widespread application are less than 20 years old.

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Children In California

More than 6 million of California's 10 Million Children Are Covered by Medi-Cal and the EPSDT Entitlement (33% increase over last 5 years)

96% of children in California are covered by a health insurance plan with a mental health benefit

7

We have failed to respond

More children are eligible for services, yet fewer are getting care.

Since 2011 Realignment:

For those receiving services, there was a 20% increase in crisis services utilization.

Overall, the "Access" Rate has declined from an already low 4.5%, to 4.1%.

For adolescents the rate of self-reported mental health needs has increased by 61% since 2005.

*__Data Source:__ California Office of Statewide Health Planning and Development special tabulation; California Dept. of Finance, Population Estimates by Race/Ethnicity with Age and Gender Detail 2000-2009; Population Reference Bureau, Population Estimates 2010-2016 (Aug. 2017).

8

These are hard truths and they require a new approach…

9

Let's look back to go forward….

Immunizations and the story of EPSDT and the Social Security Act of 1967.

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What if we already have critical components of the solution in our grasp?

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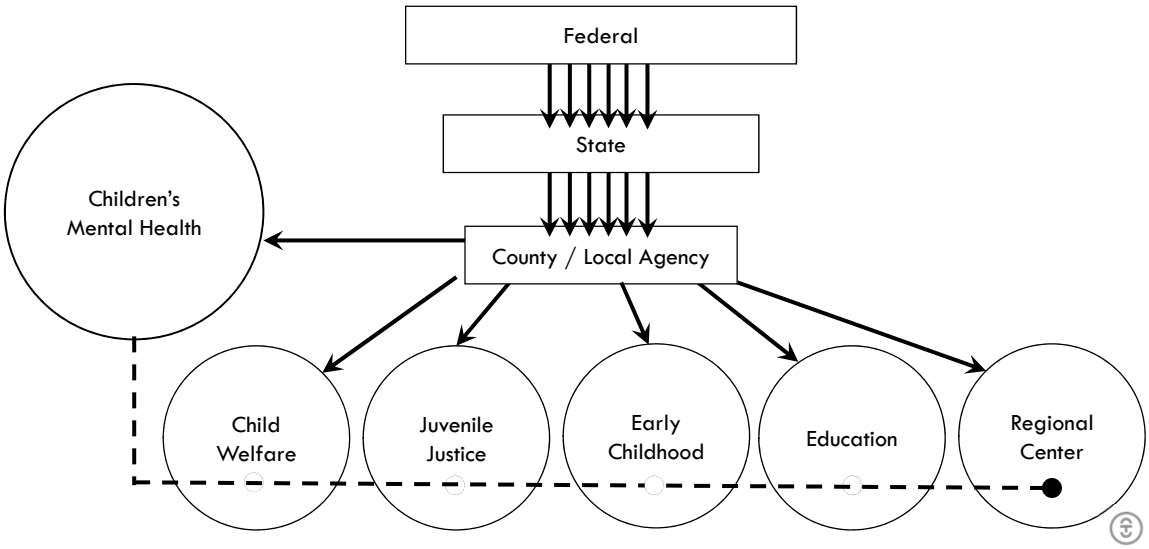
MEDICAID AS THE TIE THAT BINDS FRAGMENTED CHILDREN'S SYSTEMS



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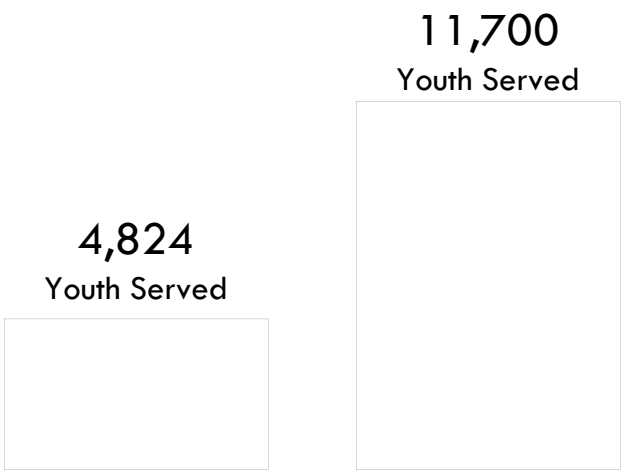
EPSDT EXPANSION TO SERVE MORE YOUTH



