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Mental Health Services
Oversight & Accountability Commission

Commission Teleconference Meeting
February 17, 2021
PowerPoint Presentations and Handouts

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MHSOAC

Mental Health Services
Oversight & Accountability Commission

Budget Overview

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MHSOAC

February 17, 2021

Commission Budget Update: Overview

		Three Year Comparison of Expenditures			
	FY 2019-20 Budgeted	FY 2019-20* Actual as of 02/03/2021	FY Budgeted 2020-21	FY 2020-21 Estimated as of 02/03/2021	FY 2021-22 Proposed
Operations	$9,810,122	$7,819,928	$8,131,653	$8,143,277	$10,610,000
Legislative Mandates	$8,040,500	$2,455,533	$5,418,000	$5,567,000	$5,418,000
Commission Priorities	$1,615,378	$706,760	$2,249,347	$2,026,603	
Local Assistance	$102,871,000	$5,866,993	$29,239,000	$29,239,000	$54,069,000
GRAND TOTAL	$122,337,000	$16,381,215	$45,038,000	$44,975,880	$70,097,000

*All FY 2019-20 funds have been encumbered in multi-year contracts.

Commission Budget Detail: Operations and Legislative Mandates

Three Year Comparison of Expenditures

	FY 2019-20 Budgeted	FY 2019-20* Actual as of 02/03/2021	FY Budgeted 2020-21	FY 2020-21 Estimated as of 02/03/2021	FY 2021-22 Proposed
Operations					
Personnel	$6,283,500	$5,264,698	$5,719,666	$5,698,014	$5,750,754
Core_Operations	$3,526,622	$2,555,230	$2,411,987	$2,445,263	$4,859,246
TOTAL Operations	$9,810,122	$7,819,928	$8,131,653	$8,143,277	$10,610,000
Legislative Mandates					
Suicide_Prevention	$0	$0	$2,000,000	$2,000,000	$0
COVID_19	$0	$0	$2,020,000	$2,020,000	$0
Incubator	$2,625,000	$653,000	$0	$149,000	$0
Stakeholder	$5,415,500	$1,802,533	$1,398,000	$1,398,000	$5,418,000
TOTAL Legislative Mandates	$8,040,500	$2,455,533	$5,418,000	$5,567,000	$5,418,000

***All FY 2019-20 funds have been encumbered in multi-year contracts.**

Commission Budget Detail, cont.: Commission Priority Areas and Local Assistance Funding

Three Year Comparison of Expenditures

	FY 2019-20 Budgeted	FY 2019-20 Actual as of 02/03/2021 *	FY Budgeted 2020-21	FY 2020-21 Estimated as of 02/03/2021	FY 2021-22 Proposed
Commission Priorities					
Communications	$525,490	$246,574	$458,680	$632,680	
Research	$1,089,888	$460,186	$1,790,667	$1,393,923	
TOTAL Commission Priorities	$1,615,378	$706,760	$2,249,347	$2,026,603	
Local Assistance					
Triage	$20,000,000	$2,339,364	$20,000,000	$20,000,000	$20,000,000
MHSSA	$48,830,000	$3,527,629	$8,830,000	$8,830,000	$33,830,000
Youth Drop In	$14,589,000	$0	$0	$0	$0
EPI+	$19,452,000	$0	$0	$0	$0
Suicide Prevention Voluntary Contribution Fund	$0	$0	$409,000	$409,000	$239,000
TOTAL Local Assistance	$102,871,000	$5,866,993	$29,239,000	$29,239,000	$54,069,000
GRAND TOTAL	$122,337,000	$16,381,215	$45,038,000	$44,975,880	$70,097,000

***All FY 2019-20 funds have been encumbered in multi-year contracts.**

Local Assistance Update

Implementation of programs status:

- Stakeholder organizations representing Consumers, Diverse Communities, Families, LGBTQ communities, Parents, and Veterans – Approved by Commission in February 2020 - **All contracts fully executed.**

- Mental Health Student Services - **Category 1 and 2 –All grants fully executed.**

- Youth Drop-In Center grants – Presented to Commission for approval in May 2020 - **Pending execution of grants**
  - Youth Drop-In Center Technical Assistance contract with Standford **– interim TA contract fully executed.**

Local Assistance Update (cont.)

Implementation of programs status:

- Early Psychosis Intervention Plus - **all grants are under review by counties and pending signature.**

- EPI+ Technical Assistance contract with the University of Davis – **under review by UCD and pending signature.**

Local Assistance Update (cont.)

February 5, 2021: released Request for Proposal for EPI+ Round 2.

- Expand Access to Care (EPI+ grants) for $4,000,000. There will be two grants in the amount of $2,000,000 each.
  - Category 1: One for supporting an existing Early Psychosis (EP) program or the development of a new EP program, and
  - Category 2: One for a “Hub and Spoke” model EP program or a program that creates a regional approach to provide EP resources to surrounding counties.

