WELLNESS • RECOVERY • RESILIENCE

Mental Health Services
Oversight & Accountability Commission

Commission Packet

Commission Meeting
August 22, 2019

MHSOAC
1325 J Street Sacramento, CA 95814

Call-in Number:
1-866-817-6550 Participant Passcode: 3190377

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

1325 J Street, Suite 1700
Sacramento, California 95814

Commission Meeting Agenda

August 22, 2019
9:00 AM – 3:00 PM

MHSOAC
1325 J Street, Suite 1700
Sacramento, CA 95814

Additional Public Locations
State Capitol, Room 2082
Sacramento, CA 95814

6401 Linda Vista Rd
San Diego, CA 92111

Call-in Number: 866-817-6550; Code: 3190377

Public Notice

The public is requested to fill out a "Public Comment Card" to address the Commission on any agenda item before the Commission takes an action on an item. Comments from the public will be heard during discussion of specific agenda items and during the General Public Comment period. Generally, an individual speaker will be allowed three minutes, unless the Chair of the Commission decides a different time allotment is needed. Only public comments made in person at the meeting will be reflected in the meeting minutes; however, the MHSOAC will also accept public comments via email, and US Mail. The agenda is posted for public review on the MHSOAC website http://www.mhsoac.ca.gov 10 days prior to the meeting. Materials related to an agenda item will be available for review at http://www.mhsoac.ca.gov. All meeting times are approximate and subject to change. Agenda items are subject to action by the MHSOAC and may be taken out of order to accommodate speakers and to maintain a quorum.

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Khatera Tamplen
Chair

AGENDA
August 22, 2019

Lynne Ashbeck
Vice Chair

Approximate Times

9:00 AM **Convene and Welcome**

Chair Khatera Tamplen will convene the Mental Health Services Oversight and Accountability Commission meeting and will introduce the Transition Age Youth representative, Jeanavy Perez. Roll call will be taken.

9:10 AM **Announcements**

9:20 AM **Consumer/Family Voice**

Juan Acosta will open the Commission meeting with a story of recovery and resilience.

9:40 AM **Action**

1: Approve May 25, 2019, June 10, 2019, and July 25, 2019 MHSOAC Meeting Minutes.

The Commission will consider approval of the minutes from the May 25, 2019, June 10, 2019 and July 25, 2019 meetings.

- Public Comment
- Vote

9:50 AM **Action**

2: Alameda County Innovation Plan

Presenters:

- Tracy Hazelton, MPH, Division Director MHSA, Alameda County Behavioral Health
- Mary Skinner, J.D., Innovations Coordinator, MHSA, Alameda County Behavioral Health
- Robert Ratner, MPH, MD, Housing Services Director, Alameda County Health Care Services Agency – Behavioral Health
- Margot Dashiell, M.A., M.S., VP, NAMI-East Bay, and Facilitator, the African American Family Support Group

The Commission will consider approval of $6,171,599 to support Alameda County's Supportive Housing Community Land Alliance Innovation Plan.

- Public Comment
- Vote

10:50 AM **Action**

3: Awarding of the Transition Age Youth Stakeholder Contract

Presenters:

- Tom Orrock, Chief of Grants, MHSOAC
- Michele Nottingham, Health Program Specialist I, MHSOAC

The Commission will consider awarding a contract for stakeholder advocacy in the amount of $1,840,000 to the highest scoring applicant for the Transition Age Youth Stakeholder Request for Proposal.

- Public Comment
- Vote

11:20 AM **Action**

4: MHSOAC Conflict of Interest Code

Presenter:

- Filomena Yeroshek, Chief Counsel, MHSOAC

The Commission will consider approving proposed amendments to the MHSOAC's Conflict of Interest Code needed because of new staffing classifications.

- Public Comment
- Vote

11:45 AM **General Public Comment**

Members of the public may briefly address the Commission on matters not on the agenda.

12:00 PM **Lunch Break**

1:00 PM **Action**

5: Legislative and Budgetary Priorities

Presenter:

- Toby Ewing, Executive Director, MHSOAC

The Commission will consider legislative and budgetary priorities, including consideration of AB 480 (Salas): Mental Health: Older Adults and SB 665 (Umberg): Mental Health Services Fund: County Jails.

- Public Comment
- Vote

2:00 PM **Action**

6: MHSOAC Budget Overview

Presenter:

- Norma Pate, Deputy Director, MHSOAC

The Commission will consider approval of its final Fiscal Year 2018-19 Operations Budget and its proposed Fiscal Year 2019-20 Operations Budget.

- Public Comment
- Vote

2:20 PM **Information**

7: Executive Director Report Out

Presenter:

- Toby Ewing, Ph.D., Executive Director, MHSOAC

Executive Director Ewing will report out on projects underway, on county Innovation plans approved through delegated authority, and other matters relating to the ongoing work of the Commission.

- Public Comment

2:45 PM **General Public Comment**

Members of the public may briefly address the Commission on matters not on the agenda.

3:00 PM **Adjourn**

AGENDA ITEM 1

Action

August 22, 2019 Commission Meeting

Approve May 23, 2019, June 10, 2019 and July 25, 2019 MHSOAC Meeting Minutes

Summary: The Mental Health Services Oversight and Accountability Commission will review the minutes from May 23, 2019, June 10, 2019 and July 25, 2019 Commission meetings. Any edits to the minutes will be made and the minutes will be amended to reflect the changes and posted to the Commission Web site after the meeting. If an amendment is not necessary, the Commission will approve the minutes as presented.

Presenter: None.

Enclosures (3): (1) May 23, 2019 Meeting Minutes; (2) June 10, 2019 Teleconference Meeting Minutes; (3) July 25, 2019 Meeting Minutes.

Handouts: None.

State of California

MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

Minutes of Meeting
May 23, 2019

We Rise 2019
Downtown Los Angeles Arts District
1262 Palmetto Street
Los Angeles, CA 90013

866-817-6550; Code 3190377

Members Participating:

Khatera Tamplen, Chair
Lynne Ashbeck, Vice Chair
Reneeta Anthony
Ken Berrick
John Boyd, Psy.D.
Sheriff Bill Brown
Keyondria Bunch, Ph.D.
Itai Danovitch, M.D.
Mara Madrigal-Weiss
Gladys Mitchell
Tina Wooton

Members Absent:

Mayra Alvarez
Senator Jim Beall
Assemblymember Wendy Carrillo
David Gordon

Staff Present:

Toby Ewing, Ph.D., Executive Director
Filomena Yeroshek, Chief Counsel
Norma Pate, Deputy Director, Program, Legislation, and Technology
Brian Sala, Ph.D., Deputy Director, Evaluation and Program Operations

CONVENE AND WELCOME

Chair Khatera Tamplen called the meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at 9:07 a.m. and welcomed everyone. Filomena Yeroshek, Chief Counsel, called the roll and confirmed the presence of a quorum.

Chair Tamplen reviewed the meeting protocols.

Announcements

Chair Tamplen provided the announcements:

- Youth Innovation Project Planning Committee members from Fresno and Monterey Counties presented last week at the California Mental Health Advocates for Children and Youth Conference.
- Many Youth Innovation Project Planning Committee members will attend the We Rise event and will host a focus group.

Youth Participation

Chair Tamplen stated the Commission made a commitment to include a young person around the table at every Commission meeting to learn the Commission process and to give their perspective on issues. Celeste Walley, Youth Advocate, Seneca Family of Agencies, introduced herself.

Meeting Calendar

The next Commission meeting will be a teleconference meeting on June 10th.

The July meeting will be held in Santa Cruz on July 25th.

Consumer/Family Voice

The Commission made a commitment to begin Commission meetings with an individual with lived experience sharing their story. Chair Tamplen invited Keris Jan Myrick to share her story of recovery and resilience.

Keris Jan Myrick, Discipline Chief for Peer Services, Los Angeles County Department of Mental Health, stated she calls stories of recovery and resilience “moments for mission” to remind everyone why they attend meetings and why these meetings occur. She stated no two stories of mental health and recovery are alike even though there may be common threads between many of them.

Ms. Myrick shared her story of living with schizophrenia, being shamed into silence, feeling isolated and unlovable, finding a therapist who focused on her goals, and the critical moment of being introduced to a peer who had been through what she had been through. This peer supporter gave Ms. Myrick the opportunity to see the possibilities in life, which helped her move forward with her life by returning to school and work while working on her symptoms. She gave credit to her family for their support during her recovery journey. She stated whole health care is important and discussed the support she received during a difficult physical illness.

Ms. Myrick ended her presentation with the poem “I rise” by Maya Angelou. She stated Los Angeles has decided that they, too, will rise and she asked that the MHSOAC rise with them.

Questions and Discussion

Chair Tamplen asked how to correct the notion that persons in recovery cannot possibly know what it is like to be seriously ill since they are recovered.

Ms. Myrick stated she does not use the term “recovered” because recovery is a journey. She stated no matter if she is experiencing symptoms or not, the thief, schizophrenia, is still here and continues to steal from her life. She stated she is not only on a journey for herself but for others who are still trying to find their way on this path.

Commissioner Mitchell thanked Ms. Myrick and honored her for sharing her story, which gives hope to consumers and family members.

Commissioner Boyd asked about the one thing Ms. Myrick would leave with Commissioners that should be woven into decision-making and the work of the Commission.

Ms. Myrick stated she would leave everyone with the importance of the work in helping individuals remain in community. Although it is helpful to be a part of community mental health, it would also be helpful to keep individuals connected to community with the supports surrounding them in order to remain in community. She stated the need to think about how to shore up the mental health system, communities, neighbors, and families to be a support to individuals where they are, when and how they need it, so that individuals do not need to seek support because the support is already there for them.

Celeste Walley thanked Ms. Myrick for sharing and stated she was moved by her story.

ACTION

1: <u>Approve April 25, 2019, MHSOAC Meeting Minutes</u>

Chair Tamplen asked for a motion to approve the minutes from the April 25, 2019, meeting.

Vice Chair Ashbeck moved approval of the April 25, 2019, meeting minutes. Commissioner Danovitch seconded.

Public Comment

Poshi Walker, LGBTQ Program Director, Mental Health America of Northern California (NorCal MHA), Co-Director, #Out4MentalHealth, referred to their second comment on page 17 and asked to change “NorCal MHA did their LGBTQ outreach with that in mind” to “the Subcommittee in general did their outreach with that in mind.”

Poshi Walker also referred to the first paragraph on page 23 and asked to remove the word “some” from “but the speaker has noticed that some stakeholders make a lot of public comment that is not reflected.”

Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), referred to their request on page 11 for “the Commission to reconsider its decision to eliminate statewide advocacy for refugees and immigrants in this grant” and stated they had elaborated on that point. The speaker stated they have not asked in the past for their comments to be noted as verbatim or written down in full in other minutes; however, due to the importance of this subject and because it remains unresolved, the speaker would like the record for this subject to be complete.

Stacie Hiramoto asked that the written record reflect a more complete and accurate account of what they said. The speaker referred to the original notes from the testimony given at the April meeting and noted that, in addition to asking for reconsideration, they stated the following:

> "I would like to ask the Commission to reconsider your decision to eliminate state advocacy for refugees and immigrants in this grant. REMHDCO remains convinced that this was a vote that was misunderstood as somehow giving more power to local groups or local decision-makers. Nothing could be further from the truth. Integrated and coordinated efforts to advocate between state and local levels makes advocacy stronger and more informed at both levels.
>
> "Furthermore, this is the only grant of all the stakeholder advocacy grants that the OAC administers that omits state-level advocacy. This was a decision that not a single community stakeholder that we know of asked for or supported.
>
> "REMHDCO did want to thank Commissioner Ashbeck for her courageous and thoughtful vote and for listening to the voice of racial and ethnic communities as well as family members and consumers. We also wanted to thank Commissioner Anthony for also listening and considering testimony of community family members and consumers, although she was not present at that meeting.
>
> "A voice at the state level as well as at the local level, going back and forth, will be lacking."

Stacie Hiramoto respectfully requested that such testimony be added to the record.

Vice Chair Ashbeck amended her motion to include the requested changes to pages 11, 17, and 23, as noted. Commissioner Danovitch agreed.

Action: Vice Chair Ashbeck made a motion, seconded by Commissioner Danovitch, that:

The Commission approves the April 25, 2019, Meeting Minutes as revised.

Motion carried 8 yes, 0 no, and 2 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Anthony, Boyd, Bunch, Danovitch, Madrigal-Weiss, and Wooton, Vice Chair Ashbeck, and Chair Tamplen.

The following Commissioners abstained: Commissioners Brown and Mitchell.

ACTION

2: <u>Orange County Innovation Plan</u>

Presenters:

- Jeff Nagel, Ph.D., Behavioral Health Director, Orange County Health Care Agency

- Clayton Chau, M.D., Ph.D., Regional Executive Medical Director, Institute for Mental Health and Wellness, Providence St. Joseph Health
- Sharon Ishikawa, Ph.D., Orange County MHSA Coordinator
- Courtney Ransom, J.D., Family Member

Chair Tamplen stated the Commission will consider approval of $18,000,000 to support Orange County's Behavioral Health System Transformation Innovation Project. She asked the representatives from Orange County to present this agenda item.

Courtney Ransom, J.D., Family Member, shared the story of losing her son to suicide in 2016 and how her family was directly impacted by the fragmented behavioral health system in Orange County. She spoke in support of Be Well Orange County (Be Well OC), this innovation project, and the efforts to drive change to the behavioral health system of care.

Sharon Ishikawa, Ph.D., Orange County MHSA Coordinator, provided an overview, with a slide presentation, of the key challenges, community planning process, innovative solution, project activities and deliverables, learning objectives, evaluation approach, and budget of the proposed innovation project.

Clayton Chau, M.D., Ph.D., Regional Executive Medical Director, Institute for Mental Health and Wellness, Providence St. Joseph Health, spoke in support of the proposed innovation project.

Commissioner Questions

Commissioner Anthony reminded counties to have a full and robust community planning process. She asked, regarding the digital navigator, if the county representatives had ever called up the Medi-Cal line to apply for benefits.

Dr. Chau stated he used to work for Los Angeles Care Health Plan, which is the nation's largest nonprofit Medicaid plan.

Commissioner Anthony walked the county representatives through the process of calling the Medi-Cal line's automated system. She stated it is difficult to navigate and callers receive inconsistent answers to questions. She stated the proposed innovation project plans to use a digital navigator for the back end; however, the front end is a huge problem.

Jeff Nagel, Ph.D., Behavioral Health Director, Orange County Health Care Agency, stated this project has been iterative in development. The 30-day posting is at the end of a lot of participation by family members that preceded that and refined the proposal so that, by the time of the 30-day posting, the county already received a lot of input. Also, the digital navigation tool being developed is a tool that will be used by peers to help navigate the system. Peers will partner with clients who need services. The resource given to them will have embedded search capabilities that allows for meaningful searches but that will be just a tool that will then be used by individuals with lived experience who can help clients navigate the systems of care.

Dr. Chau stated there will be a number where clients will call in. They will get a live person who is a peer to help them. This navigation is the directory for the person who answers the phone. The problem with inconsistency when calling a health plan is that the directory is out of date the minute it is published so five different people that answer the phone give five different answers because they do not have a consistent directory to help them to support the individuals who call in. That is the goal of this project.

Commissioner Danovitch stated he shares Commissioner Anthony's concern about the difficulty consumers face when trying to navigate services. He stated the blending of the private and public is an essential and important innovation. He stated the need to learn from both the things that are successful and the challenges. He stated one thing he did not see in the meeting materials is a project plan with a timeline and milestones. Milestones could be critical points for learnings. A timeline with milestones is a mechanism for the Commission to monitor progress and learn from it. He stated his hope that there would be an opportunity to learn county-to-county.

Dr. Ishikawa stated the timeline with milestones will be provided. That is one of the first things that will be done to help flesh out and organize all the activities and entities involved in the project.

Dr. Chau stated a timeline is included on page 16 of the meeting materials.

Commissioner Wooton asked if the digital navigator's salary is included in the project office budget.

Dr. Ishikawa stated it depends. The subject matter expertise in terms of the computer programming would be involved under the Professional Consultation budget category, which she pointed out on the presentation slide. She stated there will be a series of community stakeholder meetings to determine the criteria to curate the list of programs and to determine the information that the community is most interested in seeing provided and regularly updated in this resource navigator. This will be included in the Local Community Consultation budget category.

Commissioner Wooton asked what would happen if the hospital and crisis residential programs were filled in the new system.

Dr. Nagel stated there are key bottlenecks in the system. Among them are adequate housing resources, crisis services, and residential treatment programs. Gaps needs to be located and addressed in the integrated system.

Vice Chair Ashbeck asked who would get paid as part of the digital navigator tool.

Dr. Ishikawa stated the professional consultation costs would be for the technology experts who would be developing the digital platform.

Vice Chair Ashbeck stated $18 million for no services is a lot of money. She asked for clarification on what the county is trying to improve with this project because some of this is happening already.

Dr. Chau stated the cartoon on the left side of the presentation slide is where the county is currently and the cartoon on the right is the future.

Dr. Nagel stated without cost the county has come together, Be Well has formed, and part of a blueprint of performance indicators has been developed as Appendix A on page 19 of the meeting materials. He reviewed the six key performance indicator goals that will be part of Be Well.

Commissioner Boyd asked about the role the payers have had so far in the dialogue in shaping this in concrete ways and what the barriers will be.

Dr. Chau stated all the major payers are at the table and innovative services provided for members will be reimbursed.

Commissioner Boyd asked if there have been concrete changes to the market and to their commitments as it relates to parity specifically as a result of having all major payers at the table.

Dr. Chau stated a full network is offered regardless of insurance.

Commissioner Boyd suggested that these payers present to the Commission about their work and what they hope to achieve with a full network.

Commissioner Boyd stated he would be interested in how this work will interface with the California Technology Suite. He stated the need to look at practice transformation and how that interplays in creating additional access.

Commissioner Brown stated $18 million seems like a tremendous amount of money for planning. The Stepping Up Initiative in Fresno and Santa Barbara Counties brings communities together to address ways to mitigate individuals with mental illness being involved in the justice system. He asked for clarification that the $18 million will not only cover the costs of meetings but that there will also be legal services, contracts, Memorandums of Understanding, and agreements between agencies.

Dr. Ishikawa stated that is absolutely the case. Part of the professional consultation includes legal fees as well as different subject matter expertise in contracting and procurement and representatives who will ensure compliance with regulations across the braided funding streams. Paying for meetings is not just renting space or providing light refreshments but also includes providing stipends to consumers and family members to attend the meetings in an effort to reach more consumers and family members in the hope that they will stay involved in the planning process.

Dr. Ishikawa stated the other large amount is for technical expertise for building the digital resource navigator. She stated the hope that the resource navigator will be built through the Technology Suite so it can be shared with other counties.

Dr. Nagel stated that is the one element that is not planning. A product will be delivered as a result of this project.

Commissioner Brown asked if there were letters of support from law enforcement and to what extent the county will partner with the sheriff’s office and with law enforcement agencies.

Dr. Chau stated the sheriff is fully onboard. He has been involved with the Be Well OC since day one before he was the sheriff. Also, the county works in collaboration with various city police departments as part of Be Well OC.

Commissioner Mitchell stated her concern about spending $18 million for a plan with no services. The funding should be transformative in terms of helping people. She stated the goals are anecdotal; she requested seeing more data or hands-on work that shows that the $18 million will touch lives such as mentally ill homeless individuals. She stated there are payers and partners involved in the planning process but she asked where the clients and family members are.

Dr. Chau stated the Commission is only seeing the application to ask for funding to do some of the work of Be Well. The goal of Be Well OC is not to provide services but how the siloed system can be stitched together to create an informative system. Everyone has data but that data is meaningless unless it is stitched together to reveal impacts in the community and how programs affect the system. He stated no one is left out of the conversation; the homeless community has been involved in the planning process.

Commissioner Berrick asked for clarification of the underlying contracting and payment mechanisms, particularly on the Medicaid/Medi-Cal side.

Dr. Ishikawa asked the consultant who has subject matter expertise in this area to address Commissioner Berrick's question.

John Freeman, Administrator, Dale Jarvis and Associates, stated he has been working with Be Well and helping to support Orange County in this effort. He stated the answer to the blending and braiding question also answers the $18 million question – it is a huge lift to address the legal and other contracting barriers in existence and to get the expertise to go through and identify the funding sources that can be blended and braided, including sources from the private sector. Digging into those things and exploring what can happen gets at the core of what will be addressed through that part of the project to understand what can and cannot happen.

Commissioner Berrick asked about the payment mechanism and if the county is envisioning a capitation or a case rate.

Mr. Freeman stated the clinical design is what needs to be identified through the planning process so the appropriate financial and fiscal design can be applied to it. Then, the funding streams can be identified that will support the clinical design that will deliver the care needed by the community.

Commissioner Berrick stated his understanding that the county is assuming some fairly radical state and/or federal waivers.

Mr. Freeman stated the county will be communicating with the state and the Department of Health Care Services (DHCS) and other involved stakeholders on what can be included in upcoming waivers in the future that could support this work going forward.

Commissioner Berrick asked if funding that is clearly identified and dedicated to mental health might get lost to the health care system.

Dr. Chau stated it will not because, when looking at mental health as the essential health and lifting with the parity care, providers are held responsible for the wellness of the entire individual.

Commissioner Bunch stated parts of this proposal are similar to the proposal to be heard later from Los Angeles County. She asked if Orange County has spoken with Los Angeles County about the similarities and differences in their proposals and whether the counties can work together.

Dr. Nagel stated Orange County has reached out to Los Angeles County and will be working together with them on shared learnings. This is an opportunity to look at what is possible.

Dr. Chau stated both counties want to achieve the same goal but approach it very differently. It would be interesting to have an entity that will evaluate the two counties at the same time.

Chair Tamplen asked Dr. Nagel about his vision for the county and the leadership of consumers and family members throughout the system including at the county behavioral health care services. It is inside and outside the county system that needs to empower and include the leaders.

Dr. Nagel stated he formed a peer employee advisory committee prior to becoming the behavioral health director. That committee, which is composed of individuals with lived experience, meets with him on a monthly basis, develops the vision, and looks at how to transform the system. He stated those meetings are what inspire him. Changes to the system are currently being driven by that peer advisory committee.

Chair Tamplen recommended the Los Angeles County model of bringing in a peer and family chief like Keris Myrick who reports directly to the director, not at a monthly meeting to hear the stories. Those are powerful but it is important to utilize the expertise and the ability of peers to get out into the streets where clinicians do not want to go to connect with the community. She stated Orange County needs someone in the department who reports to Dr. Nagel directly and is his go-to.

Commissioner Wooton stated the need to hire peers for this project who will be helping out as navigators or at the wellness center. She encouraged the county to hire a consumer empowerment manager and to include involvement with family members, as well.

Public Comment

Julia Ransom spoke in support of the proposed project.

Poshi Walker echoed concerns of the Commissioners. The speaker wanted to ensure that services are integrated for LGBTQ communities, particularly transgender individuals, and that there will be services specifically for LGBTQ communities. The speaker urged continued outreach to LGBTQ agencies in Orange County and offered #Out4MentalHealth as a resource for this endeavor. The speaker stated the need for individuals trained in LGBTQ issues to be part of the digital navigation tool.

Tiffany Carter, Statewide Advocacy Liaison, ACCESS California, NorCal MHA, stated ACCESS California is not in support of the proposed project for the following reasons:

- The $7.3 million being allotted to local community consultation mirrors what the CPP dollars should be investing in. It is concerning to see these dollars being spent in a consultation manner rather than in stakeholder engagement and evaluation.
- The mention of peers is present throughout the presentation but one of the main benefits of peers being engaged is that their experiences and their skills are utilized consistently and elevated throughout their services that they provide. This is not being reflected in this program.
- The MHSA is married to the recovery model. There has been references to the clinical design throughout the program, but the intent of the MHSA needs to be reflected through the entire program and not just bits and pieces of it.

Andrea Crook, Advocacy Director, ACCESS California, NorCal MHA, spoke in opposition to the proposed project. The speaker echoed the comments of the previous speaker. This plan is an opportunity to demonstrate the commitment of integrating, elevating, and marrying the recovery model with the historical medical model. The proposed project is heavily clinically-driven. To truly transform the system, the budgets need to reflect the meaningful integration of peers. The county only plans to give stipends to individuals with lived experience to facilitate meetings. The speaker stated the need to ensure that the plan is reflective of the values, philosophy, and intent of the MHSA.

Commissioner Boyd stated his comments will be made in the spirit of healing, collaboration, and doing the right thing. He stated there are various peer groups and they do not always agree, nor does one group reflect all peers or all activities that take place in a county and state. It is troublesome to hear global statements that peers are “not involved” or “not at the table” because, almost without exception, there have been other peers and other organizations that have stepped up and said they were there, and statements like these make them not feel valued, respected, or heard. He asked how ACCESS California navigates and coordinates to the extent possible to ensure that, when statements like that are made, there really are not other peers or peer groups at the table.

Commissioner Boyd asked if there is a statewide process where salaries of peers are approved – a market rate for peers – because this keeps coming up. Various ranges are seen in the counties and it is not fair or right to the Commission to weigh in one way or another without understanding the context for a market rate or community practice. That is a discipline for every other professional group.

Andrea Crook stated the way that ACCESS California ensures that peers from communities are being represented and can speak on behalf of Orange County is through the 30 ambassadors throughout the state. They are the boots on the ground. There are individuals that live in all five MHSA regions and are very active and leaders within the communities throughout the state. In addition, ACCESS California does

trainings and outreach to all five regions in the state with not only the leadership but also the stakeholder communities. The speaker stated what they are asking today and echoing is the sentiment conveyed, which is something that the clients throughout the state are unified on. There may be differences but, when it comes to elevating the voice of peers, that is a sentiment shared from clients throughout the state. In addition to ensuring that there are individuals represented, it would be helpful to hear from those client leaders and stakeholder groups as part of county presentations.

Andrea Crook stated, regarding the salaries, it would be nice to have more information but this was not even a salaried position. This particular plan only allotted stipends. The speaker stated they would love to see more budget detail.

Steve McNally, a member of the Orange County Mental Health Board, speaking as a consumer and family member, spoke in support of the proposed project.

Steve Leoni, consumer and advocate, stated concern about the community planning process and that the private sector has not been a part of it. The speaker cautioned against the tail wagging the dog with hospitals having more political clout than the mental health system, which will cause increased hospitalizations.

Debbie Innes-Gomberg, Deputy Director, Adult System of Care and MHSA, Los Angeles County Department of Mental Health, spoke in support of the proposed project.

Commissioner Discussion

Commissioner Wooton asked if there are funding and positions for consumers and family members within this project.

Dr. Ishikawa stated there are and they are separate and distinct from the stipends for individuals who participate and provide feedback during the community meetings. Consumers and family members will be paid at the same rate as other professionals filling those positions and duties.

Commissioner Boyd asked if there have been peers involved, engaged, and at the table with full participation and equal rights in this process.

Dr. Nagel stated peers have been and will continue to be a part of the process.

Commissioner Boyd stated the work in the health plans noted in the meeting materials cover the most disadvantaged populations around the state and those populations reside in Orange County. He stated the county could learn from Commissioner requests about how to make the project move forward more effectively.

Commissioner Boyd stated lives are lost every day due to the lack of coordination. The Commission is not an administrative body but is a body that helps individuals in their most desperate state more effectively navigate one of the worst systems that have been put together on the front end to help heal people. He encouraged the county to bring in human design expertise to help create a system where individuals can get help when they want it.

Commissioner Mitchell asked if the county will come back to the Commission to demonstrate successes and failures.

Dr. Ishikawa stated the fifth point from the bottom on page 16, Aligning Local Organizations, and the red section, third from the bottom in the meeting materials, are about giving progress updates to the Commission. She stated the county is hoping to work with the Commission on reporting intervals and content.

Chair Tamplen stated staff may ask the county to return with an update in one year.

Commissioner Danovitch made a motion to approve this proposal.

Commissioner Bunch seconded.

Vice Chair Ashbeck stated she was still struggling with the $18 million, $7 million of which is consultation in the first year. She echoed Commissioner Mitchell's comments. She stated she did not know of another plan approved by the Commission in the past with such a great amount of funding that will only produce a plan. There are no deliverables and individuals are not helped. She stated she has led a five-year collective impact project in the past that, at the end, determined they were going down the wrong path. She suggested that projects that are just plans be required to come back at the end of each year to share what has been learned as a check-in along the way.

Commissioner Danovitch amended his motion to include at least one annual report on the achievements around the milestones that are developed.

Commissioner Bunch agreed.

Action: Commissioner Danovitch made a motion, seconded by Commissioner Bunch, that:

The MHSOAC approves Orange County's Innovation Plan as presented with the requirement to include at least one annual report to the Commission on the achievements around the milestones that are developed as follows.

Name: Behavioral Health System Transformation

Amount: $18,000,000

Project Length: Three (3) Years

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

The following Commissioners voted "Yes": Commissioners Anthony, Berrick, Boyd, Brown, Bunch, Danovitch, Madrigal-Weiss, Mitchell, and Wooton, Vice Chair Ashbeck, and Chair Tamplen.

ACTION

3: <u>Ventura County Innovation Plan</u>

Presenters:

- Kiran Sahota, MA, Mental Health Services Act Senior Behavioral Health Manager, Ventura County Behavioral Health

- Hilary Carson, MSW, MHSA Administrator, Innovations, Ventura County Behavioral Health

Chair Tamplen stated the Commission will consider approval of $1,047,100 to support Ventura County's Conocimiento: Addressing ACEs through Core Competencies Innovation Project. She asked the representatives from Ventura County to present this agenda item.

Kiran Sahota, Mental Health Services Act Senior Behavioral Health Manager, Ventura County Behavioral Health, reviewed the background and county demographics. She stated this project is youth-created and 100 percent community-driven.

Hilary Carson, MHSA Administrator, Innovations, Ventura County Behavioral Health, provided an overview, with a slide presentation, of the need, proposed project to address the need, innovative components, evaluation, and budget of the proposed innovation project.

Commissioner Questions and Discussion

Celeste Walley stated she is behind anything that is trauma-informed and deals with adverse childhood experiences (ACEs). She asked how the county will ensure honesty with self-reported data. She asked how individuals will be comfortable and informed about what the surveys ask.

Ms. Carson stated the first six months will include staff hiring and development trainings including an ACEs training. The self-report will be anonymous. The project ensures that the staff know the youth in order to connect them to services rather than relying on the information provided in a survey.

Commissioner Brown asked about the origin of the title word and if it is a grassroots program developed from scratch.

Ms. Carson stated the name came from the individual who submitted the idea. Conocimiento means knowledge-sharing. The meetings begin with participants sharing where they currently are, how they are feeling, and what is going on. It is more about the way of starting meetings and bringing individuals together in a group rather than a preconceived concept or program.

Vice Chair Ashbeck asked if the family liaison will be a paid position and if that is included in the direct cost.

Ms. Carson stated they are included under the Consultant Costs and Contracts budget line item. The budget narrative includes a breakdown including a paid position for the family liaison.

Celeste Walley asked about the type of dinners that will be presented.

Ms. Sahota stated the youth at the centers will plan the dinners.

Public Comment

Melissa Hannah spoke in support of the proposed project.

Zachary Hixson spoke in support of the proposed project.

Onalyn Garman spoke in support of the proposed project.

Aubrey Bader spoke in support of the proposed project.

Sophia Skoe spoke in support of the proposed project.

Mark De Jesus spoke in support of the proposed project.

L. Ruiz spoke in support of the proposed project.

Poshi Walker encouraged the county to look at the Family Acceptance Project. The speaker spoke in support of the proposed project.

Kate English spoke in support of the proposed project.

Action: Commissioner Madrigal-Weiss made a motion, seconded by Commissioner Berrick, that:

The Commission approves Ventura County's Innovation Plan as follows:

Name: Conocimiento: Addressing ACEs through Core Competencies

Amount: Up to $1,047,100

Project Length: Four (4) Years

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

The following Commissioners voted "Yes": Commissioners Anthony, Berrick, Boyd, Brown, Bunch, Danovitch, Madrigal-Weiss, Mitchell, and Wooton, Vice Chair Ashbeck, and Chair Tamplen.

LUNCH BREAK

ACTION

4: <u>Los Angeles County Innovation Plan</u>

Presenters:

- Jonathan E. Sherin, M.D., Ph.D., Director, Department of Mental Health, Los Angeles County
- Anthony Ruffin, Community Center Director, Department of Mental Health, Los Angeles County
- Jesús Romero, Jr., LCSW, MPA, Program Manager, Hollywood Mental Health Center
- David Pilon, Ph.D., C.P.R.P., Mental Health Consultant

Chair Tamplen stated the Commission will consider approval of $116,750,000 to support Los Angeles County's The TRIESTE Project. She asked the representatives from Los Angeles County to present this agenda item.

Jonathan E. Sherin, M.D., Ph.D., Director, Department of Mental Health, Los Angeles County, discussed the need for payment reform.

Anthony Ruffin, Community Center Director, Department of Mental Health, Los Angeles County, discussed the inability to bill for needed services.

Jesús Romero, Jr., LCSW, MPA, Program Manager, Hollywood Mental Health Center, discussed the proposed project to address the need.

David Pilon, Ph.D., C.P.R.P., Mental Health Consultant, stated he was the lead author of the project proposal. He stated payment reform, accountability reform, and documentation reform are extremely important because they are barriers to recovery. He stated the ability to form a relationship has almost twice the effect of any specific practice a person might engage in and bureaucratic and regulatory environments get in the way of that relationship. He provided an overview, with a slide presentation, of the innovative components of the proposed innovation project.

Commissioner Questions

Commissioner Boyd stated this project involves a level of transformation from a cultural perspective. He asked how that kind of change management and cultural transformation is being done that will support this kind of effort.

Dr. Sherin stated if, from the trenches up, providers and consumers can be empowered, it will cultivate cultural change.

Commissioner Berrick stated the proposed project is important for California, not just for the country. The proposed project should have a 50 percent federal funding match. He asked how that can happen.

Dr. Sherin agreed. The goal is to get matching funds that will allow the county to push the new approach to delivering care.

Chair Tamplen asked about the proposed innovation of shifting the provision of wellbeing-focused services. The meeting materials state this creates an assigned health home for each member appropriate to their level of care, but she stated recovery is a journey. She asked what moving through the levels of care looks like.

Dr. Pilon stated level of care is related to how self-coordinating the person is. To some extent, their journey in recovery is a part of that, but individuals can be fairly far along in the journey of recovery and be unable to coordinate all their care themselves. The level of care is defined by the amount of staff support required for quality of life in the community. The proposal recognizes that individuals are at different levels of need and that some individuals may always need help in particular areas.

Chair Tamplen asked how individuals will move through the levels of care.

Dr. Pilon stated, as individuals learn to self-coordinate and manage their own care, they can be moved down to lower levels of care. It is up to the individual as to when they are ready to move to lower levels, based on their level of care.

Vice Chair Ashbeck stated the first year of funding is about planning. She asked about the stakeholder input process to date.

Dr. Sherin stated this has been an organic process since 2017, when a number of individuals went to Trieste, Italy, to study their mental health system. Since then, there have been a number of formal engagements with the community and, when the county hosted mental health experts from Italy and other locations around the world, there were intensive conversations about this type of project.

Dr. Sherin agreed that it is a lot of money and stated it will provoke many new challenges and will only succeed if a collective is created around it. Governments do not solve problems; collective problems require collective solutions. He stated the first year will be spent building the ecosystem, culture, and array of services needed to succeed and achieve outcomes. He stated, in addition to trying to push the envelope around the service array, this project will move the needle with respect to the engagement of every stakeholder and, ultimately, with the voice of consumers out in front.

Vice Chair Ashbeck stated her concern that there is not a presentation slide on the budget. She stated, for $116 million, there should at least be a discussion about the buckets of the funding and how it will be spent.

Dr. Pilon apologized for not including a budget slide in the presentation. He reviewed the basics of the budget plan.

Vice Chair Ashbeck asked if the planning year will include the development of the electronic health record (EHR).

Dr. Pilon stated it will.

Vice Chair Ashbeck asked about integrating the EHR with other systems. Creating another EHR is not helpful because it will not talk to existing EHRs, hospitals, or other mental health services.

Dr. Pilon stated there is nothing being suggested in the documents, accountability, or billing system that could not be done in a current EHR, although there will be improvements by using a cellphone-based technology to gather the data. The EHR will have to be linked to the existing data system but the technology already exists to capture the necessary information.

Dr. Sherin stated, in order to address the segregated medical record issue, there is a focus on systems that will allow communication as a network across all urgent care facilities and emergency departments with the Department of Mental Health. The proposed project is a part of that.

Vice Chair Ashbeck stated the Orange County innovation project is similar yet different from the proposed project. The system will never be transformed with counties working independent of each other. She stated her hope that Los Angeles and Orange Counties will share their learnings.

Commissioner Brown stated Trieste, Italy, and Los Angeles, California, are two very different communities and there is nowhere near the existing problem in Trieste that there is in Los Angeles in terms of mental illness and the co-occurring homelessness and substance abuse. Trieste has been flagged as a model program for many years. He asked why this model has not been tried before in the United States.

Dr. Sherin stated there have been things done in this country that are similar, such as The Village in Los Angeles and the Progress Foundation in San Francisco. He agreed that Trieste, Italy, is very different. The county is not trying to replicate Trieste but is taking fundamental principles from the Trieste model and importing them, such as hospitality and coproduction.

Commissioner Brown stated the biggest difference between the two areas is the economics of it, where the funding comes from, and the lack of bureaucracy in the Trieste version in trying to get services. That is indicative of the social safety net that exists in many European countries, along with the cultural and taxation differences. This project focuses on Hollywood, which has a population of approximately 100,000 individuals, which is approximately 1/40th of Los Angeles's population and can be extrapolated to be a cost of approximately $1.4 billion. Extrapolated out to the state as a whole, the question becomes if the proposed project is financially feasible or sustainable. He stated his concerns about the cost issues, the differences in the existing societal and social safety net systems, and if this is a realistic approach for the problems seen in Los Angeles, which, arguably, are far greater than in Trieste, Italy.