Source: Alameda County BHCS Children's System of Care

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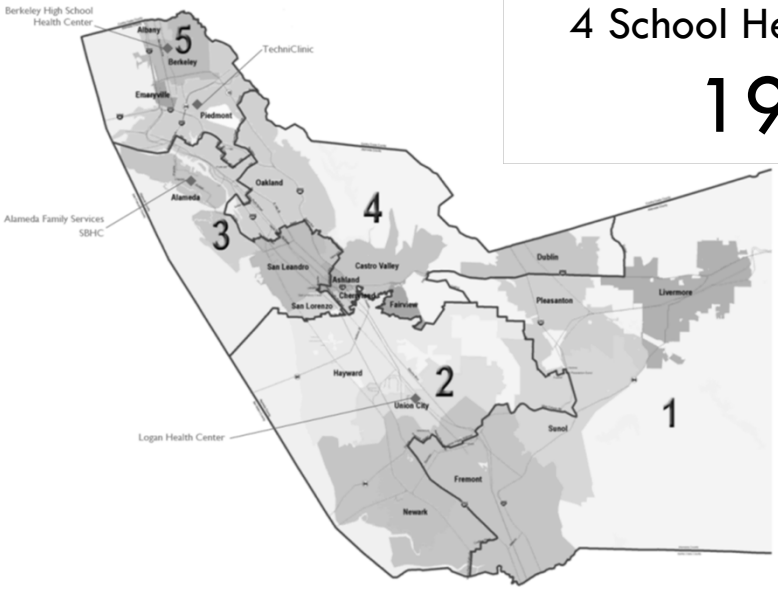
Alameda County
4 School Health Centers
1996



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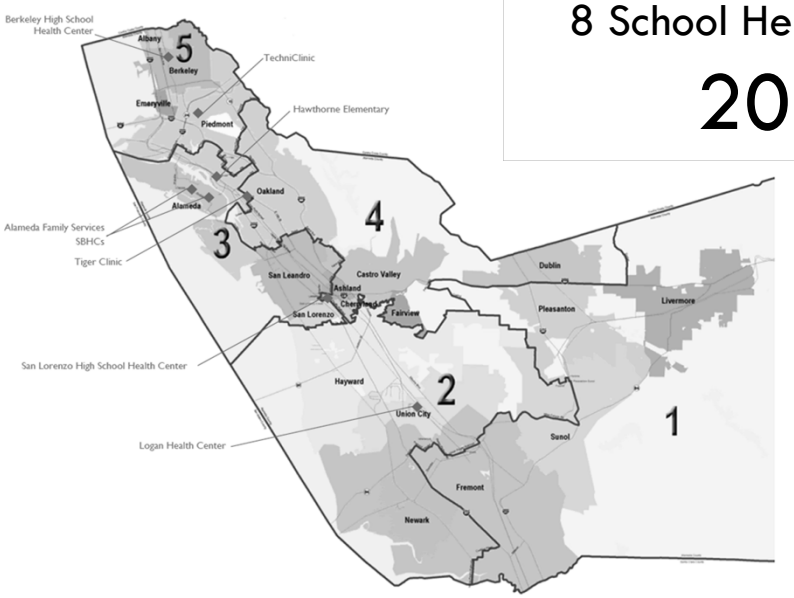
Alameda County
8 School Health Centers
2000



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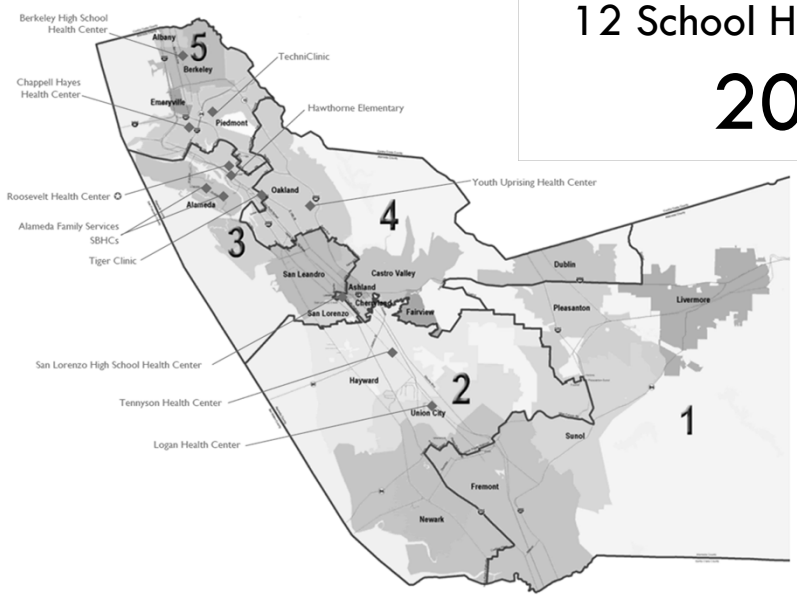
Alameda County
12 School Health Centers
2004