Local Assistance Update (cont.)

Next steps:

- Convene EPI+ Advisory Committee to discuss recommendations for allocating the remaining EPI+ funds as follows:
  - Invest in Workforce Development/Retention/Public Awareness for $1 million which targets underserved or inappropriately served communities, and
  - Research on barriers to care and improved access for diverse populations and/or improving reimbursement for coordinated care models for $565,000.

Governor’s Proposed Budget for Fiscal Year 2021-22

Includes:

Governor’s Proposed 2021-22 Budget for the Commission includes:

- Operations - $16,028,000
- Local Assistance - $53,830,000
  - Includes an additional $25 million one-time funds to augment the Mental Health Student Services Act of 2018 – Budget Act of 2021: Senate Bill 112 (Skinner) and Assembly Bill 214 (Ting).

Budget Adjustments

Budget Adjustments: Personal income taxes: voluntary contributions: Suicide Prevention Voluntary Tax Contribution Fund.

- Assembly Bill 984 (Lackey), Chapter 445, Statutes of 2019 does the following:
  - Requires the Commission to disperse donated funds.
  - Requires the funds to be distributed to crisis centers located in California that are active members of the National Suicide Prevention Lifeline in the following manner:
    - 50% to fund program services in rural and desert communities through a Commission-administered project-specific grant processes; and
    - 50% to crisis center active members for suicide prevention services in proportion to the percentage of calls each center receives annually.

- Suicide Prevention Voluntary Tax Contributions:
  - $409,000 from Fiscal Year 2020-21.
  - $239,000 as of February 2021

Expenditure Plan for Fiscal Year 2021-22

- The Commission will be presented with a proposed expenditure plan for the new fiscal year in July 2021.

Highlights of the Governor's Proposed Budget for 2021-22

These highlights of the Governor's proposed budget for 2021-22 focus on proposed allocations relevant to the Commission's mission and initiatives. The Commission has approved several initiatives over the last few years that provides recommendations for school mental health, suicide prevention, and criminal justice. The budget includes several proposals to support school mental health and well-being. The legislative budget hearings are scheduled for the next several months and we will learn more between now and the Spring.

Student Health and Well-Being

The Governor's proposed 2021 budget includes investments aimed at equipping schools and educators with the resources necessary to effectively partner with other governmental entities in addressing the overall well-being of the children they serve. The Governor's proposed budget also includes funds to support the ability of schools and community mental health providers to more effectively respond to growing needs due to the impact on students resulting from the COVID-19 stay-at-home orders and school closures. Below is the list of the specific proposals.

- Proposition 63-Mental Health Student Services Act (MHSSA) Partnership Grant Program
  The Governor's proposed budget augments the Commission's budget by $25 million one-time Mental Health Services Fund (Proposition 63), available over multiple years, to expand the MHSSA Partnership Grant Program implemented by the Commission, which funds partnerships between county behavioral health departments and schools.

  The number of applications from counties to the MHSSA Partnership Grant Program for financial support to expand access to school mental health services was greater than anticipated. Funding limitations prevented the Commission from providing financial support to all counties with demonstrated needs in Round 1 of grants. This proposal would allow the Commission to expand its support for school mental health to additional counties with demonstrated needs.

- Proposition 98 Funds (K-12 Education)
  - ✓ The Governor proposes to provide an additional $540 million ($315 million one-time Proposition 98 General Fund and $225 million non-Proposition 98 General Fund) for teacher professional development, recruitment, and preparation and a variety of proposals related to student mental health and well-being.

- ✓ The Governor proposes $25 million ongoing Proposition 98 General Fund to fund innovative partnerships with county behavioral health to support student mental health services. This funding would be provided to LEAs to match funding in county Mental Health Services Act spending plans dedicated to the mental health needs of students. We anticipate Trailer Bill Language to provide further details on these funds. **(Health and Human Services Summary)**

- ✓ Local Educational Agencies
  The Governor's budget is proposing $2 billion one-time Proposition 98 General Fund available beginning February 2021, to augment resources for schools to offer in-person instruction safely. According to the Budget Summary, the funds made available to local educational agencies shall be available for any purpose consistent with providing in-person instruction for any pupil participating in in-person instruction, including, social and mental health support services provided in conjunction with in-person instruction. **(K-12 Education Summary)**

- Increased Access to Student Behavioral Health Services
  The Governor proposes one-time $400 million ($200 million General Fund) in 2021-22, available over multiple years, for the Department of Health Care Services to implement an incentive program through Medi-Cal managed care plans, in coordination with county behavioral health departments and schools, to build infrastructure, partnerships, and capacity statewide to increase the number of students receiving preventive and early intervention behavioral health services by schools, providers in schools, or school-based health centers. **(Health and Human Services Summary)**

Strengthening Behavioral Health

- Mental Health Services Act Funds
  The proposed budget includes statutory changes to extend flexibilities in county spending of local Mental Health Services Act funds that were included in the 2020 Budget Act in response to the COVID-19 Pandemic for an additional fiscal year.
  - ✓ Authorizes counties to spend down their local MHSA prudent reserves, as opposed to requesting county-by county authority from the state.
  - ✓ Authorizes counties to spend funds within the Community Services and Supports program component regardless of category restrictions to meet local needs.
  - ✓ Authorizes counties to use their existing approved MHSA spending plans if a new plan is delayed because of COVID-19 related reasons.