Dr. Sherin stated the budget was reverse-engineered based on the spending to ensure that this project was within the realm of the current fiscal system. He argued that a tremendous amount of funding will be saved by keeping individuals in community rather than having them cycle in and out of hospitals and emergency departments, getting through that system, and being in the streets and in the jail.

Dr. Sherin stated the biggest difference between Trieste and Los Angeles is addictions, which is a massive challenge. He stated the need to figure out how to incorporate the substance use disorder funding and service delivery system as a part of the proposed project. He stated the county does not have all the answers but this has to happen in order to advance and transform the mental health system.

Dr. Pilon agreed that Trieste is more an inspiration for the proposed project. It is anticipated that, through using the model's principles, the costs of hospitalization will be reduced. He stated the hope to provide better outcomes for at least the same amount of money that is currently being provided.

Celeste Walley asked about the model of care and what the intake and closing process would look like.

Mr. Romero stated it will look like providers getting out of their offices and into the street going to where the clients are and doing whatever it takes to help clients have a meaningful life. There will be no wrong door and no wrong way to access services. He stated there is an endless array of possibilities in terms of what it might look like for someone.

Commissioner Mitchell asked who will address the skid row population.

Dr. Sherin stated the county considered skid row for the pilot but chose Hollywood, which has the second greatest area of need. He stated, because the county wanted the pilot program to have a profound impact in an area of massive need, a difficult area was chosen but not the area that is almost impossible. He stated the hope that, through

changes in regulatory constraint, investment, greater flexibility, housing, urgent cares, and engagement of the private sector, there will be a bigger influence in skid row. Locating the project in nearby downtown will raise the bar and the awareness that it will take heroic efforts and courage of politicians to address that issue.

Commissioner Mitchell agreed the skid row will not be healed with one program but suggested future projects that will impact skid row. She used the analogy that an elephant is eaten one bite at a time but, if that bite is not taken, the elephant will never be eaten. She requested that all future proposals include a nibble at skid row.

Commissioner Boyd stated Commissioners are part of a family of Commissioners. Part of the legacy is in those who served before. He asked Richard Van Horn, former Chair and Commissioner of the MHSOAC, to share his thoughts.

Commissioner Emeritus Van Horn stated stakeholder outreach began in the summer of 1980. He stated he was sitting next to Mark Karmatz, who was a member of the first Project Return Club in 1980. That was the first hint that individuals with mental illness could have a life and local support in the community. He stated it morphed from there.

Commissioner Emeritus Van Horn stated the next piece of that was, around the time that The Village was started, he hired Dr. Pilon for the specific purpose of drafting The Village proposal. He stated the importance of that is that he was already thinking about Trieste. He stated he did not go to Trieste, Italy, but to Japan, where he attended a seminar with two individuals in recovery who ran the hotel in Trieste. He stated this was the first time he had heard of individuals in recovery running a business.

Commissioner Emeritus Van Horn stated Project Return then became the Project Return Peer Support Network, which is an independent agency and has its own life.

Commissioner Emeritus Van Horn stated The Village was established January 1, 1990, as a wellbeing model but this term was not yet established. Recovery was just beginning to be discussed; wellbeing as a model had never been considered – 29 years later, the proposed project does. He stated cultural change is incredibly important but the key here is that, in the initial pilot period with The Village 29 years ago, the program was paid quarterly in advance on an annual case rate. In Los Angeles County in that year, 50 percent of all dollars were going into 24-hour care. In the first year of The Village, 4 percent of the dollars went into 24-hour care. The ratio was entirely reversed from 50 percent to 4 percent and where the big money was going was in what was then called “case management,” but what it really was was community support. That is where the proposed project is headed – toward total transformation.

Vice Chair Ashbeck stated she continued to struggle with the fact that there was no slide on the budget and it felt like the proposed project was expected to be approved by the Commission. She asked Commissioner Emeritus Van Horn what counsel he would give to the county about the money.

Commissioner Emeritus Van Horn stated the need to remember that the percentage of the funding going to planning and evaluation is approximately 4 to 5 percent total and 90-plus percent is going into services. The next piece of that is that there are many different services as a part of this first planning year that are wrapped into that bundle.

Almost all of the funding is going into direct services to the people in a defined geographic area. He stated he would not be afraid of not having a detailed budget at this point. There cannot be a detailed budget at this time because there is too much work to be done to get to that level of detail that provides a spreadsheet that shows all of the dollars.

Commissioner Mitchell asked the county to provide biannual reports to the Commission on the milestones.

Commissioner Berrick stated showing the comparison between current expenditures in clinic structure and the expected differences would be helpful.

Chair Tamplen asked how transformative the proposed project will be and about the reimbursement system and documentation for Medi-Cal billing. She asked how individuals will be assessing their level of care and how the power will be given back to the consumer who is there for support.

Dr. Pilon stated, as part of the year-long planning process, the county will ask clients how they would like the project to assess if they are getting what they need in their lives to help the project proponents better understand what clients would like evaluated.

Chair Tamplen asked if the county is open and willing to change questions that clients say do not fit and where they want something different.

Dr. Pilon stated it is.

Dr. Sherin stated he is expecting stakeholder feedback to change things. That is the idea of intensive planning and that is why the county would like to take the time to do that.

Public Comment

Alicia Rhoden, Social Worker and consumer, stated concern that the proposed project will meet the total needs of the client. Home health is a good thing but it must be a peer that can relate to the client and can talk to them like they have sense and not tell them what to do.

Pamela Inaba, Recreation Therapist and ACCESS Ambassador, encouraged hiring peers and family members at all levels of the project.

Mark Karmatz spoke in support of the proposed project.

Rudy Salinas, Chair, Hollywood 4WRD, spoke in support of the proposed project.

Devin Blake, Resources Coordinator, The Center, spoke in support of the proposed project.

Amy Perkins, Director, Interim Housing Strategies, Mayor's Office, spoke in support of the proposed project.

Sarah Dusseault, advocate and family member, Homeless Services Authority, spoke in support of the proposed project.

Yanzie Chow, Asian Americans Advancing Justice-Los Angeles, questioned if this project has been adapted to serve a diverse population, especially Asian/Pacific Island communities.

Patricia Russell, National Alliance on Mental Illness (NAMI), spoke in support of the proposed project.

Jeff Briggs, resident and business owner, Hollywood, spoke in support of the proposed project.

Kris Larson, Hollywood Business Improvement District, spoke in support of the proposed project.

Brian Folb, Hollywood Property Owners Alliance, spoke in support of the proposed project.

Stacie Hiramoto thanked Yanzie Chow for outlining some of the concerns and Commissioners Ashbeck and Mitchell for holding the county accountable. The speaker stated there is no mention in the meeting materials of reducing disparities or hiring staff that speak multiple languages.

Bill Callahan, Peer Action for Change (PACS), spoke in support of the proposed project.

Steve Leoni spoke in support of the proposed project.

Lily Weiner, Hollywood Chamber of Commerce, spoke in support of the proposed project.

Elan Shultz, Los Angeles County, Board of Supervisors, Sheila Kuehl, spoke in support of the proposed project.

Marvin Thompson, consumer, spoke in support of the proposed project.

Carolyn Neal, Hollywood 4WRD, spoke in support of the proposed project.

Caroline Kelly, Former Chair, Mental Health Commission, spoke in support of the proposed project.

Frank Robbins, businessman and family member, spoke in support of the proposed project.

Reba Stevens spoke in support of the proposed project.

Keris Myrick spoke in support of the proposed project.

Lashelle Allison spoke in opposition to the proposed project. The speaker shared experiences of their son trying to navigate the system.

Commissioner Discussion

Vice Chair Ashbeck asked about scale and if the proposed project is transformative if it is not repeatable.

Dr. Sherin predicted that money will be saved along with lives, family, and community. The Department of Mental Health for Los Angeles County has a budget that approaches $3 billion. The county reverse-engineered the budget based on the costs of the area

and looked to take this model forward based on the fact that the current budget covers a certain set of services in communities around Los Angeles County. He stated the county is using the budget based on what it is spending and believes that money will be saved with this model because resources can be used more flexibly to achieve better outcomes. This is a feasible approach to transforming mental health in Los Angeles County.

Commissioner Brown asked about the current budget being spent for the Hollywood area.

Dr. Pilon stated the current budget is approximately $18 million. This project adds in crisis residential services for approximately another $8 million to bring the total to $26 million.

Action: Chair Boyd made a motion, seconded by Commissioner Wooton, that:

The Commission approves Los Angeles County's Innovation Project with the requirement to include a progress report to the Commission in six months, as follows:

Name: Trieste

Amount: Up to $116,750,000

Project Length: Five (5) Years

Motion carried 8 yes, 1 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Berrick, Boyd, Brown, Danovitch, Madrigal-Weiss, Mitchell, and Wooton, and Chair Tamplen.

The following Commissioner voted "No": Vice Chair Ashbeck.

ACTION

5: <u>Streamline Commission Approval of Innovation Plans</u>

Presenter:

- Brian Sala, Ph.D., Deputy Director; MHSOAC

Chair Tamplen stated the Commission will consider options for streamlining procedures for approval of County Innovation Project work plans. She asked staff to present this agenda item.

Brian Sala, Ph.D., Deputy Director, MHSOAC, provided an overview, with a slide presentation, of the Commission agenda time and options for consideration for streamlined Commission approval of innovation plans.

<u>Staff Recommendations</u>:

- Enhance the Role of the Innovation Subcommittee
  - Direct the Subcommittee to oversee implementation of the Innovation Incubator

  - Clarify that plans consistent with Subcommittee recommendations are eligible for Consent Agenda or delegated approval

- Utilize a Consent Agenda
  - Limit to plans for which staff analysis has identified no significant concerns, including from public comment
  - Require approval of the Chair
  - Allow any Commissioner to remove a plan from the Consent Calendar prior to a vote
- Expand delegated authority to Staff
  - Authorize the Executive Director, with the consent of the Chair, to approve county plans that meet any of the following conditions:
    - The county INN budget is $500,000 or less
    - The county plan proposes to join an existing project and would contribute to statewide learning
    - The plan has been developed in partnership with the Commission, such as through the Innovation Incubator

Commissioner Questions

Commissioner Berrick stated, in his experience, consent agendas are used less often than any other type of agenda and are inefficient. The idea of strictly a chair review as opposed to a Subcommittee review does not meet the intent of the oversight role of the Commission. He recommended using the Subcommittee process. The purpose of the Subcommittee is to take the burden off the Commission. He suggested referring new proposals with staff recommendations to a Subcommittee consent agenda. The renewals, particularly items under $500,000, do not need to come back to the Commission. The Subcommittee would then forward the items that should be on a consent agenda and pull items that should be considered by the Commission so there will be a full oversight function at every level.

Commissioner Danovitch stated he would raise the challenge of using the Subcommittee on a regular basis. There a substantial burden that could potentially be put on the members of the Subcommittee if the Subcommittee was required to meet on a monthly basis in order to formulate a consent calendar or agenda for every meeting. If it were done on a less frequent period basis, that might meet the needs of those Commissioners.

Chair Boyd asked if Commissioner Berrick's suggestion was that the Subcommittee would not necessarily go through all of the depth of each proposal but would trust staff recommendations and, in that process, make some decision around what needs to come to the Commission versus a consent agenda.

Commissioner Berrick agreed it would create something of a burden, but having an expanded consent agenda with staff recommendations holding the weight that it can

and should hold does not create an enormous burden on the Subcommittee. The Subcommittee would have effectively two different consent agendas:

- A straightforward approval of staff recommendations for renewals, etc.
- New proposals, which would be divided into two categories:
    - A second consent agenda of staff recommendations to approve where the Subcommittee could pull items off at their discretion.
    - An agenda where staff is less certain or recommends against a proposal where the Subcommittee would have a fuller discussion and would forward those to the Commission.

This would create an expedited process, both for the Subcommittee and for the Commission.

Commissioner Brown asked for greater clarification on what the Subcommittee will do.

Commissioner Berrick stated the first consent agenda that the Subcommittee will look at will contain renewal items, where the executive director has recommended approval, to determine if they agree with staff recommendations or if they want to pull them for the Subcommittee's consideration. Those are for the areas considered to be for staff discretion so they would include a secondary portion of oversight. This first consent agenda will be voted up or down or items will be pulled for further Subcommittee discussion.

Commissioner Berrick stated the second consent agenda that the Subcommittee will look at will contain new proposals with clear staff recommendation in favor to determine if they agree with staff recommendations or if they recommend broader Commission consideration. Items in favor of staff recommendations will go onto a consent agenda for the Commission. Items with less than clear staff recommendations in support will be pulled for the Subcommittee's consideration. The vast majority of those would come to the Commission for consideration.

Commissioner Danovitch stated his understanding that Commissioner Berrick is proposing to use the Subcommittee as the filter rather than the Chair.

Commissioner Berrick agreed.

Commissioner Brown stated this would create more work rather than less work. Any attempt to have the Subcommittee be involved in the process puts an undue burden on the Subcommittee and will make recruitment for the Subcommittee difficult. He stated the Commission will still maintain oversight while delegating authority to staff because items will come back to the Commission on a consent agenda as recommendations. The Commission will still receive and review the materials in a packet, including a one-page summary of the plans, prior to voting on them.

Commissioner Berrick stated the items that would come to the Subcommittee on a consent agenda would be heard as a single item and would not be presented by staff unless they were pulled in some way. The consent items are considered as a whole.

Commissioner Brown stated the items would have to be reviewed in order to get on a consent agenda for approval by the Commission.

Commissioner Berrick stated items would require only staff approval to get to the Subcommittee consent agenda.

Commissioner Brown asked about the value of having the Subcommittee be that interim step. He suggested that staff make the recommendations that come to the Commission consent agenda.

Commissioner Berrick stated the items in the first consent agenda would never come to the Commission.

Executive Director Ewing stated the proposal prepared by staff does not require the Subcommittee to meet to validate the staff recommendations. Staff recommendations would be validated by the Chair. The consent agenda would need to be adopted by the Commission in a public hearing. He stated his understanding that Commissioner Berrick is proposing hearing consent calendar items at the Subcommittee and Commission levels.

Commissioner Berrick stated he was suggesting that items that are renewals for $500,000 or less go on a consent agenda that never comes to the Commission.

Executive Director Ewing stated the Commission has delegated authority to staff to approve extensions of existing plans under the condition that they are less than $500,000 or 15 percent of the original proposal. Those items are done administratively and are not reviewed by the Commission.

Executive Director Ewing stated staff is proposing that, if there is a county proposal that has not raised substantive objections through the staff analysis or in public comment, it would be written up as a proposed consent item. The Chair sets the agenda for the Commission and, with the Chair's consent, the item would be put on a consent calendar.

Executive Director Ewing stated, as with the current process, the full analysis would be sent to Commissioners. Any Commissioner at any time could pull a plan. There would be a full Commission review through the voting process. The concept of creating a package of consent items is modeled after the Legislature's Committee process.

Commissioner Brown stated he was fine with the staff recommendations. The only clarification is, if staff recommended not approving a project, that there would be an appeal process for that county to take before the Commission.

Deputy Director Sala stated the intent is to work through the Chair on both of those processes. He stated, if the Chair either disagreed with the staff recommendation of rejection or felt it was appropriate to bring it to the Commission for full review or consent review, then that would be the alternative. This would be the process to ensure that counties had the opportunity for review.

Commissioner Wooton stated statute specifies that innovation plans are to come to the Commission for approval. She asked if laws would need to be amended if the process is changed.

Commissioner Wooton asked how streamlining the Commission approval process will impact the stakeholder process.

Deputy Director Sala stated the current process is to provide notice to stakeholders through the email LISTSERV when a county submits a draft plan for 30-day public comment or when a final county plan is received. Public comment is then incorporated into the staff analysis. This mechanism is already in place; the intent is to continue the staff analysis process including capturing public comment as a mechanism to ensure that the public can particulate. Items brought before the Commission on consent are subject to Bagley-Keene Open Meeting Act requirements – there will be an opportunity for public comment on items on the consent calendar prior to a vote on the consent calendar with the Commission.

Commissioner Wooton stated this is not always effective. Sometimes one letter is received, if any, during 30-day public comment periods in her county.

Commissioner Danovitch agreed. He stated he is strongly in support of making the current innovation plan approval process more efficient because, as important as innovation plans are, there are many other things the Commission needs to be doing that it is unable to because of the time required approving innovation plans.

Commissioner Danovitch stated he liked staff's idea of a blended approach of delegating authority, using a consent agenda, and enhancing the role of the Subcommittee. He suggested enhancing the role of the Subcommittee by using the Subcommittee to manage the Innovation Incubator. The mechanism of the incubator could improve proposals and address concerns without encumbering a Subcommittee with becoming a new administrative bottleneck.

Commissioner Danovitch suggested extending the delegated authority by increasing the cap to $2 million. As long as Commissioners would have the ability to pull from the consent calendar, it would address the concern that Commissioner Berrick raised about the oversight responsibility.

Commissioner Wooton stated, when innovation plans are reviewed at Commission meetings, it raises an awareness about mental health.

Commissioner Danovitch suggested taking the opportunity to use something that has been successfully done with prevention and early intervention funds and scaling that across different counties. He used the example of We Rise and suggested that it could be a traveling exhibition that has local artists. There are ideas and ways that the Commission can pursue its mission when not solely focusing on innovation plan approval. The idea would be to broaden the focus to other ways to pursue agendas.

Commissioner Brown agreed and stated, arguably, the Commission could get more focused on some of what is successful and happening in counties when not solely focused on innovation plan approval. Instead of focusing on innovative programs that have not yet been tried, the Commission could focus more on what is working and how to replicate that in other areas.

Vice Chair Ashbeck stated the question is the criteria for consent calendar items. The Commission has discussed over the years how to arrange projects in tiers. Some

projects require a two-hour discussion while others can go on a consent calendar. She suggested an ongoing agenda item where a county comes back and reports to the Commission on approved innovation plan successes, failures, and lessons learned. She stated that loop needs to begin to close so there are not 58 iterations of the same thing across California. She stated it is about how projects are ranked and how consent calendar items are determined. She agreed with extending the delegated authority by increasing the cap to $2 million. She stated the need to get to what has been learned from what has been done; otherwise, nothing will be transformed.

Commissioner Mitchell stated she loved the idea of an ongoing agenda item dedicated to lessons learned because Commissioners do not see the results of the programs they have approved.

Commissioner Madrigal-Weiss agreed with an ongoing agenda item dedicated to lessons learned but stated she did not only want to hear whether programs worked or not. She stated course-correction is important. It is important to learn how the county identified what was working, what was not working, and what they did to change the course. It is not all or nothing but about being thoughtful about making the necessary modifications for success. This way, success is always strived toward.

Executive Director Ewing suggested including representatives from entities such as the DHCS, the Center for Medicaid and Medi-Care Services, and from other states to do a deeper dive into not only what the lessons learned were in a county but about the lessons learned for the broader system because the intent is for the innovations to shape the system to drive change. There has never been an ability to do this before because ambitious projects have never been attempted before. It is important for the Commission to hear from the decision-makers at the state and federal levels on their receptiveness to shifting some of the state rules to allow innovations to flourish. This is difficult to do when most of the Commission's time is taken on approving plans. Alternatives would be to move to two-day meetings, bimonthly meetings, or shift the burden of this process to a Subcommittee. He stated, for the Commission to engage the innovation component so that it is impacting statewide transformational change, it needs to be involved differently and more deeply into the projects, particularly how they influence state practices.

Commissioner Berrick stated he was happy to defer to Commissioners Brown and Danovitch and Vice Chair Ashbeck. He stated his goal is to not have a consent agenda where a bunch of items are pulled off. He stated the need to ensure there is enough due diligence for each project and agreed that there could be a more thoughtful use of the Commission's time.

Public Comment

Poshi Walker stated, although they love the staff, staff cannot be subject matter experts on all marginalized populations. There have been so many projects that have come before the Commission that passed through staff that were then questioned or even voted down. The speaker has found as an advocate that the LGBTQ issues are almost always overlooked and those populations often were not engaged well in the community planning process. Having a voice at the statewide level is important.

Poshi Walker stated concern about what happens to a county if something is pulled off the consent calendar. The speaker stated appreciation that items can be pulled off the consent calendar for further review but stated the need for some sort of process. The speaker suggested that the Commission use its subject matter experts from their stakeholder contracts.

Poshi Walker stated they are on the LISTSERV and receive emails from the Commission but it is an onerous process to read through whole innovation proposals without being able to ask questions. The speaker stated stakeholders may not understand what they are reading without the ability to ask questions. Also, this is not part of the deliverables. The speaker recommended that reviewing innovation projects and providing feedback be made a deliverable for the stakeholder contractors to provide the time and resources to do it as part of the advice to staff, the Commission, and the counties about concerns seen in these projects.

Poshi Walker recommended that counties have a webinar for the public comment process to allow individuals to ask questions. There are not many stakeholders, especially consumers, who can read a large report and figure out what is going on. Having a webinar with a PowerPoint and the ability to ask questions through chat or voice would facilitate a better stakeholder process and would allow that vetting prior to innovation projects coming to the Commission and on consent.

Poshi Walker asked if there will be a process for members of the county to request a public vote in the case that the county may not have done their job.

Stacie Hiramoto stated the details for this agenda item were not available until today. More comments and letters could have been given if individuals knew about the recommended options. Stating that this item will be discussed on the agenda is not enough detail for consumers, family members, and individuals in the community to write a letter when they did not know the options that would be presented.

Stacie Hiramoto stated reviewing these plans is important. The speaker stated, if the Subcommittee were in charge, Commissioners could be a part of it on a rotating basis such as for three-month terms. The public’s ability to comment is at the legislative Committee level, not when bills go to the floor.

Stacie Hiramoto agreed that counties should provide progress reports to the Commission but asked to what end and how that information will spread. The speaker stated the counties should be doing this already. The speaker stated the biggest thing that REMHDCO will object to is more authority to staff without the ability for robust public comment.

Ahmad Bahrami. Fresno County Department of Behavioral Health, asked that the Commission consider the new proposal to authorize the Commission or staff to provide approval or convene a special meeting for Commissioners to formally approve counties joining one or more of the identified multicounty MHSOAC-sponsored innovation projects. The speaker stated Fresno County is one of ten counties that are seeking to join a statewide MHSOAC-sponsored project using reversion funds that will sunset in five weeks. This would not be possible with the current process.

Kiran Sahota stated to bring an innovation concept from start to finish is a difficult process and counties are not allowed to present their innovation ideas to the Commission until this difficult process has been completed. Counties also race against the clock against reversion. The speaker stated Ventura County had two innovation projects ready last year that, because of waiting in the queue to be heard at a Commission meeting, did not start until the following fiscal year. These projects were both under $500,000 each and may have been approved months earlier through a consent calendar process.

Kiran Sahota stated Ventura County would love to report on the progress of their approved innovation projects but does not want to take other counties' time to get their innovation projects approved. The speaker implored the Commission to find an alternative option to counties coming and presenting before the Commission. Travel for small counties is difficult.

Anne Kim stated they would love to see innovations translate into programs in mental health that is responsive to where individuals are and where they need it.

Commissioner Discussion

Commissioner Brown moved the staff recommendations with the modification to the enhanced delegated authority to increase the authority for any plan that was $1 million or less rather than $500,000.

Commissioner Danovitch seconded. He stated the criteria for the extend delegated authority option would be the price of the proposal or that it went through the incubator.

Commissioner Berrick asked what the process would have been if the proposal brought forward in Agenda Item 4 had gone through the incubator.

Commissioner Danovitch stated there would be communication between the Executive Director and the Chair as to whether that particular project should be agendized for full consideration or approved through the delegated authority.

Commissioner Berrick stated his understanding that, hypothetically, Agenda Item 4 could have been approved through the delegated authority.

Commissioner Danovitch stated it could have been approved through the delegated authority under that condition.

Executive Director Ewing added it could have been approved through the delegated authority only on the condition that it had gone through the Innovation Incubator. Part of that package of proposals is that it would have been vetted by the Innovation Subcommittee. If the Subcommittee had elected to invest in that project, it would have shaped it, there would have been public meetings of the Subcommittee, and, only with the Chair's consent, then it would have gone through the streamlined delegated authority.

Commissioner Danovitch stated that pathway does not currently exist but must be developed.

Commissioner Brown stated it would have been unlikely that Agenda Item 4 would have gone through on a consent agenda because of the language “had not raised substantive issues or concerns, including public comments received by the Commission.”

Vice Chair Ashbeck stated she was uncomfortable having the Innovation Subcommittee option in the motion when the process is unclear. She stated attending meetings takes a three-day commitment due to travel time.

Commissioner Brown stated he would be happy to amend his motion to not include the Innovation Subcommittee. He asked staff to present the clarified process at a future meeting for Commission consideration. He stated his amended motion includes only the establishment of the consent calendar and the delegation of authority to staff and the Executive Director with the amount to be raised to $1 million.

Executive Director Ewing stated the mental health system is running at approximately $8.5 billion; innovation funds are approximately 1 percent of the funding. The Commission has not had the opportunity to ask questions about the other 99 percent of the funding. The Commission’s ability to engage on the entire mental health system is constrained by time and staff.

Action: Commissioner Brown made a motion, seconded by Commissioner Danovitch, that:

The MHSOAC adopts the staff recommendations to utilize a consent agenda and expend delegated authority to staff with the modification of increasing the authority for any plan that is $1 million or less, and directs staff to present a clarified process to enhance the role of the Innovation Subcommittee at a future meeting for Commission consideration.

Motion carried 9 yes, 0 no, and 1 abstain, per roll call vote as follows:

The following Commissioners voted “Yes”: Commissioners Berrick, Boyd, Brown, Bunch, Danovitch, Madrigal-Weiss, and Mitchell, Vice Chair Ashbeck, and Chair Tamplen.

The following Commissioner abstained: Commissioner Wooton.

GENERAL PUBLIC COMMENT

Lashelle Allison shared her experiences in trying to work through the system for her son, who is in a full-service partnership program in Los Angeles County. The speaker asked about alternatives for families who have filed grievances with the patient rights offices that have not been acted upon.

Executive Director Ewing stated, under state law, there is a process called the issue resolution process. The first step is to try to engage the county and, if dissatisfied, to then appeal to the DHCS. The DHCS will follow up to work with the family to try to resolve grievances. He stated staff will be happy to walk Lashelle Allison through that process. He provided his email address to Lashelle Allison.

Lashelle Allison stated they are tired of emailing everyone. The speaker has been counseled to file a lawsuit because nothing will be done.

Commissioner Mitchell stated everyone has a connection to mental illness. She stated she has a child with severe mental illness who is in and out of systems. She stated she understands Lashelle Allison's pain and frustration. She stated, to be the most effective advocate for her child, there is a way to approach the system because the system is needed. She offered to mentor, advocate for, and be whatever Lashelle Allison needs in order to get them the help that either they or their son needs. Commissioner Mitchell cautioned that there is a time and a place; there is a way to be loud and be heard. She stated she is willing to teach Lashelle Allison how to do that in the most effective manner to get what they need, if they are willing to listen and learn. She stated she will give Lashelle Allison her contact information.

Poshi Walker stated a hard copy of the State of LBGTQ Communities Report is now available. The statewide convening will be May 28th with a reception that evening. The speaker invited Commissioners and staff to a special pre-conference gathering. The speaker also distributed this year's brochure.

Mark Karmatz stated the system's leadership meetings are no longer being held. The monthly meetings need to be reconvened so more input can be given at local meetings.

Ruth Tiscareno, parent and advocate, stated the phrase "peers and family members" does not include parents and caregivers. If the word parents is not used in the conversation, the speaker does not feel included.

Mimi Martinez, Deputy Director, Los Angeles County Department of Mental Health, thanked the Commission for convening this meeting at We Rise and for approving the innovation project this afternoon. The speaker stated a lot of what the county is doing, including the Trieste project, is about connectiveness and purpose.

Ricardo Kim, Service Area Advisory Committee, Los Angeles County Department of Mental Health, agreed with Commissioner Mitchell's comments on revisiting skid row. The speaker asked the Commission to consider what can be done for skid row when hearing the reports from the Trieste project.

Commissioner Wooton stated ACCESS California's annual conference is to be held on August 23rd at the California Endowment in Los Angeles.

Celeste Walley thanked the Commission for including her at the table to help make decisions today and thanked the public for the comments made. This experience has shined light on both barriers and benefits each project presented, which has helped her determine how to implement those types of changes in programs to come.

ADJOURN

There being no further business, the meeting was adjourned at 4:42 p.m.

State of California

MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

Minutes of Teleconference Meeting
June 10, 2019

MHSOAC
Darrell Steinberg Conference Room
1325 J Street, Suite 1700
Sacramento, CA 95814

Additional Public Locations

811 Wilshire Blvd, Suite 1000
Los Angeles, CA 90017

2000 Embarcadero Cove, Suite 400
Oakland, CA 94606

9300 Valley Childrens Place
Madera, CA 93636

State Capitol, Room 2082
Sacramento, CA 95814

13650 Mindanao Way
Marina Del Rey, CA 90292

7919 Folsom Blvd, Suite 180
Sacramento, CA 95826

6925 Chabot Road
Oakland, CA 94618

1144 Camino Del Rio
Santa Barbara, CA 93110

866-817-6550; Code 3190377

Members Participating:

Khatera Tamplen, Chair (via teleconference)
Lynne Ashbeck, Vice Chair (via teleconference)
Mayra Alvarez (via teleconference)
Reneeta Anthony (via teleconference)
Senator Jim Beall (via teleconference)
Ken Berrick (via teleconference)
Keyondria Bunch, Ph.D. (via teleconference)
Gladys Mitchell
Tina Wooton (via teleconference)

Members Absent:

John Boyd, Psy.D.
Sheriff Bill Brown
Assembly Member Wendy Carrillo
Itai Danovitch, M.D.
David Gordon
Mara Madrigal-Weis

Staff Present:

Toby Ewing, Ph.D., Executive Director
Norma Pate, Deputy Director, Program, Legislation, and Technology
Brian Sala, Ph.D., Deputy Director, Evaluation and Program Operations
Tom Orrock, Chief, Commission Operations and Grants

CONVENE AND WELCOME

Chair Khatera Tamplen called the teleconference meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at 9:04 a.m. and welcomed everyone. Norma Pate, Deputy Director, Program, Legislation, and Technology, called the roll and announced a quorum was not yet present. A quorum was achieved after Commissioner Anthony arrived.

Chair Tamplen reviewed the meeting protocols.

ACTION

1: Transition Age Youth Request for Proposal Outline

Presenter:

- Tom Orrock, Chief of Commission Operations and Grants, MHSOAC

Chair Tamplen stated the Commission will consider approval of an outline for the Request for Proposal for Transition Age Youth (TAY) mental health advocacy. She asked staff to present this agenda item.

Commissioner Berrick recused himself from the discussion and decision-making with regards to this agenda item pursuant to Commission policy.

Tom Orrock, Chief of Commission Operations and Grants, MHSOAC, provided an overview, with a slide presentation, of the background, community engagement, contract structure, scope of work, and minimum qualifications for state- and local-level contractors.

Commissioner Questions

Commissioner Alvarez asked if the new hybrid approach also includes additional technical assistance (TA) for the statewide contractor to administer since it is a new responsibility being placed on them.

Mr. Orrock stated a lot of the TA takes place in the stakeholder collaboration component. A cohort of state-level advocates meets regularly to share important information with each other. Whether the statewide contractor will require additional TA will require further thought.

Public Comment

Sally Zinman, Executive Director, California Association of Mental Health Peer-Run Organizations, stated these advocacy contracts are important. Youth and all constituency groups should operate their own services; they are directly impacted and know what they need. The speaker referred to number 4 on page 2, “at least 51 percent of the program staff, board members, or advisory board members are TAY.” The speaker suggested including the word “and” so it would read, “at least 51 percent of the program staff and board members or advisory board members are TAY.”

Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), did not disagree with the previous speaker but asked for clarification on the word “or” regarding the 51 percent. It needs to be clarified when the RFP goes out. The speaker suggested clarifying that the applicant must specify how they will reach racial, ethnic, LGBTQ, and other underserved communities, including English learners. The speaker suggested including a place to list local organizations planning to apply that are willing to partner and the communities, youth, or areas that they serve, to allow statewide organizations who wanted to partner to contact them.

Ruth Tiscareno, parent and advocate, was happy that the term “parents and caregivers” was included. The speaker suggested the involvement or participation of a parent or caregiver of 16- through 18-year-old youth. There are different views and laws for youth who are over 18 years of age. The 16- through 18-year-old TAY voice tends not to be heard because of their age.

Monique Hart-Washington (phonetic), Chair, Children, Teens, and Young Adults Committee, Contra Costa County, asked about the plan once the TAY staff age out since TAY will comprise 50 percent of the staff. It would be good to address long-term employment in the plan.

Commissioner Discussion

Commissioner Wooton suggested amending number 4 on page 2 to read “and 51 percent of the program staff, board members, and advisory board members are TAY.”

Commissioner Mitchell asked if all organizations can meet the requirement to include 50 percent TAY in all three areas.

Mr. Orrock stated staff would be concerned about that criteria based on history and lessons learned - there were only two applicants for the last TAY RFP. This additional restriction may create a barrier for many organizations. The thinking behind the word “or” versus “and” was to allow more organizations to meet the minimum qualifications to apply for the RFP.

Commissioner Wooton stated she understood that but, as was stated in public comment, it is the voice of the individuals who are receiving the services that should be planning their services and activities. The applicants should try to meet this.

Mr. Orrock stated the way to do this is to ensure that there is a wide gate so organizations can apply, and then to ensure that the activities and events are created, crafted, and led by TAY at the local and state levels in order for them to be effective.

Commissioner Mitchell suggested putting Mr. Orrock's language in. Changing the "or" to "and" will eliminate potential programs that would like to at least try to meet the requirements. It is better to write in that the activities are led by TAY.

Mr. Orrock stated staff would ensure that TAY-led activities and events are part of the main concept.

Commissioner Mitchell made a motion to approve.

Commissioner Wooton seconded with the friendly amendment to amend number 4 on page 2 to read "and 51 percent of the program staff, board members, and advisory board members are TAY." She stated, if the Commission cannot agree with this, she offered the friendly amendment that number 4 on page 2 include the phrase "TAY-led activities."

Commissioner Mitchell suggested going forward with the language as presented and asking staff to work "TAY-led activities" language into the RFP.

Action: Commissioner Mitchell made a motion, seconded by Commissioner Wooton, that:

- *The Commission approves the proposed outline of the scope of work for the TAY RFP and asks staff to work "TAY-led activities" language into the RFP.*
- *The Commission authorizes the Executive Director to initiate a competitive bid process.*

Motion carried 6 yes, 0 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Alvarez, Anthony, Beall, Mitchell, and Wooton, and Chair Tamplen.

ACTION

2: <u>Contract Authority</u>

Presenter:

- Dawnté Early, Chief of Research and Evaluation, MHSOAC

Chair Tamplen stated the Commission will consider authorizing the Executive Director to enter into two or more contracts not to exceed $1,300,000 to support research and evaluation efforts, and two or more contracts not to exceed $214,000 to support communication efforts and IT services. She asked staff to present this agenda item.

Dawnté Early, Ph.D., Chief of Research and Evaluation, MHSOAC, provided an overview, with a slide presentation, of the goals and proposed funding for four contracts.

Public Comment

Steve Leoni commented about consumer and family participation. The first three of the four contracts are mostly technical, although, even there, the first contract talks about training individuals for policy research. Sometimes there are sources within consumer and family communities. The speaker stated the need to ensure that that was included in the curriculum.

Steve Leoni stated the need for robust stakeholder participation in the fourth contract with individuals, including consumers and family members, from the various communities the anti-stigma is focusing on.

Stacie Hiramoto stated REMHDCO sent a letter with its concerns to staff. REMHDCO wants to support the Commission's work but information on these contracts was not made available until Friday morning and the information was limited, making it difficult to determine whether it should be supported. There are questions about what the first grant is to be used for. This process is not in the spirit of the MHSA. An Evaluations Committee meeting would have been an ideal way for stakeholders to ask questions such as where this money comes from, how long it will go on, what the qualifications are, and what the U.C. is being asked to do. The speaker requested Committee meetings where million-dollar contracts could be discussed and stakeholders could ask questions.

Tiffany Carter, Assistant Statewide Advocate, ACCESS California, Mental Health America of Northern California (NorCal MHA), echoed Stacie Hiramoto's comments. The speaker questioned the use of the evaluation goals and measurement tools that will be implemented throughout the state. The speaker also questioned the tracking mechanism for the collection and tracking of mental health data. The speaker asked about the tracking tools for meaningful recovery outcomes deliverable from U.C. San Diego. It is premature to enter into additional contracts without a standardized tracking mechanism in place.

Executive Director Ewing stated the reason for this agenda item is because the amount of the contracts is above the delegated authority provided by the Commission. He stated this is a personnel issue. This work normally would be done by state employees, but, as the Commission has gotten into higher-level data analytics, the data tools are more complex. This proposal allows the Commission to contract for staff from the University of California to do the higher-level technical data work and to provide training for staff.

Action: Commissioner Berrick made a motion, seconded by Commissioner Beall, that:

The Commission authorizes the Executive Director to enter into four contracts as follows:

- *Regents of UC, San Francisco, for research and evaluation support*
  - *Not to exceed $1,161,008*
- *Crusade, Inc., for website support*
  - *Not to exceed $103,990*

- *Tableau Software for data visualization software*
  - *Not to exceed $130,079*
- *Crossings TV for multicultural and multilingual commercials and segments*
  - *Not to exceed $109,880*

Motion carried 7 yes, 0 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted “Yes”: Commissioners Alvarez, Anthony, Beall, Berrick, Mitchell, and Wooton, and Chair Tamplen.

GENERAL PUBLIC COMMENT

Ruth Tiscareno stated language is important, especially with the TAY population. The term “resiliency” is more appropriate for this population than terms such as “the recovery model.” Recovery makes TAY feel that they need to get fixed.

Andrea Crook, Advocacy Director, ACCESS California, NorCal MHA, suggested posting a report and the tool that was created through the work the Commission did through UC San Diego.

Mark Karmatz asked why Senate Bill 10 was pulled off the menu for tomorrow. The speaker also requested a list of the names of the statewide organizations for the RFP so local organizations can have the opportunity to network with them.