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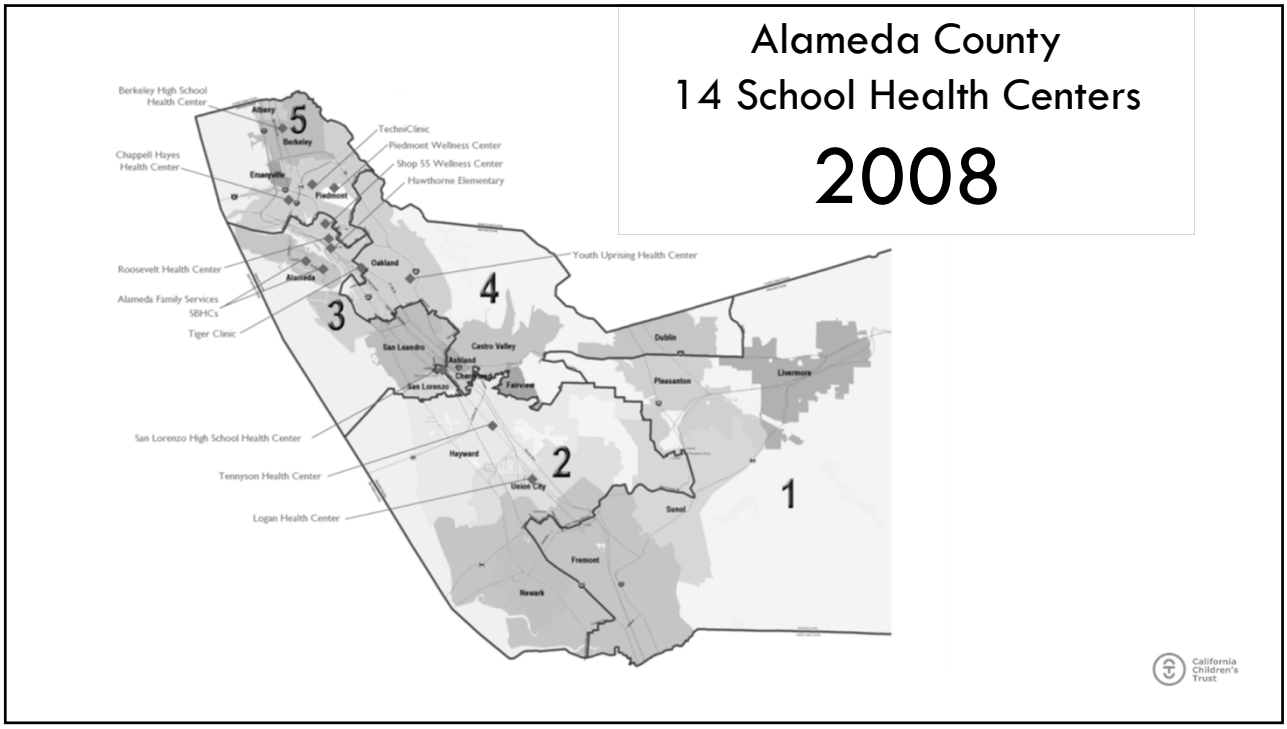
Alameda County
14 School Health Centers
2008
Berkeley High School Health Center
Chappell Hayes Health Center
Roosevelt Health Center
Alameda Family Services SBHCs
Tiger Clinic
San Lorenzo High School Health Center
Tennyson Health Center
Logan Health Center
TechniClinic
Piedmont Wellness Center
Shop 55 Wellness Center
Hawthorne Elementary
Youth Uprising Health Center
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Berkeley
Emeryville
Piedmont
Oakland
Alameda
San Leandro
Ashland
Cherryland
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Castro Valley
Fairview
Hayward
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Fremont
Newark
Dublin
Pleasanton
Livermore
Sunol
California Children's Trust