- California Advancing and Innovating Medi-Cal (CalAIM) Initiative
  The proposed budget includes $1.1 billion ($541.9 million General Fund) in 2021-22, growing to $1.5 billion ($755.5 million General Fund), as well as proposed statutory changes to the Medi-Cal program. Of the funds allocated for CalAIM, the budget proposes the following allocations to support behavioral health:

- ✓ $300 million ($150 million General Fund) to fund incentives for managed care plans to invest in voluntary In-lieu-of services programs and partner with community-based organizations and providers, including but not limited to community clinics, public hospital systems, and county behavioral health systems.
- ✓ $21.8 million General Fund for the behavioral health quality improvement program, which helps county behavioral health programs make technical and other improvements to facilitate future behavioral health integration and payment reform efforts.

- <u>Behavioral Health Continuum Infrastructure</u>
  The proposed budget includes one-time $750 million General Fund in 2021-22, available over multiple years, for competitive grants to counties to acquire and rehabilitate real estate assets to expand the community continuum of behavioral health treatment resources. These include:
  - ✓ short-term crisis stabilization,
  - ✓ acute needs,
  - ✓ peer respite,
  - ✓ and other clinically enriched longer-term treatment and rehabilitation services for persons with behavioral health needs.

- <u>Mental Health Services Assisted Outpatient Treatment (AB 1976)</u>
  The Governor proposes allocating funding to the Department of Health Care Services to implement the Mental Health Services Assisted Outpatient Treatment (AOT) Assembly Bill 1976, Chapter 140, Statutes of 2020. The budget provides $288,000 General Fund in fiscal year 2021-22 and $270,000 General Fund in fiscal year 2022-23 and in fiscal year 2023-24 to implement the AOT program to provide training and technical assistance, provide an annual data analysis, track AOT program implementation for all 58 California Counties and submit an annual legislative report.

Mental Health and Substance Use Efforts

- <u>Health coverage: Mental Health or Substance Use Disorders (SB 855)</u>
  The budget provides $1,500,000 Managed Care Fund in 2021-22, and $1,345,000 in 2022-23 and annually thereafter to review and enforce mental health and substance use disorder treatment coverage mandates on health plans as specified pursuant to **(Senate Bill 855, Chapter 151, Statutes of 2020)**

Youth/Transition Age Youth

- <u>Office of Youth and Community Restoration</u>
  The proposed budget includes $3.4 million General Fund in 2021-22 and $3.1 million ongoing General Fund to establish the Office of Youth and Community Restoration within the Health and Human Services Agency, effective July 1, 2021. The objective of the Office of Youth and Community Restoration is to fulfill the rehabilitative purpose of the state's juvenile justice

system through trauma-informed and developmentally appropriate services and programs. The budget also includes appropriations related to the Juvenile Justice Realignment Block Grant starting in 2021-22.

Housing and Homelessness Efforts

- Homekey Program
  The proposed budget includes additional funds for the Homekey program: $1.75 billion one-time General Fund to purchase additional motels, develop short-term community mental health facilities and purchase or preserve housing dedicated to seniors. The budget also proposes changes to the state's Medi-Cal system to better support behavioral health and housing services that can help prevent homelessness.

Criminal Justice

- Incompetent to Stand Trial (IST)
  Department of State Hospitals (DSH) continues to experience a significant number of incompetent to stand trial (IST) commitments from local courts, with the number of individuals awaiting placement into a state hospital exceeding 1,400 as of December 2020.

  DSH has undertaken several significant efforts over recent years to address the waiting list of IST commitments, including capacity expansions and the implementation of a mental health diversion program to provide local grants and judicial flexibility for community-based treatment of individuals at risk of IST commitment.