Steve Leoni stated the word “recovery” was adopted in the client community many years ago and it means something closer to resilient. It is about getting lives back and getting back on track. There are false assumptions, such as in the clinical community, that recovery means being cured, better, well, and it is done, but that is not how the client community has been using it. It is now in danger of being lost. The difference between the word “resilience” and “recovery” is not great. It is important that the TAY population understand how this word is being used.

ADJOURN

There being no further business, the meeting was adjourned at 10:22 a.m.

Mental Health Services
Oversight and Accountability Commission

STATE OF CALIFORNIA
GAVIN NEWSOM
Governor

State of California

MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

Minutes of Meeting
July 25, 2019

Hyatt Place Santa Cruz
407 Broadway
Santa Cruz, CA 95060

866-817-6550; Code 3190377

Members Participating:

Khatera Tamplen, Chair
Lynne Ashbeck, Vice Chair
Reneeta Anthony
Senator Jim Beall
Ken Berrick
Sheriff Bill Brown
Keyondria Bunch, Ph.D.
Mara Madrigal-Weiss

Members Absent:

Mayra Alvarez
John Boyd, Psy.D.
Assembly Member Wendy Carillo
Itai Danovitch, M.D.
David Gordon
Gladys Mitchell
Tina Wooton

Staff Present:

Toby Ewing, Ph.D., Executive Director
Filomena Yeroshek, Chief Counsel
Norma Pate, Deputy Director, Program, Legislation, and Technology
Brian Sala, Ph.D., Deputy Director, Evaluation and Program Operations

[Note: Agenda Item 4 was taken out of order. These minutes reflect this Agenda Item as taken in chronological order and not as listed on the agenda.]

CONVENE AND WELCOME

Chair Khatera Tamplen called the meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at 9:10 a.m. and welcomed everyone. Filomena Yeroshek, Chief Counsel, called the roll and stated a quorum was not present.

Youth Participation

Chair Tamplen stated the Commission made a commitment to include a young person around the table at every Commission meeting to learn the Commission process and to give their perspective on issues. Kalyn Jones introduced herself.

Announcements

Chair Tamplen stated the next MHSOAC meeting is scheduled for August 22nd in Sacramento.

The proposals for the transition age youth (TAY) stakeholder advocacy Request for Proposals (RFP) are due on August 2nd and the contract will be awarded at the August 22nd meeting.

The Workplace Mental Health Subcommittee will be chaired by Commissioner Bunch and vice chaired by Commissioner Madrigal-Weiss.

The next Early Psychosis Intervention Advisory Committee meeting will be held in Sacramento on August 29th from 10:00 a.m. to 3:30 p.m.

Consumer/Family Voice

The Commission made a commitment to begin Commission meetings with an individual with lived experience sharing their story. Chair Tamplen invited BJ North to share her story of recovery and resilience.

BJ North, Copeland Center for Wellness and Recovery, Wellness, Recovery, Action Plan (WRAP) facilitator, shared her story of living with the diagnosis of manic depression with psychotic tendencies. She stated the importance of considering who you have become from the inside out instead of listening to what people have told you outside in. She stated she grew up with shame, blame, guilt, judgment, and criticism of who she was but that her mother was her support and her savior.

Ms. North stated she did not know how to advocate for or support herself except in taking her medications, which she did not feel good taking. She stated she asked a psychiatrist when she could get off her medications and he told her she would have to take them for the rest of her life. This made her feel hopeless.

Ms. North joined a gang and learned how to smoke, drink, do drugs, and live on the street at a very young age, but that felt better than taking her medications. She received an ultimatum at the age of 29 from two of the most respected people in her life at that time, her probation officer and mental health worker. They told her, if she did not clean herself up, she would go to prison. That was a wake-up call and she has been clean ever since.

Ms. North stated she began a journey to find out who she was, what she needed in her life, and how to get it. There were no tools in mental health at that time because it was all about an outside-in job. No one asked her how she felt, what she wanted, or who she wanted to be.

Ms. North stated she found jewels within the system who told her that she was amazing and could do whatever she wanted to do. She went to college, got a job, and found a therapist who suggested tools such as yoga, meditation, and exercise. Then she went to a WRAP meeting, which changed her life. WRAP helped her to learn what wellness looked like and that wellness and recovery is an inside-out job, not an outside-in job. She learned to respond instead of react to things that were a trigger for her.

Ms. North stated she learned to eventually get off her medication by using the tools her therapist suggested. She stated today she is an amazing person because she let go of that blame, shame, guilt, judgment, and criticism and she does not take in things that do not belong to her. She stated the negative is always seen because it takes up more space and the positive is always a pinpoint and the pinpoint is easy to miss. She has surrounded herself with positive people, pinpoints that she looks to when everything else becomes blurry, who remind her to focus on who she is inside out and who have supported her along the way.

Questions and Discussion

Commissioner Anthony stated she liked Ms. North's approach and appreciated Ms. North's willingness to share her story with the Commission even though she has now left some of it behind. She stated individuals are what their history has made them – both the good and the bad. Commissioner Anthony applauded Ms. North for identifying gossip and negativity as an issue.

Chair Tamplen stated Ms. North is an inspiration to many individuals in California and across the nation. She stated she honors the work Ms. North does and how she does it. Chair Tamplen stated her appreciation for Ms. North's comment about looking internally versus externally and knowing ourselves first.

Chair Tamplen stated Ms. North helps challenge the systems approach around learned helplessness and teaches through her story and actions that individuals do not need to take on the negative messages from the external world. Ms. North's teachings are not only relevant to the mental health system but they apply to the workplace. The Commission is interested in learning more about workplace wellness. The system needs more mentors like Ms. North.

Commissioner Madrigal-Weiss stated Ms. North's comment about what wellness means to each individual resonated with her. She stated it is not about resiliency checklists from the outside but it is about each person defining their own wellness.

Kalyn Jones stated Ms. North presented empowering messages such as that the negative takes up space and the positive is a pinpoint. She agreed that the negative overshadows the positive but the positive should be highlighted.

Commissioner Berrick stated every time Ms. North shares her story, the people who are doing the work get to hear about the impact, which is inspirational. He thanked Ms. North for agreeing to share her story today.

ACTION

1: Approve May 23, 2019, and June 10, 2019, MHSOAC Meeting Minutes

Chair Tamplen tabled this item to the next meeting due to the lack of a quorum.

INFORMATION

2: Criminal Justice Data Linkage Project Update

Presenter:

- Dawnté Early, M.S., Ph.D., Chief of Research and Evaluation, MHSOAC

Chair Tamplen stated the Commission will be presented with an update and relevant findings in the Commission's ongoing Criminal Justice data linkage efforts. She asked staff to present this agenda item.

Dawnté Early, M.S., Ph.D., Chief of Research and Evaluation, MHSOAC, provided an overview, with a slide presentation, of the background, purpose, and methods of the Department of Justice-Full Service Partnership (DOJ-FSP) data linkage preliminary findings.

Commissioner Questions and Discussion

Commissioner Berrick asked, in those counties that saw negligible declines or increases in arrest rates, if staff was able to drill down and compare the content, numbers, and penetration rates of their programs to the populations.

Dr. Early stated not yet.

Commissioner Anthony stated her son's FSP, although not very effective at first because it was just starting up, has allowed her son to live independently with support for four years.

Dr. Early stated that is the power of the FSPs – they do whatever it takes to ensure that clients do not go through the criminal justice system or the state hospital.

Vice Chair Ashbeck referred to the Changes in County Arrest Rates slide stated the colors are difficult to distinguish between and could not tell what category Fresno County was in.

Dr. Early stated Glenn County is the only county that is in the more than 10 percent increase category. Fresno County is in the 18 to 35 percent decline category. She stated the Americans with Disabilities Act (ADA) compliance version includes the tables that link back to the color maps.

Commissioner Berrick suggested including the number of individuals in FSPs by county in the Changes in County Arrest Rates slide as a point of reference.

Dr. Early suggested that it may be more helpful to include that information as a column in the tables.

Commissioner Bunch stated she was surprised by the data because, in her experience with FSPs, there are good FSPs and FSPs that are not willing to do whatever it takes. She suggested identifying FSPs that are doing a good job to see what it is they are doing differently.

Executive Director Ewing stated staff is doing three things with FSPs. This is one of them. Data has been posted on the website on outcomes for individuals who have disenrolled, which shows conflicting data and challenges. Data on outcomes pm different strategies is not yet available.

Executive Director Ewing stated funding has recently been provided through the $2.5 million Innovation Incubator funding for a collaboration of approximately 20 counties to digest this data and to ask the questions what is and is not working, for whom, under what conditions, and why.

Executive Director Ewing stated counties recognize that the data can be valuable, but they are struggling to understand the data. Part of the intent for the funding that has been made available is that the funding will be used to help counties write a collaborative Innovation project proposal to strengthen the FSPs, learn how counties contract with providers, and learn what works.

Executive Director Ewing stated the goal is to better understand what is working and how to support replication of those effective practices, recognizing that strategies will be different and the data linking on the criminal justice and mental health sides will need to be strengthened to do more upstream types of prevention and early intervention opportunities. This is one piece of a broader strategy.

Commissioner Berrick stated the data shows clients linked to counties. He asked if clients can be linked to programs within counties.

Dr. Early stated the data received shows the county where services have been provided and the provider that performed the services, but not the program those services were part of. The challenge is that each provider can support many different programs.

Commissioner Anthony asked about the margin of error.

Dr. Early stated it depends on the type of margin of error. There is always a margin of error when it comes to linkage but the linkage has been validated twice: once by our contractor Kate Cordell and once by UC San Francisco (UCSF).

Commissioner Anthony asked when the Commission can share these findings and how the findings compare nationally.

Executive Director Ewing stated because of the large reductions that are then sustained after FSP participation, it is counterintuitive. A secondary expert was brought in to verify the findings and the links. It was then presented to small groups of individuals to test the

messaging and to further validate that the numbers have been interpreted correctly. Today is the first time the data has been presented in an open public forum because of the confidence the secondary reviewer has given. He stated the hope that this data can be shared statewide in approximately three months.

Commissioner Bunch stated the title Reducing Criminal Justice Involvement for People with Mental Illness is broad and the data focuses specifically on FSP programs, some of which are not as good as others. She asked if there is a way to look at the other side – at the individuals who have a mental illness when they were arrested and if training for police departments might decrease the number of arrests of people with mental illness.

Executive Director Ewing stated the collaboration between the 20 counties will help them better understand their own FSP data and strengthen their programming. The Commission has provided funding for a group of five counties to do that analysis internally, linking their mental health data and law enforcement data to understand patterns in law enforcement involvement and ways in which they can change those patterns.

Commissioner Brown asked if the data included probation violations resulting in an arrest.

Dr. Early stated the data includes all arrests, including probation violations.

Commissioner Brown asked if the data could differentiate which of these referrals to FSPs were voluntary versus court ordered. He stated it would be interesting to see if that had an effect on arrest rates.

Dr. Early stated she did not know.

Commissioner Brown asked if the data is preliminary or if an analysis on the data had been done.

Dr. Early stated an analysis has been ongoing and the UCSF statistician has spent the last month verifying the data. The last thing she will require the UCSF statistician to do is to agree with the way the data is represented and that there is not another statistical variation that should have been used.

Commissioner Brown stated data is important and this is a big breakthrough in terms of showing how data can be used to support a hypothesis that the Commission has had for some time: if individuals can be diverted from the criminal justice system and given comprehensive services in the community, then the need to arrest many individuals will be eliminated and positive effects on the criminal justice system will be seen.

Commissioner Brown stated a co-response team, consisting of a sheriff's deputy and a mental health professional, was set up in his county six months ago. He shared encouraging statistics produced by the co-response team in that short period of time:

- Total of 83 10-hour shifts
- Responded to a total of 226 in-progress calls
- Resulted in proactive engagement in 220 of the 226 calls with the following results:

- 39 5150 applications
- 33 instances of voluntarily psychiatric examination referrals
- 46 individuals were diverted from arrest
- 7 arrests were made out of 226 responses, which is approximately 3 percent of the total
- 38 individuals were taken to the crisis stabilization unit and hub of services now available
- 8 individuals were transferred to the organization that handles juvenile mental health issues

Commissioner Brown stated this pilot project has recently been funded for an additional three years through Proposition 47 grants to increase services and hopefully put co-response teams throughout the county. He stated as data is gathered and shared it can show that a positive difference can be made in this area.

Vice Chair Ashbeck stated it would be interesting to list the communities that have this type of program to see the impact they are having because collectively it could be significant. She stated not all FSPs are the same or will produce the reported results. She agreed with Commissioner Bunch's concern that some FSPs are not very good. This requires more investigation.

Vice Chair Ashbeck asked if there is a link between counties with jail reentry programs that start while individuals are still in custody before they are discharged to an FSP and their success.

Vice Chair Ashbeck stated the utilization of emergency departments is an important feature because many individuals end up there with nowhere else to go. The goal is to transform the system, not the lane. Hospitals can save money by not seeing individuals in the emergency department, which adds to the collective advantage. It is important to focus on emergency department utilization since it is the first spot where the pressure begins to build up and communities start to unravel.

Kalyn Jones asked if data can be gathered by age and can be broken down by individuals involved with juvenile hall.

Dr. Early stated it cannot because court orders are required to review juvenile arrest records.

Commissioner Beall stated he is on the Senate Budget Subcommittee for criminal justice. Two years ago, bills were introduced that required law enforcement and criminal justice agencies to do mental health training. Also, last year, Senate Bill (SB) 215 was passed. This diversion bill allows a pretrial conference to occur where individuals will agree to participate in an FSP-type program with housing. If they agree to participate, they will not be charged with the offense if they, after a certain period of time, meet the conditions of the FSP program. SB 215 allows that kind of process to occur. This study validates that there will be fewer arrests if these types of programs are continued.

Commissioner Beall stated this year the big thing was police use of force. He reviewed two bills that were recently passed:

- Assembly Bill (AB) 392 redefines police use of force so that police officers can now be trained on the new law. The previous law was on the books since 1871 – the oldest unamended statute in the state codes.
- SB 231 is about training police officers. $30 million was allocated in the budget for training police officers on use of force when dealing with situations involving individuals with mental illness and other issues.

Commissioner Beall stated one of the next steps is, if individuals will be diverted, there needs to be somewhere to divert them to and a place for individuals that will replace incarceration.

Commissioner Beall stated there is another bill being discussed regarding bail bond reform that will reduce the number of individuals in county jails by offering a court-ordered participation in FSP-type programs as an alternative to posting bail. The current budget is $109,000 per inmate per year in state prison. Commissioner Beall stated diverting an individual to a program for therapy would cost much less.

Commissioner Beall suggested some direction be given from the Commission on this subject based on its research. It would be valuable for the Governor and the Legislature to have this information to help them in their decision-making on this subject.

Chair Tamplen stated it would also be helpful to learn what individuals are being arrested for. Sometimes it seems that the individual is blamed for being arrested when it is really a result of laws and policies and communities that are not welcoming and supporting the journey to recovery.

Commissioner Berrick suggested highlighting county FSP programs that are getting extraordinary results to help create a movement to improve the quality of programs across the state.

Executive Director Ewing reminded Commissioners that the Commission has $2.5 million to incentivize counties to explore solutions with a link to reducing criminal justice involvement with the intention of reducing the burden on state hospitals for individuals with an incompetent to stand trial declaration.

Commissioner Bunch suggested looking at substance abuse and the role that it plays in arrests and subsequent linkage to substance abuse treatment programs.

Public Comment

Smitha Gundavajhala, Youth Leadership Institute, commended the Commission for doing this research. This underscores the need for greater investments and attention to how rehabilitation is done in this area. The speaker noted that data was not collected for individuals under the age of 18 and stated the hope to see a greater data linkage between the juvenile justice and criminal justice systems in the future. This data may help prevent juvenile-justice-involved youth from converting to the adult criminal justice system. The disconnect between the youth-serving and adult-serving systems is what makes the transition challenging for the TAY population. Gathering data can help

increase the understanding of the drop-off of support that happens when entering the adult system.

Smitha Gundavajhala stated the evaluation data for FSP and other rehabilitation programs might help further reduce rearrests and identify strategies that work for those FSP partners that have the higher need. The speaker stated it would be interesting to see the impacts that the 2011 Realignment had in the way services were administered and how that might have benefited or reduced reentry rates. Evaluation data can show what was successful and why to help further reduce reentry rates. The speaker stated collaboration with community-based organizations and community-based rehabilitation programs is essential to sustain the success of individuals once they are released, including needs such as employment.

Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), suggested including a comparison between individuals placed in FSPs versus non-FSP programs, particularly if the findings are shared nationwide.

Stacie Hiramoto referred to Slide 7, FSP Partners by Race and Ethnicity, and stated the Latino population should be approximately 40 percent if it mirrors their population in the state of California. By far, they are being underserved by FSPs, which is a problem. Also, the Asian population is approximately 2 to 2.5 percent while the total population in the state of California is 13 percent. The speaker stated there must be a reason why there are such low proportions of those populations in the FSP programs. The speaker stated this has always been suspected and the Commission's research data bears this out.

Steve Leoni, consumer and advocate, stated the data presented echoes what has always been presumed. The speaker stated the importance of learning the characteristics of FSPs – how good they are and what they produce and, when the performance of FSPs are graphed, if they have a random spectrum or if they cluster in some way that may hint at something that can be reviewed.

Steve Leoni referred to Slide 13, Arrest Rates by Criminal Justice Involvement, and stated individuals who have no arrest record prior to the FSP have a 16.4 percent arrest rate by the time they are discharged a year later. The speaker questioned this and considered that perhaps these are individuals who, immediately prior to the FSP, had their first break. It is important to learn who these people are and what course they are on in the disease when looking at this data. The speaker questioned if these individuals have been at this for a long time where dealing with law enforcement has become regularized for them, or if these individuals have been living a middle-class lifestyle in a college and something came through and this is their first experience with mental illness and after the FSPs they are still dealing with it.

Steve Leoni asked if the type of follow-up individuals receive affects the results. Some counties have no support services available after being discharged from the FSP program.

Mandy Taylor, Health Access, California LGBT Health and Human Services Network, noted that sexual orientation and gender identity (SOGI) data was not included. AB 959 went into effect in July of 2018 mandating the Department of Health Care Services

(DHCS) to collect SOGI information. The speaker would like to see if the LGBTQ community is being served by FSPs, if FSPs reduce their criminal justice involvement, and if FSPs are including community-defined best practices.

Mandy Taylor asked to hear how the No Place Like Home Project is impacting criminal justice involvement. The speaker also asked the Commission to ensure that SOGI data is being included in the research.

ACTION

3: Legislative and Budgetary Priorities

Presenters:

- Senator Jim Beall, Commissioner
- Toby Ewing, Ph.D., Executive Director, MHSOAC
- Norma Pate, Deputy Director, MHSOAC

Chair Tamplen stated the Commission will consider legislative and budgetary priorities, including consideration of SB 582 (Beall), SB 665 (Umberg), and AB 480 (Salas). She asked staff to present this agenda item.

Executive Director Ewing stated the Commission periodically is asked to take positions on legislation. He deferred to Commissioner Beall to provide the update on SB 582.

Senate Bill 582

Commissioner Beall distributed a handout on SB 582. He thanked the Commission for sponsoring his mental health bills, SB 10, Peer Provider Certification, SB 12, Youth Mental Health Drop-In Centers, and SB 582, School-Based Mental Health Partnerships. He provided an overview of the background, existing law, and amendments for these bills. The bills are currently in the Assembly Appropriations Committee, so it is a critical time for the Commission's support.

Assembly Bill 480

Norma Pate, Deputy Director, MHSOAC, provided an update on AB 480, Mental Health: Older Adults. Ms. Pate stated that the author has asked for the Commission's support on AB 480. The bill creates an Older Adult Mental Health Services Administrator within the DHCS who will oversee mental health services for older adults. The administrator position will be funded with MHSA funds. Deputy Director Pate provided an overview of the bill as currently written and stated that the author is still working on proposed amendments. The hearing is scheduled for August 12th.

Senate Bill 665

Executive Director Ewing provided an update on SB 665, Mental Health Services Fund: County Jails. This bill authorizes the use of MHSA funds in jail settings for individuals who are not charged with certain felonies. Executive Director Ewing stated that the MHSA is silent on using MHSA funds in the jail environment. It does prohibit the use of funds in prison or for individuals who are on state-level parole.

Executive Director Ewing stated, when the Department of Mental Health first put regulations in place to implement the MHSA, they included a provision that prevents the use of MHSA funds for jail-based services except for discharge planning. There have been conversations over the past couple of years over the value of opening that up based on the community planning process and decisions by county supervisors to allow more flexibility in the use of MHSA funds to connect mental health services from the community into jail environments and upon discharge.

Executive Director Ewing stated the DHCS has indicated that next year they will rethink that regulatory decision. SB 665 makes it explicit, if counties choose to do so and it is supported through their community planning process, that MHSA funds could be used for this purpose.

Commissioner Questions

Vice Chair Ashbeck suggested reaching out to the Children's Hospital Association for SB 582. There is a huge gap between what happens to children in schools versus in children's hospitals.

Commissioner Beall agreed and stated one of the arguments for these bills is youth suicide and substance abuse deaths are increasing. He stated these bills are not intended to solve all problems but are a start to get the direction the Governor needs to have a comprehensive systematic program established in California.

Commissioner Anthony stated there are plusses and minuses for AB 480. She stated she was in support of AB 480; however, SB 582 would benefit from looking at all available funding sources.

Vice Chair Ashbeck stated SB 665 indicates that counties can use their MHSA funds for projects, programs, and services inside a county jail. She stated the spirit of Proposition 63 is to help individuals outside that system. Services and reentry programs are important, but the jails have received funding from Proposition 47, the Community Corrections Partnerships, and others. She questioned whether taxpayers voted to spend more funding inside as opposed to outside of the jail system.

Executive Director Ewing stated Proposition 63 is explicit on the prison issue and parolees but is silent on what happens in a county jail. Under PEI language, it says to use MHSA funds to reduce criminal justice involvement. Part of the argument is that the ability to strengthen care in county jails can reduce future criminal justice involvement. Early discussions were to put in place a regulatory prohibition on this.

Executive Director Ewing stated significant concerns were raised in the early discussions such as the difference between state funds and state obligations versus county dollars and county obligations. This was the primary prohibition on using these funds for individuals who are under state custody. At the same time, there were longstanding conflicts between county behavioral health departments and law enforcement officials about which entity was financially responsible. Today, collaboration and cooperation has increased with more recognition that it is about training and opportunities for diversion.

Executive Director Ewing stated SB 665 defers to the community planning process and the decision of the county board of supervisors. There are concerns from county behavioral health directors that this would mean that funding would be taken out of community-based programs and put into custody environments and that there is other public safety funding that should be part of the mix to design integrative strategies.

Executive Director Ewing stated, in terms of the work that the Commission has done looking at the data and the comments from Commissioners around training, awareness, and strengthening the partnership, there is a rationale to remove that prohibition and give counties discretion. The author and county behavioral health directors have asked staff for their input. Staff has suggested things such as putting a cap on the funding.

Commissioner Berrick asked if there are restrictions in the legislation about who the provider of those services needs to be.

Executive Director Ewing stated not at this time.

Commissioner Berrick stated his concern if there was no restriction on it being a community-based mental health provider or the county mental health department as the provider of those services as opposed to those services being housed in and under the control of the locked facility. He gave the example of the broad variance in the local community process and how much ultimate influence they have over the expenditure of funds despite the intent of legislation.

Commissioner Berrick asked Commissioners to wait to give direction on SB 665 until there is a quorum. He stated he would not feel comfortable supporting SB 665 without restrictions on how the implementation will occur.

Public Comment

Andrea Crook, Advocacy Director, ACCESS California, Mental Health America of Northern California (NorCal MHA), spoke in opposition to SB 665. The speaker thanked Vice Chair Ashbeck for her feedback and stated SB 665 is not within the spirit of the MHSA or what voters intended that the funding would be spent towards. SB 665 breaks a promise that these dollars were not to go to individuals in locked settings; however, this is an opportunity to look at how individuals being discharged are being supported to ensure that they are integrated into the community with necessary supports to meet their needs.

BJ Nadeau, resident of Santa Cruz County, advocated for older adults, suicide prevention, and workforce education and training (WET). The speaker shared their frustration that suicide and WET programs are not being funded. The speaker stated, in the absence of those programs, they personally funded four assessing and managing suicide risk workshops two years ago for 95 clinicians and plans to do two more this year. The speaker stated the waitlist for these workshops is lengthy.

BJ Nadeau stated the need for suicide bereavement support. For every suicide, there are at least 25 individuals who suffer from stigma, anxiety, depression, and lack of resources. Santa Cruz County has partnered with Twin Lakes Church and the Clarence and Katherine Bailey (phonetic) Trust Fund to bring in Dr. John Jordon, the foremost expert in suicide bereavement. Dr. Jordon will do a full-day training for 80 clinicians in

Santa Cruz on October 10th. There will also be a hope and healing event the night before for survivors of suicide loss.

Chair Tamplen stated one of the components of the MHSA is WET. Each county sets aside its own resources for that. She suggested speaking with the Santa Cruz Board of Supervisors and county officials. She stated staff will speak with her offline.

Stacie Hiramoto spoke in opposition to SB 665. The speaker echoed Andrea Crook's comments regarding SB 665 and the suggested solution of looking at discharge planning. The speaker stated concern that the local community did not have the opportunity to weigh in on SB 665 because of its urgency clause. The amendments sought by the County Behavioral Health Directors Association (CBHDA) are equally problematic because of their suggestion to take the funding out of the Innovation fund rather than the Community Services and Supports (CSS) fund. The Innovation fund is one source to fund community-defined programs, which are the programs often preferred by racial, ethnic, non-English-speaking, LGBTQ, and other underserved communities.

Stacie Hiramoto thanked Commissioner Berrick for bringing up the fact that the community planning process in many counties has diminished, people's voices are not heard, and the county board of supervisors can overrule the community.

Smitha Gundavajhala spoke in support of SB 582 and underscored the school and community collaboration piece that shines through in SB 582. The speaker stated their hope that SB 582 will provide for investment into training for teachers, guidance counselors, and individuals who are meant to support youth and more investment for community-based services. Training adults to be caring is an important investment.

Ruth Tiscareno spoke in support of SB 582. The speaker stated what is already in place is often forgotten such as the Individualized Educational Program (IEP) process and the Educationally-Related Mental Health Services (ERMHS).

Mandy Taylor was pleased that the funding for the youth drop-in centers was set aside through triage and other funding streams because of the concern that the funding would be taken away from Prevention and Early Intervention (PEI). The speaker suggested writing into the law or into the RFP for services to be accessible on school campuses or next to school campuses and that youth who are 12 years or older can access mental health care without parental consent. The speaker asked that this be clearly highlighted at the youth drop-in centers.

Steve Leoni spoke in opposition to SB 665. The speaker thanked Vice Chair Ashbeck for asking the right question about whether SB 665 is in the spirit of the MHSA. The speaker stated it is not.

Steve Leoni was part of the group that conceptualized the legislation that preceded the MHSA, helped write the MHSA, and helped design its guidelines and regulations. The MHSA is about supporting voluntary community alternatives to institutional care. SB 665 cannot be reconciled with voluntary community services. Although good services are needed in jail environments, there are other ways to do that without spending MHSA dollars, especially when those dollars are needed to fund more FSPs in the community

to support individuals who come out of those jails or are diverted from them. The speaker asked where these individuals would go if the funding is taken up in the jails. SB 665 is contrary to the spirit of the MHSA.

Pam Hawkins, United Parents, spoke in support of SB 582. The speaker asked that the services that SB 582 provides between schools and parents will not usurp the IEP process and those rights and entitlements under federal law for children. The speaker asked that all services be evidence-based practices, if available, and all services be measured to determine if the desired results were achieved. The speaker asked that parents participate in the development and implementation of respite care services and any parent-supported training.

Commissioner Discussion

Commissioner Anthony stated what bothers her about SB 582 is the requirement for half of the funds to support the partnership. She stated some of the coordination could be achieved just by the activity of having SB 582 language requiring the participation. Also, the requirements for children's mental health are currently funded through child welfare. She suggested that the child welfare directors be involved because many of the children involved with children's mental health are also in child welfare. She stated she would support SB 582 if these conditions were met.

Commissioner Brown respectfully disagreed on a number of items with respect to the use of MHSA funds for individuals who are incarcerated in county jails. He stated the MHSA does not preclude dollars being spent for individuals in a jail setting or for individuals who have been released into the community from a jail setting. It is important to understand that 99 percent of the individuals who are in jails across California are going to be released from custody. Arguably, jails are not separate from the community, but they are a part of the community. They are an area that exists because some individuals have violated the law and need to be contained while their guilt or innocence is determined and while their sentences are being carried out, most of which are much shorter than are being carried out in the state prison system.

Commissioner Brown stated, if inmates who are mentally ill have committed serious crimes languish in jail without proper mental health services, there is a likely chance that they are going to get worse instead of better and the seriousness of their mental illness will increase and be worse at the time that they are eventually discharged into the community.

Commissioner Brown stated it is lost that jail is the place where people often hit rock bottom and they recognize that it is in their best interest to be receptive to treatment, either for mental illness or for substance abuse or, in so many occasions, for both, and, if they embark on a course of treatment while they are in jail and continue that treatment when they are discharged from jail, it can often be lifechanging and positive. It is especially true of people who have that cooccurring disorder.

Commissioner Brown stated it is time to realize that jails are not separate from the community but are part of the community and part of the system and they should be considered for programs – not necessarily awarded funding in and of itself because they

are jails, but they should at least be considered and should be in the mix for funds that are available to communities.

Commissioner Brown stated the need to be careful to not discriminate against individuals who are mentally ill who happen to be incarcerated rather than happen to still be out in the community. The reality is that sheriffs oftentimes are some of the greatest advocates for change and for supporting mental health programs and mental health treatment. But the other reality is that most counties either do not have or do not provide sheriffs with adequate resources to provide the mental health treatments or a mechanism otherwise. It is in everyone's best interest that those services are provided. The further upstream that those services are provided, the more effective they can be and the less it will cost in the long-term to treat people with severe mental illness that are in the communities. He encouraged everyone to look at SB 665 more globally.

No action was taken on this item due to the lack of a quorum. Chair Tamplen stated she will not decide on the direction the Commission will take. More discussion is required, and this item will be on the agenda for the next Commission meeting.

[Note: Agenda Item 4 was taken out of order and was heard after the lunch break, prior to Agenda Item 5.]

GENERAL PUBLIC COMMENT

Richard Gallo, Ambassador, ACCESS California, NorCal MHA, stated counties need guidance and procedures from the Commission. Counties need to submit their annual reports regularly to determine if funds are being utilized effectively and if programs and services are making a positive impact with the mental health community in utilizing the services.

Stacie Hiramoto referred to Agenda Item 6, Children's Mental Health Funding Proposal, and stated REMHDCO is concerned about how this got on today's agenda. It is becoming a pattern where agenda items are placed without going through a committee and information on agenda items is sometimes not available until the day of the meeting. There were significant items in the last meeting that were not discussed prior to being voted on. Although the organization discussed in Agenda Item 6 may be a very good program, it is not understood how these items are placed on the agenda.

Stacie Hiramoto stated there are two Commissioner who are on the Steering Committee of the organization that will be discussed in Agenda Item 6. The speaker asked what that looks like to the public when an organization gets to jump in and ask for funding because they have two Commissioners on their Steering Committee, even if those Commissioners recuse themselves from voting.

Stacie Hiramoto stated a conflict of interest code will be voted on at the next Commission meeting. The speaker suggested that that be discussed and voted on prior to voting on Agenda Item 6 today.

Andrea Crook invited everyone to participate in the annual Return to Recovery Mental Health Conference, hosted by ACCESS California at the California Endowment in Los Angeles on Friday, August 23, 2019. Elyn R. Saks, J.D., Ph.D., and Mark Ragins, M.D., will be presenting, and ACCESS California will present their key findings on recovery outcomes in the public mental health system. Scholarships are available for persons with lived experience.

LUNCH BREAK

ACTION

4: MHSOAC Budget Overview

Presenter:

- Toby Ewing, Ph.D., Executive Director

Chair Tamplen stated the Commission will hear but will not take action on this item due to the lack of a quorum. She asked staff to present the Commission's final Fiscal Year (FY) 2018-19 Operations Budget and its proposed FY 2019-20 Operations Budget.

Executive Director Ewing provided a slide presentation of the MHSOAC budget overview including expenditures for FYs 2018-19 and 2019-20.

Public Comment

There was no public comment provided on this item.

ACTION

5: MHSOAC New Funding and Programs

Presenter:

- Toby Ewing, Ph.D., Executive Director

Chair Tamplen stated the Commission will hear an update on funding provided in the Budget Act to support school-mental health partnerships, Early Psychosis Programs, and Integrated Youth Drop-in Centers. She asked staff to present this agenda item.

Executive Director Ewing provided an overview of the primary changes in the budget this year:

- The Governor's 2019 Budget creates the Mental Health School Services Act Fund and includes $40 million one-time funds and $10 million ongoing funds for the Commission to support crisis intervention services for children and youth. The funds will be awarded through a competitive grant program to facilitate access and linkages of ongoing mental health services for children and youth.
- The Governor's 2019 Budget includes $20 million one-time funds for early psychosis research and treatment to expand the use of evidence-based

treatment that can prevent mental health conditions from becoming severe or disabling. Currently, only 24 counties have specialty early psychosis programs.

In January, the Governor's 2019 Proposed Budget set aside funding for the DHCS to administer the grants for this program; however, the Governor in the final budget shifted those funds to the Commission to support early psychosis programming already underway.

- The Governor's 2019 Budget includes $15 million one-time funds to develop mental health drop-in centers for youth, which will support a statewide strategy to improve health outcomes for youth and young adults. The Commission, in partnership with county behavioral health leaders, researchers, and community providers, has initiated an approach to improve how youth and young adults are served through integrated approaches to health, mental health, substance use services, reproductive health, and related needs, including education, social, employment, and housing support.

Public Comment

There was no public comment provided on this item.

ACTION

6: <u>Children's Mental Health Funding Proposal</u>

Presenter:

- Alex Briscoe, Principal, California Children's Trust

Chair Tamplen stated the Commission will hear a presentation but will not take action on this item due to the lack of a quorum. She asked staff to introduce the presenter for this agenda item.

Executive Director Ewing stated the Commission provided a small amount of funding last year to help launch the California Children's Trust. The work is consistent with the work that the Commission has done on children's crisis issues, fiscal accountability, and trying to understand how funds were being drawn down. He introduced Alex Briscoe and asked him to give an overview of the California Children's Trust.

Alex Briscoe, Principal, California Children's Trust, stated California could transform the way it approaches the social and emotional health of children with a multibillion-dollar investment on existing state expenditures. He provided an overview, with a slide presentation, of the crisis, utilization data, access data, the current state of the Early Periodic Screening Diagnostic Treatment (EPSDT) program, and the solution of EPSDT expansion to serve more youth.

Mr. Briscoe stated the EPSDT program includes seven benefits including immunizations. He stated Medicaid children are entitled to mental health benefit but a diagnosis is required to receive the EPSDT mental health service. This is an illegal and unethical narrowing of the benefit and is inconsistent with the spirit of the federal

entitlement. He stated the need to reimagine the approach to mental health and to think of it more like an immunization – something that most children should receive.

Mr. Briscoe asked the Commission to support AB 898, EPSDT services: behavioral health.

Commissioner Questions

Commissioner Anthony stated she believes this is an answer for the state to come up with a unified plan and hopes the California Children's Trust is successful.

Vice Chair Ashbeck stated hospitals are not meeting the needs of these children.

Mr. Briscoe stated any safety net system has to have a top and a bottom – a way up when needed and a way out when not. Individuals will devolve to hospitals when they need a higher level of care, but that system needs to be extended out in the community based on lived experience.

Vice Chair Ashbeck agreed that reimagining the system is the only chance possible. The work of the California Children's Trust is important.

Commissioner Beall asked if Mr. Briscoe had considered the Laternman Developmental Disabilities Act (AB 846) during the process and how it might fit into this.

Mr. Briscoe stated EPSDT benefits should apply to children who have regional center diagnosis designation.

Commissioner Beall stated one thing the Laternman Act does that Medi-Cal or any other health care does not do is it strives to help individuals lead happy lives with individual development plans that include what each person states will make them happy. The Laternman Act also gives respect and inclusiveness to family members and individuals who will support that person. This circle of support is emphasized and strengthened for that person to help them lead a happy life.

Commissioner Berrick stated a relatively small amount of MHSA funding is matched. He asked about the Laternman Act funds and the potential pool of unmatched funds that would provide a sense of what can be done.

Commissioner Anthony asked if other states have been examined and if other states are doing this type of funding plan.

Mr. Briscoe stated very few states do it as badly as California does. He provided the example that fragmentation is horizontal such as between child-serving systems, but California is plagued by vertical fragmentation – between federal, state, and county. Very few states carve out mental health to a public pre-paid inpatient health plan. The way they are funded is uniquely complex.

Executive Director Ewing asked about the quality of outcome data that came out of the 1991 Realignment. He also asked about next steps and what the Commission's support would be used for.

Mr. Briscoe stated there are indications that the 1991 Realignment was a benefit to individuals with serious mental illness. The problem with the 2011 Realignment is there was not a large investment to redirect.

Executive Director Ewing stated he was more concerned that the 1991 Realignment stated outcome measures would be developed. There is a need to learn how the dollars are being used and what the missed opportunities are and to use that information and shape how everyone else is doing things.

Mr. Briscoe stated California has a per-minute per-unit diagnosis-driven reimbursement model that chases units of service and symptomatology. California is not paying for what it wants, which is a job, a house, a good therapist, and happiness. The architecture of the system must change. California is locked into a model that will take a lot of money to smooth the transition over so that individuals can move to a new system in a way that does not hurt them or the care provided.

Executive Director Ewing asked about next steps and what the Commission's support would be used for.

Mr. Briscoe stated his organization has the Framework for Solutions, which is their state policy agenda. There are six activities in each of its four sections: advancing equity and justice; quality, efficacy, and outcome measures; redefining medical necessity; and maximization of federal revenue.