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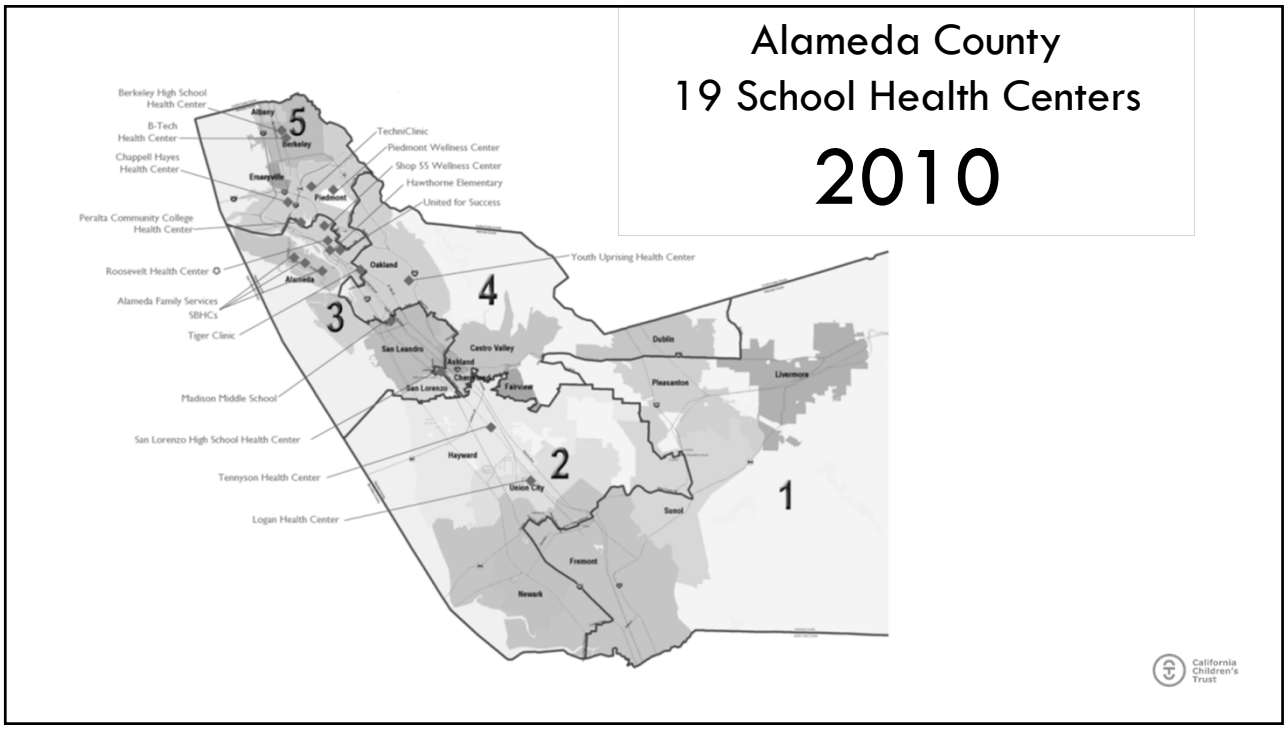
Alameda County
19 School Health Centers
2010
Berkeley High School Health Center
B-Tech Health Center
Chappell Hayes Health Center
Peralta Community College Health Center
Roosevelt Health Center
Alameda Family Services SBHCs
Tiger Clinic
Madison Middle School
San Lorenzo High School Health Center
Tennyson Health Center
Logan Health Center
TechniClinic
Piedmont Wellness Center
Shop 55 Wellness Center
Hawthorne Elementary
United for Success
Youth Uprising Health Center
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California Children's Trust