  The proposed budget includes several proposals to address the number of IST commitments pending placement, including:

  - ✓ $233.2 million General Fund in 2021-22 and $136.4 million General Fund annually thereafter to contract with three counties to provide a continuum of services to up to 1,252 individuals determined IST.
  - ✓ $9.8 million General Fund in 2020-21, $4.5 million in 2021-22, and $5 million annually thereafter to expand the current Los Angeles County CBR program beginning in 2020-21 and establish new CBR programs in additional counties in 2021-22. These programs would increase capacity by up to 250 beds in 2021-22.
  - ✓ Reappropriates $46.4 million General Fund expenditure authority to expand the existing IST Diversion Programs and expand to additional counties. These funds were set to expire in 2020-21.
  - ✓ $785,000 General Fund in 2020-21 and $6.3 million in 2021-22 and annually thereafter to expand jail-based competency treatment programs to seven additional counties.

- ✓ $5.6 million General Fund in 2021-22, $8 million in 2022-23 and 2023-24, and $8.2 million annually thereafter to implement a FACT team model in the CONREP program, which would increase capacity by up to 100 beds in 2021-22.
- ✓ $3.2 million General Fund in 2020-21 and $7.3 million in 2021-22 and annually thereafter to increase step-down capacity in the community to transition stable non-IST patients out of state hospital beds. This program would expand capacity by up to 40 beds in 2021-22.

Race and Social Equity Efforts

- <u>Health Disparities and Health Equity</u>
  The budget proposes $600,000 Proposition 98 General Fund one-time to implement AB 1460 (Weber) ethnic studies course requirements and systemwide anti-racism initiatives.

- <u>Health and Human Services</u>
  The budget proposes the following allocations to address health disparities and health equity:
  - ✓ $1.7 million General Fund to conduct a retrospective analysis of the intersection of COVID-19, health disparities and health equity to help inform any future response.
  - ✓ $3.7 million General Fund to develop an equity dashboard to identify data completeness, disparities, disproportionalities, and program participation for California Health and Human Services programs.
  - ✓ $2.5 million General Fund to support the CALeads initiative to diversify the state workforce within California Health and Human Services departments.

Technology

- <u>Center for Data Insights and Innovation</u>
  The Budget proposes to consolidate existing resources to establish a Center for Data Insights and Innovation within the Health and Human Services Agency. The Center will focus on leveraging data to develop knowledge and insights to improve program delivery and drive system transformation across health and human services. This proposal is cost neutral and will redirect positions and funding from CHHS Offices.

- <u>Cradle-to-Career Data System</u>
  The Cradle-to-Career Data System proposed for development in the Governor's Budget would, when built, enable policymakers, practitioners, and the public to better understand the relationship between individuals and the various state programs designed to support their paths to achievement. It offers the prospect of a single, unified approach to creating "whole person" data sets that would facilitate the Commission's ability to integrate mental health data into a broad understanding of how persons with mental health challenges, and

the treatments and services they receive, shape their recovery, resilience, and opportunities to live full lives in their communities.

System planning began with SB 75 (Chapter 51, Statutes of 2019), which created a multi-agency planning process led by the Governor's Office of Planning and Research. The planning body submitted a report to the Legislature in December 2020 proposing an ambitious and comprehensive agenda and project workplan, representing the culmination of a robust, year-long process involving over 50 public meetings. A second report to the Legislature with more project detail is expected in July 2021.

The Governor's Budget proposes to continue the development of the Cradle-to-Career Data System and provides $15 million General Fund, of which $3 million is one-time, to establish an office within the Government Operations Agency.

Additionally, the Budget provides $3.8 million ongoing Proposition 98 General Fund to support the California Career Guidance Initiative (CCGI). CCGI provides an interface for student data between high schools, students, and families that will be integrated into the Cradle-to-Career Data System.

The Commission's ongoing data work, in which we have so far executed data sharing agreements with the California Department of Justice, Employment Development Department, California Department of Education, and California Department of Public Health, parallels and integrates with the Cradle-to-Career vision. The Commission has recognized and acted upon the need to better understand how Mental Health Service Act programs and services interconnect with many other service systems to meet, or fail to meet, the needs of Californians with mental health needs.

SENATE BILL No. 14

Introduced by Senator Portantino
(Principal coauthor: Assembly Member Low)

December 7, 2020

An act to amend Section 48205 of, and to add Sections 49428.1 and 49428.2 to, the Education Code, relating to pupil health.

LEGISLATIVE COUNSEL'S DIGEST

SB 14, as introduced, Portantino. Pupil health: school employee and pupil training: excused absences: youth mental and behavioral health.

(1) Existing law, notwithstanding the requirement that each person between 6 and 18 years of age who is not otherwise exempted is subject to compulsory full-time education, requires a pupil to be excused from school for specified types of absences, including, among others, if the absence was due to the pupil's illness.

This bill would include as another type of required excused absence an absence that is for the benefit of the mental or behavioral health of the pupil. To the extent this bill would impose additional duties on local educational entities, the bill would impose a state-mandated local program.