Kalyn Jones stated she supports whole person health care and unconditional happiness.

Public Comment

Stacie Hiramoto stated that the meeting materials reminded the public that funding had gone to this organization before. The speaker asked how the previous funds were used and how the potential $500,000 will be used. Stakeholders need more detail in order to provide their input. The speaker asked the Commission to wait to vote on this until after they present their conflict of interest policy at the next Commission meeting.

Smitha Gundavajhala asked about the number of youth Mr. Briscoe spoke to and worked with directly in developing this vision. The speaker asked how the youth voice will be centered while reimagining the way that California addresses youth mental health. The speaker asked if Mr. Briscoe spoke with the Innovation Project Planning Committee. The speaker asked if the race and equity models include and are informed by data around TAY. The speaker asked if there are individuals on the team that share marginalized identities with the young people they will serve.

Ruth Tiscareno asked if the California Children's Trust includes parent peers and how much they have influenced or been part of the discussion. The speaker referred to the recovery model and stated children do not recover – they are resilient. The word "recovery" means being taken to a therapist for some people and there is a lot of stigma with that. Wording is important.

Mandy Taylor stated concern that this item was on the agenda. The MHSOAC is a public government entity charged by elected officials and the executive branch to oversee mental health through the public system and public process, which means individuals should not be able to come before the Commission to ask for funding.

Commissioner Discussion

Commissioner Bunch asked about the process to put this proposal before the Commission and whether it went through the same type of process as county Innovation plans.

Executive Director Ewing stated counties are required by regulation to go through a series of steps in order to present their Innovation plans to the Commission. This process does not apply to the Commission; they apply specifically to the counties. The Commission has a standard process for putting items on the agenda. Requests come in and staff works with the chair.

Executive Director Ewing stated, in the case of the California Children's Trust, the Commission was asked to sit next to Mr. Briscoe and present to the Assembly Education Committee. Mr. Briscoe's proposal is getting a lot of interest and traction. Staff wanted to put this on the agenda because it is a compelling presentation and is consistent with the issues raised in the children's crisis work done by the Commission.

Executive Director Ewing stated this work was never completed but it generated interest in the Legislature, which resulted in funding but, as Mr. Briscoe pointed out, there are many challenges such as integration and data, which intersect with issues the Commission has raised in the past and has been on the agenda in the past. California Children's Trust was put on the agenda to make Commissioners aware while, at the same time, they are also looking for funding. As in all requests, anything over the dollar amount of $100,000 is placed on the agenda.

Chair Tamplen noted that this agenda represents the first time that county Innovation plans were not presented. Commissioners asked during the strategic planning process to hear about larger issues around the state. The timing was right to include other types of presentations on this agenda.

Executive Director Ewing stated there are opportunities to make school mental health funding available to opportunities pointed out by Mr. Briscoe or opportunities through the Commission's ability to facilitate multi-county Innovation to support that work.

INFORMATION

7: <u>Executive Director Report Out</u>

Presenter:

- Toby Ewing, Ph.D., Executive Director

Executive Director Ewing presented his report as follows:

<u>Art with Impact</u>

The Commission provided approximately $25,000 to Art with Impact, which gave micro-grants to filmmakers for films that were focused on mental health in the indigenous community. They raised separate funds for films on mental health and sexual violence.

They commissioned ten five-minute films, which are available to schools and colleges to do engagements around these themes. It was very successful.

Personnel

The new Communications Director will be introduced at the next Commission meeting.

Committees

Staff has been working with the Subcommittee chairs on the SB 1004 Work Plan, the Workplace Mental Health Work Plan, the AB 1315 Work Plan, and how to spend school mental health dollars and EPI Plus dollars.

Project Updates

Innovation

Staff continues to work through policy and practice changes in terms of Innovation.

There was a significant change in the law with regard to the Innovation segment of the MHSA. When the Commission identified unspent funds, it resulted in the audit that Commissioner Beall asked for and legislation that allowed counties to keep those funds if they spent them within a certain timeframe. Counties argued that they were put into a difficult spot because they were unable to spend the money fast enough to make the deadlines.

The law then again changed to essentially say that, through the Commission approval process, the Commission will define the parameters under which the Innovation dollars must be spent. The Commission's approval protects those funds against reversion.

There may be an additional challenge in that counties that have encumbered Innovation dollars for a five-year period, for example, where the dollars would have expired had they not been encumbered but the Commission's approval protected them from reversion, the county may be disincentivized to cancel a project even when it looks like it is not going well because that funding would revert.

The biggest statutory change is that the timeframe the Commission approves becomes the reversion timeframe. Currently, the rule is that Innovation programs run no longer than five years but the Legislature was explicit that, if the Commission wanted to approve a plan beyond five years, it has the authority to do so.

The Commission delegated authority to staff under certain conditions with concurrence from the chair to approve Innovation plans. Three plans have been approved for Fresno County – to participate in the FSP project, to strengthen the community planning process, and psychiatric advance directives. Staff still does the analyses and posts them on the website but is still working through the process to inform the Commission.

It was an oversight that materials were not included in today's meeting packet, but they are online and are being sent to Commissioners. Staff is working on how to make that work so that Commissioners get the information they need while streamlining that process.

Staff has received inquiries from counties to extend plans approximately one year. Staff will report back as those conversations move forward.

MHSOAC Website

Material has been taken off the website due to noncompliance with the ADA. The material is being amended for compliance and will be put back on the website, but this will take time.

Fiscal Transparency Tool

Staff has received many calls for updates to the transparency tool. Fiscal information links and county data on funds received, spent, and closing balances for each fiscal year have been posted on the website. The data goes through the 2016-17 FY. The reason the 2017-18 FY information has not been posted is last year the DHCS modified the form to only include county funds that were spent. The state is asserting that they are the one to determine unspent balances and they will provide that information to the Commission. The concern is that the county's accounting of the amount of money they have in their bank account may not match with what the state says the county has in its bank account.

Staff will talk with the chair about potentially asking the DHCS to come before the Commission to explain their rationale for their decision because it has halted the Commission's ability to update the fiscal transparency that has been so important. The Assembly will be holding an oversight hearing on this issue the day before the August Commission meeting. Staff has been asked to present, along with the DHCS and the Legislative Analyst office. Answers may come out through that process.

State Suicide Prevention Plan

The Suicide Prevention Report has been released publicly. Staff presented the report to approximately 60 to 70 individuals on July 16th in Los Angeles. Community Forums will be held on August 15th in Humboldt and on August 28th in Sacramento. Staff is also discussing implementation with the Governor's office.

Stakeholder Contracts

The stakeholder contracts for TAY will be awarded at the next Commission meeting.

Current stakeholder contracts will expire in March of 2020; new contracts need to be in place prior to the expiration date. Between now and November, staff will engage stakeholder advocacy groups and partners to talk about what has worked, what has not worked, and how it can be improved with the intent to give the Commission an outline for review at the November meeting, complete the RFP process, and award new contracts by the March meeting. He asked that Commissioners let staff know if they are interested in participating in this process.

Commissioner Questions and Discussion

Chair Tamplen stated the Commission visited the peer respite, Second Story, yesterday. There was meaningful engagement with Second Story guests on how peer

respite helped them save their lives, keep out of hospitals, avoid being re-hospitalized, find meaning in their life, and know that it is a safe place.

Chair Tamplen stated Second Story is the first peer respite in California and has been going strong and doing well serving the community. She stated her appreciation for communities that give support to programs like peer respites that are hospital diversion programs so individuals do not have to end up being retraumatized in hospital systems when there are homes in the communities that can serve individuals and prevent crisis.

GENERAL PUBLIC COMMENT

Stacie Hiramoto stated in the past the creation of the agenda was open to the public via conference call between the chair, Commission members, and members of the public This has changed over time.

Stacie Hiramoto suggested inviting the California Reducing Disparities Project to present at a future Commission meeting. They have asked to be on the agenda numerous times.

ADJOURN

There being no further business, the meeting was adjourned at 3:38 p.m.

AGENDA ITEM 2

Action

August 22, 2019 Commission Meeting

Alameda County Innovation Plan

Summary: The Mental Health Services Oversight and Accountability Commission (Commission) will consider approval of Alameda County's request to fund the following Innovative project:

(A) **Supportive Housing Community Land Trust: $6,171,599**

Alameda County is requesting authorization to use Innovation funds to develop and operate a supportive housing community land trust. Traditionally, the Community Land Trust model has been used in a non-mental health setting as a nonprofit, community-based organization to preserve land usage.

This model, adapted for a mental health setting proposes to include supportive services, and provides an opportunity for Alameda County Behavioral Health Care Services clients to live in affordable supportive housing, who traditionally have been unable to do so. With this project, clients, either due to their mental health issues, their relationship to caregivers or family members, and/or because of their income, will be given the opportunity to live in a stable environment, an important element of wellness and recovery.

In July 2016, the Mental Health Services Act (MHSA) Innovation statutes in Sections 5830 (a-c) were changed and provided authority for counties to use innovation funds to increase access to mental health services, including but not limited to services provided through permanent supportive housing.

The Mental Health Services Act (MHSA) requires that an INN project does one of the following: (a) introduces a new mental health practice or approach, including but not limited to prevention and early intervention; (b) makes a change to an existing mental health practice or approach, including, but not limited to, adaptation for a new setting or community; (c) introduces to the mental health system a promising community-driven practice/approach, that has been successful in non-mental health contexts or settings; or (d) participates in a housing program designed to stabilize a person's living situation while also providing supportive services on site. The law also requires that an INN project address one of the following as its primary purpose: (1) increase access to underserved groups, (2) increase the quality of services including measurable outcomes, (3) promote interagency and community collaboration, or (4) increase access to services.

Presenters for Alameda County's Innovation Project:

- Tracy Hazelton, MPH, MHSA Division Director, Alameda County Behavioral Health
- Mary Skinner, J.D., MHSA Innovations Coordinator, Alameda County Behavioral Health
- Dr. Robert Ratner, Housing Director, Alameda County Health Care Services Agency
- Margot Dashiell, M.A., M.S., VP, NAMI-East Bay, The African American Family Support Group

Enclosures (3): (1) Biographies for Alameda County's Innovation Presenters; (2) Supportive Housing Community Land Trust Staff Analysis; (3) Supportive Housing Community Land Trust Final Plan.

Handout (1): PowerPoint will be presented at the meeting.

Additional Materials (1): A link to the County's Innovation Plan is available on the Commission website at the following URL:

http://mhsoac.ca.gov/document/2019-08/alameda-county-supportive-housing-community-land-alliance-innovation-plan-august

Proposed Motion: The Commission approves Alameda County's Innovation Projects, as follows:

Name:	**Supportive Housing Community Land Trust**
Amount:	**Up to $6,171,599 in MHSA Innovation funds**
Project Length:	**5 years**

Biographies for Alameda County Presenters

Supportive Housing Community Land Trust

Tracy Hazelton, MPH
Division Director MHSA
Alameda County Behavioral Health
Ms. Hazelton is currently a Division Director for Alameda County Behavioral Health focusing on the oversight of the Mental Health Services Act (Prop 63) funding stream. She has extensive experience in the areas of project development and implementation, evaluation, and community engagement/support with a special emphasis in prevention and early intervention services. Before coming to Behavioral Health, Ms. Hazelton spent a number of years conducting social science research and managing evaluations of various sizes. She earned her Master's degree in Public Health from the University of California Los Angeles with a focus on community health and planning. Tracy was also a Peace Corps volunteer in Ghana, West Africa where she taught high school science.

Mary Skinner, J.D.
Innovations Coordinator, MHSA
Alameda County Behavioral Health
Ms. Skinner is currently Innovations Coordinator for Alameda County Behavioral Health focusing on the Innovations component of the Mental Health Services Act (Prop 63) funding stream. She has comprehensive experience in the areas of legal research; project management; administration and evaluation of community-based organizations programs; and contracts including providing oversight, analysis, evaluation, and technical assistance. Prior to Behavioral Health, Ms. Skinner was in the legal field performing research and drafting legal documents for presentation to the Board of Immigration Appeals, the Ninth Circuit Court of Appeals, and the Supreme Court of the United States. She earned her J.D. from San Francisco Law School and holds a Bachelor's in Sociology from the University of Wisconsin-Madison.

Dr. Robert Ratner, MPH, MD
Housing Director
Alameda County Health Care Services Agency
Robert has over 18 years of experience working on health care services integration and housing as a health care issue. He received his public health and medical training from UC Berkeley and UC San Francisco. He spent six years as the director of a supportive housing program for formerly homeless individuals at LifeLong Medical Care, a community health center based in Berkeley. He currently works at Alameda County Health Care Services as their Behavioral Health - Housing Services Director. During his tenure within the County, Robert has played a significant role in two Medi-Cal waiver programs including the "Bridge to Health Reform" and currently "Whole Person Care." Robert champions the importance of holistic health care and a place to call home for all.

Margot Dashiell, M.A., M.S.,
Vice President, NAMI-East Bay and
Facilitator, The African American Family Support Group

Margot Dashiell is a retired community college instructor who is the current Vice President of NAMI-East Bay. As a family member who has witnessed the huge challenges mental illness has presented to three generations of loved ones, she knows the importance of family member education and advocacy. In addition to leading her NAMI affiliate's advocacy efforts, she has also facilitated the African American Family Support Group in Alameda County for the past twenty years. Margot is also a long-standing member of the Alameda County MHSA Stakeholder Committee.

STAFF ANALYSIS - ALAMEDA COUNTY

Innovation (INN) Project Name:	**Supportive Housing Community Land Trust (Alameda County Supportive Housing Community Land Alliance (CLA))**
Total INN Funding Requested	**$6,171,599**
Duration of Innovative Project:	**5 years**

Review History:

Approved by the County Board of Supervisors:	April 8, 2018
County submitted INN Project:	July 22, 2019
Staff Analysis Completed:	August 6, 2019

Project Introduction:

Alameda County is requesting authorization to use up to $6,171,599 of Innovation spending authority to develop and operate a supportive housing community land trust.

Traditionally, the Community Land Trust model has been used in a non-mental health setting as a nonprofit, community-based organization to preserve land usage.

This model, adapted for a mental health setting, proposes to include supportive services, and provides an opportunity for Alameda County Behavioral Health Care Services clients to live in affordable supportive housing who traditionally have been unable to do so.

With this project, clients, either due to their mental health issues, their relationship to caregivers or family members, and/or because of their income, will be given the opportunity to live in a stable environment, an important element of wellness and recovery.

In July 2016, the Mental Health Services Act (MHSA) Innovation statutes in Sections 5830 (a-c) were changed and provided authority for counties to use innovation funds to increase access to mental health services, including but not limited to services provided through permanent supportive housing.

The Need

Alameda County reports that licensed board and cares, and independent living facilities were used to house individuals with serious mental illness; however, due to recent closures of several of these locations including the loss of 80 board and care beds, the County reports having to displace an estimated 500 individuals over a three year period.

In conversations with the County about these closures, it was shared that owners have been selling their properties because the value of the property is worth more than running the supportive mental health facility.

Oakland, the largest city in Alameda County, had a 55% reduction of residential hotel units between the years 2004 and 2015 going from over 2,200 rooms to slightly over 1,200 rooms.

The County also reports that homelessness has been steadily increasing, and those with mental illness and incomes at 200% of the federal poverty level are increasingly unable to find stable, affordable, supportive housing. The County's homeless point in time (PIT) count in 2017 was 5,629 and that number increased to 8,022 (over 6,300 reported being unsheltered) in 2019. Of those individuals, 41% reported having psychiatric or emotional problems.

Alameda County estimates it needs 54,000 residential units to meet its current demand.

In 2006 in order to address the increase in homelessness, the County developed a 15-year plan and committed to develop 15,000 supportive housing units. By 2019, the County had only achieved 1% of that goal (1500 new units) largely due to the financial crisis of 2007-08 and the national and global economic downturn.

In addition, the County also reported developing 175 supportive housing units with the MHSA Housing funds it received in 2007-08 and is still unable to meet the demand.

The inability to complete housing projects, the loss of board and cares and independent living facilities, and significant increases in homelessness - a situation of instability for those suffering with serious mental illness – continues to persist in Alameda County. Although solutions were implemented, the County believes that they have not been effective and that other challenges have emerged that require a more sustainable solution.

Given that homelessness for persons with SMI has exponentially grown and has surpassed the County's capacity to address their housing needs with traditional housing methods, the County feels that an innovative solution is merited.

The Response

Alameda County proposes to test the use of the Community Land Trust Model, as defined above, to provide supportive permanent housing to those suffering from serious mental illness. The Community Land Trust Model preserves the land and designates any structure built on it to be permanent, thereby reducing the risk of closures and displacement of consumers.

Land trusts, known in non-mental health settings, have been successful in preserving large areas of land as reserves or for a specific purpose (agriculture, ecosystem preservation, etc.). Land trusts have also been established to manage rent costs and in the case of a recently established community land trust in Sacramento, CA, to "**harness the power of rarely-heard and often-disenfranchised people"**, partner with groups fighting for greater equity, compete for property and buildings that would normally go to the highest bidder, and obtain land for the permanent use of and direction by historically discriminated communities." http://www.sacclt.org/the-need.html, retrieved July 27, 2019.

Alameda County proposes to establish the Supportive Housing Community Land Alliance, (CLA) through a public Request for Proposal Process that will seek an existing affordable housing developer and a mental health service provider. The chosen agencies will be responsible for:

- Drafting and outlining the membership and goals for the Board of Directors
- Recruiting the Board members
- Identifying an Executive Director
- Developing an Advisory Committee to the Board of Directors
- Obtaining legal counsel to draft 501(c)(3) documents for the Trust

The 9-12-member Board of Directors will be comprised of clients and family members, public sector representatives, including legal counsel and community partners with specific areas of expertise and a commitment to improving supportive housing. The Board will be responsible for clearing legal requirements, establishing fiscal purchases and the supportive needs requirements, monitoring and maintenance. **The county may wish to describe how and what supportive services will be provided once the CLA is established.**

In addition to developing processes for itself and its respective properties, the CLA will be responsible for "utilizing existing and planned financial and other resources to implement its key strategic aims," including HUD continuum of Care subsidies, MHSA Community Services and Supports locally created housing subsidy funds, and No Place Like Home bonds. Initially, the County anticipates adding two new housing units to the CLA (one for private ownership and one for utilization of either a board and care unit or an independent living structure and ultimately adding 200 housing units to the County's inventory. **The County may wish to consider NIMBYism and if SB 167 protection from NIMBYism will be useful to them when addressing these concerns.**

The Community Program Planning Process

The County conducted its CPP between June to October 2017. It developed three ways for stakeholders to provide input on the planning process; by attending one of five community forums, attending one of 18 diverse focus groups (Chinese speaking, LBGTQ community, transitional aged youth, Afghan immigrants, older adults, API and refugee providers, providers for persons with developmental disabilities and mental illness and the pool of consumer champions), and through community surveys. The county reports that 550 surveys were completed by a diverse group which included mental health consumers, providers, homeless/housing providers, hospital providers, law enforcement, NAMI, and veterans.

In all venues, the County reports that housing and homelessness were key issues. 72% of respondents ranked homelessness as their number one priority/issue and 63% of respondents ranked persons experiencing homelessness as the top underserved population. Additional responses for the County included new mobile crisis services, school-based services for children, more peer support programs, substance use education and culturally responsive training. Based on the responses from the community, the County Department of Housing submitted a proposal for this community land trust to the County BHCS department where it was ultimately vetted by the MHSA staff for conformity with Innovation regulations and later was presented to the MHSA Stakeholder Committee in December 2017. Ultimately, the County submitted the proposal for public comment in December 2018 and generally received positive feedback. One comment did address that the proposal did not address the immediate crisis and the County responded by indicating that it had made an investment of $13M to address homelessness primarily through its Full Service Partnership slots, staffing to coordinate outreach activities, increased board and care payment rates and created additional respite beds.

Commission Staff received this project in concept form on August 27, 2018 and after receiving substantial technical assistance, the County re-submitted their project. Commission Staff then shared the DRAFT proposal with its stakeholders on December 17, 2018. The County was simultaneously working on another INN project which took precedence and chose to wait before finalizing this project. In the meantime, the County held their 30-day public comment from February 8, 2019 through March 8, 2019. The County received some comments which were addressed in the final proposal. The FINAL version was shared with our stakeholders on July 24, 2019, two letters of support were received; one from the Executive Director of United Parents and another from a private person who indicated:

“I support Alameda County’s request for this grant to set up a land trust. Robert Ratner of Alameda County BHCS understands the desperate need for licensed housing for the seriously mentally ill, and this proposal is a step in that direction, in the face of all the trends that cause board-and-cares to shut down and put our schizophrenic children on the street and into jail.

“Housing has to be specifically tailored to the seriously mentally ill—ideally, to Alameda County’s thousand sickest—so that people coming out of mental hospitals and jails have

a safe place to stay where someone is keeping track of them and where they have a chance of a long-term stay."

Learning Objectives and Evaluation

Alameda County seeks to introduce a supportive housing land trust into the behavioral health environment to meet the primary purpose of increasing access to mental health services, including those provided through permanent supportive housing. Specifically, the County will target adults in Alameda County with a serious mental illness living with extremely low incomes (approximately 200% of the federal poverty level or below; on SSI and/or Medi-Cal), and have been referred to BHCS and are not currently receiving services to address their housing needs. It is estimated that 10 BHCS clients will be served directly through the two proposed housing projects, with an anticipated 200+ BHCS clients also benefiting from the housing subsidy and other components of the project.

The County has identified several learning objectives that will guide their project. These learning objectives will examine:

(1) The process-oriented outcomes that will test the overall ability for the CLA to create a sustainable community land trust amongst the target population,
(2) The ability for the community land trust model to create a functioning "" Board of Directors that is comprised of 1/3 family consumers, 1/3 family members, and 1/3 community housing experts,
(3) Whether or not the CLA can affect the closure rates amongst various supportive housing models, and
(4) Whether or not the project can have individual impacts in terms of building personal, and community "wealth."

Both qualitative and quantitative data will be collected from several sources to gather the information necessary for evaluation, including (but not limited to): consumer and family surveys, focus groups and interviews, training surveys, as well as records relative to income, land trust records, and Board of Directors occurrences. Additionally, information will be gathered from Medi-Cal billing as well as from electronic health records (**see pgs. 12-14**). Measures for each learning objective have been identified and will appropriately meet the needs of the evaluation, including measuring the extent to which the project leads to an increase in access to services, including those provided through permanent supportive housing.

The final evaluation will be completed by an outside contractor, who will also complete the final evaluation report. At the conclusion of the project, lessons learned will be shared by the County and CLA Advisory Committee via presentations at local and state meetings to various groups, including (but not limited to): MHSA Stakeholder Group, Alameda County Mental Health Board, Cultural Responsiveness Committee, NAMI, and affordable housing development stakeholder groups.

The Budget

The County is seeking authorization to spend up to $6,171,599 over a five (5) year period. Personnel costs in the amount of $4,287,066 represent 69.4% of the total budget. These salary costs will support County staff responsible for monitoring the Community Land Alliance (CLA); including an Innovation Coordinator, a Procurement staff person and a Project Manager from the County Housing Department who will ensure the management of funds so that Innovation funds are not compromised. Additional salary costs are included for the Executive Director of the CLA, a Director of Property Management, a Workforce Developer/Training Director and an Administrative Assistant for the Community Land Alliance staff.

Operating costs in the amount of $944,532 represent 16.1% of the budget. Contract costs in the amount of $805,000 represent 13% of the total budget and include evaluation. Additional contract costs will include consultations with real estate experts, project management and strategic guidance for community-owned and community governed project. **The county may wish to identify the costs it anticipates for the provision of supportive services.** Non-recurring costs (incorporation and legal fees as well as equipment and technology) in the amount of $85,000 represent slightly over 1% of the budget.

After the CLA is established, the County intends to utilize MHSA Capital Facilities Technological Needs (CFTN) funds which will be earmarked in their next three-year program and expenditure plan (FY 21-23) for acquisition and rehabilitation of property. They will also consider other funding sources such as HUD subsidies, No Place Like Home grants, private donors and any other partnerships that would support the sustainability of this project. **The county may wish to identify or approximate the amount of funds it is considering.**

Additional Regulatory Requirements

The proposed project appears to meet the minimum requirements listed under MHSA Innovation regulations.

References

https://sacramentoneighborhooodcoalition.com/community-land-trust/

https://community-wealth.org/strategies/panel/clts/index.html
https://en.wikipedia.org/wiki/Community_land_trust

“Community Land Trusts (CLTs).” Community, 2 May 2019, retrieved from community-wealth.org/strategies/panel/clts/index.html.

INNOVATIVE PROJECT PLAN DESCRIPTION

County: **Alameda**	Date Submitted: **July 22, 2019**
Project Name: **Supportive Housing Community Land Alliance**	
Total Amount Requested: **$6,171,599**	
Duration of Project: **5 years**	

Executive Summary

Program Summary

Alameda County has been in search of innovative solutions that address affordable supportive housing for individuals with serious mental illness (SMI) because current solutions are not effective due to a housing crisis that continues to escalate and significantly affect this very vulnerable population. The County has been experiencing a decline in available housing units since 2004. During 2015-2017 alone, homelessness grew by 40%. Of these individuals who became homeless, 41% reported a psychiatric or emotional condition impacted their ability to obtain housing. This already dire situation has been recently exacerbated by the Northern California fires in Sonoma, Napa and Butte County.

Stable housing provides the foundation upon which people build their lives. Without a safe, affordable place to live, it's almost impossible to achieve good health or to achieve one's full potential. For people living with an SMI, stable and supportive housing not only has the potential to improve mental health, but also physical health, both of which help to increase overall quality of life and wellbeing.

The County is proposing to use a **community land trust model** to bring permanent affordability and community control to help ease its housing crisis for SMI consumers whose income is 200% of the federal poverty level.

A community land trust is a nonprofit formed to hold title to land to preserve its long-term availability for affordable housing. The trust retains ownership of the land and the homebuyer pays a lease fee on the land, which protects the trust's investment in the land. With land costs often being 30 to 40 percent of the price of a home, this model allows a buyer to afford a home by only borrowing on the structure. The homeowner can sell the property and make a small profit and recover the down payment, some equity and the cost of improvements. The trust keeps the rest of the money to provide for future buyers. This setup not only fosters pride of ownership and community, it provides an opportunity to move restrictive supportive housing approaches into the private sector for the public good.

Using innovation funds, a nonprofit community land trust entity will be created, which we've named, the **Alameda County Supportive Housing Community Land Alliance (CLA)**. The CLA will be developed by an agency chosen through Alameda County's public request for proposal (RFP) procurement process. The agency chosen will develop an organizing committee, Project Management Team, (PMT); Community Land Trust consultant; a Board of Directors (identified after the PMT is established) comprised of one-third each mental health consumers, family members, and public sector representatives; and legal counsel.

The CLA will be charged with not only creating the community land trust, but also developing housing guidelines, and best practices for board and care operations. Additionally, the CLA will launch an open membership structure within the CLA that provides community members with a means to participate in supporting the goals of the program.

Alameda County is aware that innovation funds *cannot* be used for the purchase of property or rehabilitation and/or construction of new housing. BHCS' Finance Department will have a fiscal tracking mechanism to specifically monitor these funds to ensure Innovation funding is appropriately being utilized under CCR§ 3910.010(b)(1).

Innovative Components

The Innovation component of the Mental Health Services Act provides counties the "opportunity to develop and test new, unproven mental health models with the potential to become tomorrow's best practices."[1] Alameda's proposed Innovation project's primary purpose is to increase access to mental health services through permanent supportive housing by using a community land trust model. This model has never been developed to house individuals with a serious mental illness, and if successful, has the potential to become part of tomorrow's best practices as it's shared with other counties. Moreover, this pilot project is testing the innovative ideas of the CLA being able sustain and fund itself through its fiscal modeling, and using rental fees to afford additional housing units.

What Success Will Look Like

The lack of affordable supportive housing does not provide individuals with SMI the opportunity for long term mental health support and recovery. Success of this model may bring new avenues to supportive housing and mental health services. Currently, homeless individuals receiving mental health care are more likely to continue to be homeless upon discharge or may not be able to continue mental health services due to not having stable housing. With this model, the individual's home is permanent, versus the current model of being assigned after discharge to what is available and potentially temporary. Having a *safe* and *secure* place to live is a vital part of wellness and recovery.

Success in the short term will include, but not limited to:

- Incorporating the community land trust (CLA) as a 501(c)(3);
- Forming a Board of Directors and staffing structure that allows for equitable participation by mental health consumers and family members, and
- Development of financing models that will sustain the operation of the CLA.

Long Term success will include, but not limited to:

- Effect on board and care closures, and
- The financial model is sustainable with funds being directed towards the development of new units.

[1] http://www.mhsoac.ca.gov/innovation-0

I. Innovations Regulations Requirement Categories

1) General Requirement

The proposed project applies a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system.

2) Primary Purpose

The proposed project increases access to mental health services, including but not limited to, services provided through permanent supportive housing.

II. Project Overview

1) Primary Problem

The need for affordable supportive housing for individuals with a severe mental illness continues to increase in Alameda County as traditional approaches to the problem have not been effective due to a housing crisis that continues to escalate and significantly affect this very vulnerable population. It should also be noted that while the Bay Area has been in a housing crisis for several years now, the recent Northern California fires in Sonoma, Napa and Butte County have drastically increased this crisis to an even more alarming and dire rate.

Across the Bay Area, an inadequate supply of housing stock, particularly affordable housing, has contributed to rising home prices, rental rates, evictions, displacement and homelessness. Households living on fixed incomes such as seniors and people with disabilities, including individuals with severe mental illness, face the most significant challenges in maintaining a home in this environment. In the Bay Area, there are only an estimated 25 affordable housing units for every 100 extremely low-income households. Housing and Urban Development (HUD) Fair Market Rents for one-bedroom apartment units grew by 71% between 2013 and 2018. Conversely, Supplemental Security Income (SSI) payments for disabled individuals in 2018 cover *less than half* of the rent of a one-bedroom at the 2018 Fair Market Rate in Alameda County. The County requires approximately 54,000 more affordable rental homes to meet current demand. This housing landscape has had a devastating impact on individuals and families impacted by serious mental illness.

In 2006, Alameda County issued a 15-year plan to address homelessness and the housing needs of people with special needs including those with mental illness. This plan called for the creation of an additional 15,000 affordable supportive housing units by 2020.[2] To date, an estimated 1,500 new supportive housing units have been created, *far below the pace needed to meet the goal.* While some supportive housing units have been created, Alameda County has also experienced significant declines in the number of licensed board and cares, residential hotels, and room and board facilities frequently utilized by individuals with serious mental illness.

[2] The County's 2006 plan was hampered by a number of internal and external factors. None was more damaging than the financial crisis of 2007-2008 which was followed by a global downturn, or the *Great Recession*. The immediate cause or trigger of the crisis was the collapse of the US housing bubble which peaked in 2006-2007.

Between 2004 and 2015, Oakland experienced a nearly 55% decline in the number of available residential hotel units from 2,237 to 1,224 rooms. Alameda County Behavioral Health Care Services (BHCS) Housing Services Office identified 50 room and board or independent living facilities utilized by individuals with serious mental illness that had either been sold or closed displacing an estimated 500 individuals within a three year period (2014 and 2017). During the same time period, BHCS has lost over 80 licensed board and care beds previously occupied by people with serious mental illness. Inadequate supportive housing unit creation coupled with declines in shared housing options of last resort for seniors and people with disabilities have contributed to steep increases in homelessness and housing instability among people with serious mental illness. Between 2017 and 2019, the number of people experiencing homelessness at a point-in-time (PIT) grew by nearly 43% (2017 PIT was 5,629 and 2019 PIT is 8,022 [6,312 were unsheltered])[3]; of these individuals who became homeless, 41% reported a psychiatric or emotional condition impacted their ability to obtain housing or employment. In FY2014-15, 6% of BHCS clients were homeless upon entry into services and 5% were homeless upon discharge. In FY2017-18 that rose to 9% on admission and 10% on discharge. The situation is dire.

The federal Substance Abuse and Mental Health Services Administration (SAMHSA) identifies "home" as an essential domain for a life in recovery.[4] Alameda County's current housing and services landscape makes obtaining and maintaining a "home" extremely challenging for individuals struggling with a serious mental illness. Innovative approaches that help create new supportive housing units and that minimize the loss of shared housing options are urgently needed.

Traditional affordable housing financing approaches remain time-consuming and costly when compared to private housing market strategies. A typical Bay Area affordable housing project can take 3-5 years to gather appropriate financing, approvals, and complete construction. Available properties frequently get acquired by private entities before affordable housing developers can even secure initial funding. The major federal and state sources of affordable housing financing often have rules that preclude the blending of market rate and affordable housing units in a single project. In addition, these sources create priorities that make financing smaller projects non-competitive. Publicly financed affordable housing projects also typically preclude family members from investing and securing a supportive housing unit for a loved one with a disability. Innovative approaches to address these traditional housing financing models and identifying ways to target and reduce these barriers are vital to shore up the housing gaps.

Given the critical nature of "home" for recovery and the worsening housing crisis in the Bay Area, several members of East Bay National Alliance for the Mentally Ill (NAMI) chapter created a supportive housing workgroup to investigate ways in which family members could support, advocate for, and invest in the creation of quality supportive housing for their loved ones. Many family members in this workgroup expressed a willingness to invest in a housing project if their investment could result in a guaranteed place for their loved one to live. Traditional affordable housing financing strategies do not allow for consumer/client ownership of their housing. In addition to this workgroup, Alameda County's recent Community Planning Process (CPP) identified homelessness as the top priority for adults and older adults, and the third priority issue for children, youth, and transition age youth.

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[3] The PIT confirms the analysis of EveryOne Home's *Plan to End Homelessness: 2018 Strategic Update* that says: for every two people becoming homeless, only one person returns to permanent housing. The report can be found here: http://everyonehome.org/wp-content/uploads/2018/12/EveryOne-Home-Strategic-Update-Report-Final.pdf

[4] https://www.samhsa.gov/recovery

Through its original MHSA housing funds, Alameda has developed 175 units within 25 MHSA housing projects across the County. These units serve all age groups (depending on the development) with subsidies included with multiple units. Even though Alameda is proud of these successful property projects it's only a "drop in the bucket" of what's truly needed.

2) The Proposed Project

a) *Provide a brief narrative overview description of the proposed project.*

The Supportive Housing Community Land Alliance pilot project will promote interagency and community collaboration among BHCS, family members, consumers, and affordable housing developers to create a Community Land Alliance using a community land trust model to preserve and create affordable supportive housing units for BHCS clients. A community land trust is a nonprofit organization formed to hold title to land to preserve its long-term availability for affordable housing. The homes are sold to lower-income families. The community land trust:

- Retains ownership of the land and provides long-term lease, generally a ground lease, of the structure(s) to homebuyers;
- Maintains an interest in maintenance of the structures and property while tenant/co-owner makes improvements to the property;
- Retains a long-term option to repurchase the homes at an agreed-upon formula-driven price giving the *homeowner partial equity* with the remaining equity staying with the community land trust; and
- The structure is re-sold below-market rate and the cost of the land is retained in perpetuity within the trust.

Supportive housing property and subsidy management refers to creating an organization with expertise in direct and third-party property management and master leasing of supportive housing units coupled with expertise in managing long-term rental assistance/ housing subsidy funding from programs such as Section 8, MHSA, and HUD Continuum of Care grants.

Innovation funding will be used over five years to create and fully develop a non-profit Supportive Housing Community Land Alliance based on a community land trust and supportive housing model. The first two years will be used to create initial infrastructure, staffing, establish agreements between community partners, and develop policies and procedures.

The proposed community land trust will operate under the auspices of a board of directors comprised of 9-12 individuals with one-third consumers and family member representatives, one-third public sector representatives, and one-third community partners with specific areas of expertise and a commitment to expanding and improving supportive housing in Alameda County.

This community land trust model is designed to balance the interest of individual land trust homeowners with the interests of the community as a whole. The rationale for this structure is based on the recognition that all land trust residents have a common interest in the organization that owns the land the residents live on and also have a degree of control over that organization. The community land

trust model fosters homeownership versus giving subsidies which solely aid initial recipients and leaves the County expending more resources in the future.

The Community Land Alliance, which will be developed by an agency chosen through the County's Request for Proposal (RFP) procurement process, will establish an organizing committee called the "Project Management Team", who will be responsible to:

- Draft and outline membership of the board of directors;
- Recruit board members;
- Identify an executive director;
- Develop CLA Advisory Committee to the board of directors comprised of a diverse membership including, but not limited to, the project management team, MHSA Stakeholders, interested community members, NAMI members, consumers, and family members; and
- Acquire legal counsel who will draft documents necessary to create a 501(c)(3) non-profit corporate structure; along with documents that will include, but not be limited to, articles of incorporation, bylaws, and application for federal tax-exemption.

The County has identified MHSA Capital Facilities and Technological Needs (CFTN) funding to purchase initial property for the pilot project, once the Community Land Alliance is up and running. The funding has been secured separately because MHSA Innovation funds are not permitted to be utilized for the purchase of land as Innovation funds cannot be used for projects exceeding five (5) years as specified in CCR§ 3910.010(b)(1).

The BHCS' Finance Department will have a fiscal tracking mechanism to specifically monitor and track these Innovation funds to ensure Innovation funding is not used for the purchase of property or rehabilitation and/or construction of new housing. In BHCS, each MHSA component has a unique organization and program number that's attached to all projects so that Finance staff can accurately track appropriation and spending by component area. This is BHCS' standard practice in order correctly document expenditures on the MHSA Annual Revenue and Expenditure Report.

Further funding will be sought to continue operation of the project from other sources such as No Place Like Home, tax credits, or alternative sources identified by the Supportive Housing Community Land Alliance.

The Supportive Housing Community Land Alliance is expected to increase the ability to secure and maintain affordable supportive housing for clients living with a severe mental illness by:

- Leveraging public and private investments in a single property. Examples include family member and client ownership, mixed affordable and market rate developments, and cross-subsidization with condominium developments where some units are purchased at market rate, and the remaining will be less than market rate for affordability for BHCS' clients;
- Building an organization with supportive housing property management skills, master leasing capacity, housing partnership, and the subsidy management expertise necessary to secure housing units for BHCS consumers when opportunities arise;
- Using a non-profit 501(c)(3) structure to preserve the use of land and associated structures for sustaining supported housing units for people with histories of serious mental illness.