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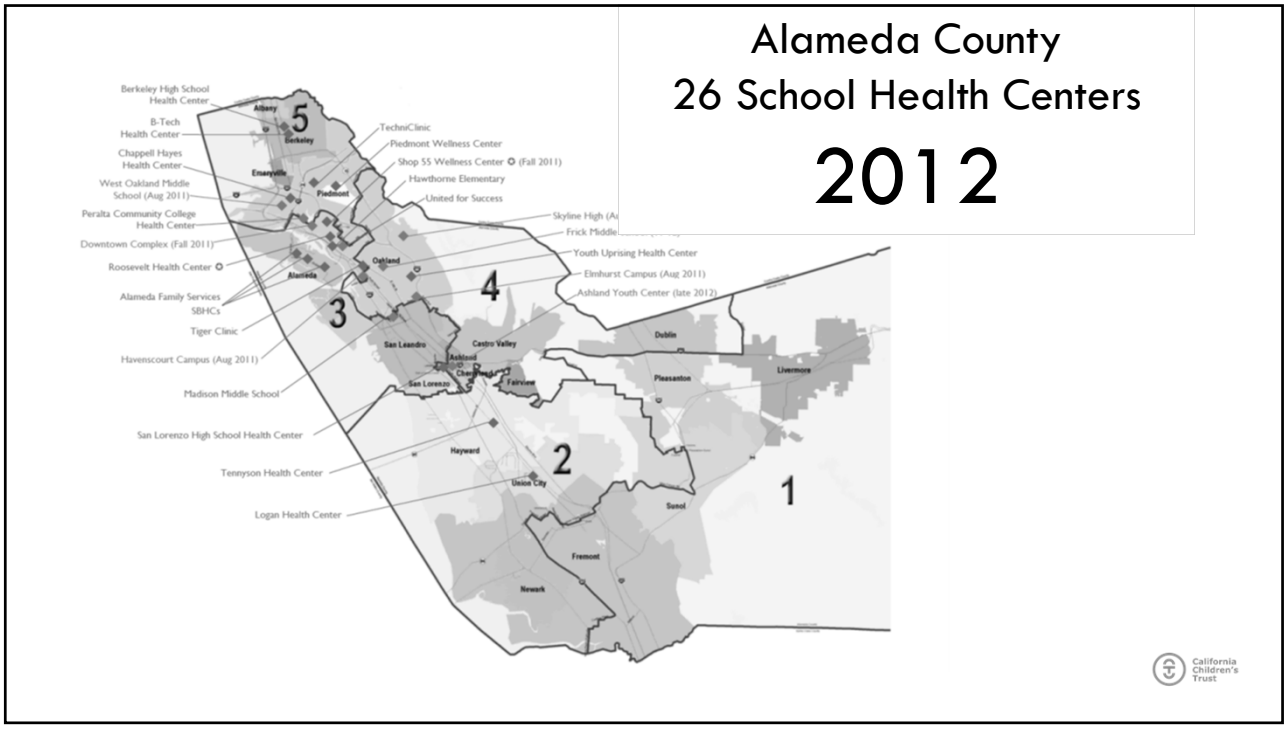
Alameda County
26 School Health Centers
2012
Berkeley High School Health Center
B-Tech Health Center
Chappell Hayes Health Center
West Oakland Middle School (Aug 2011)
Peralta Community College Health Center
Downtown Complex (Fall 2011)
Roosevelt Health Center
Alameda Family Services SBHCs
Tiger Clinic
Havenscourt Campus (Aug 2011)
Madison Middle School
San Lorenzo High School Health Center
Tennyson Health Center
Logan Health Center
TechniClinic
Piedmont Wellness Center
Shop 55 Wellness Center (Fall 2011)
Hawthorne Elementary
United for Success
Youth Uprising Health Center
Elmhurst Campus (Aug 2011)
Ashland Youth Center (late 2012)
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California Children's Trust

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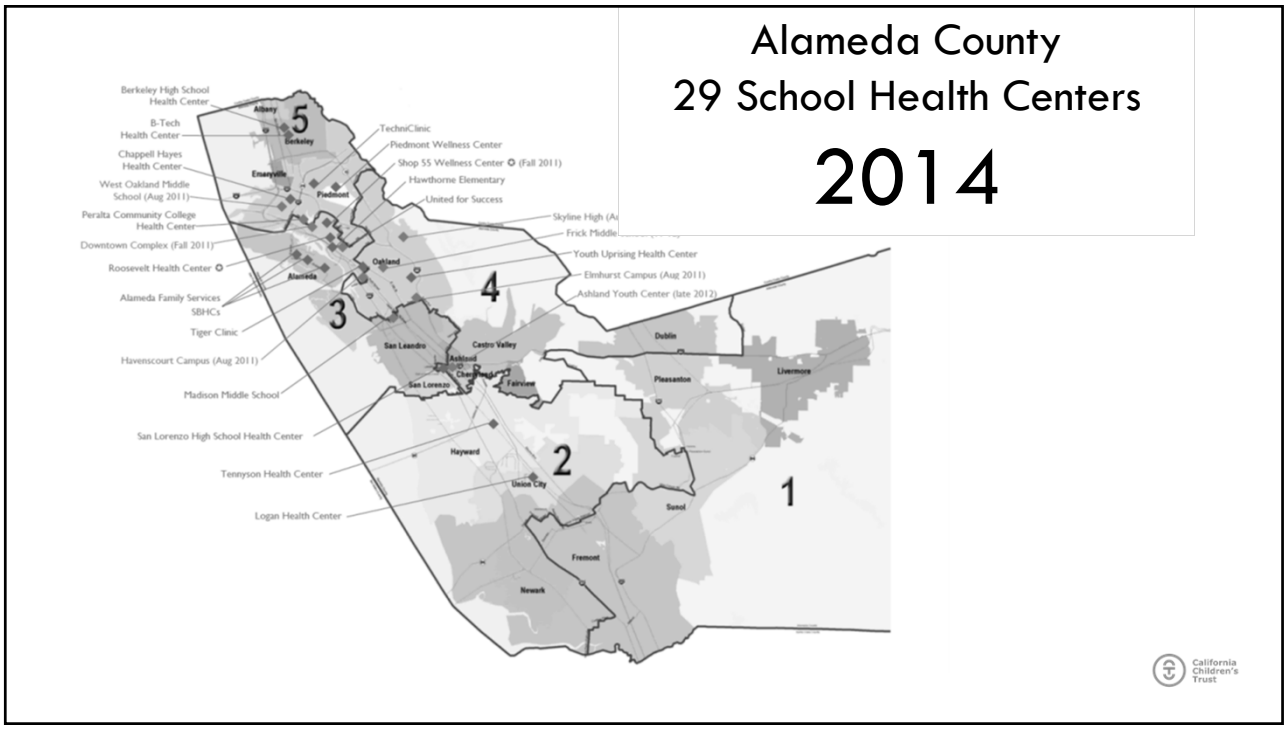
Alameda County
29 School Health Centers
2014
Berkeley High School Health Center
B-Tech Health Center
Chappell Hayes Health Center
West Oakland Middle School (Aug 2011)
Peralta Community College Health Center
Downtown Complex (Fall 2011)
Roosevelt Health Center
Alameda Family Services SBHCs
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Newark
California Children's Trust