(2) Existing law requires the governing board of a school district to give diligent care to the health and physical development of pupils and authorizes the governing board of a school district to employ properly certified persons for the work. Existing law requires a school of a school district or county office of education and a charter school to notify pupils and parents or guardians of pupils no less than twice during the school year on how to initiate access to available pupil mental health services on campus or in the community, or both, as provided.

This bill, contingent on an appropriation made for these purposes, would require the State Department of Education to identify an

evidence-based training program for a local educational agency to use to train classified and certificated school employees having direct contact with pupils on youth mental and behavioral health, as specified. The bill would define a local educational agency for purposes of these provisions to mean a county office of education, school district, state special school, or charter school that serves pupils in any of grades 7 to 12, inclusive. The bill would require a local educational agency, on or before January 1, 2023, to certify to the department that at least 50% of its certificated employees having direct contact with pupils at each schoolsite, or at least 2 classified and at least 2 certificated employees having direct contact with pupils at each schoolsite, whichever is greater, have received the youth mental and behavioral health training identified by the department. By requiring local educational agencies to provide training, the bill would impose a state-mandated local program.

This bill, contingent on an appropriation made for these purposes, would require the department to identify an evidence-based mental and behavioral health training program with a curriculum tailored for pupils in grades 10 to 12, inclusive, for use by a local educational agency, as defined, that meets certain requirements. The bill would require a local educational agency, on or before January 1, 2023, to report to the department the number of pupils who have voluntarily completed the mental and behavioral health training program. By requiring local educational agencies to prepare this report, the bill would impose a state-mandated local program.

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

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

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

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

1 SECTION 1. Section 48205 of the Education Code is amended
2 to read:
3 48205. (a) Notwithstanding Section 48200, a pupil shall be
4 excused from school when the absence is:

(1) Due to the pupil’s illness.

(2) Due to quarantine under the direction of a county or city health officer.

(3) For the purpose of having medical, dental, optometrical, or chiropractic services rendered.

(4) For the purpose of attending the funeral services of a member of the pupil’s immediate family, so long as the absence is not more than one day if the service is conducted in California and not more than three days if the service is conducted outside California.

(5) For the purpose of jury duty in the manner provided for by law.

(6) Due to the illness or medical appointment during school hours of a child of whom the pupil is the custodial parent, including absences to care for a sick child for which the school shall not require a note from a doctor.

(7) For justifiable personal reasons, including, but not limited to, an appearance in court, attendance at a funeral service, observance of a holiday or ceremony of the pupil’s religion, attendance at religious retreats, attendance at an employment conference, or attendance at an educational conference on the legislative or judicial process offered by a nonprofit organization when the pupil’s absence is requested in writing by the parent or guardian and approved by the principal or a designated representative pursuant to uniform standards established by the governing ~~board.~~ *board of the school district.*

(8) For the purpose of serving as a member of a precinct board for an election pursuant to Section 12302 of the Elections Code.

(9) For the purpose of spending time with a member of the pupil’s immediate family who is an active duty member of the uniformed services, as defined in Section 49701, and has been called to duty for, is on leave from, or has immediately returned from, deployment to a combat zone or combat support position. Absences granted pursuant to this paragraph shall be granted for a period of time to be determined at the discretion of the superintendent of the school district.

(10) For the purpose of attending the pupil’s naturalization ceremony to become a United States citizen.

(11) For the benefit of the mental or behavioral health of the pupil.

~~(11)~~

(12) Authorized at the discretion of a school administrator, as described in subdivision (c) of Section 48260.

(b) A pupil absent from school under this section shall be allowed to complete all assignments and tests missed during the absence that can be reasonably provided and, upon satisfactory completion within a reasonable period of time, shall be given full credit therefor. The teacher of the class from which a pupil is absent shall determine which tests and assignments shall be reasonably equivalent to, but not necessarily identical to, the tests and assignments that the pupil missed during the absence.

(c) For purposes of this section, attendance at religious retreats shall not exceed four hours per semester.

(d) Absences pursuant to this section are deemed to be absences in computing average daily attendance and shall not generate state apportionment payments.

(e) "Immediate family," as used in this section, means the parent or guardian, brother or sister, grandparent, or any other relative living in the household of the pupil.

SEC. 2. Section 49428.1 is added to the Education Code, to read:

49428.1. (a) The department shall identify an evidence-based training program for a local educational agency to use to train classified and certificated school employees having direct contact with pupils in youth mental and behavioral health.

(b) In identifying an evidence-based training program pursuant to subdivision (a), the department shall ensure that the training program meets all of the following requirements:

(1) Is a peer-reviewed evidence-based training program.

(2) Provides instruction on recognizing the signs and symptoms of mental illness and substance use disorders, including common psychiatric conditions such as schizophrenia, bipolar disorder, major clinical depression, anxiety disorders, and common substance use disorders such as opioid and alcohol abuse.