- Developing financial and operational models, and best practices for acquiring, rehabilitating, and managing licensed board and care and independent living shared housing facilities;
- Utilizing publicly-funded rental subsidies in creative ways to expand opportunities for those with rental subsidies, to create opportunities for tenant ownership, and/or reinvestment of subsidy funds into expanding supportive housing unit availability;
- Provide ongoing stewardship to the clients and property co-owners while they own their homes and manage resales to ensure the home or property stays affordable to subsequent buyers.

The primary staffing of the Community Land Alliance and their roles will include:

- BHCS Project Manager: The BHCS Housing Services Office Director will supervise a Project Management consultant to oversee the implementation of the Innovation project, such as developing agency and community support and linkages, developing the initial Request for Proposal (RFP) model for project launch, ensuring the project achieves its intended innovation objectives, and coordinated project evaluation and reporting to stakeholders.

- Community Land Alliance Executive Director: Provide primary oversight of the Community Land Alliance, consultants, and staff; development of a Community Land Trust Board of Directors and By-Laws, financing models, family investment model, and sustainability model; cultivating housing projects.

- Property Management Director: Supportive housing property management policies and practices will need to be developed that integrate existing best practices and the unique requirements created by the mixed funding sources, such as family/client ownership. Management of supportive housing properties requires unique approaches, workflows, and staffing.

- Workforce Development and Training Director : Successful supportive housing projects require that staff members involved in specific projects clearly understand their role and responsibilities, have the supervision and support necessary to fulfill their roles, and have training, feedback, and skill development opportunities that enhance their work performance and job satisfaction. The workforce development and training coordinator will focus on ensuring staff involved with specific supportive housing projects have the supports and tools necessary to maximize the success of housing projects.

- Multiple consultant and contractors: BHCS will engage legal and professional consultants regarding community land trusts, affordable housing development, financing, and operating models.

Once established, the Community Land Alliance will utilize existing and planned financial and other resources to implement its key strategic aims. Examples of these resources include HUD Continuum of Care housing subsidies, MHSA Community Services and Supports (CSS) locally created housing subsidy funds, No Place Like Home MHSA bond funds, and a one-time set-aside of local MHSA Capital Facilities and Technological Needs funds for the Community Land Alliance initiated housing projects.

By developing a new model for securing and governing affordable supportive housing, we hope to assist other counties facing similar housing crises. The County's model, if successful, could not only reduce the learning curve for other counties who want to develop their own community land trust, but generate an *opportunity for larger statewide collaboration.*

b) Identify which of the three approaches specified in CCR, Title 9, Sect. 3910(a) the project will implement (introduces a practice or approach that is new to the overall mental health system; makes a change to an existing practice in the field of mental health; or applies to the mental health system a promising community-driven practice approach that has been successful in non-mental health contexts or settings).

This proposal makes a change to an existing practice in the field of mental health through the development of new approaches to securing, governing, financing, and operating supportive housing units for people with serious mental illness. This proposal also applies to the mental health system a promising community-driven practice approach that has been successful in non-mental health contexts or settings.

c) Briefly explain how you have determined that your selected approach is appropriate. For example, if you intend to apply to mental health a practice from outside of mental health, briefly describe how the practice has been historically applied.

This approach blends a variety of strategies utilized in other settings to address the needs of individuals with serious mental illness in a challenging housing market. As discussed in question 2, pages 4-6, each of the strategies being used has successfully addressed *some* aspect of the problem.

Community land trusts secure land and property for long-term affordability, create home and property ownership opportunities for low-income households, and provide ongoing stewardship of land for a defined public purpose.

Supportive housing property management and subsidy expertise has been utilized in other communities to master lease housing from private owners and to maximize the quality of supportive housing operations.

Continuing Care Retirement Communities (CCRC) provide models of tiering several levels of supportive care within a single property. In addition, some CCRCs highlight the possibility of combining market rate and affordable units within a single development.

The proposed Community Land Alliance creates an opportunity to *integrate these models* into an organization focused on the creation of quality supportive housing units for individuals struggling with a serious mental illness and their families.

d) Estimate the number of individuals expected to be served annually and how you arrived at this number.

Alameda County Behavioral Health Care clients will be directly served by this Innovation project. During the proposed five-year initial funding cycle, BHCS anticipates completing at least two new supportive housing projects through the new organizational infrastructure:

- One of the projects will incorporate a home ownership model for clients with serious mental illness, and
- The other project will utilize a land trust model to secure an independent living or licensed board and care home(s) for individuals with serious mental illness.

At least 10 BHCS clients will be served through these two housing projects. In addition, it's anticipated that over 200 BHCS clients will benefit from the newly created alliance's housing subsidy and property management skills and capabilities over the five-year innovation cycle. These estimates come from:

- Initial plans to start with two smaller housing projects of 4-6 units in size; and
- Coordination efforts of the alliance's housing subsidy and property management skills for at least 200 of Alameda County's current supportive housing inventory units.

Over the long-term, BHCS anticipates that this organizational model developed with Innovation funds will accelerate the creation and maintenance of supportive housing units within the County.

e) Describe the population to be served, including relevant demographic information (age, gender identity, race, ethnicity, sexual orientation, and/or language used to communicate).

The target population includes adults with serious mental illness residing in Alameda County that are living with extremely low incomes. Participants' income is to be roughly 200% of the federal poverty level or below; on SSI and/or Medi-Cal; have been referred through BHCS' healthcare system; and are not receiving the care they need because of their housing needs. The population of Alameda County in 2017 was 1,663,190 residents, of which there's an estimated 4%, or 66,528, Alameda County residents who struggle with serious mental illness, so the need for housing and supportive services in the County is high.[5]

3) Research on Innovative Component

a) What are you proposing that distinguishes your project from similar projects that other counties and/or providers have already tested or implemented?

While this project borrows from a number of models, it's innovative in the following ways:

- A community land trust model allows for more financing models that traditionally are used for creating affordable supportive housing.
  - It creates opportunities to secure properties for public use more quickly which can lead to an increase in preserving and developing housing projects.

[5] http://www.dhcs.ca.gov/provgovpart/Documents/CaliforniaPrevalenceEstimates.pdf

- It offers an opportunity to leverage private investment and an opportunity for cross-subsidization of supportive housing units with market rate units.
- It allows for family members to invest in housing units for their adult children with serious mental illness.
- A community land trust provides a mechanism to protect the public and private investment; this subsidy retention keeps the home affordable generation after generation without additional subsidy required to keep the home affordable at resale.
- The community land trust model creates an opportunity to build community wealth, making the land a community asset in perpetuity and also creates an opportunity to build equity for the homeowner.

- A community land trust provides an opportunity for inclusion of people with serious mental illness and their families into leadership around developing, operating and maintaining housing.
  - Community land trusts have a history of benefitting disenfranchised populations; and
  - The flexibility of the community land trust model has nurtured a development of empowerment for its members.

- A community land trust allows for innovation, inclusive, and integrated forms of housing developments that are difficult to finance and operate within traditional affordable housing models.

- Expanding supportive housing models into non-traditional settings, such as a community land trust, allows for increasing the opportunity to provide support in affordable units.

b) *Describe the efforts made to investigate existing models or approaches close to what you're proposing.*

There are over 200 community land trusts in the United States. Most of these community land trusts vary from one another depending on their targeted community. The model's targeted population served affects the type and tenure of whatever housing is developed; amount of subsidy for affordability; type of funds available from governmental sources; design of the resale formula; marketing plan; selection criteria; and organizing strategy.

There are *no community land trust models whose targeted populations are individuals with severe mental illness.* However, there are programs that are using inventive ways for supportive housing through the collaborative efforts between the private market and a government agency:

- Brilliant Corners in Los Angeles, in cooperation with the Conrad N. Hilton Foundation, has launched a new supportive housing rental subsidy program called Flexible Housing Subsidy Pool. Their goal is to secure decent, safe, affordable housing for homeless DHS patients and have complex physical and behavioral health conditions. Tenants will be linked with wrap-around, intensive case management services to support them from transition to permanent housing. http://brilliantcorners.org/brilliant-solutions/housing-for-health/

- Seattle's Landlord Liaison Project, which currently is operated by King County, WA, is a collaborative partnership between property managers and service providers that helps people who can afford rent,

but have barriers to accessing housing. https://kingcounty.gov/depts/community-human-services/housing/services/homeless-housing/landlord-liaison-project.aspx

Many of the current community land trusts have been in existence for 20 years or more. A number of community land trusts are in the Bay Area and along the West Coast. Executive Director, and founder of the Lopez Community Land Trust, Sandy Bishop; and Executive Director of the Housing Land Trust of Sonoma County, Devika Goetschius, are being consulted on an ongoing basis. https://www.lopezclt.org/staff/; https://housinglandtrust.org/. It must be noted that Ms. Goetschius is also a consultant for Burlington Associates, a national consulting cooperative who specializes in the development of community land trusts and other shared equity homeownership strategies. http://www.burlingtonassociates.com/#!/home

The controversy of affordable housing tends to trigger an immediate NIMBY ("Not in my backyard") response. Ironically, most communities would agree that affordable housing should be OKIMBY ("Okay in my backyard") if that housing contributed to the neighborhood and made it possible for stable families and individuals to live in the neighborhood. A common denominator for any affordable housing plan is effective communication among stakeholders which must exist for the plan to be successful[6].

The County's proposal is clear on who to serve and why. As part of this project, the County will be meeting with the surrounding communities and communicating with stakeholders. We believe the key is education and taking the time to provide information and receive feedback through various methods (in-person community meetings, emails, written comments, phone discussions, etc.).

4) Learning Goals / Project Aims

a) What is it that you want to learn or better understand over the course of the INN Project, and why have you prioritized these goals?

Alameda has four Learning Goals:

1. Can a community land trust model, targeting the SMI population, facilitate a successful financing model that results in adequate resources to sustain operation of a community land trust?

2. Can Alameda County within two years of using a community land trust model create an equitable representation on a well-run/effective Board of Directors (BOD) that includes one-third consumers, one-third family members, and one-third community housing experts?

3. Can the use of a community land trust model for supportive affordable housing targeted to the SMI population have an effect on the rates of closure on various supportive housing models (i.e. respites) in Alameda County?

[6] (*Affordable Housing: Can Nimbyism Be Transformed into Okimbyism?, Peter W. Salsich, Jr., Saint Louis University Public Law Review, Vol 19:453, 2000*).

4. Can the community land trust model provide an opportunity to build personal wealth, balanced with community wealth using the private sector for public good?

b) How do your learning goals relate to the key elements/approaches that are new, changed or adapted in your project?

The proposed learning goals match the intentions of the proposed community land trust innovation model.

Overall, Alameda is wanting to test the hypothesis that the traditional land trust model can be introduced into the behavioral health environment for the benefit of individuals with a severe mental illness and their family members.

By utilizing MHSA Innovation funds as "seed" funding to set up the proposed land trust we envision a sustainable entity, with equitable stakeholder representation, that in the long run utilizes non Innovation funds to create supported housing units. The stability from the supportive housing environment will ultimately increase access to mental health services and promote wellness and recovery.

5) *Evaluation or Learning Plan*
Specifically, please identify how each goal will be measured and the proposed data you intend on using.

- Can a community land trust model, targeting the SMI population, facilitate a successful, financing model that results in adequate resources to sustain operation of a community land trust?

Data to collect	Data collection method
• What funding types can this model attract and secure? (funding from foundations, healthcare, local/state revenue, MHSA, reinvestment of rental income, etc.)	• The land trust records including, but not limited to, grant proposal, contracts, rental, agreements, and loan documents. • The Project Coordinator will also track length of time and effort it takes to secure funds.
• Operating and Expense analysis	• Comparison and research of operating/expense costs between different fiscal models. • Various fiscal models that are developed

- Can Alameda County within two years of using a community land trust model create an equitable representation on a well-run/effective Board of Directors (BOD) that includes one-third consumers, one-third family members, and one-third community housing experts?

Data to collect	Data collection method
• Who participates on the BOD? • How often does the BOD meet? • What discussions and decisions are made and by whom that provide guidance to the project?	• The assistant to the BOD will collect membership rosters, sign-in sheets, meeting minutes, etc.
• BOD's perception of the effectiveness of the land trust, including what contributed to or impeded success. • "Effectiveness" will be operationalized as: well facilitated/structured meetings, opportunities for all voices to be heard, concrete decision making structure, terms of service for the BOD, clear/structured application process to become a BOD member, etc.	• Annual surveys, focus groups and/or key informant interviews with BOD members. • Application documents, decision-making documents, meeting minutes, and bylaws.

- Can the use of a community land trust model for supportive affordable housing targeted to SMI population have an effect on board and care closure rates in Alameda County.

Data to collect	Data collection method
Current assessment of board and care facilities in Alameda County: • # of facilities • Provider satisfaction with being a board and care operator • Training/resource needs of board and care operators • Other items the evaluation team will define	• As part of the evaluation of this project, the evaluation team will conduct a basic needs assessment to determine baseline information. this will include quantitative and qualitative methods (surveys, focus groups and/or key information interviews) internet search for sites, etc.
• Trainings/support offered to board and care operators on best practices and residents (on how to be a good resident/roommate)	• Training surveys, follow up surveys/interviews
Follow-up assessment of board and care facilities once the land trust model is up and running: • # of facilities • Provider satisfaction with being a board and care operator • Training/resource needs of board and care operators	• The evaluation team will conduct the follow-up needs assessment to determine change from baseline. This will include quantitative and qualitative methods (surveys, focus groups and/or key information interviews) internet search for sites, etc.

- Can the community land trust model provide an opportunity to build personal wealth, balanced with community wealth using the private sector for public good?

Data to collect	Data collection method
Does the financing model developed enable family/clients to purchase units, this will include: • Financing and legal structure for family ownership of housing for adult relatives.	• Consumer/family response to guidelines and process established. Survey of BHCS consumers/family members after the guidelines are drafted. • Gathering copies of written materials outlining proposed ownership method and associated legal issues.
• What investments from family members have been made in specific land trust projects?	• Copies of records of family investments in specific housing projects.
For clients who become stably housed as a result of the community land trust model: • Percent who have employment income • Percent of consumer's usage of acute mental health services after 1-year • Percent of consumers who have obtained health insurance after 1-year.	• SSI and income before and after being housed in a supportive housing unit facilitated through the community land trust • Comparison of acute services used before and 1-year after. Data will be obtained through the County Medi-Cal billing system or current EHR. • Comparison of consumers' having health insurance before and 1-year after. Data will be collected through interviews and/or County Medi-Cal billing system or current EHR.

Data collection, evaluation and reporting for this project will be in alignment with the current Innovation Regulations. This includes collecting indicated demographic data, tracking changes made to the project in the course of implementation, and providing annual and final reports covering all required elements.

Evaluation of this project will be contracted out. The evaluators will assist in finalizing the evaluation plan, developing the appropriate tools, gathering and analyzing the data, and vetting the evaluation plan and tools with appropriate stakeholders. They will document factors that might affect the outcomes and will attempt to increase the validity of the results.

III. Additional Information for Regulatory Requirements

1) Contracting

The implementation of this project will be led by the BHCS Housing Services Office Director. He will supervise a project manager hired to oversee and implement this project. After receiving approval from the Mental Health Services Oversight and Accountability Commission (MHSOAC) for the project, BHCS will conduct a Request for Proposal (RFP) process seeking an existing affordable housing developer and mental health service provider with an interest and commitment to creating a Supportive Housing

Community Land Alliance. A review panel inclusive of family members, consumers, housing finance experts, service providers, and County staff will select the nonprofit partner(s) to help implement this proposed Innovation project.

2) Community Program Planning/Public Comment

The Community Planning Process (CPP) for the MHSA Three Year Plan was conducted from June – October 2017. During that process BHCS staff provided updates and information on current MHSA programs and community members provided input on mental health needs and services.

There were three modes for providing input:

- Five large community forums (one in each Supervisorial District);
- Eighteen focus groups were conducted throughout Alameda County: Chinese speaking family members, African American family members, providers for refugees, providers for LGBTQ community, transitional age youth (2), Afghan immigrants, older adults, API and refugee providers and advocates, providers for individuals with developmental disabilities and mental illness, and Pool of Consumer Champions (BHCS's mental health consumer group);
- Community Input Surveys in all threshold languages: submitted by 550 unique individuals. Respondents were very diverse in age, race, and ethnicity. Fifty percent of respondents were from Oakland, while they make up only 30% of Alameda's population. Survey respondents included: Mental health consumers (25%), family members (17%), community members (15%), education agency (2%), community mental health providers (14%), homeless/housing services (6%), County Behavioral Health staff (1%), faith-based organization (2%), substance abuse services provider (<1%), hospital/provider care (4%), law enforcement (1%), NAMI (1%), Veteran/Veteran services (1%), other community (Non-MH) service provider (5%), other/decline to state (9%).

Throughout the CPP housing and homelessness was a key theme:

- 72% of community respondents ranked homelessness as the number one issue for adult and older adults;
- 70% ranked homelessness as the number three issue for children/youth/transitional age youth, and
- 63% ranked "persons experiencing homeless" the top underserved population.

Moreover, when community members were asked open-ended questions about potential new Innovation project ideas they'd like to see planned and implemented 21% of respondents mentioned multiple areas around housing including: creating a land trust, purchasing property for more supportive housing, creating more board and cares, supporting and "cleaning up" existing board and care facilities, etc.

Other innovative project areas included new mobile crisis services, school-based services for children, more peer support programs, substance use (cannabis) education and culturally responsive programing;

of which several of these topic areas have already been incorporated into other Innovation projects.

Details of the CPP are provided in the Alameda County MHSA Three Year Plan (www.ACMHSA.org under Resources/MHSA Plans).

Based on the data from the CPP and public comment/input from the Alameda County MHSA Stakeholder Committee, the BHCS Housing Department submitted a proposal framework to the BHCS Department. The proposed project was vetted by County BHCS MHSA staff based on whether it addressed community priorities, as well as other factors such as MHSA Innovation criteria. . This project was approved for planning in late 2017 and was presented to the Alameda County MHSA Stakeholder Committee at their December 2017 meeting for initial input. From there, BHCS staff worked on the proposal internally with additional input from BHCS housing staff, MHSOAC staff, and the Alameda County Social Services Agency, which may become a collaborative partner for this project once approved.

Public comment

The following comments were received during alameda's 30 day Public Comment period for its FY 18/19 MHSA Plan Update

Morgan Kanninen Oakland resident (and lifelong in Alameda County resident) morgan.kanninen@gmail.com	I recently skimmed the Alameda County Health Plan update, and while I did not do it justice, I was pleased by the inclusion of an affordable, supportive housing community land trust (page 303). Thank you for the comment. As the Land Trust proposal moves forward we will keep people updated through our MHSA website at www.acMHSA.org We'll also keep your email and send out notices on the movement of the Land Trust.
Amber Straus 925 East 28th St. Oakland, CA 94610 Amber Straus Instructor, Learning Assistance Department City College of San Francisco astraus@ccsf.edu	I am a long-time Oakland resident who has witnessed the devastating impact that homelessness has had on many of our community members. My Sister also lives in Oakland and has a disabling mental health condition -- luckily she has low-rent in a shared house. I often think about what could happen to her if her landlord were to sell her home or if she were to be displaced because the dilapidated house becomes wholly unsafe to live in. For the above personal reasons and because it makes good sense to invest in housing infrastructure, I strongly support the proposed Alameda County Behavioral Health Care Services (BHCS) plan for Alameda County Supportive Housing Community Land Alliance. Implementation will bring agencies together with community collaborators and affordable housing developers to create a community land trust focused on preserving and creating supportive housing units to keep people with mental health condition housed in safe and stable conditions. "Using a nonprofit structure to preserve the use of land and associated structures for sustaining supportive housing units for people with histories of serious mental illness," is a humane approach to caring for our vulnerable community members in our expensive county. I strongly urge you to move this vital plan forward.

	Thank you for the comment. As the Land Trust proposal moves forward we will keep people updated through our MHSA website at www.acMHSA.org We'll also keep your email and send out notices on the movement of the Land Trust.
Alan Dones alandones@aol.com Alan E. Dones, Managing Partner Strategic Urban Development Alliance, LLC (510) 206-7203 Cell & Message (510) 482-7020 Office (510) 985-1544 Home-Office alan@sudallc.com www.sudallc.com	This email is to provide my strong expression of support and appreciation of establishing a Community Land Trust as described on page 303 of the MENTAL HEALTH SERVICES ACT ALAMEDA COUNTY FY 2018 - 2019 ANNUAL PLAN UPDATE. The land trust idea is one of several remedies that are critically needed to more effectively address the growing crisis of providing adequate/affordable housing, and supportive services, solutions for at-risk populations in the East Bay region. Thank you for the comment. As the Land Trust proposal moves forward we will keep people updated through our MHSA website at www.acMHSA.org We'll also keep your email and send out notices on the movement of the Land Trust.
Alison Monroe 510-575-5926 amonroe@jps.net Email/Public Hearing Comment Card	Here are a few reactions to the document: I am greatly in favor of the Land Trust innovation proposal. I appreciate that the discussion of that proposal acknowledges that 500 "room and board" beds and perhaps 1600 "board and care" beds have been LOST in this county over three years. Together with the LOSSES in acute and subacute hospital beds, the situation for our children is getting worse every year. Thank you for the comment. As the Land Trust proposal moves forward we will keep people updated through our MHSA website at www.acMHSA.org We'll also keep your email and send out notices on the movement of the Land Trust.
Julia Eagan MHSA Stakeholder Committee member	1. What are the strengths of the program(s)? Reserving space for low income individuals who need housing. Quite a crisis in Alameda County these days (and bay area in general). Affordable realistic housing is necessary. 2. What are challenges of the program(s)? Sustainability given the expense to build and operate buildings on the property. This project may take many years, which does not impact the current crisis. ACBH agrees that this project is a long term investment that won't immediately effect the housing crisis, but we hope that if approved and implemented it will create long term housing resources for clients with SMI and their family members. In the short term ACBH has invested an additional $13 million dollars in housing and homelessness which include additional Full Service Partnership slots coupled with housing subsidies, staffing to better coordinate county outreach efforts, increased board and care rates, additional respite beds, and an increase in the Supplemental Security Income (SSI) subsidy rate for clients on general Assistance awaiting their SSI approval.

3) MHSA General Standards

a) Community Collaboration: This project includes clients, family members, and other stakeholders in the process of developing a community land trust and the governance structure of the community land trust.

b) Cultural Competency: This project will serve the diverse BHCS client population. While the model will include an option to purchase a housing unit, it's not necessary, so finances are not a barrier to who can be served. The supportive services provided will be governed by the same requirements all BHCS services are in terms of ensuring cultural competence of staff, reducing disparities in access, and cultural appropriateness of housing units and services.

c) Client-Driven: Clients will be included in the collaborative process of developing and the governance structure of the community land trust. This includes participating in developing policies, procedures, and the evaluation.

d) Family-Driven: Families will be included in the collaborative process of developing and the governance structure of the community land trust. This includes participating in developing policies, procedures, and the evaluation.

e) Wellness, Recovery, and Resilience-Focused: Supportive housing aims to house people in the least restrictive environment with the maximum amount of self-determination and self-responsibility. In addition, the community land trust model supports client empowerment through participation in the governance structure.

f) Integrated Service Experience for Clients and Families: Supportive housing aims to provide services "at-home" to increase access to services, as well as housing stability.

4) Cultural Competence and Stakeholder Involvement in Evaluation

*a) Explain how you plan to ensure that the Project evaluation is **culturally competent**.*

The evaluation of this project will aim to be culturally competent by including family members and consumers in the initial design and implementation of the project evaluation. This project intends to utilize a community-based participatory research approach that serves as a vehicle for ongoing improvement of the model and its effectiveness. The evaluation plan and tools will be discussed with BHCS' Cultural Responsiveness Committee.

b) *Explain how you plan to ensure **meaningful stakeholder participation** in the evaluation.*

Clients and family members will be part of the collaboration to develop the community land trust, including the development of the RFP process, evaluation of RFP proposals, seats on the CLA Advisory Committee as well as the governance structure of the community land trust. These bodies will participate in developing the evaluation, assisting to implement any tools such as satisfaction surveys, as well as analyzing and presenting the results.

5) Innovation Project Sustainability and Continuity of Care

a) Will individuals with serious mental illness receive services from the proposed project?

If the pilot project proves successful, BHCS will support the continuation of the project or components of the project based on a number of internal and external factors and processes including: 1) the evaluation results from the project, 2) recommendations from the MHSA Stakeholder Committee and 3) available funding. Ideally this project will result in a financial model that will allow for the sustainment of the operation of the Community Land Alliance as well as funding for future purchase and maintenance of properties.

As stated in *2) The Project Proposal, pages 5-9,* further funding will be sought for sustainability of the project through other funding sources. There is also continuing negotiations with several consumer family members, and private donors, interested in either donating property or purchasing housing through a community land trust if the pilot proves successful.

In addition to other funding sources BHCS will utilize the first several years of funding to develop and learn about various fiscal modeling tools to sustain the operation of the organization and to learn how to re-invest funding for future properties and land opportunities, these models include:

- Affordable Pricing and Resale Formula Design or Review
- Shared Equity Business Planning
- Fee and Revenue Analysis
- Shared Equity Program Adoption Analysis
- Integrating Lasting Affordability into Policies and Investments
- Market Research and Financial Feasibility Analysis
- Revenue Generation and Housing Trust Funds
- Co-Op/Shared Housing Programmatic and Fiscal Models
- Affordable Housing Preservation Strategies

6) Communication and Dissemination Plan

a) How do you plan to disseminate information to stakeholders within your County and (if applicable) to other counties?

The Project Coordinator will be responsible for developing updates and coordinating dissemination plans. Updates on the project will be provided to stakeholders on an ongoing basis via email and presentations at existing meetings. The CLA Advisory Committee will be responsible for disseminating updates and results to their agencies, other stakeholders, and other counties. The final evaluation report for this project will be shared widely by posting it on the BHCS website and announcements via email to stakeholders, including to mental health directors, mental health housing offices, supportive housing agencies, and MHSA coordinators throughout the state. In addition, presentations will be made by Advisory Committee members to the MHSA Stakeholder Group, the Alameda County Mental Health Board, the Cultural Responsiveness Committee, other consumer groups, NAMI, the Board of Supervisors, and affordable housing development stakeholder groups and conferences.

b) *How will program participants or other stakeholders be involved in communication efforts?*

The Advisory Committee members will share updates with their agencies and stakeholders, as well as participate in providing presentations to the organizations listed above. The project coordinator will be responsible for website postings, email announcements, and coordinating communication plans.

c) *KEYWORDS for search:*

Key words that were used in research for this innovation project were: supportive housing, Community Land Alliance, community land trust, housing crisis, mental health supportive housing, and mental health community land trust.

7) Timeline

a) Specify the expected start date and end date of your INN Project:
Start: July 2019 End: June 30, 2024

b) Specify the total timeframe (duration) of the INN Project? 5 years
c) Include a project timeline that specifies key activities, milestones and deliverables – by quarter.

Timeline	**Activities/Milestones**
July 2019	Preparation and release of RFP
September 2019	Selection of nonprofit partner(s) for land trust implementation
December 2019 – June 2020	Development and creation of Supportive Housing Alliance organization – recruitment of board members, finalize by-laws and governance charter, complete articles of incorporation and new legal entity, identify and hire executive director.
June 2020 – January 2021	Secure and establish work space for organization, establish nonprofit operational infrastructure, hire key leadership positions, develop supportive housing property management policies and procedures for differing housing models, develop workforce development and training plan, start financial modeling for first two housing projects. Secure MHSA one-time CFTN funding for first two housing projects.
November 2020 – January 2021	Develop master leasing and housing subsidy management policies and procedures, hire and train key staff to operationalize property and subsidy management plans, begin transition of property and subsidy management approach from existing entities to this new entity.
February – July 2021	Initiate master leasing and housing subsidy arrangements with existing private owners. Identify properties and land for potential acquisition. Establish third-party property management activities in at least two properties. Develop business plan for condominium home ownership and cross-subsidization with at least one supportive housing unit on the property. Develop business plan for licensed board and care. Develop business plan for shared independent living/cooperative housing.

August - October 2022	Secure additional financing necessary for acquisition and rehabilitation of property. Acquire first land trust property using separate funding because innovation funds cannot be used under CCR§ 3910.010(b)(1).
November – July 2022	Renovate and prepare first land trust property for occupancy utilizing model(s) developed by organization.
August – December 2022[7]	Selection and move-in of residents/owners to first land trust property; implementation of supportive housing model for property.
September 2022 – January 2023	Secure additional financing necessary for acquisition and rehabilitation of second property. Acquire second land trust property.
January – September 2023	Renovate and prepare second land trust property for occupancy utilizing model(s) developed by organization.
October – December 2023	Move-in of residents/owners to second land trust property; implementation of supportive housing model for property.
January 2024 – March 2024	Acquisition and rehabilitation of new properties for land trust; expand and test models; continue supportive housing property and subsidy management with staged expansions over time
April – June 2024	Completion of final evaluation report on land trust model; dissemination of findings to key stakeholders

IV. INN Project Budget and Source of Expenditures

1) INN Project Budget and Source of Expenditures

This INN Plan will utilize any remaining AB114 funds that were deemed reverted and returned to the County for use until June 30, 2020. These funds will include funding from FY 10/11 funds as well as non-AB114 funds from FYs 17/18 and FY 18/19.

2) Budget Narrative

Salaries

FY 19/20:

Alameda County Staff Salary and Benefits (benefits are calculated at 50%)

[7] The County's research has shown that, minimally, it can take up to two to three years for the non-profit entity formed with all necessary legal requirements approved, along with the property in place before being able to have the first move in.

Innovation Coordinator: .25 FTE ($96,616 + 48,308-benefits) x .25 FTE= **$36,231** (Program Specialist classification). This staff will provide MHSA technical assistance and support so that the project is set up correctly and Innovation Regulations are followed.

BHCS Procurement Staff: 4 months at .33 FTE ($105,040 + $52,520-benefits) x .33 =$51,995/12= $4,333/mo x 4 mo= **$17,332** (Supervising Program Specialist classification). This staff will work with the BHCS Project Manager to develop and release the Request for Proposal (RFP) and submit the results to the Board of Supervisors.

BHCS Project Manager from the BHCS Housing Department: 1.0 FTE ($99,403 + 49,702-benefits)= **$149,105** (Senior Program Specialist classification) This staff will oversee the implementation of the Innovation project, such as developing agency and community support and linkages, developing the initial RFP model (in collaboration with the procurement staff) for project launch, ensuring the project achieves its intended innovation objectives, and coordinating the project evaluation and reporting to stakeholders.

Community Land Alliance Staff and Benefits (benefits are calculated at 35%)

Executive Director: 1 FTE ($144,200 + $50,470)= **$194,670** This position will provide primary oversight of the Community Land Alliance, consultants, and staff; development of a community land trust Board of Directors and By-Laws, financing models, family investment model, and sustainability model; cultivating housing projects.

Director of Property Management: 1 FTE (95,000 + 32,250)= **$128,250** This position will develop and integrate supportive housing property management policies and practices, existing best practices and the unique requirements created by the mixed funding sources, such as family/client ownership. Management of supportive housing properties requires unique approaches, workflows, and staffing. This positon will also require a real estate license, as per California law, in order to provide property management and supervise property staff.

Workforce Dev/Training Director: 1 FTE ($103,000 + $36,050)= **$139,050** This position will focus on ensuring staff involved with specific supportive housing projects have the supports and tools necessary to maximize the success of housing projects. Successful supportive housing projects require that staff members involved in specific projects clearly understand their role and responsibilities, have the supervision and support necessary to fulfill their roles, and have training, feedback, and skill development opportunities that enhance their work performance and job satisfaction.

Administrative Assistant: 1 FTE ($60,000 + $21,000)= **$81,000** This position will perform a variety of administrative and clerical tasks. Duties of the Administrative Assistant include providing support to the Executive Director and other Community Land Alliance staff, assisting in daily office needs and managing the agency's general administrative activities.

Total FY 19/20: All Salaries and Benefits=$745,638

FY 20/21:
Includes 3% COLA for ALL personnel listed below

Alameda County Staff Salary and Benefits (benefits are calculated at 50%)
BHCS Project Manager from the BHCS Housing Department: $153,578

Community Land Alliance Staff and Benefits (benefits are calculated at 35%)
Executive Director: $200,510
Director of Property Management: $132,098
Workforce Dev/Training Manager: $143,222
Administrative Assistant: $83,430

Total FY 20/21: All Salaries= $712,837

FY 21/22
Includes 3% COLA for ALL personnel listed below

Alameda County Staff Salary and Benefits (benefits are calculated at 50%)
BHCS Project Manager from the BHCS Housing Department: $158,186

Community Land Alliance Staff and Benefits (benefits are calculated at 35%)
Executive Director: $206,525
Director of Property Management: $136,061
Workforce Dev/Training Manager: $147,518
Administrative Assistant: $85,933

Total FY 21/22: All Salaries= $734,222

FY 22/23
Includes 3% COLA for ALL personnel listed below

Alameda County Staff Salary and Benefits (benefits are calculated at 50%)
BHCS Project Manager from the BHCS Housing Department: $162,931
Community Land Alliance Staff and Benefits (benefits are calculated at 35%)
Executive Director: $212,721
Director of Property Management: $140,142
Workforce Dev/Training Manager: $151,944
Administrative Assistant: $85,511
Total FY 21/22: All Salaries= $756,249

FY 23/24
Includes 3% COLA for ALL personnel listed below

Alameda County Staff Salary and Benefits (benefits are calculated at 50%)
BHCS Project Manager from the BHCS Housing Department: $167,819

Community Land Alliance Staff and Benefits (benefits are calculated at 35%)
Executive Director: $219,103
Director of Property Management: $144,347
Workforce Dev/Training Manager: $156,502
Administrative Assistant: $91,166

Total FY 21/22: All Salaries= $778,937

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Total Salaries and Benefits FY 19/20-23/24: $3,727,883
Total Indirect Costs (15%) FY 19/20-23/24: $559,182

TOTAL Personnel Costs: $4,287,066

Operating Costs

The operating costs of the Community Land Alliance are based on the standard County budgeting process where the total personnel costs are multiplied by 30% to closely estimate the operating costs of a new program. Once the project is up and running the operating costs may be adjusted, but funds will not exceed the budgeted request that the MHSOAC approves. Operational costs will include, but not limited to: rent, utilities, communications/phone service, technology maintenance, maintenance services, audit services, furniture, insurance, travel and transportation/mileage, training services, accounting/payroll.

FY 19/20: Total CBO personnel costs=$692,075 x 30%= $162,891
FY 20/21: Total CBO personnel costs=$712,837 x 30%= $167,778
FY 21/22: Total CBO personnel costs=$734,222 x 30%= $172,811
FY 22/23: Total CBO personnel costs=$756,249 x 30%= $177,995
FY 23/24: Total CBO personnel costs=$778,936 x 30%= $183,335

TOTAL Operating Costs (including 15% indirect costs): $994,532

Non Re-occurring Costs

FY 19/20: Incorporation and legal fees $10,000

FY 19/20 start-up costs: $75,000 This will include, but not limited to, furniture, computers, printers, cell phones, signage, first/last month's rent, internet/phone set up, photocopier, printed materials (business cards, agency brochure, etc.) initial software licenses, etc.

TOTAL Non Re-occuring Costs: $85,000

Consultants/Contractors

This project will entail contracting for various areas of expertise including: legal counsel, evaluation services, land trust consultants (including the Burlington Land Trust Association), real estate consultant, Restorative Economics consultant to assist with project management and strategic guidance for community-owned and community governed projects that are exploring new economic models-including sustainability of the land trust entity, expertise to develop multiple

agreements/templates such as ground lease, condominium ownership, master lease agreements, rent to own agreements, etc.

Consultation costs (excluding the evaluation) will initially be budgeted at the following amounts:

FY 19/20: $175,000
FY 20/21: $150,000
FY 21/22: $150,000
FY 22/23: $125,000
FY 23/24: $100,000

It should be noted that once the project starts the consultant costs may be adjusted, but funds will not exceed the budgeted request that the MHSOAC approves.

The evaluation costs will be budgeted at $45,000/yr x 5 years=$225,000

TOTAL Contractor/Consultant Costs (including 15% indirect costs): $805,000

Indirect Costs

As a standard practice Alameda County BHCS requests 15% for county administration of the project. This 15% rate has also been applied to the land Trust Alliance CBO that will be created-this percent for the CBO is in alignment and within the approved CBO limit for indirect costs. This 15% applies to Personnel, Operating and Contract expenditures to provide Human Resources, Accounting, Budgeting, Information Technology, Business Services Office, and Legal management of staff and contract positions; rent, utilities, insurance; and other expenses necessary to administer and implement the project.