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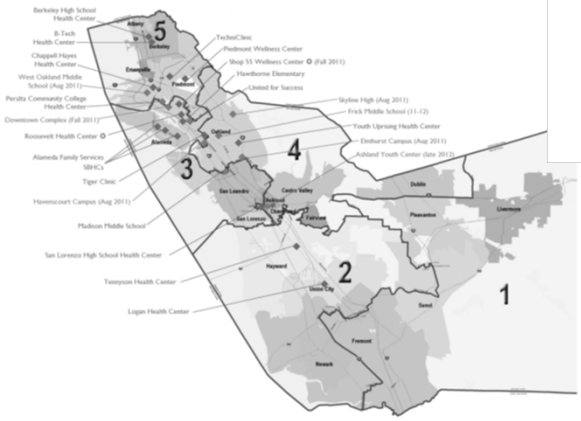

Alameda County
29 School Health Centers

2014

TODAY THERE ARE 200 SCHOOL BASED BEHAVIORAL HEALTH PROGRAMS IN ALAMEDA COUNTY

21

There are lessons that have been learned that could be applied at scale.

And critically, we have new science and emerging practices that demonstrate the promise of behavioral health.

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We have new science and emerging practices that demonstrate the promise of behavioral health

AND
There is striking evidence of a crisis

AND

The Economic Imperative is aligned with the social justice imperative

AND
There is a way to finance broad reform

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WHAT THIS MEANS

- We Would Redefine Mental Health by developing a new understanding of the nature and scope of services that centers racial justice and equity.
- We Would Generate a Significant New Investment in Children and Families by matching existing state and local expenditures with federal dollars and dramatically expand our investment in children
- We Would Require New Collaborative Purchasing Models across child serving systems
- Implement New Measures of child well being across all child serving systems.

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HOW COULD WE PAY FOR IT?

- The Waiver Strategy
- The Growth Strategy
- State Plan Amendment
- Capitation or Enhanced FMAP
- County Mental Health Plan Capacity Building

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Highlights

- Formed a state wide coalition of leading children's advocates, providers, clinicians, and those with lived experience that is now over 400 strong.
- We have spoken at more than 60 state wide convenings of children's advocates and providers.
- Sponsored AB 898
- Secured funding commitments from public and private partners.

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WHAT'S NEXT AND WHAT YOU CAN DO

- SIGN UP at www.cachildrenstrust.org and Join our Coalition.
- READ AND SHARE our Policy Briefs.
- Support AB 898
- Support our Regional Planning Process
- Match our recent philanthropic commitments at 500k a year for two years to support our Regional Planning Initiative and our Framework for Solutions at the state level.