(3) Provides instruction on how school staff can best provide referrals to mental health services, substance use disorder services, or other support to individuals in the early stages of developing a mental illness or substance use disorder.

(4) Provides instruction on how to maintain pupil privacy and confidentiality in a manner consistent with federal and state privacy laws.

(5) Provides instruction on the safe deescalation of crisis situations involving individuals with a mental illness.

(6) Is capable of assessing trainee knowledge before and after training is provided in order to measure training outcomes.

(7) Is administered by a nationally recognized nonprofit training authority in mental illness and substance use disorders.

(8) (A) Includes in-person and virtual training with certified instructors who can recommend resources available in the community for individuals with a mental illness or substance use disorder.

(B) For purposes of this paragraph, "certified instructors" means individuals who obtain or have obtained a certification to provide the selected training in mental illness and substance use disorders by a nationally recognized authority in behavioral health training programs.

(c) (1) A local educational agency shall provide the youth mental and behavioral health training identified pursuant to subdivision (a) to certificated and classified employees during regularly scheduled work hours.

(2) If a certificated or classified employee receives the youth mental and behavioral health training in a manner other than through an in-service training program provided by the local educational agency, the employee may present a certificate of successful completion of the training to the local educational agency for purposes of satisfying the requirements of subdivision (d).

(3) Training in youth mental and behavioral health shall not be a condition of employment or hiring for classified or certificated employees.

(d) On or before January 1, 2023, a local educational agency shall certify to the department that at least 50 percent of its certificated employees having direct contact with pupils at each school, or at least two classified and at least two certificated employees having direct contact with pupils at each school, whichever is greater, have received the youth mental and behavioral health training identified pursuant to subdivision (a).

(e) For purposes of this section, "local educational agency" means a county office of education, school district, state special school, or charter school that serves pupils in any of grades 7 to 12, inclusive.

(f) This section shall be implemented only to the extent an appropriation is made in the annual Budget Act or another statute for these purposes.

SEC. 3. Section 49428.2 is added to the Education Code, to read:

49428.2. (a) The department shall identify an evidence-based mental and behavioral health training program with a curriculum tailored for pupils in grades 10 to 12, inclusive, for use by local educational agencies, that meets all of the following requirements:

(1) Is peer-reviewed and evidence-based.

(2) Provides developmentally appropriate instruction and skill building on the signs and symptoms of mental health disorders, the prevention of mental health disorders, and mental health awareness and assistance.

(3) Provides instruction on how to reduce the stigma around mental health disorders and available resources, including local school and community resources, and the process for accessing treatment.

(4) Provides instruction on strategies to develop healthy coping techniques and to support a peer, friend, or family member with a mental health disorder.

(5) Seeks to prevent suicide and the abuse of and addiction to alcohol, nicotine, and drugs.

(6) Adheres to a curriculum developed by a nationally recognized nonprofit training authority in mental illness and substance use disorders that is structured to train all pupils in grades 10 to 12, inclusive, ensuring every pupil in each grade level is equipped with the essential skills needed to seek help for themselves and to direct others seeking help to the appropriate avenues for support.

(7) Includes training with certified instructors who can recommend resources available in the community for individuals with a mental illness or substance use disorder.

(b) On or before January 1, 2023, a local educational agency shall report to the department the number of pupils who have voluntarily completed the mental and behavioral health training program.

(c) For purposes of this section, "local educational agency" means a county office of education, school district, state special

1 school, or charter school that serves pupils in any of grades 10 to
2 12, inclusive.
3 (d) This section shall be implemented only to the extent an
4 appropriation is made in the annual Budget Act or another statute
5 for these purposes.
6 SEC. 4. If the Commission on State Mandates determines that
7 this act contains costs mandated by the state, reimbursement to
8 local agencies and school districts for those costs shall be made
9 pursuant to Part 7 (commencing with Section 17500) of Division
10 4 of Title 2 of the Government Code.

O

SENATE BILL No. 224

Introduced by Senator Portantino

January 14, 2021

An act to add Article 6 (commencing with Section 51925) to Chapter 5.5 of Part 28 of Division 4 of Title 2 of the Education Code, relating to pupil instruction.

LEGISLATIVE COUNSEL'S DIGEST

SB 224, as introduced, Portantino. Pupil instruction: mental health education.

Existing law requires, during the next revision of the publication "Health Framework for California Public Schools," the Instructional Quality Commission to consider developing, and recommending for adoption by the State Board of Education, a distinct category on mental health instruction to educate pupils about all aspects of mental health. Existing law requires mental health instruction for these purposes to include, but not be limited to, specified elements, including reasonably designed and age-appropriate instruction on the overarching themes and core principles of mental health.