TOTAL Indirect Costs across all Budget Categories: $793,904

Expend by Fund Source – Narrative

Administration

70% of Innovation Coordinator time= $25,362
70% of BHCS Project Manager time= $554,113
80% of Administrative Assistant time= $344,032
Indirect expenses (as stated above) = $793,904

Total = $1,717,431

Evaluation

30% of Innovation Coordinator time= $7,609
30% of BHCS Project Manager time= $237,486
30% of Administrative Assistant time= $86,008
Evaluator: $45,000/yr x 5 years=$225,000

Total = $556,102

B. New Innovative Project Budget By FISCAL YEAR (FY)*							
EXPENDITURES							
PERSONNEL COSTs (salaries, wages, benefits)		**FY 19-20**	**FY 20-21**	**FY 21-22**	**FY 22-23**	**FY 23-24**	**Total**
1	Salaries	**$745,638**	**$712,837**	**$734,222**	**$756,249**	**$778,937**	**$3,727,883**
2	Direct Costs						**$0**
3	Indirect Costs	**$ 111,846**	**$ 106,926**	**$ 110,133**	**$ 113,437**	**$ 116,840**	**$ 559,182**
4	Total Personnel Costs	**$857,484**	**$819,763**	**$844,356**	**$869,686**	**$895,777**	**$4,287,066**
OPERATING COSTs							**Total**
5	Direct Costs of Land Alliance CBO	**$ 162,891**	**$ 167,778**	**$ 172,811**	**$ 177,995**	**$ 183,335**	**$ 864,810**
6	Indirect Costs	**$ 24,434**	**$ 25,167**	**$ 25,922**	**$ 26,699**	**$ 27,500**	**$ 129,722**
7	Total Operating Costs	**$ 187,325**	**$ 192,944**	**$ 198,733**	**$ 204,695**	**$ 210,836**	**$ 994,532**
NON RECURRING COSTS (equipment, technology)		**FY 19-20**	**FY 20-21**	**FY 21-22**	**FY 22-23**	**FY 23-24**	**Total**
8	start up funds	**$75,000**					**$75,000**
9	Incorporation & legal fees	**$10,000**					**$10,000**
10	Total Non-recurring costs	**$85,000**	**$0**	**$0**	**$0**	**$0**	**$85,000**
CONSULTANT COSTS/CONTRACTS (clinical, training, facilitator, evaluation)		**FY 19-20**	**FY 20-21**	**FY 21-22**	**FY 22-23**	**FY 23-24**	**Total**
11	Direct Costs	**$175,000**	**$150,000**	**$150,000**	**$125,000**	**$100,000**	**$700,000**
12	Indirect Costs	**$26,250**	**$22,500**	**$22,500**	**$18,750**	**$15,000**	**$105,000**
13	Total Consultant Costs	**$201,250**	**$172,500**	**$172,500**	**$143,750**	**$115,000**	**$805,000**
OTHER EXPENDITURES (please explain in budget narrative)		**FY 19-20**	**FY 20-21**	**FY 21-22**	**FY 22-23**	**FY 23-24**	**Total**
14							**$0**
15							**$0**
16	Total Other expenditures	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
BUDGET TOTALS							
Personnel (line 1)		**$745,638**	**$712,837**	**$734,222**	**$756,249**	**$778,937**	**$3,727,883**
Direct Costs (add lines 2, 5 and 11 from above)		**$337,891**	**$317,778**	**$322,811**	**$302,995**	**$283,335**	**$1,564,810**
Indirect Costs (add lines 3, 6 and 12 from above)		**$162,529**	**$154,592**	**$158,555**	**$158,887**	**$159,341**	**$793,904**
Non-recurring costs (line 10)		**$85,000**	**$0**	**$0**	**$0**	**$0**	**$85,000**
Other Expenditures (line 16)		**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
TOTAL INNOVATION BUDGET		**$1,331,058**	**$1,185,207**	**$1,215,588**	**$1,218,131**	**$1,221,613**	**$6,171,599**

	C. *Expenditures By Funding Source and FISCAL YEAR (FY)*						
Administration:							
A.	**Estimated total mental health expenditures for ADMINISTRATION for the entire duration of this INN Project by FY & the following funding sources:**	**FY 19-20**	**FY 20-21**	**FY 21-22**	**FY 22-23**	**FY 23-24**	**Total**
1	Innovative MHSA Funds	$ 357,065	$ 328,841	$ 338,031	$ 343,747	$ 349,747	$ 1,717,431
2	Federal Financial Participation						
3	1991 Realignment						$ -
4	Behavioral Health Subaccount						$ -
5	Other funding*						
6	**Total Proposed Administration**	**$ 357,065**	**$ 328,841**	**$ 338,031**	**$ 343,747**	**$ 349,747**	**$ 1,717,431**
Evaluation:							
B.	**Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:**	**FY 19-20**	**FY 20-21**	**FY 21-22**	**FY 22-23**	**FY 23-24**	**Total**
1	Innovative MHSA Funds	$ 113,540	$ 107,759	$ 109,642	$ 111,581	$ 113,579	$ 556,102
2	Federal Financial Participation						$ -
3	1991 Realignment						$ -
4	Behavioral Health Subaccount						$ -
5	Other funding*						$ -
6	**Total Proposed Evaluation**	**$ 113,540**	**$ 107,759**	**$ 109,642**	**$ 111,581**	**$ 113,579**	**$ 556,102**
TOTAL:							
C.	**Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources:**	**FY 19-20**	**FY 20-21**	**FY 21-22**	**FY 22-23**	**FY 23-24**	**Total**
1	Innovative MHSA Funds	$ 1,331,058	$ 1,185,207	$ 1,215,588	$ 1,218,131	$ 1,221,613	$ 6,171,599
2	Federal Financial Participation						$ -
3	1991 Realignment						$ -
4	Behavioral Health Subaccount						$ -
5	Other funding*						$ -
6	**Total Proposed Expenditures**	**$ 1,331,058**	**$ 1,185,207**	**$ 1,215,588**	**$ 1,218,131**	**$ 1,221,613**	**$ 6,171,599**

*If "Other funding" is included, please explain.

AGENDA ITEM 3

Action

August 22, 2019 Commission Meeting

Awarding of the Transition Age Youth Stakeholder Contract

Summary: The Mental Health Services Oversight and Accountability Commission will consider awarding one stakeholder contract to the highest scoring applicant in response to the Request for Proposals for mental health advocacy on behalf of Transition Age Youth. The Commission will consider authorizing the Executive Director to act in accordance with the Commission's decision. The total amount available for the statewide advocacy organization is $500,000 in Year 1, $610,000 in Year 2, and $730,000 in Year 3 for a total of $1,840,000.

Background: The Commission oversees the activities of eight statewide stakeholder advocacy contracts funded under Welfare and Institution Code Section 5892(d). These contracts are funded by Mental Health Services Act State Administration dollars and focused on supporting the mental health needs of consumers, families, diverse communities, parents and caregivers, LGBTQ, transition aged youth, veterans, and immigrant and refugee communities through advocacy, education and training, and outreach and engagement efforts.

At its June of 2019 meeting the Commission approved the scope of work and minimum qualifications for the Request for Proposal and authorized the Executive Director to initiate a competitive bid process to make one award available to a state level advocacy organization who would then sub-contract with fifteen local-level organizations which provide advocacy, education and training, and outreach and engagement services on behalf of TAY populations in their communities.

The Request for Proposals were released on June 27, 2019. They were posted on Cal eProcure, the MHSOAC website, and were advertised through an email notification to the MHSOAC listserv.

Scope of Work

Proposers were asked to develop deliverables in response to the scope of work as outlined in the Request for Proposal in the following three priority areas:

- Advocacy
- Training and Education
- Outreach and Engagement

The statewide advocacy contractor will work in conjunction with local level entities which serve the TAY population to provide technical assistance and support to conduct training, outreach activities and advocacy meetings. The statewide advocacy contractor will also

be responsible to represent the needs of TAY through state-level advocacy and policy engagement. The statewide advocacy contractor will be responsible for the following:

- Provide state-level, statewide advocacy for mental health policies which support TAY wellness.
- Collaborate with local organizations to conduct advocacy visits with local decision makers and outreach events to the TAY community.
- Provide training and technical assistance to the local organizations to grow their capacity for ongoing advocacy efforts.
- Write a State of the Community report each year.
- Plan and implement a TAY-led statewide event each year in collaboration with the local level partner organizations.

The local program contractor will be responsible for the following:

- Collaborate with statewide advocacy contractor and local-level leadership to increase awareness of the specific MH needs of TAY.
- Assist in the planning and implementation of a community outreach event which is informed by TAY and provides information regarding access to mental health services, opportunities to partner with local organizations, and future training and education opportunities.
- Provide quantitative and qualitative event data which provides a count of participants and post event satisfaction survey results and conduct follow up advocacy activities.
- Provide statewide advocacy organization with relevant information on the needs of TAY and services provided in the local community for inclusion in the state-level organization's State of the Community report.

RFP Timeline

- June 27, 2019: RFP released to the public
- August 2, 2019: Deadline to submit proposals
- August 5-16: Multiple stage evaluation process to review and score proposals
- August 22, 2019: Results presented to the Commission

RFP Evaluation Process

The entire scoring process from receipt of proposals to posting of the Notice of Intent to Award is confidential. In accordance with the State of California standard competitive selection process, all proposals were evaluated in a multiple stage process.

Stage 1: Administrative Submission Review

Each proposal was reviewed by Commission staff for the presence of all required documents including certification that the proposer met all minimum requirements as listed in the RFP. This first Stage was scored on a pass/fail basis. Proposals that passed the requirements of Stage 1 moved to Stage 2. Proposals that did not meet the requirements of Stage 1 were deemed non-compliant and are not eligible to receive an award.

Stage 2: Technical Review
Proposals were scored by a review panel comprised of state agency subject matter experts during the Stage 2 evaluation. The panel reviewed and scored proposals on the following requirements:

- Background
- Work Plan
- References

The maximum points possible for this stage was 9,350 points.

Stage 3: Calculation of Proposer's Scores
Commission staff calculated the point totals for all proposals which were deemed eligible after Stage 1 to determine the total scores for each qualifying proposer.

Final selection is determined on the basis of the highest overall point score. The recommended award is to be made to the proposer receiving the highest overall point score.

RFP Award and Protest Process

Within five working days of the Commission's vote to award the contracts, unsuccessful proposers, wishing to protest the decision, must submit to the Commission an Intent to Protest letter. Within five working days after the Commission receives the Intent to Protest letter, the protesting proposer must submit a Letter of Protest detailing the grounds for protest. The Letter of Protest must describe the factors that support the protesting Proposer's claim that:

1. The protesting proposer would have been awarded the contract had the Commission correctly applied the prescribed evaluation rating standards in the RFP; or
2. The protesting proposer would have been awarded the contract had the Commission followed the evaluation and scoring methods in the RFP.

As outlined in the RFP, the MHSOAC Executive Director reviews the grounds for protest and renders a final decision.

Presenters:

- Tom Orrock, Chief of Grants, MHSOAC
- Michele Nottingham, Health Program Specialist I, MHSOAC

Enclosures (1): Power Point Presentation.

Handout: None.

MHSOAC
Mental Health Services
Oversight & Accountability Commission

Awarding of the Transition Age Youth Stakeholder Contract

Tom Orrock, Chief, Commission Grants
Michele Nottingham, Health Program Specialist I, MHSOAC

August 22, 2019
Agenda Item 2

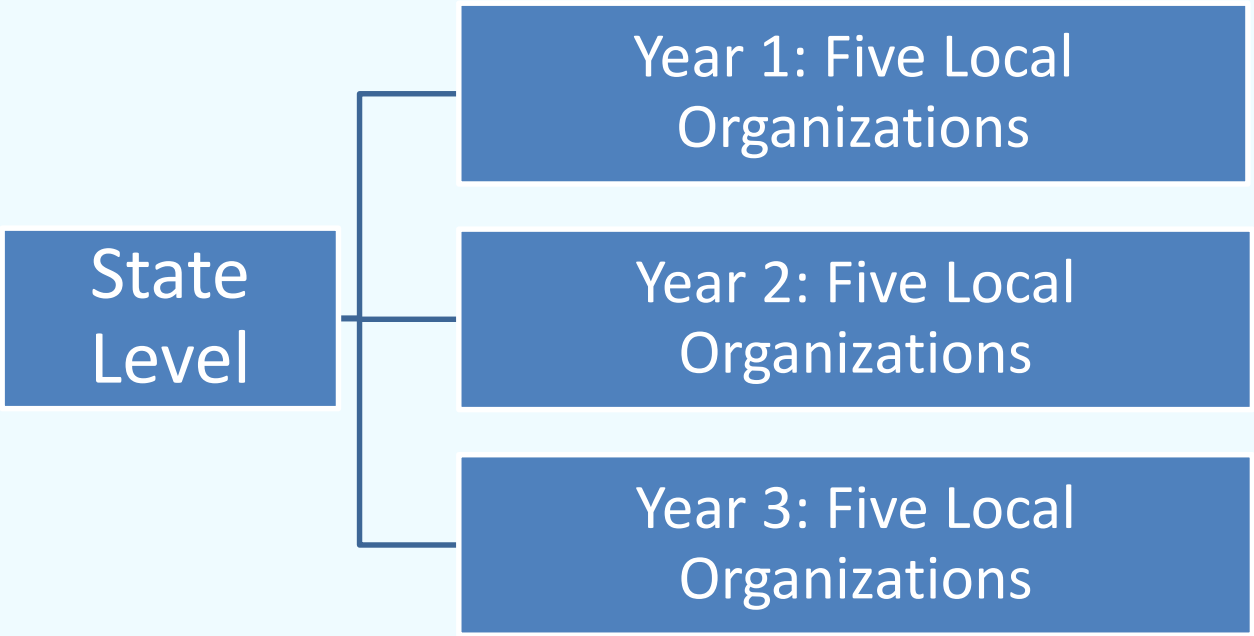
RFP Timeline

- June 27, 2019: RFP released to the public
- August 2, 2019: Deadline to submit proposals
- August 5-16: Multiple stage evaluation process to review and score proposals
- August 22, 2019: Results presented to the Commission
- October 2019: Anticipated start date

Background

- At the June 2019 Commission meeting the scope of work and minimum qualifications for the Transition Age Youth RFP were approved.
- One contract to a state-level advocacy organization of $1,840,000.

State/Local Collaboration



RFP Response

- The Commission received 5 proposals.
- Three more proposals than in previous TAY Requests for Proposals.

RFP Evaluation Process

The RFP contained the scoring requirements and rubric.

Stage 1: Administrative Submission Review

Stage 2: Technical Review

Stage 3: Calculation of Scores

As outlined in the RFP, the proposal with the highest overall score is recommended for an award.

Proposed Motion

For the organization with the highest scoring proposal, staff recommends the Commission:

- Authorize the Executive Director to issue a “Notice of Intent to Award Contract” to the highest scoring proposer.
- Establish August 29, 2019 as the deadline for unsuccessful bidders to file an “Intent to Protest” and September 6, 2019 as the deadline to file a letter of protest consistent with the requirements set forth in the RFP.
- Direct the Executive Director to notify the Commission Chair and Vice Chair of any protests within two working days of the filing and adjudicate protests consistent with the procedure provided in the Request for Proposals.
- Authorize the Executive Director to execute the contract upon expiration of the protest period or consideration of protests, whichever comes first.

AGENDA ITEM 4

Action

August 22, 2019 Commission Meeting

MHSOAC Conflict of Interest Code

Summary: The Commission will consider approving draft amendments to the MHSOAC's Conflict of Interest Code needed because of new staffing classifications.

California Fair Political Practices Commission (FPPC) requires every state entity, including the Commission, to conduct a biennial review of its conflict of interest code to determine if amendments are needed. The draft amendments are needed because of statewide changes in the classification names of staff positions and new hires. The amendments change who must report the specified economic interests on the Statement of Economic Interest (Form 700) but do not change the disclosure categories (i.e. the economic interests that must be reported).

Staff worked with the FPPC to develop the draft amendments to the Commission's conflict of interest code being considered at the August 22, 2019 meeting.

Background: Under the Political Reform Act, every state agency is required to have a conflict of interest code which identifies all agency officials and employees who make or participate in making governmental decisions. A conflict of interest code:

- designates the positions (i.e. who) is required to disclose specified economic interest on the Form 700
- assigns disclosure categories specifying the types of economic interest that must be disclosed on the Form 700

It is essential and legally required that an agency's conflict of interest code reflect the current structure of its organization, properly identify officials who should be filing Form 700, and assign disclosure categories specifying the types of financial interests that may create conflicts of interest.

Staff worked with the FPPC and determined that due to position changes an amendment to the conflict of interest code is necessary. Staff also worked with the FPPC to develop the draft amendments.

The following changes are proposed to the designated positions:

- Delete the “Mental Health Program Supervisor” and replace it with “Health Program Manager III” to better align with the scope and duties of the position.
- Delete the “Research Program Specialist (All levels)” and replace it with “Research Data Specialist (All levels)” because the Research Program Specialist series was abolished by the State and replaced with the Research Data Specialist.
- Add Health Program Specialist (All levels) to include new position authorized by the Budget.
- Delete the “Staff Information Systems Analyst” and replace it with “Information Technology Specialist (All levels)” because the Staff Information Systems Analyst was abolished by the State and replaced with the Information Technology specialist.

The draft amendments also update the code to align with the FPPC’s new electronic filing system.

The enclosed draft amended code shows the proposed new language in underline text and proposed deletions in strikethrough text.

Next Steps: If the Commission approves the draft amended code at the August 22, 2019 meeting, the next steps (i.e. rulemaking process) are as follows:

- There is a 45-day public comment period on the draft amendments.
- Upon completion of the comment period, the Commission at a future meeting decides whether to adopt the amendments as proposed.
- Once adopted, the amended code is filed with FPPC and the FPPC will have a 45-day public comment period on the Commission’s code.
- At the end of FPPC’s public comment period, the FPPC either approves the code as submitted by the Commission or returns it for revision.
- Once the code is approved by both the Commission and the FPPC, it is filed with the Office of Administrative Law (OAL) that forwards it to the Secretary of State’s Office (SOS) for official endorsement. The conflict of interest code is effective 30 days from the SOS’s endorsement date.

Presenter:

- Filomena Yeroshek, Chief Counsel

Enclosures (2): (1) Draft Amended MHSOAC Conflict of Interest Code; (2) Explanation of Changes.

Handouts: A PowerPoint presentation will be provided.

Proposed Motion: The Commission adopts the draft amendments to the conflict of interest code and authorizes the Executive Director to take the necessary steps to begin the rulemaking process and to submit the code with the supporting documentation as required by law.

Mental Health Services Oversight and Accountability Commission

DRAFT AMENDED

CONFLICT-OF-INTEREST CODE

The Political Reform Act (Government Code Section 81000, et seq.) requires state and local government agencies to adopt and promulgate conflict-of-interest codes. The Fair Political Practices Commission has adopted a regulation, 2 California Code of Regulations Section 18730 that contains the terms of a standard conflict-of-interest code, in an agency's code. After public notice and hearing, the standard code may be amended by the Fair Political Practices Commission to conform to amendments in the Political Reform Act. Therefore, the terms of 2 California Code of Regulations Section 18730 and any amendments to it duly adopted by the Fair Political Practices Commission are hereby incorporated by reference. This regulation and the attached Appendices designating positions and establishing disclosure categories, shall constitute the conflict-of-interest code of the **Mental Health Services Oversight and Accountability Commission** (MHSOAC).

~~Individuals holding designated positions shall file their statements of economic interests with the Mental Health Services Oversight and Accountability Commission, which will make the statements available for public inspection and reproduction. (Gov. Code Section 81008.) Upon receipt of the statement(s) of the Commission Members, and the Executive Director, the Mental Health Services Oversight and Accountability Commission shall make and retain copies and forward the original of the statement(s) to the Fair Political Practices Commission. All other statements will be retained by the Mental Health Services Oversight and Accountability Commission.~~

Commission members and the Executive Director shall file their statements of economic interests electronically with the **Fair Political Practices Commission**. All other individuals holding designated positions shall file their statements with the **MHSOAC**. All statements must be made available for public inspection and reproduction under Government Code Section 81008.

NOTE: authority cited: Sections 81008, 87300, 87306, Government Code. Reference: Section 87302, Government Code.

Mental Health Services Oversight and Accountability Commission
Conflict of Interest Code, Form 700 Designation

APPENDIX A
Designated Positions

Designated Positions	**Disclosure Category**
Commission Member	1, 2
Executive Director	1, 2
CEA (All levels)	1, 2
Staff Counsel (All levels)	1, 2
Consulting Psychologist	1, 2
Information Officer (All levels)	2
Research Scientist Supervisor (II)	2
Research Scientist (All levels)	2
Staff Services Manager (All levels)	1, 2
~~Mental Health Program Supervisor~~	~~1, 2~~
Health Program Manager (III)	1, 2
~~Research Program Specialist (All levels)~~	~~2~~
Research Data Specialist (All levels)	2
Health Program Specialist (All levels)	2
Staff Mental Health Specialist	2
Associate Governmental Program Analyst	2
~~Staff Information Systems Analyst~~	~~3~~
Information Technology Specialist (All levels)	3
Consultant and/or New Positions	*

*Consultants and/or New Positions shall be included in the list of designated employees and shall disclose pursuant to the broadest disclosure category in the code subject to the following limitations:

The Executive Director may determine in writing that a particular consultant and/or a New Position, although a "designated position," is hired to perform a range of duties that is limited in scope and thus is not required to fully comply with the disclosure requirements in this section. Such written determination shall include a description of the consultant's and/or New Position's duties and, based upon that description, a statement of the extent of disclosure requirements. This determination is a public record and shall be retained for public inspection in the same manner and location as this conflict-of-interest code.

Mental Health Services Oversight and Accountability Commission
Conflict of Interest Code, Form 700 Designation

APPENDIX B
Disclosure Categories

Disclosure Category 1
A person holding a position designated in Disclosure Category 1 must report all investments and business positions in business entities, and all income (including gifts, loans, and travel payments) from sources, that operate a program of the type approved by the MHSOAC including any program of the type providing mental health services to a local agency such as voluntary and outpatient services under a plan approved by the MHSOAC.

Disclosure Category 2
A person holding a position designated in Disclosure Category 2 must report all investments, and business positions in business entities, and all income (including gifts, loans, and travel payments) from sources of the type that provide services, equipment, materials, vehicles, supplies, to the MHSOAC including but not limited to:

- Contracts to evaluate the outcomes and performance of the Mental Health Services Act and the community mental health system
- Contracts related to Commission and Committee meetings and community forums such as court reporters/transcribers, interpreters, leased facilities, and public relations
- Contracts related to training, consulting, or stakeholder involvement

Disclosure Category 3
A person holding a position designated in Disclosure Category 3 must report all investments and business positions in business entities and all income (including gifts, loans, and travel payments) from sources, of the type that engage in the information technology field services of the type utilized by the MHSOAC including training and consulting.

Conflict of Interest Code for MHSOAC

Explanation of Changes

Conflict-of-Interest Code, Page 1

Description of Changes
The second paragraph was rewritten to update the code to align with the Fair Political Practices Commission's new electronic filing system for filers of the Form 700

Conflict-of-Interest Code, Appendix A, Page 2

Position	Description of Changes
Commission Member	No Change
Executive Director	No Change
CEA (All levels)	No Change
Staff Counsel (All levels)	No Change
Consulting Psychologist	No Change
Information Officer (All levels)	No Change
Research Scientist Supervisor (II)	No Change
Research Scientist (All levels)	No Change
Staff Services Manager (All levels)	No Change
Mental Health Program Supervisor	DELETE position. Reclassified to Health Program Manager III to better align with the scope and duties of the position.
Health Program Manager III	ADD position. New position, formerly Mental Health Program Supervisor. Reclassification was necessary to reflect the expanded scope and duties of the positon.
Research Program Specialist (All levels)	DELETE position. Abolished by CalHR's Research Data Series Consolidation Project, which was adopted by SPB on July 6, 2018 and effective August 1, 2018.

Position	Description of Changes
Research Data Specialist (All levels)	ADD position. Established by CalHR's Research Data Series Consolidation Project, which was adopted by SPB on July 6, 2018 and effective August 1, 2018. Formerly Research Program Specialist.
Staff Mental Health Specialist	No Change
Health Program Specialist (All Levels)	ADD position. New position. Health Program Specialist positions were first authorized for the MHSOAC in FY 2016-17 for the newly created Innovation Plan Review Unit.
Associate Governmental Program Analyst	No Change
Staff Information Systems Analyst	DELETE positon. Abolished by CalHR's Information Technology Consolidation Project, which was adopted by SPB on January 11, 2018 and effective January 31, 2018.
Information Technology Specialist (All levels)	ADD position. Established by CalHR's Information Technology Consolidation Project, which was adopted by SPB on January 11, 2018 and effective January 31, 2018. Formerly Staff Information Systems Analyst.
Consultant and/or New Positions	No Change

Conflict-of-Interest Code, Appendix B, Page 3

Description of Changes
No Change

AGENDA ITEM 5

Action

August 22, 2019 Commission Meeting

Legislative and Budgetary Priorities

Summary: The Commission will receive an update on legislative activities, consider support for additional legislation and discuss potential future budget priorities.

Background: The Legislature was on Summer Recess from July 12 to August 12 and Interim Recess begins September 13, leaving one month to finalize legislative priorities for the 2019 calendar year. The Governor and Legislature are finalizing decisions for the 2019-20 Fiscal Year and the State's budget process for the 2020-21 fiscal year begins in September.

The Commission has been asked by the authors to consider supporting the following bills: Assembly Bill 480 (Salas): Mental Health Older Adults and Senate Bill 665 (Umberg): Mental Health Services Fund: County Jails.

Assembly Bill 480 (Salas): Would establish, within the State Department of Health Care Services, an Older Adult Mental Health Services Administrator to oversee mental health services for older adults. AB 480 would require that position to be funded with administrative funds from the Mental Health Services Fund. The Administrator's responsibilities would include: developing outcome and related indicators for older adults to assess the status of mental health services for older adults, monitoring the quality of programs for those adults, and guiding decision making on how to improve those services. The Administrator also would work in close coordination and collaboration with the Commission, the California Department of Aging, county behavioral health departments, and other relevant entities and stakeholders.

Senate Bill 665 (Umberg): Would authorizes a county to use Mental Health Services Act (MHSA) funds to provide mental health services to persons incarcerated in a county jail for a conviction other than a felony and to persons subject to mandatory supervision. Under current law, MHSA funding cannot be used for persons in state prison, on state parole or persons in a county jail, with the exception of services for persons in a jail that are supportive of release planning. SB 665 would authorize County Supervisors, subject to the community planning provisions of the MHSA, to allow MHSA funds to be used to support services for persons in a county jail. However, MHSA funds could not be used for persons in jail with a felony conviction.

Presenter:

- Toby Ewing, Executive Director, MHSOAC

Enclosures (6):

- **Assembly Bill 480 (Salas)** Bill Text, Fact Sheet, Senate Health Committee Analysis.
- **Senate Bill 665 (Umberg)** Bill Text, Fact Sheet, Senate Health Committee Analysis.

Handout: None

AMENDED IN SENATE JUNE 25, 2019

AMENDED IN ASSEMBLY APRIL 22, 2019

AMENDED IN ASSEMBLY APRIL 11, 2019

CALIFORNIA LEGISLATURE—2019–20 REGULAR SESSION

ASSEMBLY BILL No. 480

Introduced by Assembly Member Salas

February 12, 2019

An act to add Article 5 (commencing with Section 5816) to Part 3 of Division 5 of the Welfare and Institutions Code, relating to mental health.

LEGISLATIVE COUNSEL'S DIGEST

AB 480, as amended, Salas. Mental health: older adults.

Existing law, the Mental Health Services Act (MHSA), an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, establishes the continuously appropriated Mental Health Services Fund to fund various county mental health programs, including the Adult and Older Adult Mental Health System of Care Act. Existing law authorizes the MHSA to be amended by a 2/3 vote of the Legislature if the amendments are consistent with, and further the purposes of, the MHSA, and also permits the Legislature to clarify procedures and terms of the MHSA by a majority vote.

This bill would establish within the ~~California Department of Aging~~ *State Department of Health Care Services* an Older Adult Mental Health Services Administrator to oversee mental health services for older adults. The bill would require that position to be funded with administrative funds from the Mental Health Services Fund. The bill would prescribe the functions of the administrator and its

responsibilities, including, but not limited to, developing outcome and related indicators for older adults for the purpose of assessing the status of mental health services for older adults, monitoring the quality of programs for those adults, and guiding decisionmaking on how to improve those services. The bill would require the administrator to receive data from other state agencies and departments to implement these provisions, subject to existing state or federal confidentiality requirements. The bill would require the administrator to report to the entities that administer the MHSA on those outcome and related indicators by July 1, 2022, and would authorize the administrator to make the report available to the Legislature, upon request. The bill would also require the administrator to develop a strategy and standardized training for all county mental health personnel in order for the counties to assist the administrator in obtaining the data necessary to develop the outcome and related indicators.

This bill would declare that it clarifies procedures and terms of the Mental Health Services Act.

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

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

SECTION 1. Article 5 (commencing with Section 5816) is added to Part 3 of Division 5 of the Welfare and Institutions Code, to read:

Article 5. The Older Adult Mental Health Services Administrator

5816. (a) There is within the ~~California Department of Aging~~ *State Department of Health Care Services* an Older Adult Mental Health Services Administrator who shall oversee mental health services for older adults. The administrator position shall be funded with administrative funds pursuant to, and shall act in accordance with the purposes described in, subdivision (d) of Section 5892.

(b) The Older Adult Mental Health Services Administrator shall work in close coordination and collaboration with stakeholders, including, but not limited to, the following:

(1) The Mental Health Services Oversight and Accountability Commission.

(2) The Director of ~~Health Care Services.~~ *the California Department of Aging.*

(3) County behavioral health services departments.

(4) Any other relevant stakeholders to ensure that older adults have access to necessary behavioral health services and supports.

(c) In order to fulfill duties to consumers and family members as well as the requirements for research and evaluation of mental health services and outcomes as described in subdivision (d) of Section 5892, the Older Adult Mental Health Services Administrator's responsibilities shall include, but shall not be limited to, the following:

(1) Service integration for mental health services for older adults.

(2) Determining which outcome and related indicators counties are currently collecting, and which current services are being offered.

(3) Developing outcome and related indicators for older adults, using existing data, for the purpose of assessing the status of mental health services for older adults, for monitoring the quality of programs intended to serve those older adults, and to guide decisionmaking on how to improve those services.

(4) Ensuring that indicators shall reflect the following issues, including, but not limited to, screenings and assessments of affective disorders, suicide risk and suicide rates, medication review, cognitive review and assessment, alcohol use and substance misuse, housing and independent living assessment, social connections and social isolation, consumer and family satisfaction with care, access to care overall and for diverse populations, continuity and integration of care, health services utilization such as psychiatric hospitalizations and emergency room use for mental and behavioral health care, the number of eligible older adults with a mental health service need compared with the number of eligible older adults who received services in the measurement year, and services provided on a regional basis to determine regional areas with the greatest need for services.

(5) To the extent that data does not exist to sufficiently determine the outcome and related indicators identified in paragraph (4), working with all relevant stakeholders to develop a strategy to identify high-level indicators, including, but not limited to, for those indicators from paragraph (4) that cannot be sufficiently defined using existing and available data.

(6) Utilization of the new outcome and related indicators to prepare and disseminate, on an annual basis, reports to the State Department of Health Care Services, the Mental Health Services Oversight and Accountability Commission, and counties that would also include, but are not limited to, numbers of older adults served by age, differences in age categorization of older adult groups served, and effectiveness of services.

(7) In close coordination and consultation with experts in the field, establishing a standardized geriatrics training module for mental health professionals that would include a plan to account for cultural, linguistic, ethnic, geographic, and socioeconomic diversity among the older adult population, and that address barriers and stigma experienced by older adult populations. The standardized training module shall be made available to mental health professionals and other providers.

(d) The Older Adult Mental Health Services Administrator shall receive any data, the access to which is not restricted by any state or federal law, that is necessary to develop outcome-related indicators as specified in paragraph (4) of subdivision (c), including, but not limited to, data held by other state agencies or departments.

(e) The Older Adult Mental Health Services Administrator shall maintain the confidentiality of information received pursuant to this section in a manner that is equal to the manner in which other state agencies or departments maintain the confidentiality of data.

(f) The Older Adult Mental Health Services Administrator may establish one or more advisory bodies to guide and inform the selection of outcome and related indicators and the strategy for developing and reporting those indicators. An existing state entity that involves diverse representation of older adults, including, but not limited to, the California Commission on Aging, may act as an advisory body for purposes of this section.

(g) The Older Adult Mental Health Services Administrator shall report to the entities listed in subdivision (d) of Section 5892, on or before July 1, 2022, all of the outcome and related indicators developed by the administrator pursuant to paragraph (4) of subdivision (c). The report shall also include recommendations on ways to establish a system for monitoring those indicators on a continual basis, including additional staffing or technology that might be necessary, and any regulatory or fiscal barriers that may

hinder future progress on the development of a monitoring system. The report may be made available to the Legislature, upon request by the Legislature.

(h) The Older Adult Mental Health Services Administrator shall also develop a strategy and standardized training for all county mental health personnel, including clinicians, involved in delivering Mental Health Services Act mental health care and prevention services to older adults in order for counties to assist the administrator in obtaining the data necessary to develop the outcome and related indicators specified in paragraph (4) of subdivision (c).

SEC. 2. The Legislature finds and declares that this act clarifies procedures and terms of the Mental Health Services Act within the meaning of Section 18 of the Mental Health Services Act.

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Assemblymember Rudy Salas, 32nd District

ASSEMBLY BILL 480 – MENTAL HEALTH SERVICES FOR OLDER ADULTS

FACT SHEET

BACKGROUND

According to the Centers for Disease Control and Prevention, it is estimated that 20 percent of people age 55 years or older experience some type of mental health concern.

Mental health issues that older adults face – which range from anxiety and depression to serious mental illness – can be complicated by other ailments and chronic diseases that are more common among older adults, such as dementia, heart disease, diabetes, arthritis, or cancer. Moreover, older adults diagnosed with a mental illness are more likely to develop chronic conditions and dementia as they age.

Mental health issues are often implicated as a factor in cases of suicide and, unfortunately, older adults also have the highest suicide rate in the country. Furthermore, the percentage increase in suicides from 1996 to 2016 in California has risen dramatically, notably among older adults. From 1991 to 2017, California saw a 58 percent increase in the number of suicides for those aged 65-84 and 50 percent for those 85 and older (compared with a 14.8 average increase statewide across all age groups). Suicide rates are particularly high in rural parts of California where access to mental health care is severely lacking.

In California, the older adult population will increase 64 percent by 2035 to 12 million adults age 60 and above. By that same time, the U.S. Census Bureau projects senior citizens will outnumber youth for the first time in our nation's history.

Mental health and well-being are as important for older adults as for any other age group. Therefore, it is critical that our state take steps to address this growing need.

ISSUE

Far too often older adults do not seek or receive the help they need, despite that fact that one in five older adults experience mental health concerns. By the age of 75, close to half of all Americans will have experienced a diagnosable mental disorder. The World Health Organization estimates that worldwide, 15 percent of adults age 60 and over live with mental illness.

However, according to a study conducted by the UCLA Center for Health Policy Research, less than one-third of all older adults in the United States who need mental health care receive it.

Undiagnosed and untreated mental health issues have a serious impact for older adults and their loved ones. The study conducted by the UCLA Center for Health Policy Research found a number of deficiencies in the current structure as it relates to mental health services for older adults. Among the deficiencies highlighted in the study, it found that: a) implementation of older adult mental health services is uneven; b) MHSA outcome reporting is inadequate for measuring the reach and effectiveness of services among older adults; c) there are significant and persistent deficits in the geriatrics workforce; d) there are numerous barriers to mental health services for older adults.

Given the rapidly growing segment of the state's population that is made up of older adults, and the significant and unique challenges that older adults face as it relates to mental health, it is critical that the state appoint a leader and adopt a plan to increase, improve and integrate mental health services for older adults.

EXISTING LAW

Under existing law, the Mental Health Services Act (MHSA), an initiative measure approved by voters as Proposition 63 in 2004, establishes the continuously appropriated Mental Health Services Fund to fund various mental health programs, including the Adult and Older Mental Health System of Care Act.

Since the passage of Prop. 63 until 2014, over $13 billion in the state's tax revenue has been allocated for public mental health services, yet a distinct administrative structure and specific funding older adult services are not mandated in MHSA, as they are for children under the age of 18.

Previously, there was a position within the California Department of Aging – the Geriatric Mental Health Specialist – that was funded by MHSA funds who was responsible for overseeing mental health services for older adults since 2007. However, this position no longer exists after state budget cuts in 2011 eliminated funding for the geriatric mental health specialist.

THIS BILL

This bill would establish an Older Adult Mental Health Services Administrator (Administrator) within the Department of Health Care Services to oversee mental health services for older adults, to be funded with administrative funds from the Mental Health Services Fund.

Specifically, the administrator would be responsible for increasing service integration, developing and identify outcome and related indicators, and establishing a standardized geriatrics training module for mental health professionals that would include a plan to account for cultural, linguistic, ethnic, geographic, and socioeconomic diversity.

SUPPORT

California Alliance for Retired Americans
California Assisted Living Association
California Association for Health Services at Home
California Behavioral Health Planning Council
California Commission on Aging
California Council of Community Behavioral Health Agencies
Contd. next page

Support contd:

California Hospital Association
California State Retirees
LeadingAge California
Steinberg Institute

FOR MORE INFORMATION

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SENATE COMMITTEE ON HEALTH
Senator Dr. Richard Pan, Chair

BILL NO:	AB 480
AUTHOR:	Salas
VERSION:	June 25, 2019
HEARING DATE:	July 3, 2019
CONSULTANT:	Reyes Diaz

SUBJECT: Mental health: older adults

SUMMARY: Creates an Older Adult Mental Health (MH) Services Administrator (Administrator) within the Department of Health Care Services who is required to oversee MH services for older adults. Sets forth various responsibilities for the Administrator, including working in close coordination and collaboration with various state and local entities, as specified.

Existing law:

1) Establishes the Bronzan-McCorquodale Act to organize and finance community MH services for those with MH disorders in every county through locally administered and controlled programs. [WIC §5600, et seq.]

2) Establishes the Medi-Cal program, administered by the Department of Health Care Services (DHCS), under which qualified low-income individuals receive health care services. [WIC §14001.1]

3) Requires DHCS to require counties to use available state and matching funds for specified client target populations, which includes adults and older adults who have a serious mental disorder, and to develop a comprehensive array of services, as specified. Requires DHCS to require counties that receive funding to develop interagency collaboration with shared responsibilities, including provision of interagency case management services to coordinate resources to target population members who are using the services of more than one agency [WIC §5805, 5807]

4) Requires DHCS, pursuant to the MHSA and in coordination with counties, to establish a program designed to prevent mental illnesses from becoming severe and disabling, and requires the program to emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness:

    a) Suicide;
    b) Incarcerations;
    c) School failure or dropout;
    d) Unemployment;
    e) Prolonged suffering;
    f) Homelessness; and,
    g) Removal of children from their homes. [WIC §5840]

5) Establishes the Mental Health Services Oversight and Accountability Commission (MHSOAC) to oversee the implementation of the Mental Health Services Act (MHSA), enacted by voters in 2004 as Proposition 63 to provide funds to counties to expand services, develop innovative programs, and integrate service plans for mentally ill children, adults, and seniors through a 1% income tax on personal income above $1 million. Requires the

MHSOAC to consist of 16 voting members, including a family member of an adult or senior with a severe mental illness. [WIC §5845]

6) Establishes the Mello-Granlund Older Californians Act, which establishes the Department of Aging (CDA), and sets forth its duties and powers, including, among other things, entering into a contract for the development of information and materials to educate Californians on the concept of aging in place. [WIC §9100, et seq.]