California Children's Trust

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Mental Health Services
Oversight & Accountability Commission

Prevention and Early Intervention Project

Project Framework

Introduction

An estimated one in five people in the United States live with mental health needs, and less than half receive services.[1] Mental health needs are similar to physical health needs in that they result from a complex dynamic of biological, psychological, social, and cultural factors.[2] Mental health needs can emerge at any point in life, but most emerge before the age of 24 and half emerge before the age of 14.[3]

Similar to other health challenges, some factors increase risk for experiencing mental health needs while others can reduce risk.[4] Common factors that increase risk include trauma, unmet health care needs, isolation, alienation, or other stressful experiences such as unemployment.[5] Factors that lessen risk – or that protect against mental illness – include having access to services that meet needs, having social support and networks, and the ability to manage stress and emotions.[6] The burden of mental illness on people, families, and communities can be prevented by reducing risk factors and increasing protective factors.[7]

Background

California's Mental Health Services Act (MHSA), was passed to transform the State's mental health system by providing additional resources for mental health care by prioritizing prevention and early intervention and supporting new, more effective approaches to meeting needs. The MHSA generates more than $2 billion every year, with approximately 20 percent of those funds earmarked for Prevention and Early Intervention (PEI) services. Those services are intended to prevent mental illness from becoming severe and disabling and to intervene early as mental health needs emerge. Each year California dedicates some $400 million to these services, creating a tremendous opportunity to reduce risks and support protective factors that can save lives and lower costs.[8]

Recent change in state law by Senate Bill 1004 (Chapter 843, Statutes of 2018) directs the Commission to establish priorities and a statewide strategy for prevention and early intervention services. The goal of this effort is to create a more focused approach to delivering effective prevention and early intervention services and increasing coordination and collaboration across communities and mental healthcare systems.

Senate Bill 1004 outlines the following priorities for prevention and early intervention:

- Childhood trauma prevention and early intervention at the origins of mental health needs
- Early psychosis and mood disorder detection and intervention, and mood disorder and suicide prevention across the lifespan
- Youth outreach and engagement strategies that target secondary school and transition age youth, with a priority on partnerships with college mental health programs
- Culturally competent and linguistically appropriate prevention and intervention services and strategies
- Strategies targeting the mental health needs of older adults

Prevention and Early Intervention Project

The Commission's Prevention and Early Intervention (PEI) Project was created to establish priorities for investment and to develop a monitoring strategy. The project also will explore challenges and opportunities for strengthening mental health prevention and early intervention strategies across California. The Commission will explore best practices implemented in California, and elsewhere, and opportunities for increasing collaboration with private and public partners and existing mental healthcare systems.

Project Structure and Activities

To lead this project, the Commission has created a subcommittee of Commissioners that includes Commissioners Mara Madrigal-Weiss (Project Chair) and Mayra Alvarez. The project will include community engagement, policy and research reviews, and data and analysis. The Commission will develop the plan with community members and will leverage previous and current efforts. Commission staff will review the latest research on prevention and early intervention and will review the status of programs and services delivered throughout California.

Proposed public engagement activities include:

Public Hearings Public hearings will be organized to explore opportunities to enhance delivery of prevention and early intervention strategies, conduct evaluation, and understand opportunities to provide technical assistance where needed. The first public hearing will be held in fall 2019 and will be organized to support the Commission's understanding of challenges to improving services delivered using PEI funding, and barriers to local and state data monitoring and reporting of outcomes. The second public hearing will be held in early 2020 and will explore strategies for overcoming barriers by enhancing public understanding of best practices for improving service delivery, as supported by a data monitoring plan to measure and sustain improvements.

Subcommittee Meetings The Subcommittee will meet with community members and subject matter experts to develop a shared understanding of challenges and opportunities. The Commission anticipates holding a meeting in August 2019 in Northern California, a meeting in September 2019 in Central California, and a meeting in Southern California in early 2020.

Community Forums Community forums will be organized to highlight and understand challenges and opportunities to strengthen the impact of prevention and early intervention programs and services.

Site Visits Site visits may be organized to acquire first-hand knowledge and understanding of challenges facing prevention and early intervention programs, as well as existing efforts to address such challenges.

To ensure public awareness of these activities, full transparency throughout the project, and timely dissemination of findings from these events, the Commission will implement a strong communications effort augmented by provision of relevant background materials and available data.

Project Report

Information and data gathered during the project will be synthesized into a final report, which is anticipated to be adopted by the Commission by December 2020. Components of the final report will

include a section describing PEI priorities, and a section outlining a strategy for the Commission to monitor implementation of PEI services. The strategy will include recommendations for data collection, reporting, and analysis, technical assistance, and enhancing public understanding of PEI.