This bill would require each school district to ensure that all pupils in grades 1 to 12, inclusive, receive medically accurate, age-appropriate mental health education from instructors trained in the appropriate courses at least once in elementary school, at least once in junior high school or middle school, as applicable, and at least once in high school. The bill would require that instruction to include, among other things, reasonably designed instruction on the overarching themes and core principles of mental health. The bill would require that instruction and related materials to, among other things, be appropriate for use with pupils of all races, genders, sexual orientations, and ethnic and cultural backgrounds, pupils with disabilities, and English learners. By imposing

additional requirements on school districts, the bill would impose a state-mandated local program.

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

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

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

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

1 SECTION 1. (a) The Legislature finds and declares all of the
2 following:
3 (1) Mental health is critical to overall health, well-being, and
4 academic success.
5 (2) Mental health challenges affect all age groups, races,
6 ethnicities, and socioeconomic classes.
7 (3) Millions of Californians, including at least one in five youths,
8 live with mental health challenges. Millions more are affected by
9 the mental health challenges of someone else, such as a close friend
10 or family member.
11 (4) Mental health education is one of the best ways to increase
12 awareness and the seeking of help, while reducing the stigma
13 associated with mental health challenges. The public education
14 system is the most efficient and effective setting for providing this
15 education to all youth.
16 (b) For the foregoing reasons, it is the intent of the Legislature
17 in enacting this measure to ensure that all California pupils in
18 grades 1 to 12, inclusive, have the opportunity to benefit from a
19 comprehensive mental health education.
20 SEC. 2. Article 6 (commencing with Section 51925) is added
21 to Chapter 5.5 of Part 28 of Division 4 of Title 2 of the Education
22 Code, to read:

Article 6. Mandatory Mental Health Education

51925. Each school district shall ensure that all pupils in grades 1 to 12, inclusive, receive medically accurate, age-appropriate mental health education from instructors trained in the appropriate courses. Each pupil shall receive this instruction at least once in elementary school, at least once in junior high school or middle school, as applicable, and at least once in high school. This instruction shall include all of the following:

(a) Reasonably designed instruction on the overarching themes and core principles of mental health.

(b) Defining common mental health challenges. Depending on pupil age and developmental level, this may include defining conditions such as depression, suicidal thoughts and behaviors, schizophrenia, bipolar disorder, eating disorders, and anxiety, including post-traumatic stress disorder.

(c) Elucidating the medically accurate services and supports that effectively help individuals manage mental health challenges.

(d) Promoting mental health wellness, which includes positive development, social connectedness and supportive relationships, resiliency, problem solving skills, coping skills, self-esteem, and a positive school and home environment in which pupils feel comfortable.

(e) The ability to identify warning signs of common mental health problems in order to promote awareness and early intervention so that pupils know to take action before a situation turns into a crisis. This shall include instruction on both of the following:

(1) How to seek and find assistance from mental health professionals and services within the school district and in the community for themselves or others.

(2) Medically accurate evidence-based research and culturally responsive practices that are proven to help overcome mental health challenges.

(f) The connection and importance of mental health to overall health and academic success and to co-occurring conditions, such as chronic physical conditions, chemical dependence, and substance abuse.

(g) Awareness and appreciation about the prevalence of mental health challenges across all populations, races, ethnicities, and

socioeconomic statuses, including the impact of race, ethnicity, and culture on the experience and treatment of mental health challenges.

(h) Stigma surrounding mental health challenges and what can be done to overcome stigma, increase awareness, and promote acceptance. This shall include, to the extent possible, classroom presentations of narratives by trained peers and other individuals who have experienced mental health challenges and how they coped with their situations, including how they sought help and acceptance.

51926. Instruction and materials required pursuant to this article shall satisfy all of the following:

(a) Be appropriate for use with pupils of all races, genders, sexual orientations, and ethnic and cultural backgrounds, pupils with disabilities, and English learners.

(b) Be accessible to pupils with disabilities, including, but not limited to, providing a modified curriculum, materials and instruction in alternative formats, and auxiliary aids.

(c) Not reflect or promote bias against any person on the basis of any category protected by Section 220.

51927. (a) This article does not limit a pupil's health and mental health privacy or confidentiality rights.

(b) A pupil receiving instruction pursuant to this article shall not be required to disclose their confidential health or mental health information at any time in the course of receiving that instruction, including, but not limited to, for the purpose of the peer component described in subdivision (h) of Section 51925.

51928. For purposes of this article, the following definitions apply:

(a) "Age appropriate" has the same meaning as defined in Section 51931.

(b) "English learner" has the same meaning as defined in Section 51931.

(c) "Instructors trained in the appropriate courses" means instructors with knowledge of the most recent medically accurate research on mental health.