This bill:

1) Creates an Administrator within DHCS who is required to oversee MH services for older adults. Requires the Administrator's position to be funded by MHSA administrative funds, as specified.

2) Requires the Administrator to work in close coordination and collaboration with stakeholders, including, but not limited to, MHSOAC, CDA, county behavioral health services departments, and other relevant stakeholders, as specified.

3) Requires the Administrator's responsibilities to include, but not be limited to, the following:

    a) Service integration for MH services for older adults;
    b) Determining which outcome and related indicators counties collect, and services offered;
    c) Developing outcome and related indicators for older adults, as specified;
    d) Ensuring that indicators reflect such things as screenings and assessments of affective disorders, suicide risk and suicide rates, medication review, substance use and misuse, housing and independent living assessment, and social connections and isolation;
    e) Working with all relevant stakeholders to develop a strategy to identify high-level indicators, when information is not readily available, as specified;
    f) Utilization review of the new outcome and related indicators to prepare and disseminate annually to DHCS, the MHSOAC, and counties, as specified; and,
    g) Establishing a standardized geriatrics training module for MH professionals, in close coordination and consultation with experts, as specified, to be made available to MH professionals and other providers.

4) Requires the Administrator to receive any data, as permitted by state or federal law, necessary to develop outcome-related indicators, as specified, including data held by other state agencies or departments. Requires the Administrator to maintain the confidentiality of information received, as specified.

5) Permits the Administrator to establish one or more advisory bodies to guide and inform the selection of outcome and related indicators, and the strategy for developing and reporting those indicators. Permits an existing state entity, such as the California Commission on Aging, to act as an advisory body.

6) Requires the Administrator to report to DHCS, the California Behavioral Health Planning Council, the Office of Statewide Health Planning and Development, the MHSOAC, the Department of Public Health, and any other state agency that receives MHSA administrative funds on or before July 1, 2022, of all the outcome and related indicators developed by the Administrator, and to include recommendations on ways to establish a system for monitoring

those indicators, as specified. Permits the report to be made available to the Legislature, upon request.

7) Requires the Administrator to develop a strategy and standardized training for all county MH personnel, including clinicians, involved in delivering MHSA-funded MH care and prevention services to older adults in order for counties to assist the Administrator in obtaining the data necessary to develop the outcome and related indicators, as specified.

FISCAL EFFECT: According to the Assembly Appropriations Committee, as this bill was amended on April 22, 2019, with the Administrator within CDA:

1) Estimated one-time costs of up to $1million (General Fund [GF]) for CDA to develop the database that would collect specified MH-related data from a variety of sources. Additional annual costs in the range of $50,000 to $150,000 GF for ongoing maintenance of the database.

2) Estimated one-time costs in the range of $75,000 to $500,000 (Mental Health Services Fund [MHSF]), depending on the scope of work, for a consultant contract to provide expert guidance to the development of the geriatric training module and data collection and reporting training.

3) Estimated ongoing annual costs of approximately $686,000 MHSF to CDA for three positions to oversee and carry out the duties of the bill.

PRIOR VOTES:

Assembly Floor:	78 - 0
Assembly Appropriations Committee:	18 - 0
Assembly Health Committee	15 - 0
Assembly Aging and Long Term Care Committee:	7 - 0

COMMENTS:

1) *Author's statement.* According to the author, the Centers for Disease Control and Prevention estimates that 20% of people aged 55 years or older experience some type MH concern, but less than one-third of all older adults in the U.S. who need MH care receive it. In California, the older adult population will increase 64% by 2035 to 12 million adults aged 60 and above. By that same time, the U.S. Census Bureau projects seniors will outnumber youth for the first time in our nation's history. Given the rapidly growing segment of the state's population that is made up of older adults, and the significant and unique challenges that older adults face as it relates to MH, it is critical that the state appoint a leader and adopt a plan to increase, improve, and integrate MH services for older adults.

2) *MHSA.* The MHSA requires each county MH program to prepare and submit a three-year plan to DHCS that must be updated each year and approved by DHCS after review and comment by the MHSOAC. DHCS is required to provide guidelines to counties related to each component of the MHSA. In the three-year plans, counties are required to include a list of all programs for which MHSA funding is being requested and that identifies how the funds will be spent and which populations will be served. The MHSA provides funding for programs within five components:

a) *Community Services and Supports (CSS)*: Provides direct MH services to the severely and seriously mentally ill, such as MH treatment, cost of health care treatment, and housing supports. Regulations require counties to direct the majority of its CSS funds to Full-Service Partnerships (FSPs). FSPs are county coordinated plans, in collaboration with the client and the family, to provide the full spectrum of community services. These services consist of MH services and supports, such as peer support and crisis intervention services; and non-MH services and supports, such as food, clothing, housing, and the cost of medical treatment. Outside of FSPs, counties do not use CSS funds to assist with housing;
b) *Prevention and Early Intervention (PEI)*: Provides services to MH clients in order to help prevent mental illness from becoming severe and disabling;
c) *Innovation*: Provides services and approaches that are creative in an effort to address MH clients' persistent issues, such as improving services for underserved or unserved populations within the community;
d) *Capital Facilities and Technological Needs*: Creates additional county infrastructure such as additional clinics and facilities and/or development of a technological infrastructure for the MH system, such as electronic health records for MH services; and,
e) *Workforce Education and Training*: Provides training for existing county MH employees, outreach and recruitment to increase employment in the MH system, and financial incentives to recruit or retain employees within the public MH system.

SB 1004 (Wiener and Moorlach, Chapter 843, Statutes of 2018) requires, among other things, the MHSOAC, on or before January 1, 2020, to establish priorities for the use of PEI funds and to develop a statewide strategy for monitoring implementation of PEI services, including enhancing public understanding of PEI and creating metrics for assessing the effectiveness of how PEI funds are used and the outcomes that are achieved. SB 1004 also requires PEI funds in a county's three-year plan to focus on priorities established by the MHSOAC that include the following, at a minimum:

a) Childhood trauma prevention and early intervention to deal with the early origins of MH needs;
b) Early psychosis and mood disorder detection and intervention, and mood disorder and suicide prevention programming that occurs across the lifespan;
c) Youth outreach and engagement strategies that target secondary school and transition age youth, with a priority on partnership with college MH programs;
d) Culturally competent and linguistically appropriate prevention and intervention;
e) Strategies targeting the MH needs of older adults; and,
f) Other programs the MHSOAC identifies, with stakeholder participation, that are proven effective in achieving, and are reflective of, the goals of the MHSA.

3) *MH of older adults.* According to the World Health Organization, older adults (those aged 60 or above) make important contributions to society as family members, volunteers, and as active participants in the workforce. While most have good MH, many older adults are at risk of developing mental disorders, neurological disorders, or substance use problems, as well as other health conditions, such as diabetes, hearing loss, and osteoarthritis. Furthermore, as people age, they are more likely to experience several conditions at the same time. Between 2015 and 2050, the proportion of the world's older adults is estimated to almost double from about 12% to 22%, an expected increase from 900 million to two billion people over the age

of 60. Older people face special physical and MH challenges. Over 20% of adults aged 60 and over suffer from a mental or neurological disorder (excluding headache disorders), and 6.6% of all disability among people over 60 years is attributed to mental and neurological disorders. The most common mental and neurological disorders in this age group are dementia and depression, which affect approximately 5% and 7% of the world's older population, respectively. Anxiety disorders affect 3.8% of the older population, substance use problems affect almost 1%, and around a quarter of deaths from self-harm are among people aged 60 or above. Substance abuse problems among older people are often overlooked or misdiagnosed. MH problems are under-identified by health care professionals and older people themselves, and the stigma surrounding these conditions makes people reluctant to seek help.

4) *UCLA Center for Health Policy Research.* A study conducted by the UCLA Center for Health Policy Research, "California's Public Mental Health Services: How are Older Adults Being Served," found a number of deficiencies in the current structure as it relates to MH services for older adults, including that the availability of a complete system of services for older adults with mental illness is a work in progress and there is a need for programs to engage in targeted outreach specifically tailored to older adults. The study found that implementation of older adult MH services is uneven; MHSA outcome reporting is inadequate for measuring the reach and effectiveness of services among older adults; there are significant and persistent deficits in the geriatrics workforce; and, there are numerous barriers to MH services for older adults. The study concluded that California counties with a formal, designated older adult system of care offered more programming and services tailored to older adult needs than those without. The report recommended that such a dedicated system should be implemented in all counties.

5) *Governor's Master Plan for Aging.* On June 10, 2019, Governor Newsom signed Executive Order (EO) N-14-19 calling for the creation of a Master Plan for Aging to be developed by October 1, 2020, to serve as a blueprint that can be used by state government, local communities, private organizations, and philanthropy to build environments that promote healthy aging. The EO directs the Secretary of the California Health and Human Services Agency (CHHSA) to convene a cabinet-level Workgroup for Aging to advise the Secretary in developing and issuing the Master Plan. CHHSA, along with other state partners, will also convene a Master Plan for Aging Stakeholder Advisory Committee, which will include a Research Subcommittee and a Long-Term Care Subcommittee, with an interest in building an age-friendly California. These subcommittees are expected to include older Californians, adults with disabilities, local government representatives, health care providers, health plans, employers, community-based organizations, foundations, academic researchers, and organized labor. The Long-Term Care Subcommittee is tasked with issuing a report to the Governor by March 2020 on stabilizing state long-term care programs and infrastructure, including In-Home Supportive Services, with the full Master Plan completed by October 2020. The Workgroup's focus will go beyond the health and human services area to include transportation and housing issues and their impact on an individual's health outcomes and well-being, as well as focus outside of public programs as many older Californians do not utilize or have access to public programs and services the state administers.

6) *Double referral.* This bill was heard in the Senate Human Services Committee on June 10, 2019, and passed out by a vote of 5-0.

7) *Related legislation.* AB 1287 (Nazarian) requires CDA, in partnership with other specified departments and in consultation with stakeholders, to develop a plan and strategy for a phased statewide implementation of the No Wrong Door system, as specified. Requires CHHSA, in consultation with specified departments, to develop a universal tool and process to assess individual need and determine initial eligibility for programs and services available in the long-term services and supports delivery network. *AB 1287 is set to be heard in the Senate Human Services Committee on July 8, 2019.*

   AB 1382 (Aguiar-Curry) requires the state to develop a Master Plan for Aging, emphasizing workforce priorities, as provided in this section. Requires the Master Plan for Aging to prioritize the following issues related to preparing and supporting California's paid paraprofessionals, professionals, and unpaid family caregiver. *AB 1382 is set to be heard in the Senate Human Services Committee on July 8, 2019.*

   SB 228 (Jackson) requires the Governor to appoint a Master Plan Director (MPD) and establishes an Aging Task Force, as specified. Requires the MPD and the task force, to work with representatives from impacted state departments, stakeholders, and other agencies to identify the policies and priorities that need to be implemented in California to prepare for the aging of its population. *SB 228 was heard in the Assembly Aging and Long-Term Care Committee and passed by a vote of 7-0 on June 25, 2019.*

   SB 611 (Caballero) establishes the Master Plan for Aging Housing Task Force to, among other things, make recommendations to the Legislature for legislation that will help increase the supply of affordable housing for older adults and reduce barriers to providing health care and social services to older adults in affordable housing. *SB 611 is set to be heard in the Assembly Aging and Long-Term Care Committee on July 9, 2019.*

8) *Prior legislation.* SB 1004 (Wiener and Moorlach, Chapter 843, Statutes of 2018) among other things, requires the MHSOAC to establish priorities for the use of PEI funds to include, but are not limited to, early psychosis and mood disorder detection and intervention, and mood disorder and suicide prevention programming that occurs across the lifespan, and strategies targeting the MH needs of older adults.

9) *Support.* Supporters of this bill, largely MH and senior advocates, state that there currently is no behavioral health structure for older adults, and while one-in-five experience mental illness, less than one-third who need MH care receive it. Supporters argue that often mental wellness in older adults is overlooked in order to treat existing physical health needs, despite that mental and physical well-being are connected. Supporters also argue that as the aging population is expected to increase dramatically, coupled with a sharp increase in suicide rates among this population, it is critical to establish and prioritize geriatrics training for MH professionals.

10) *Policy comment*. While there is a stated need for attention to the aging population and their health care needs in general, it appears that there are existing methods for addressing the MH needs of the older adult population, particularly through the MHSOAC, the state's Commission on Aging, DHCS's existing responsibilities, the Governor's proposed Master Plan for Aging taskforce, and the recently enacted SB 1004, which prioritizes PEI funds to focus on various populations, including older adults. It is unclear why an Administrator focusing only on older adults and not all populations suffering mental illness is needed to

perform tasks that may be accomplished through increased coordination by existing entities focusing on MH issues and the aging population.

SUPPORT AND OPPOSITION:

Support: California Alliance for Retired Americans
California Assisted Living Association
California Association for Health Services at Home
California Behavioral Health Planning Council
California Commission on Aging
California Council of Community Behavioral Health Agencies
California Hospital Association
California State Retirees
LeadingAge California
Steinberg Institute

Oppose: None received

-- END --

AMENDED IN SENATE APRIL 23, 2019

AMENDED IN SENATE APRIL 10, 2019

SENATE BILL No. 665

Introduced by Senator Umberg

February 22, 2019

An act to amend Section 5813.5 of the Welfare and Institutions Code, relating to mental health, ~~and~~ making an appropriation ~~therefor.~~ *therefor, and declaring the urgency thereof, to take effect immediately.*

LEGISLATIVE COUNSEL'S DIGEST

SB 665, as amended, Umberg. Mental Health Services Fund: county jails.

Existing law, the Mental Health Services Act (MHSA), an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, funds a system of county mental health plans for the provision of mental health services. The MHSA establishes the continuously appropriated Mental Health Services Fund to fund various county mental health programs. Existing law prohibits MHSA funds from being used to pay for persons incarcerated in state prison or parolees from state prisons. The MHSA authorizes its provisions to be amended by the Legislature by a ⅔ vote of the Legislature if the amendment is consistent with and furthers the intent of the act, and authorizes the Legislature to clarify procedures and terms of the act by majority vote.

Existing law, the 2011 Realignment Legislation addressing public safety and related statutes, requires that certain specified felonies be punished by a term of imprisonment in a county jail, rather than the state prison, and provides for mandatory supervision, a period of

suspended execution of a concluding portion of the sentence that is supervised by the county probation officer.

This bill would authorize a county to use MHSA funds, if that use is included in the county plan, to provide services to persons who are incarcerated in a county jail or subject to mandatory supervision, except persons who are incarcerated in a county ~~jail, or subject to mandatory supervision,~~ *jail* for a conviction of a ~~felony.~~ *felony, except for purposes of facilitating discharge.* By allocating moneys in the Mental Health Services Fund for a new purpose, this bill would make an appropriation. The bill would also declare that ~~it clarifies procedures and terms~~ *this change is consistent with and furthers the intent* of the MHSA.

This bill would declare that it is to take effect immediately as an urgency statute.

Vote: ~~majority~~ *2/3*. Appropriation: yes. Fiscal committee: yes. State-mandated local program: no.

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

SECTION 1. Section 5813.5 of the Welfare and Institutions Code is amended to read:

5813.5. Subject to the availability of funds from the Mental Health Services Fund, the state shall distribute funds for the provision of services under Sections 5801, 5802, and 5806 to county mental health programs. Services shall be available to adults and seniors with severe illnesses who meet the eligibility criteria in subdivisions (b) and (c) of Section 5600.3. For purposes of this act, "seniors" means older adult persons identified in Part 3 (commencing with Section 5800) of this division.

(a) Funding shall be provided at sufficient levels to ensure that counties can provide each adult and senior served pursuant to this part with the medically necessary mental health services, medications, and supportive services set forth in the applicable treatment plan.

(b) The funding shall only cover the portions of those costs of services that cannot be paid for with other funds, including other mental health funds, public and private insurance, and other local, state, and federal funds.

(c) Each county mental health program's plan shall provide for services in accordance with the system of care for adults and

seniors who meet the eligibility criteria in subdivisions (b) and (c) of Section 5600.3.

(d) Planning for services shall be consistent with the philosophy, principles, and practices of the Recovery Vision for mental health consumers:

(1) To promote concepts key to the recovery for individuals who have mental illness: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination.

(2) To promote consumer-operated services as a way to support recovery.

(3) To reflect the cultural, ethnic, and racial diversity of mental health consumers.

(4) To plan for each consumer's individual needs.

(e) The plan for each county mental health program shall indicate, subject to the availability of funds as determined by Part 4.5 (commencing with Section 5890) of this division, and other funds available for mental health services, adults and seniors with a severe mental illness being served by this program are either receiving services from this program or have a mental illness that is not sufficiently severe to require the level of services required of this program.

(f) Each county plan and annual update pursuant to Section 5847 shall consider ways to provide services similar to those established pursuant to the Mentally Ill Offender Crime Reduction Grant Program. Notwithstanding any other law and consistent with subdivision (a) of Section 5891, funds may be used, if that use is included in the county plan pursuant to Section 5847, to provide services to persons who are incarcerated in a county jail or subject to mandatory supervision, except as otherwise provided in this subdivision. Funds shall not be used to pay for persons who are incarcerated in a county ~~jail, or subject to mandatory supervision,~~ *jail* for a conviction of a ~~felony~~ *felony, except for purposes of facilitating discharge,* or for persons incarcerated in the state prison or on parole from the state prison. If included in county plans pursuant to Section 5847, funds may be used for the provision of mental health services under Sections 5347 and 5348 in counties that elect to participate in the Assisted Outpatient Treatment Demonstration Project Act of 2002 (Article 9 (commencing with Section 5345) of Chapter 2 of Part 1).

(g) The department shall contract for services with county mental health programs pursuant to Section 5897. After November 2, 2004, the term "grants," as used in Sections 5814 and 5814.5 refers to those contracts.

~~SEC. 2. The Legislature finds and declares that this act clarifies procedures and terms of the Mental Health Services Act within the meaning of Section 18 of the Mental Health Services Act.~~

SEC. 2. The Legislature finds and declares that this act is consistent with and furthers the intent of the Mental Health Services Act within the meaning of Section 18 of the Mental Health Services Act.

SEC. 3. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the California Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to address the ongoing health issues inside of county jails and to further the alignment of state funding with new policies being proposed by county governments throughout California as soon as possible, it is necessary that this act take effect immediately.

O

TOM UMBERG

SENATOR, 34TH SENATE DISTRICT

SB 665: Mental Health Services Act: County Jails

SUMMARY

Senate Bill 665 will authorize a county to use certain Mental Health Services Act (MHSA) funds to provide mental health services to persons incarcerated in a county jail for a conviction other than a felony and to persons subject to mandatory supervision. SB 665 will also authorize the use of MHSA funds to provide re-entry mental health services to persons incarcerated in a county jail on a felony conviction.

BACKGROUND/EXISTING LAW

On November 2, 2004, California voters passed proposition 63, which enacted California's MHSA Although existing law expressly prohibits use of MHSA funds for provision of mental health services to persons incarcerated in state prison or parolees from state prison, it is silent on the use of these funds for provision of mental health services to persons incarcerated in county jails.

In Orange County, approximately 30% of the incarcerated population have a mental health issue. According to 2018 data from the Board of State and Community Corrections, approximately one fifth of county jail inmates throughout the state are taking psychotropic medications, a 25% increase since 2013.

With the number of those incarcerated who are suffering from a mental health issue and the limited funding sources for treatment services, it is critical to explore the flexibility of existing mental health funding sources. Therefore, funds should be provided to county jails, to help this population and to help reduce the recidivism rate among this vulnerable population.

SOLUTION

SB 665 will allow certain MHSA funds, such as the Community Support Services component, to be used to provide mental health services to people incarcerated in county jails. These mental health services can be provided to people who are incarcerated for a conviction other than a felony. Further, the person must meet the MHSA target population criteria specified in Welfare and Institutions Code Section 5006.3, subdivision (b). These MHSA funds will also be available to pay for re-entry mental health services to people incarcerated in a county jail on a felony conviction.

SUPPORT

Orange County Board of Supervisors (Sponsor)
Orange County Sheriff Don Barnes

FOR MORE INFORMATION

Zach Keller
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SENATE COMMITTEE ON HEALTH
Senator Dr. Richard Pan, Chair

BILL NO: SB 665
AUTHOR: Umberg
VERSION: April 23, 2019
HEARING DATE: July 10, 2019
CONSULTANT: Reyes Diaz

SUBJECT: Mental Health Services Fund: county jails

SUMMARY: Permits Mental Health Services Act funds to be used to provide services to persons incarcerated in county jails or subject to mandatory supervision, except for those convicted of a felony, as specified. Contains an urgency clause that will make this bill effective upon enactment.

Existing law:

1) Establishes the Mental Health Services Oversight and Accountability Commission (MHSOAC) to oversee the implementation of the Mental Health Services Act (MHSA), enacted by voters in 2004 as Proposition 63, to provide funds to counties to expand services, develop innovative programs, and integrate service plans for mentally ill children, adults, and seniors through a 1% income tax on personal income above $1 million. [WIC §5845]

2) Requires each county mental health program (CMHP) to prepare and submit a three-year program and expenditure plan, with annual updates, adopted by the county board of supervisors, to the MHSOAC and the Department of Health Care Services (DHCS) within 30 days after adoption. Requires the plan to include, among other things, programs for services to adults and seniors. [WIC §5847]

3) Requires DHCS, pursuant to the MHSA and in coordination with CMHPs, to establish a program designed to prevent mental illnesses from becoming severe and disabling, and requires the program to emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness:

    a) Suicide;
    b) Incarcerations;
    c) School failure or dropout;
    d) Unemployment;
    e) Prolonged suffering;
    f) Homelessness; and,
    g) Removal of children from their homes. [WIC §5840]

4) Prohibits MHSA funds from being used to pay for persons incarcerated in state prison or parolees from state prison. [WIC §5813.5]

5) Permits CMHPs to use MHSA funds from the Community Services and Supports (CSS) component for programs and services provided in juvenile hall and/or county jails only for the purpose of facilitating discharge. [9 CCR §3610(g)]

6) Requires a "health authority" in cooperation with the mental health (MH) director and facility administrator of a local detention facility/system, to establish policies and procedures to provide MH services, including identification and referral of inmates with MH needs,

treatment provided by qualified staff, crisis intervention services, and basic MH services as clinically indicated. Defines "health authority" to include a physician, an individual, or a health agency designated with responsibility for health care policy pursuant to a written agreement, contract, or job description. [15 CCR §1209, 1006]

This bill:

1) Permits MHSA funds, if included in a CMHP's plan, to be used to provide services to persons incarcerated in a county jail or subject to mandatory supervision, as specified.

2) Prohibits the use of funds to pay for persons who are incarcerated in a county jail for a conviction of a felony, except for purposes of facilitating discharge, or for persons incarcerated in state prison or on parole from state prison.

3) Contains an urgency clause for this bill to go into immediate effect in order to address the ongoing health issues inside of county jails.

4) Makes other technical, nonsubstantive changes.

FISCAL EFFECT: This bill has not been analyzed by a fiscal committee.

COMMENTS:

1) *Author's statement.* According to the author, the MHSA partly funds counties' MH system of care for certain adults and older adults. Although existing law expressly prohibits use of MHSA funds for provision of MH services to persons incarcerated in state prison or parolees from state prison, it is silent on use of these funds for services to persons incarcerated in county jails. Therefore, this bill would authorize a county to use MHSA funds to provide MH services to persons incarcerated in a county jail for a conviction other than a felony and to persons subject to mandatory supervision. This bill would also authorize use of MHSA funds to provide community re-entry MH services to persons incarcerated in a county jail on a felony conviction.

2) *MHSA.* The MHSA requires each CMHP to prepare and submit a three-year plan to DHCS that must be updated each year and approved by DHCS after review and comment by the MHSOAC. DHCS is required to provide guidelines to CMHPs related to each component of the MHSA. In the three-year plans, CMHPs are required to include a list of all programs for which MHSA funding is being requested and that identifies how the funds will be spent and which populations will be served. CMHPs also must submit their plans for approval to the MHSOAC before they can spend innovation program funds. The MHSA provides funding for programs within five components:

    a) *CSS*: Provides direct MH services to the severely and seriously mentally ill, such as treatment, cost of health care treatment, and housing supports. Regulations require CMHPs to direct the majority of CSS funds to Full-Service Partnerships (FSPs). FSPs are county-coordinated plans, in collaboration with the client and the family, to provide the full spectrum of community services. These services consist of MH services and supports, such as peer support and crisis intervention services; and non-MH services and supports, such as food, clothing, housing, and the cost of medical treatment;
    b) *Prevention and Early Intervention*: Provides services to MH clients in order to help prevent mental illness from becoming severe and disabling;

c) *Innovation*: Provides services and approaches that are creative in an effort to address MH clients' persistent issues, such as improving services for underserved or unserved populations within the community;
d) *Capital Facilities and Technological Needs*: Creates additional county infrastructure, such as additional clinics and facilities, and/or development of a technological infrastructure for the MH system, such as electronic health records for MH services; and,
e) *Workforce Education and Training*: Provides training for existing county MH employees, outreach, and recruitment to increase employment in the public MH system, and financial incentives to recruit or retain employees within the public MH system.

The MHSA requires that funds be used to pay for programs for children, adults and older adults, innovative programs, prevention and early intervention programs, and the No Place Like Home Program. The MHSA requires funds to be used to expand MH services and for funds to supplement, rather than supplant, other funding sources for MH services. The provision in existing law that permits CMHPs to use MHSA funds for programs and services provided in juvenile hall and/or county jails only for facilitating discharge has been interpreted differently by counties and is not specific about what constitutes facilitating discharge. DHCS issued Mental Health and Substance Use Disorder Services (MHSUDS) Information Notice 19-007 on February 26, 2019, which reiterates that those who are supervised by county probation departments are not considered parolees or inmates and thus are eligible for MHSA-funded services as long as requirements are met. The information notice also states that, when included in a county's three-year plan for the CSS component, counties may use MHSA funds to pay for MH services for those who are on county probation.

DHCS has indicated to Committee staff that, typically, facilitating discharge involves developing a plan to transition a person from an institutional setting to a community-based setting successfully. For example, CMHPs are required in their contracts to provide appropriate discharge planning for Medi-Cal beneficiaries receiving short-term and long-term hospital and institutional care in order to coordinate care between those institutional settings and community-based settings. Similarly, MHSA funding may be used to develop a discharge plan to ensure an individual incarcerated in a county jail is connected to appropriate community-based services that meet the individual's MH needs. DHCS states the discharge plan should be developed near the individual's anticipated release from the institution. Although there are not specific timeframe standards set to begin discharge planning in county jails using MHSA funds, discharge planning in similar situations typically begins around 30 days prior to the date of discharge. For example, Medi-Cal allows MH plans to be reimbursed for targeted case management services provided to someone in a hospital 30 days prior to the individual's discharge from the hospital. Understanding that a person's condition may change in that 30 days, requiring the individual to remain in the hospital longer than expected, MH plans may bill targeted case management for three nonconsecutive 30-day periods prior to discharge.

3) *MH and the incarcerated population.* According to the federal Substance Abuse and Mental Health Services Administration's (SAMHSA) 2017 "Guidelines for Successful Transition of People with Mental or Substance Use Disorders from Jail and Prison," jails and prisons house significantly greater proportions of individuals with mental, substance use, and co-occurring disorders than are found in the general public. While it is estimated that approximately 5% of people living in the community have a serious mental illness,

comparable figures in state prisons and jails are 16% and 17%, respectively. The prevalence of substance use disorders (SUDs) is notably more disparate, with estimates of 8.5% in the general public (aged 18 or older) but 53% in state prisons and 68% in jails. The co-occurrence of mental disorders and SUDs has been higher among people who are incarcerated in prisons or jails (33% to 60%) compared with people who are not incarcerated (14% to 25%). SAMHSA states that the high prevalence of mental disorders and SUDs in correctional settings produces poorer outcomes for both affected individuals and correctional agencies. Individuals with mental disorders and SUDs are less likely to make bail, and more likely to have longer jail stays, serve time in segregation during incarceration, and experience victimization or exploitation. Within jails and prisons, justice system personnel report that individuals with mental disorders or SUDs present with a range of physical, behavioral, and developmental conditions and exhibit greater difficulty coping with institutional rules. According to SAMHSA, upon release from jail or prison, many people with mental disorders or SUDs continue to lack access to services and too often become enmeshed in a cycle of costly justice system involvement. The days and weeks following community reentry are a time of heightened vulnerability.

4) *Related legislation.* SB 389 (Hertzberg) permits MHSA funds to be used to provide services to persons who are participating in a presentencing or postsentencing diversion program or who are on parole, probation, postrelease community supervision, or mandatory supervision. *SB 389 was heard in the Assembly Health Committee on June 25, 2019, and passed by a vote of 15-0.*

5) *Support.* The Orange County Board of Supervisors (OCBS) cites SAMHSA's guidelines for transitioning people with mental illness and SUDs from jail and prison to the community. OCBS cites many of the same statistics from SAMHSA related to the prevalence of those in jails and prison who experience mental illness and SUD, as well as the difficulty in accessing and receiving services once the individual is in the community. OCBS also states that expanding the eligible use of MHSA funds reduces net county cost expenditures for services provided to persons who are incarcerated or subject to mandatory supervision.

6) *Oppose unless amended.* The County Behavioral Health Directors Association of California (CBHDAC) states that, currently, the use of MHSA funding for individuals who are incarcerated is limited to discharge planning and related services. County behavioral health agencies work closely with justice partners to fund programs for the justice-involved population including, but not limited to: inmate discharge planning, mobile crisis response, forensic FSPs, MH court, and co-located staff with probation departments through a variety of funding streams. CBHDAC requests this bill be amended to test lifting the exclusion on services in county jail as a pilot program under MHSA Innovation funding, and requests the pilot be time-limited and rigorously evaluated to see if this new usage of MHSA funds reduces arrest rates and recidivism, and improves linkages to community treatment, housing attainment, and employment.

SUPPORT AND OPPOSITION:

Support: Orange County Board of Supervisors (sponsor)

Oppose: County Behavioral Health Directors Association of California (unless amended)

-- END --

AGENDA ITEM 6

Action

August 22, 2019 Commission Meeting

Budget Overview

Summary: The Commission will consider approval of its final Fiscal Year 2018-19 Operations Budget and its proposed Fiscal Year 2019-20 Operations Budget.

Background:

Fiscal Year 2018-19

The Commission will be presented with the final expenditures for its 2018-19 Budget. The total budget in 2018 was $36.5 million, which included a significant reduction for the Triage grant program in the amount of $12 million, an increase in the amount of $670,000 annually to support immigrants and refugees advocacy efforts and $2.5 million for the Innovation Incubator focusing on the Incompetent to Stand Trial population.

Fiscal Year 2019-20

The Commission's current budget for Fiscal Year 2019-20 is $121.8 million, which includes $105 million for local assistance (an increase of $85 million).

The local assistance budget includes:

- $20 million one-time funds for Early Psychosis Detection and Intervention;
- $15 million one-time funds to develop mental health drop-in centers for youth;
- $40 million one-time funds for partnerships between county mental or behavioral health departments and K-12 schools;
- $10 million ongoing funds to encourage collaboration between county mental health or behavioral health departments and K-12 schools; and
- $20 million ongoing funds for the Triage grant program.

The budget also includes $2.5 million for the Innovation Incubator and $5.4 million for stakeholder advocacy efforts.

Presenter: Norma Pate, Deputy Director

Enclosures: None.

Handouts (1): A PowerPoint will be provided at the meeting.

AGENDA ITEM 7

Information

August 22, 2019 Commission Meeting

Executive Director Report Out

Summary: Executive Director Ewing will report out on projects underway, on county Innovation plans approved through delegated authority and on other matters relating to the ongoing work of the Commission.

Presenter:

- Toby Ewing, Executive Director, MHSOAC

Enclosures (8): (1) Motions Summary from the May 24, 2019 Meeting; (2) Motions Summary from the June 10, 2019 Teleconference Meeting; (3) Evaluation Dashboard; (4) Innovation Dashboard; (5) County Presentation Guidelines; (6) Calendar of Tentative Agenda Items; (7) Department of Health Care Services Revenue and Expenditure Reports Status Update; (8) Legislative Report to the Commission.

Handouts: None.

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motions Summary
Commission Meeting
May 23, 2019

Motion #: 1

Date: May 23, 2019 **Time:** 9:41AM

Motion:

The Commission approves the April 25, 2019 meeting minutes as amended on pages 11, 17, and 23.

Commissioner making motion: Vice-Chair Ashbeck
Commissioner seconding motion: Commissioner Danovitch

Motion carried 6 yes, 0 no, and 2 abstain, per roll call vote as follows:

Name	Yes	No	Abstain
1. Commissioner Alvarez	☐	☐	☐
2. Commissioner Anthony	☒	☐	☐
3. Commissioner Beall	☐	☐	☐
4. Commissioner Berrick	☐	☐	☐
5. Commissioner Boyd	☐	☐	☐
6. Commissioner Brown	☐	☐	☒
7. Commissioner Bunch	☒	☐	☐
8. Commissioner Carrillo	☐	☐	☐
9. Commissioner Danovitch	☒	☐	☐
10. Commissioner Gordon	☐	☐	☐
11. Commissioner Madrigal-Weiss	☒	☐	☐
12. Commissioner Mitchell	☐	☐	☒
13. Commissioner Wooton	☐	☐	☐
14. Vice-Chair Ashbeck	☒	☐	☐
15. Chair Tamplen	☒	☐	☐

Motion #: 2

Date: May 23, 2019 **Time:** 11:26AM

Motion: The Commission approves the following Orange County's Innovation Plan with a requirement that the County submit an annual report to the Commission:

Name: Behavioral Health System Transformation

Additional Amount: Up to $18,000,000 in MHSA Innovation funds

Project Length: 3 years

Commissioner making motion: Commissioner Danovitch
Commissioner seconding motion: Commissioner Bunch

Motion carried 9 yes, 1 no, and 0 abstain, per roll call vote as follows:

Name	Yes	No	Abstain
1. Commissioner Alvarez	☐	☐	☐
2. Commissioner Anthony	☐	☐	☐
3. Commissioner Beall	☐	☐	☐
4. Commissioner Berrick	☒	☐	☐
5. Commissioner Boyd	☒	☐	☐
6. Commissioner Brown	☒	☐	☐
7. Commissioner Bunch	☒	☐	☐
8. Commissioner Carrillo	☐	☐	☐
9. Commissioner Danovitch	☒	☐	☐
10. Commissioner Gordon	☐	☐	☐
11. Commissioner Madrigal-Weiss	☒	☐	☐
12. Commissioner Mitchell	☐	☒	☐
13. Commissioner Wooton	☒	☐	☐
14. Vice-Chair Ashbeck	☒	☐	☐
15. Chair Tamplen	☒	☐	☐

Motion #: 3

Date: May 23, 2019 **Time:** 12:03PM

Motion: The Commission approves Ventura County's Innovation Project, as follows:

Name: Conocimiento: Addressing ACEs through Core Competencies

Additional Amount: Up to $1,047,100 in MHSA Innovation funds

Project Length: 4 years

Commissioner making motion: Commissioner Madrigal-Weiss
Commissioner seconding motion: Commissioner Berrick

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

Name	Yes	No	Abstain
1. Commissioner Alvarez	☐	☐	☐
2. Commissioner Anthony	☐	☐	☐
3. Commissioner Beall	☐	☐	☐
4. Commissioner Berrick	☒	☐	☐
5. Commissioner Boyd	☒	☐	☐
6. Commissioner Brown	☒	☐	☐
7. Commissioner Bunch	☒	☐	☐
8. Commissioner Carrillo	☐	☐	☐
9. Commissioner Danovitch	☒	☐	☐
10. Commissioner Gordon	☐	☐	☐
11. Commissioner Madrigal-Weiss	☒	☐	☐
12. Commissioner Mitchell	☒	☐	☐
13. Commissioner Wooton	☒	☐	☐
14. Vice-Chair Ashbeck	☒	☐	☐
15. Chair Tamplen	☒	☐	☐

Motion #: 4

Date: May 23, 2019 **Time:** 3:08PM

Motion: The Commission approves the following Los Angeles County's Innovation Project with a requirement to provide an update to the Commission in six months:

Name: The TRIESTE Project: True Recovery Innovation Embraces Systems That Empower

Additional Amount: Up to $116,750,000 in MHSA Innovation funds

Project Length: 5 years

Commissioner making motion: Commissioner Boyd

Commissioner seconding motion: Commissioner Wooton

Motion carried 8 yes, 1 no, and 0 abstain, per roll call vote as follows:

Name	Yes	No	Abstain
1. Commissioner Alvarez	☐	☐	☐
2. Commissioner Anthony	☐	☐	☐
3. Commissioner Beall	☐	☐	☐
4. Commissioner Berrick	☒	☐	☐
5. Commissioner Boyd	☒	☐	☐
6. Commissioner Brown	☒	☐	☐
7. Commissioner Bunch	☐	☐	☐
8. Commissioner Carrillo	☐	☐	☐
9. Commissioner Danovitch	☒	☐	☐
10. Commissioner Gordon	☐	☐	☐
11. Commissioner Madrigal-Weiss	☒	☐	☐
12. Commissioner Mitchell	☒	☐	☐
13. Commissioner Wooton	☒	☐	☐
14. Vice-Chair Ashbeck	☐	☒	☐
15. Chair Tamplen	☒	☐	☐

Motion #: 5
Date: May 23, 2019 **Time:** 4:22PM
Motion:
The MHSOAC adopts the following County Innovation plan approval process:

- Utilize a Consent Agenda:
  - A county Innovation plan for which staff analysis has identified no significant concerns or issues, including from public comments received by the Commission prior to the posting of the agenda, with the approval of the Commission Chair shall be placed on the Consent Agenda
  - Any Commissioner may without explanation remove a plan from the Consent Agenda prior to a vote
- The Commission authorizes the Executive Director, with the consent of the Commission Chair, to approve a county Innovation plan that meet any of the following conditions:
  - The county Innovation plan, plan extension or modification does not raise significant concerns or issues and includes total MHSA Innovation spending authority of $1,000,000 or less
  - The county Innovation plan is substantially similar to a county Innovation proposal that has been approved by the Commission within the past three years, if in the judgement of the Executive Director, differences in the county Innovation proposal and a previously approved plan are not material to concerns raised by the Commission in its previous review, are non-substantive, and the new project furthers the ability of the previously approved Innovation plan to support statewide transformational change.