References

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[4] World Health Organization (2004). *Prevention of mental disorders: Effective interventions and policy options*. Summary Report of the World Health Organization, Department of Mental Health and Substance Abuse in collaboration with the Prevention Research Centre of the Universities of Nijmegen and Maastricht: France. Retrieved on April 26, 2019 from https://www.who.int/mental_health/evidence/en/prevention_of_mental_disorders_sr.pdf.
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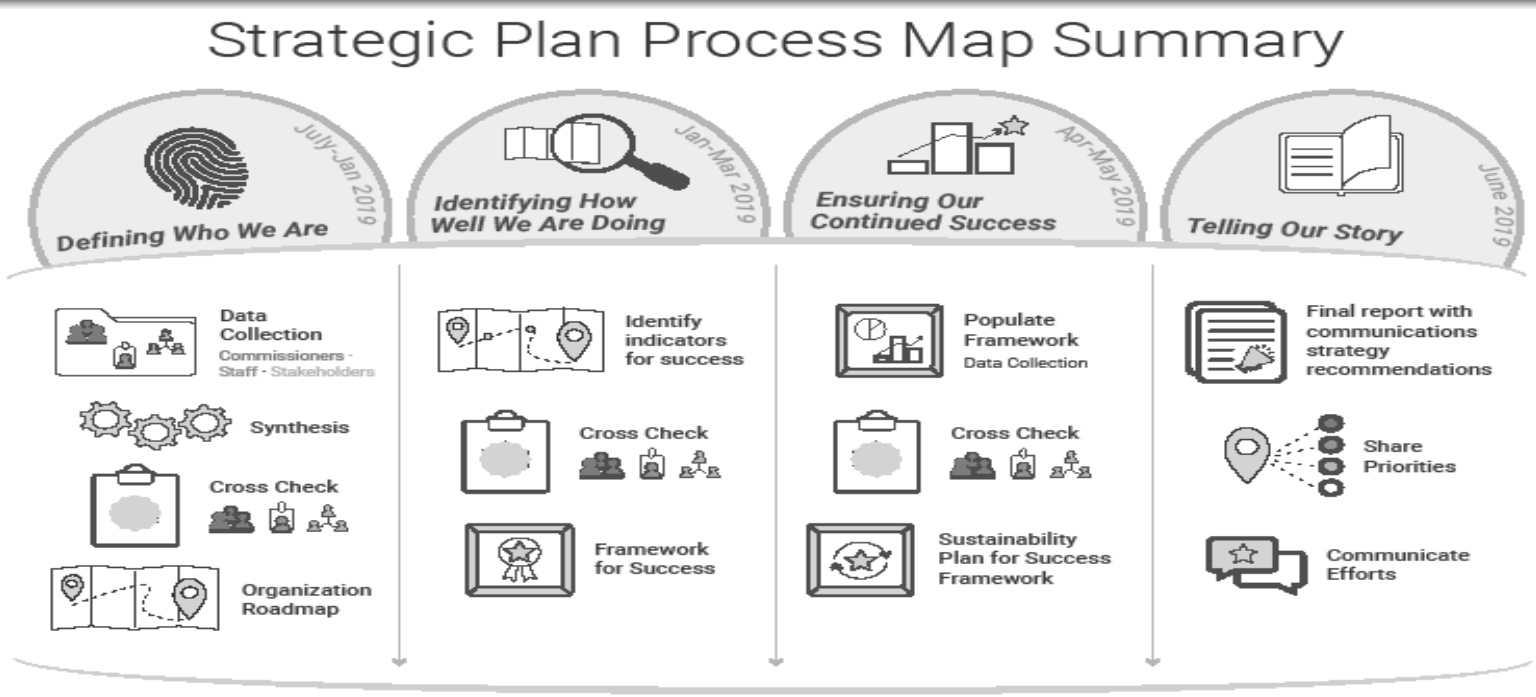
MHSOAC Results Based Strategic Plan 2018-19

Planning Update: July

Helping People Build Better Communities



Where We've Been

Since the spring of 2019, ASR has continued to work with the MHSOAC design team to further their efforts in the results based strategic planning process. ASR and the design team have been working to finalize the organizational roadmap, create the results framework, and develop measures to continue to prototype the results scorecard.

Where We're Going

In summer 2019, the Commission will continue identifying indicators for success in this results-based strategic planning process. In late July, the ASR team will be preparing for an MHSOAC all staff meeting, inviting staff to provide feedback to the results framework and explore what success looks like for the Commission. This will include identifying measures and indicators for success, seeking enhanced understanding, and striving for meaning making. In early fall, the ASR team will present a draft of the Strategic Plan, including a sustainability and communication plan, to the Commission at a regular Commission meeting, with opportunity for comment and feedback.

If you have any questions, please email ASR President, Susan Brutschy, at susan@appliedsurveyresearch.org.