  The Executive Director shall publicly report to the Commission, at the first available opportunity, any county Innovation plan approved by the Executive Director on behalf of the Commission.

Commissioner making motion: Commissioner Brown

Commissioner seconding motion: Commissioner Danovitch

Motion carried 7 yes, 0 no, and 1 abstain, per roll call vote as follows:

Name	Yes	No	Abstain
1. Commissioner Alvarez	☐	☐	☐
2. Commissioner Anthony	☐	☐	☐
3. Commissioner Beall	☐	☐	☐
4. Commissioner Berrick	☒	☐	☐
5. Commissioner Boyd	☒	☐	☐
6. Commissioner Brown	☒	☐	☐
7. Commissioner Bunch	☐	☐	☐
8. Commissioner Carrillo	☐	☐	☐
9. Commissioner Danovitch	☒	☐	☐
10. Commissioner Gordon	☐	☐	☐
11. Commissioner Madrigal-Weiss	☐	☐	☐
12. Commissioner Mitchell	☒	☐	☐
13. Commissioner Wooton	☐	☐	☒
14. Vice-Chair Ashbeck	☒	☐	☐
15. Chair Tamplen	☒	☐	☐

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motions Summary
Commission Meeting
June 10, 2019

Motion #: 1

Date: June 10, 2019

Motion:

- The Commission approves the proposed outline of the scope of work for the Transition Age Youth RFP and asks staff to work "TAY-led activities" language into the RFP.
- The Commission authorizes the Executive Director to initiate a competitive bid process.

Commissioner making motion: Commissioner Mitchell

Commissioner seconding motion: Commissioner Wooton

Motion carried 6 yes, 0 no, and 0 abstain, per roll call vote as follows:

Name	Yes	No	Abstain
1. Commissioner Alvarez	☒	☐	☐
2. Commissioner Anthony	☒	☐	☐
3. Commissioner Beall	☒	☐	☐
4. Commissioner Berrick	☐	☐	☐
5. Commissioner Boyd	☐	☐	☐
6. Commissioner Brown	☐	☐	☐
7. Commissioner Bunch	☐	☐	☐
8. Commissioner Carrillo	☐	☐	☐
9. Commissioner Danovitch	☐	☐	☐
10. Commissioner Gordon	☐	☐	☐
11. Commissioner Madrigal-Weiss	☐	☐	☐
12. Commissioner Mitchell	☒	☐	☐
13. Commissioner Wooton	☒	☐	☐
14. Vice-Chair Ashbeck	☐	☐	☐
15. Chair Tamplen	☒	☐	☐

Motion #: 2

Date: June 10, 2019

Motion:
The Commission authorizes the Executive Director to enter into four contracts as follows:

- **Regents of UC, San Francisco for research and evaluation support**
  - Not to exceed $1,161,008
- **Crusade, Inc. for website support**
  - Not to exceed $103,990
- **Tableau Software for data visualization software**
  - Not to exceed $130,079
- **Crossings TV for multicultural and multilingual commercials and segments**
  - Not to exceed $109,880

Commissioner making motion: Commissioner Berrick

Commissioner seconding motion: Commissioner Beall

Motion carried 7 yes, 0 no, and 0 abstain, per roll call vote as follows:

Name	Yes	No	Abstain
1. Commissioner Alvarez	☒	☐	☐
2. Commissioner Anthony	☒	☐	☐
3. Commissioner Beall	☒	☐	☐
4. Commissioner Berrick	☒	☐	☐
5. Commissioner Boyd	☐	☐	☐
6. Commissioner Brown	☐	☐	☐
7. Commissioner Bunch	☐	☐	☐
8. Commissioner Carrillo	☐	☐	☐
9. Commissioner Danovitch	☐	☐	☐
10. Commissioner Gordon	☐	☐	☐
11. Commissioner Madrigal-Weiss	☐	☐	☐
12. Commissioner Mitchell	☒	☐	☐
13. Commissioner Wooton	☒	☐	☐
14. Vice-Chair Ashbeck	☐	☐	☐
15. Chair Tamplen	☒	☐	☐

Summary of Updates

Contracts

New Contract: None

Total Contracts: **5**

Funds Spent Since the July Commission Meeting

Contract Number	Amount
17MHSOAC024	$13,650
17MHSOAC081	$0
17MHSOAC085	$0
18MHSOAC020	$4,975
18MHSOAC040	$0
Total	**$18,625**

Contracts with Deliverable Changes

17MHSOAC024

18MHSOAC020

The iFish Group: Hosting & Managed Services (17MHSOAC024)

MHSOAC Staff: Rachel Heffley

Active Dates: 12/28/17 - 9/30/19

Total Contract Amount: $423,943

Total Spent: $423,943

To provide hosting & managed services (HMS) such as Secure Data Management Platform (SDMP) & a Visualization Portal where software support will be provided for SAS Office Analytics, Microsoft SQL, Drupal CMS 7.0 Visualization Portal, & other software products. Support services & knowledge transfer will also be provided to assist MHSOAC staff in collection, exploration, & curation of data from external sources.

Deliverable	Status	Due Date	Change
Secure Data Management Platform	Complete	12/28/17	No
Visualization Portal	Complete	12/28/17	No
Data Management Support Services	Complete	09/30/19	Yes

Regents of University of California, Los Angeles: Population Level Outcome Measures (17MHSOAC081)

MHSOAC Staff: Katherine Elliot

Active Dates: 7/1/2018-7/31/2020

Total Contract Amount: $1,200,000

Total Spent: $385,300

The purpose of this project is to develop, through an extensive public engagement effort and background research process, support for datasets of preferred (recommended) & feasible (delivered) measures relating to

1) negative outcomes of mental illness
2) prevalence rates of mental illness by major demographic categories suitable for supporting the evaluation of disparities in mental health service delivery & outcomes
3) the impact(s) of mental health & substance use disorder conditions (e.g., disease burden),
4) capacity of the service delivery system to provide treatment and support,
5) successful delivery of mental health services
6) population health measures for mental health program client populations.

Deliverable	Status	Due Date	Change
Work Plan	Complete	09/30/18	No
Survey Development Methodology/Survey	Complete	12/31/18	No
Survey Data Collection/Results/Analysis of Survey	In Progress	3/30/20	No
Summary Report (3 Public Engagements)	Complete	3/30/19	No

MHSOAC Evaluation Dashboard Month August 2019
(Updated August 8th, 2019)

Deliverable	Status	Due Date	Change
Summary Report (3 Public Engagements)	In Progress	6/30/19	No
Outcomes Reporting Draft Report —3 Sections	Not Started	9/31/19	No
Outcomes Reporting Draft Report – 4 Sections	Not Started	12/31/19	No
Outcomes Reporting Final Report	Not Started	06/01/20	No
Outcomes Reporting Data Library & Data Management Plan	Not Started	06/01/20	No
Data Fact Sheets and Data Briefs	Not Started	06/01/20	No

Mental Health Data Alliance: FSP Pilot Classification & Analysis Project (17MHSOAC085)

MHSOAC Staff: Rachel Heffley

Active Dates: 07/01/18 - 12/31/19

Total Contract Amount: $234,279

Total Spent: $100,405

The intention of this pilot program is to work with a four-county sample (Amador, Fresno, Orange, & Ventura) to collect FSP program profile data, link program profiles to the FSP clients they serve, & model a key outcome (early exit from an FSP) as a function of program characteristics, service characteristics, & client characteristics

Deliverable	Status	Due Date	Change
Final Online Survey	Complete	02/04/19	No
FSP Program Data Sets	Complete	05/06/19	No
FSP Formatted Data Sets	In Progress	09/07/19	No
FSP Draft Report	Not Started	10/07/19	No
FSP Final Report	Not Started	12/09/19	No

The iFish Group: Hosting & Managed Services (18MHSOAC020)

MHSOAC Staff: Rachel Heffley

Active Dates: 01/01/19 - 12/31/19

Total Contract Amount: $310,743

Total Spent: $266,418

To provide hosting & managed services (HMS) such as Secure Data Management Platform (SDMP) & a Visualization Portal where software support will be provided for SAS Office Analytics, Microsoft SQL, Drupal CMS 7.0 Visualization Portal, & other software products. Support services & knowledge transfer will also be provided to assist MHSOAC staff in collection, exploration, & curation of data from external sources.

Deliverable	Status	Due Date	Change
Secure Data Management Platform	Complete	01/01/19	No
Data Management Support Services	In Progress	12/31/19	Yes

The Regents of the University of California, San Francisco: Partnering to Build Success in Mental Health Research and Policy (18MHSOAC040)

MHSOAC Staff: Dawnte Early

Active Dates: 07/01/19 - 06/30/21

Total Contract Amount: $1,161,008

Total Spent: $0

UCSF is providing onsite staff and technical assistance to the MHSOAC to support project planning, data linkages, and policy analysis activities.

Deliverable	Status	Due Date	Change
Quarterly Progress Report	Not Started	09/30/19	No
Quarterly Progress Report	Not Started	12/31/19	No
Quarterly Progress Report	Not Started	03/31/2020	No
Quarterly Progress Report	Not Started	06/30/2020	No
Quarterly Progress Report	Not Started	09/30/2020	No
Quarterly Progress Report	Not Started	12/31/2020	No
Quarterly Progress Report	Not Started	03/31/2021	No
Quarterly Progress Report	Not Started	06/30/2021	No

Mental Health Services
Oversight & Accountability Commission

INNOVATION DASHBOARD

AUGUST 2019

UNDER REVIEW	Final Proposals Received	Draft Proposals Received	TOTALS
Number of Projects	7	6	**13**
Participating Counties	6	3	**9**
Dollars Requested	$14,017,099	$10,739,118	**$24,756,217**

PREVIOUS PROJECTS	Reviewed	Approved	Total INN Dollars Approved	Participating Counties
FY 2014-2015	N/A	26	$128,853,402	16 (27%)
FY 2015-2016	N/A	23	$52,534,133	15 (25%)
FY 2016-2017	33	30	$68,634,435	18 (31%)
FY 2017-2018	34	31	$149,219,320	19 (32%)
FY 2018-2019	53	53	$303,143,420	32 (54%)

TO DATE	Reviewed	Approved*	Total INN Dollars Approved	Participating Counties
FY 2019-2020	UPCOMING	UPCOMING	UPCOMING	UPCOMING

* **Delegated**: UPCOMING
Consent: UPCOMING
Full Commission: UPCOMING

Total number of counties that have presented an INN Project since 2013:
56 (95%)

Average Time from Final Proposal Submission to Commission Deliberation†:
52 days

Definitions

Delegated Authority: Authorizes the Executive Director, with the consent of the Chair, to approve county projects that meet any of the following conditions: Project budget of $1,000,000 or less, or county project proposes to join an existing project

Consent Agenda: For projects over $1,000,000 and limited to plans for which staff analysis has identified no significant concerns, including from public comment; requires approval of the chair; allows any Commissioner to remove the plan from the consent calendar prior to vote

Full Commission: For any project in which staff analysis or any Commissioner deems it necessary for the county to present before the Commission for live deliberation and vote

FY: Fiscal Year (July 1st – June 30th)

† This excludes extensions of previously approved projects, Tech Suite additions, and government holidays.

PROJECT DETAILS

FINAL PROPOSALS						
STATUS	COUNTY	PROJECT NAME	FUNDING AMOUNT REQUESTED	PROJECT DURATION	DRAFT PROPOSAL SUBMITTED TO MHSOAC	FINAL PROJECT SUBMITTED TO MHSOAC
Under Review	Glenn	Crisis Response and Community Connections (CRCC)	$787,535	5 Years	3/26/2019	5/31/2019
Under Review	Siskiyou	Integrated Care Project	$518,180	5 Years	2/14/2019	4/19/2019
Under Review	Alameda	Supportive Housing Community Land Alliance (CLA)	$6,171,599	5 Years	11/2/2018	7/22/2019
Under Review	Sutter-Yuba	Innovative and Consistent Application of Resources and Engagement (iCARE)	$5,228,688	5 Years	5/6/2019	6/17/2019
Under Review	Napa	Statewide Early Psychosis Learning Health Care Network	$251,286	5 Years	4/30/2019	7/16/2019
Under Review	San Luis Obispo	San Luis Obispo Threat Assessment Program (SLOTAP)	$559,811	4 Years	3/21/2019	7/25/2019
Under Review	San Luis Obispo	Holistic Adolescent Health	$500,000	4 Years	3/21/2019	7/25/2019

DRAFT PROPOSALS						
STATUS	COUNTY	PROJECT NAME	FUNDING AMOUNT REQUESTED	PROJECT DURATION	DRAFT PROPOSAL SUBMITTED TO MHSOAC	FINAL PROJECT SUBMITTED TO MHSOAC
Under Review	Colusa	Social Determinants of Rural Mental Health Project	$161,200	3 Years	8/30/2018	Pending
Under Review	El Dorado	Partnership Between Senior Nutrition & Behavioral Health to Reach Home Bound Older Adults in Need of Mental Health Services	$450,000	2 Years	4/30/2019	Pending
Under Review	El Dorado	HUBS Project	$2,158,704	1 Year	4/30/2019	Pending
Under Review	Stanislaus	MoPride It's My Life: Social Self-Directed Care (IML)	$2,546,955	5 Years	7/5/2019	Pending
Under Review	Stanislaus	NAMI On Campus High School	$923,259	5 Years	7/5/2019	Pending
Under Review	Stanislaus	Whole Health Approach to Improve Mental Health Outcomes	$4,499,000	5 Years	7/5/2019	Pending

Mental Health Services
Oversight & Accountability Commission

COMMISSION MEETING PRESENTATION GUIDELINES

These recommendations for innovation plan presentations have been developed to support the dialogue between the Commission and the counties. Please note that the recommendations below regarding length, the county brief, PowerPoint presentation and presenter information are to ensure that counties and the Commission have ample opportunity to engage in a dialogue to gain a better understanding of the needs in the county, how the innovation plan meets those needs, why it is innovative and how will it be evaluated to support shared learning.

1. **Length of Presentation**
    a. County presentations should be no more than 10-15 minutes in length
    b. The Commission will have received the Innovation Project Plan as well as the Staff Analysis prior to the meeting
    c. The remaining time on the agenda is reserved for dialogue with the Commission and for public comment

2. **County Brief**
    a. Recommend 2-4 pages total and should include the following three (3) items:
        i. Summary of Innovation Plan / Project
        ii. Budget
        iii. Address any areas indicated in the Staff summary

3. **PowerPoint Presentation**
    a. Recommend 5 slides and include the following five (5) items:
        i. Presenting Problem / Need
        ii. Proposed Innovation Project to address need
        iii. What is innovative about the proposed Innovation Project? How will the proposed solution be evaluated (learning questions and outcomes)?
        iv. Innovation Budget
        v. If successful, how will Innovation Project be sustained?

4. **Presenters and Biographies**
    a. We request no more than a few (2-4) presenters per Innovation Project
        i. If the county wishes to bring more presenters, support may be provided during the public comment period
    b. Recommend biography consisting of brief 1-2 sentences for individuals presenting in front of the Commission
        i. Include specific names, titles, and areas of expertise in relation to Innovation Plan / Project

Note: Due dates will be provided by Innovation Team upon Commission calendaring for the following items: Presenter Names, Biographies, County Brief, and PowerPoint presentation.

Calendar of Tentative Commission Meeting Agenda Items

Proposed 08/12/19

Agenda items and meeting locations are subject to change

September 26: Sacramento, CA

- **Innovation Projects**
  The Commission will consider approval of county Innovation plans.
- **Suicide Prevention Strategic Plan**
  The Commission will be presented with the draft of the statewide Suicide Prevention Strategic Plan.
- **Rules of Procedure**
  The Commission will consider revisions to the Rules of Procedure.
- **Draft Strategic Plan**
  The Commission will be presented with the draft MHSOAC Strategic Plan.
- **Executive Director Report Out**
  The Executive Director will report out on projects underway and other matters relating to the ongoing work of the Commission.

October 24: San Diego, CA

- **Workplace Mental Health Project**
  Panel presentation on the Commission's SB 1113 project on voluntary standards for Mental Health in the Workplace.
- **School Mental Health Policy Project**
  The Commission will be presented with a draft of the School Mental Health Policy Project findings.
- **Innovation Projects**
  The Commission will consider approval of county Innovation plans.
- **Executive Director Report Out**
  The Executive Director will report out on projects underway and other matters relating to the ongoing work of the Commission.

November 21: TBD

- **SB 1004 Prevention and Early Intervention Project**
  The Commission will hear panel presentations on statewide PEI priorities, evaluation strategies, and technical assistance strategies. *[Tentative]*
- **Suicide Prevention Strategic Plan**
  The Commission will be presented with the Final Statewide Suicide Prevention Strategic Plan.
- **Innovation Projects**
  The Commission will consider approval of county Innovation plans.
- **Executive Director Report Out**
  The Executive Director will report out on projects underway and other matters relating to the ongoing work of the Commission.

December: No Meeting Scheduled

DHCS Status Chart of County RERs Received
August 22, 2019 Commission Meeting

Attached below is a Status Report from the Department of Health Care Services regarding County MHSA Annual Revenue and Expenditure Reports received and processed by Department staff, dated August 9, 2019.

This Status Report covers the FY 2014-15 through FY 2017-18 County RERs.

For each reporting period, the Status Report provides a date received by the Department of the County's RER and a date on which Department staff completed their "Final Review."

The Department provides MHSOAC staff with weekly status updates of County RERs received, processed, and forwarded to the MHSOAC. MHSOAC staff process data from County RERs for inclusion in the Fiscal Reporting Tool only after the Department determines that it has completed its Final Review.

The Department also publishes on its website a web page providing access to County RERs. This page includes links to individual County RERs for reporting years FY 2006-07 through FY 2015-16. This page can be accessed at: http://www.dhcs.ca.gov/services/MH/Pages/Annual-Revenue-and-Expenditure-Reports-by-County.aspx. Additionally, County RERs for reporting years FY 2016-17 through FY 2017-18 can be accessed at the following webpage: http://www.dhcs.ca.gov/services/MH/Pages/Annual_MHSA_Revenue_and_Expenditure_Reports_by_County_FY_16-17.aspx.

Counties also are required to submit RERs directly to the MHSOAC. The Commission provides access to these reports through its Fiscal Reporting Tool at http://mhsoac.ca.gov/fiscal-reporting for Reporting Years FY 2012-13 through FY 2016-17 and a data reporting page at http://mhsoac.ca.gov/documents?field_county_value=All&date_filter%5Bvalue%5D%5Byear%5D=&field_component_tid=46.

On July 1, 2018 DHCS published a report detailing MHSA funds subject to reversion for allocation years FY 2005-06 through FY 2014-15 to satisfy Welfare and Institutions Code (W&I), Section 5892.1 (b). The report details all funds deemed reverted and reallocated to the county of origin for the purpose the funds were originally allocated. The report can be accessed at the following webpage: http://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/MHSA_Reversion_Funds_Report.pdf

DHCS MHSA Annual Revenue and Expenditure Report Status Update

	FY 14-15		FY 15-16		FY 16-17			FY 17-18		
County	Electronic Copy Submission Date	Final Review Completion Date	Electronic Copy Submission Date	Final Review Completion Date	Electronic Copy Submission Date	Return to County Date	Final Review Completion Date	Electronic Copy Submission Date	Return to County Date	Final Review Completion Date
Alameda	9/14/2017	9/29/2017	9/29/2017	9/29/2017	1/2/2018		1/3/2018	3/25/2019	3/26/2019	4/9/2019
Alpine	6/26/2017	6/26/2017	11/22/2017	11/27/2017	7/23/2018		7/23/2018	5/10/2019	5/13/2019	5/15/2019
Amador	3/27/2017	3/27/2017	4/7/2017	4/10/2017	4/12/2018		4/13/2018	12/19/2018	12/19/2018	12/21/2018
Berkeley City	5/2/2016	7/26/2016	4/13/2017	4/13/2017	1/25/2018		2/1/2018	12/28/2018	1/2/2019	1/8/2019
Butte	4/4/2016	6/23/2016	4/17/2017	4/18/2017	5/4/2018		5/7/2018	6/26/2019		6/26/2019
Calaveras	1/4/2016	1/13/2016	4/18/2017	4/19/2017	6/1/2018	6/14/2018	7/20/2018	1/10/2019		1/11/2019
Colusa	1/8/2016	2/10/2016	5/17/2017	5/17/2017	5/8/2018		5/9/2018	3/28/2019	4/25/2019	4/30/2019
Contra Costa	3/8/2016	3/14/2016	4/17/2017	4/18/2017	12/29/2017	1/5/2018	1/24/2018	12/31/2018	1/7/2019	1/22/2019
Del Norte	5/13/2016	5/16/2016	4/17/2017	5/19/2017	2/23/2018		2/26/2018	12/31/2018		1/2/2019
El Dorado	2/9/2016	2/11/2016	4/17/2017	4/19/2017	12/29/2017	1/5/2018	1/24/2018	12/28/2018	1/3/2019	1/25/2019
Fresno	12/14/2015	12/18/2015	4/17/2017	4/18/2017	12/29/2017	1/8/2018	5/7/2018	12/28/2018	1/2/2019	1/2/2019
Glenn	3/17/2016	3/24/2016	7/20/2017	7/20/2017	2/22/2018		2/22/2018	12/31/2018	1/7/2019	2/11/2019
Humboldt	9/30/2016	10/3/2016	4/13/2017	4/18/2017	12/21/2017	1/3/2018	4/25/2018	12/20/2018	12/21/2018	1/2/2019
Imperial	12/31/2015	1/4/2016	4/27/2017	4/27/2017	12/28/2017		1/9/2018	12/26/2018		1/2/2019
Inyo	2/24/2016	2/24/2016	5/9/2017	5/9/2017	7/6/2018		7/9/2018	3/19/2019	3/20/2019	3/22/2019
Kern	10/31/2016	10/31/2016	5/30/2017	2/7/2018	1/30/2018		2/7/2018	1/4/2019		1/7/2019
Kings	4/7/2016	5/2/2017	5/2/2017	5/24/2017	1/29/2018		1/29/2018	1/31/2019	2/4/2019	2/11/2019
Lake	7/25/2018	7/26/2018	7/25/2018	7/26/2018	9/12/2018	9/12/2018	7/2/2019	7/12/2019		7/16/2019
Lassen	9/21/2016	9/29/2016	5/18/2017	5/25/2017	5/14/2018	5/16/2018	7/23/2018	1/8/2019	1/14/2019	1/31/2019
Los Angeles	4/20/2017	4/21/2017	1/31/2018	2/1/2018	6/29/2018	7/2/2018	7/20/2018	12/31/2018	1/14/2019	1/29/2019
Madera	12/6/2016	12/7/2016	5/12/2017	6/13/2018	3/27/2018	6/14/2018	7/26/2018	12/31/2018	1/7/2019	2/4/2019
Marin	10/21/2016	10/21/2016	5/10/2017	5/11/2017	1/31/2018		2/1/2018	12/21/2018	12/21/2018	12/21/2018
Mariposa	9/23/2016	9/28/2016	5/18/2017	5/19/2017	3/14/2018		3/14/2018	12/20/2018	1/3/2019	1/31/2019
Mendocino	5/31/2017	5/31/2017	8/31/2017	8/31/2017	4/27/2018		4/30/2018	12/31/2018		1/3/2019
Merced	3/28/2017	3/29/2017	7/21/2017	7/21/2017	2/1/2018		2/1/2018	12/21/2018	12/21/2018	12/31/2018
Modoc	3/24/2016	3/25/2016	4/17/2017	4/19/2017	4/20/2018		4/23/2018	1/16/2019	1/16/2019	1/24/2019
Mono	3/30/2016	4/6/2016	4/25/2017	6/20/2017	5/18/2018	5/22/2018	6/13/2018	12/28/2018	1/3/2019	1/17/2019
Monterey	3/29/2018	4/23/2018	10/4/2018	10/4/2018	10/4/2018		10/4/2018	3/5/2019	3/6/2019	
Napa	8/18/2017	8/25/2017	11/9/2017	11/13/2017	5/15/2018		5/15/2018	12/28/2018	1/2/2019	1/4/2019
Nevada	6/21/2018	6/21/2018	7/20/2018	7/25/2018	8/13/2018		8/13/2018	12/21/2018		12/21/2018
Orange	12/30/2015	12/30/2015	12/27/2016	4/13/2017	12/29/2017	1/17/2018	1/25/2018	12/28/2018	1/2/2019	1/31/2019
Placer	11/15/2016	11/17/2016	4/14/2017	4/18/2017	12/22/2017		1/23/2018	1/18/2019		1/22/2019
Plumas	6/8/2017	6/23/2017	3/27/2018	3/28/2018	10/8/2018		10/15/2018			
Riverside	5/12/2017	5/15/2017	6/9/2017	6/12/2017	12/29/2017	1/24/2018	1/25/2018	12/31/2018		1/29/2019
Sacramento	5/8/2017	5/8/2017	6/19/2017	6/20/2017	12/29/2017	1/24/2018	1/25/2018	12/31/2018	1/2/2019	1/2/2019
San Benito	10/24/2016	3/8/2016	9/8/2017	9/12/2017	9/25/2018		9/27/2018	3/8/2019	3/8/2019	3/18/2019
San Bernardino	5/19/2016	5/19/2016	5/1/2017	5/1/2017	6/29/2018		7/2/2018	12/31/2018		1/2/2019
San Diego	12/18/2015	5/26/2017	5/26/2017	5/26/2017	5/11/2018		6/11/2018	12/26/2018		1/15/2019
San Francisco	3/4/2016	3/4/2016	7/5/2017	9/18/2017	3/21/2018		3/27/2018	12/31/2018	1/3/2019	1/30/2019
San Joaquin	6/8/2017	6/13/2017	10/3/2017	10/4/2017	12/29/2017	1/24/2018	1/25/2018	12/31/2018		1/7/2019
San Luis Obispo	1/15/2016	1/15/2016	5/12/2017	5/16/2017	2/15/2018		2/16/2018	12/14/2018	12/18/2018	12/28/2018
San Mateo	5/9/2017	5/9/2017	10/10/2017	10/18/2017	4/20/2018		4/30/2018	12/31/2018		1/2/2019
Santa Barbara	5/24/2017	6/20/2017	5/24/2017	6/20/2017	12/22/2017	1/22/2018	1/25/2018	12/21/2018	1/3/2019	1/14/2019
Santa Clara	5/5/2017	5/11/2017	12/18/2017	1/4/2018	4/20/2018		4/23/2018	12/27/2018		1/2/2019
Santa Cruz	4/5/2018	4/9/2018	7/19/2018	7/20/2018	8/15/2018		8/16/2018	12/31/2018	1/3/2019	1/7/2019
Shasta	10/7/2016	10/7/2016	4/14/2017	4/17/2017	3/29/2018		4/23/2018	12/13/2018	12/17/2018	1/2/2019
Sierra	10/17/2016	10/17/2016	8/16/2017	5/25/2018	6/28/2018	6/28/2018	7/23/2018	12/28/2018		1/2/2019
Siskiyou	6/30/2017	7/10/2017	6/30/2017	7/10/2017	7/27/2018		1/15/2019			
Solano	12/29/2015	12/30/2015	3/23/2017	4/4/2017	12/28/2017	1/23/2018	1/25/2018	12/31/2018	1/3/2019	2/21/2019
Sonoma	4/10/2017	4/10/2017	6/26/2017	6/27/2017	7/13/2018		7/23/2018	1/16/2019	1/29/2019	2/1/2019
Stanislaus	12/22/2015	12/22/2015	4/5/2017	4/5/2017	4/27/2018		4/30/2018	12/26/2018		1/3/2019
Sutter-Yuba	8/15/2018	8/17/2018	8/15/2018	8/17/2018	8/15/2018	5/1/2018	8/17/2018	1/7/2019	1/28/2019	1/31/2019
Tehama	4/29/2016	5/11/2017	5/8/2017	5/16/2017	7/25/2018		7/26/2018	6/20/2019		
Tri-City	12/30/2015	2/3/2016	4/6/2017	4/6/2017	12/29/2017	1/24/2018	2/15/2018	12/31/2018	1/3/2019	1/30/2019
Trinity	9/19/2016	9/23/2016	7/14/2017	7/14/2017	6/29/2018		7/2/2018	1/30/2019		2/7/2019
Tulare	3/17/2016	3/22/2016	4/12/2017	4/12/2017	12/26/2017	1/22/2018	1/25/2018	12/19/2018	12/21/2018	12/26/2018
Tuolumne	12/23/2015	12/28/2015	4/10/2017	5/18/2017	2/16/2018		3/1/2018	12/11/2018	12/12/2018	12/12/2018
Ventura	12/31/2015	1/4/2016	4/14/2017	4/27/2017	4/27/2018		5/25/2018	12/20/2018		12/21/2018
Yolo	6/21/2017	6/21/2017	3/9/2018	3/12/2018	3/23/2018		3/26/2018	1/30/2019	1/31/2019	1/31/2019
Total	59	59	59	59	59		59	57	37	55

* FY 2005-06 through FY 2013-14, all Counties are current

Current Through: 08/09/2019

2019 Legislative Report to the Commission
As of August 12, 2019

SPONSORED LEGISLATION

Senate Bill 10 (Beall)
Title: Mental health services: peer support specialist certification.

Summary: Would require the State Department of Health Care Services to establish, no later than July 1, 2020, a statewide peer certification program, as a part of the state's comprehensive mental health and substance use disorder delivery system and the Medi-Cal program.

Status/Location: 7/3/19 Coauthors revised. From committee: Do pass and re-refer to Com. on APPR. (Ayes 15. Noes 0.) (July 2). Re-referred to Com. on APPR.

Co-Sponsors: Steinberg Institute

Senate Bill 11 (Beall)
Title: Health care coverage: mental health parity.

Summary: Would require the Department of Managed Health Care and the Department of Insurance annually to report to the Legislature the information obtained through activities taken to enforce state and federal mental health parity laws.

Status/Location: 5/17/19 Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 5/13/2019) (May be acted upon Jan 2020).

Co-Sponsors: The Kennedy Forum; Steinberg Institute

Senate Bill 12 (Beall)
Title: Mental health services: youth.

Summary: This bill would require the commission, contingent on appropriation, to administer an Integrated Youth Mental Health Program for purposes of establishing local centers to provide integrated youth mental health services, as specified. The bill would authorize the commission to establish the core components of the program, subject to specified criteria, and would require the commission to develop the selection criteria and process for awarding funding to local entities for these purposes.

Status/Location: 6/26/19 June 26 set for first hearing. Placed on APPR. suspense file.

SPONSORED LEGISLATION

Assembly Bill 46 (Carrillo)

Title: Individuals with mental illness: change of term.

Summary: Current law refers to an insane or mentally defective person in provisions relating to, among other things, criminal proceedings, correctional facilities, and property tax exemptions. This bill would state the intent of the Legislature to enact legislation to replace derogatory terms, including, but not limited to, "insane" and "mentally defective," with more culturally sensitive terms when referring to individuals with mental illness.

Status/Location: 6/26/19 Approved by the Governor. Chaptered by Secretary of State - Chapter 9, Statutes of 2019.

Co-Sponsors: Disability Rights California

SUPPORTED LEGISLATION

Senate Bill 66 (Atkins)

Title: Medi-Cal: federally qualified health center and rural health clinic services.

Summary: This bill will facilitate the ability to transition patients from primary care to an onsite mental health specialist on the same day, to ensure that a patient receives needed care and follows through with treatment. This bill would authorize reimbursement for a maximum of 2 visits taking place on the same day at a single location if after the first visit the patient suffers illness or injury requiring additional diagnosis or treatment, or if the patient has a medical visit and a mental health visit.

Status/Location: 7/3/19 Coauthors revised. From committee: Do pass and re-refer to Com. on APPR. with recommendation: To consent calendar. (Ayes 15. Noes 0.) (July 2). Re-referred to Com. on APPR.

Senate Bill 582 (Beall)

Title: Youth mental health and substance use disorder services.

Summary: Would require the Mental Health Services Oversight and Accountability Commission, when making grant funds available on and after July 1, 2021, to allocate at least 1/2 of those funds to local educational agency and mental health partnerships, as specified. The bill would require this funding to be made available to support prevention, early intervention, and direct services, as determined by the commission. The bill would require the commission, in consultation with the Superintendent of Public Instruction, to consider specified criteria when determining grant recipients.

Status/Location: 7/11/19 From committee: Do pass and re-refer to Com. on APPR. with recommendation: To consent calendar. (Ayes 7. Noes 0.) (July 10). Re-referred to Com. on APPR. (Received at desk July 10 pursuant to JR 61(a)(10)).

SUPPORTED LEGISLATION

Senate Bill 604 (Bates)

Title: Mental Health Services Act: centers of excellence.

Summary: Would require the Mental Health Services Oversight and Accountability Commission, by January 1, 2021, to establish one or more centers of excellence to provide counties with technical assistance to implement best practices related to elements of the act. The bill would require those centers of excellence to be funded with state administrative funds provided under the act. In implementing these provisions, the bill would require the commission to determine the areas of focus for the centers of excellence, including, but not limited to, the areas of service delivery that need improvement.

Status/Location: 5/16/19 May 16 hearing: Held in committee and under submission.

Assembly Bill 43 (Gloria)

Title: Mental health.

Summary: This bill would require the commission, in consultation with specified state, local, and private entities, to develop a strategy for the collection, organization, and public reporting of information on mental health funding, mental health programs, services, and strategies, funded by the Mental Health Services Act or other sources, and mental health outcomes, as specified. By authorizing a new use of MHSA moneys, this bill would amend the act. The bill would require the commission to make the information available as prescribed to the public and policymakers. The bill would authorize the commission, subject to available funding, to develop an innovation challenge and utilize one or more hackathons, open coding initiatives, or other approaches to an effective strategy to collect, display, and make publicly available relevant information to support the intent of the provisions.

Status/Location: 7/8/19 In committee: Referred to APPR. suspense file.

Assembly Bill 512 (Ting)

Title: Medi-Cal: specialty mental health services.

Summary: Current law requires the State Department of Health Care Services to implement managed mental health care for Medi-Cal beneficiaries through contracts with mental health plans, and requires mental health plans to be governed by various guidelines, including a requirement that a mental health plan assess the cultural competency needs of the program. This bill would require each mental health plan to prepare a cultural competency assessment plan to address specified matters, including disparities in access, utilization, and outcomes by various categories, such as race, ethnicity and immigration status.

Status/Location: 7/10/19 From committee: Do pass and re-refer to Com. on APPR. (Ayes 7. Noes 1.) (July 10). Re-referred to Com. on APPR.

SUPPORTED LEGISLATION

Assembly Bill 713 (Mullin)

Title: Early Psychosis Intervention Plus (EPI Plus) Program.

Summary: Current law establishes the Early Psychosis and Mood Disorder Detection and Intervention Fund and authorizes the commission to allocate moneys from that fund to provide competitive grants to counties or other entities to create or expand existing capacity for early psychosis and mood disorder detection and intervention services and supports. Currently, implementation of the grant program is contingent upon the deposit into the fund of at least $500,000 in nonstate funds for those purposes. This bill would delete the prohibition on General Fund moneys being appropriated for purposes of those provisions and would delete the requirement that the minimum $500,000 deposit be from nonstate funds.

Status/Location: 7/12/19 Failed Deadline pursuant to Rule 61(a)(10). (Last location was HEALTH on 6/6/2019)(May be acted upon Jan 2020).

Assembly Bill 1126 (O'Donnell)

Title: Mental Health Services Oversight & Accountability Commission.

Summary: Would require the Mental Health Services Oversight and Accountability Commission, by January 1, 2021, to establish technical assistance centers and one or more clearinghouses to support counties in addressing mental health issues of statewide concern, with a focus on school mental health and reducing unemployment and criminal justice involvement due to untreated mental health issues.

Status/Location: 5/16/19 In committee: Held under submission.

Assembly Bill 1352 (Waldron)

Title: Community mental health services: mental health boards.

Summary: The Bronzan-McCorquodale Act governs the organization and financing of community mental health services for persons with mental disorders in every county through locally administered and locally controlled community mental health programs. Current law generally requires each community mental health service to have a mental health board consisting of 10 to 15 members who are appointed by the governing body and encourages counties to appoint individuals who have experience with and knowledge of the mental health system. This bill would require a mental health board to report directly to the governing body, and to have the authority to act, review, and report independently from the county mental health department or county behavioral health department, as applicable.

Status/Location: 6/20/19 From committee: Do pass and re-refer to Com. on APPR. (Ayes 9. Noes 0.) (June 19). Re-referred to Com. on APPR.

SUPPORTED LEGISLATION

Assembly Bill 1443 (Maienschein)

Title: Mental health: technical assistance centers.

Summary: Would require, subject to available funding, the Mental Health Services Oversight and Accountability Commission to establish one or more technical assistance centers to support counties in addressing mental health issues, as determined by the commission, that are of statewide concern and establish, with stakeholder input, which mental health issues are of statewide concern. The bill would require costs incurred as a result of complying with those provisions to be paid using funds allocated to the commission from the Mental Health Services Fund. The bill would state the finding and declaration of the Legislature that this change is consistent with and furthers the intent of the act.

Status/Location: 7/8/19 In committee: Referred to APPR. suspense file.