(d) "Medically accurate" means verified or supported by research conducted in compliance with scientific methods and published in peer-reviewed journals, where appropriate, and

1 recognized as accurate and objective by professional organizations
2 and agencies with expertise in the mental health field.
3 SEC. 3. If the Commission on State Mandates determines that
4 this act contains costs mandated by the state, reimbursement to
5 local agencies and school districts for those costs shall be made
6 pursuant to Part 7 (commencing with Section 17500) of Division
7 4 of Title 2 of the Government Code.

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SB 224 (Portantino) Pupil instruction: mental health education

PROBLEM

Approximately 75% of mental illness manifests between the ages of 10 and 24. Since adolescents visit the doctor less often than any other age group, early warning signs of mental health needs can go undetected.

Youth mental health is suffering in the era of COVID. In a June 2020 CDC study, 1 in 4 youth ages 18 to 24 said they had seriously considered suicide in the past 30 days — more than twice as the rate of any other age group.

California is failing on children's mental health and preventive care: According to the most recent Commonwealth Fund Scorecard on State Health System Performance, our state ranks 48th in the nation for providing children with needed mental health care.

BACKGROUND

Education about mental health is one of the best ways to increase awareness, empower students to seek help, and reduce the stigma associated with mental health challenges. Schools are ideally positioned to be centers of mental health education, healing, and support. As children and youth spend more hours at school than at home, the public education system is the most efficient and effective setting for providing universal mental health education to children and youth.

Historically, health education in subjects such as alcohol, tobacco and drugs, the early detection of certain cancers, and HIV have become required because they were recognized as public health crises. The mental health of our children and youth has reached a crisis point. California must make educating its youth about mental health a top priority.

SUMMARY

This bill ensures that pupils between grades 1 and 12 receive mental health education from a qualified instructor at least one time during elementary school, one time during middle school, and one time during high school. As a result, students will receive instruction on mental health at least three separate times during their schooling.

EXISTING LAW

Existing law requires, during the next revision of the publication "Health Framework for California Public Schools," the Instructional Quality Commission to consider developing, and recommending for adoption by the State Board of Education, a distinct category on mental health instruction to educate pupils about all aspects of mental health. While the 2019 draft health framework, which was adopted by the State Board of Education in May 2019, includes sections on mental, emotional, and social wellness, there is limited curriculum within the proposed Framework and what is included by no means encompasses all of the topics found in statute. California *Education Code Section 51210* does require "health instruction in the principles and practices of individual, family, and community health" in grades one through six. However, mental health is not specifically addressed in the law. Furthermore, given the fact that there is no state-mandated health education course at the middle or high school level in California, a vast majority of California students do not receive any instruction in mental health.

SUPPORT

CA Youth Empowerment Network (co-sponsor)
CA Alliance of Child and Family Services (co-sponsor)
CA Association of Student Councils (co-sponsor)
The Children's Partnership (co-sponsor)
National Alliance on Mental Illness (co-sponsor)
National Center for Youth Law (co-sponsor)

Office of Senator Anthony J. Portantino
SB 224 – Fact Sheet
Contact: Tara McGee– (916) 651-4025 or Tara.McGee@Sen.ca.gov

california legislature—2021–22 regular session

ASSEMBLY BILL No. 573

Introduced by Assembly Member Carrillo

February 11, 2021

An act to add Chapter 1.2 (commencing with Section 5625) to Part 2 of Division 5 of the Welfare and Institutions Code, relating to mental health.

legislative counsel's digest

AB 573, as introduced, Carrillo. Youth Mental Health Boards.

Existing law, the Bronzan-McCorquodale Act, contains provisions governing the operation and financing of community mental health services for the mentally disordered in every county through locally administered and locally controlled community mental health programs. 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. As part of the MHSA, existing law requires counties to engage in specified planning activities, including creating and updating a 3-year program and expenditure plan through a stakeholder process.

This bill would establish the California Youth Mental Health Board (state board) within the California Health and Human Services Agency to advise the Governor and Legislature on the challenges facing youth with mental health needs and determine opportunities for improvement. The state board would be comprised of 15 members who are between 15 and 23 years of age, appointed as specified, at least half of whom are youth mental health consumers who are receiving, or have received,

mental health services, or siblings or immediate family members of mental health consumers. The bill would specify the powers and duties of the state board, including reviewing program performance in the delivery of mental health and substance use disorder services for youth.

This bill would require each community mental health service to have a local youth mental health board (board), appointed as specified, consisting of members between 15 and 23 years of age, at least half of whom are, to the extent possible, mental health consumers who are receiving, or have received, mental health services, or siblings or close family members of mental health consumers and half of whom are, to the extent possible, enrolled in schools in the county. The bill would require the board, among other duties, to advise the county mental health programs, school districts, and other entities on issues relating to youth mental health and to review and advise on the procedures used to ensure youth involvement at all stages of the mental health planning process for the county's 3-year program and expenditure plan. The bill would require the county to provide a budget for the board, as specified. By increasing the duties of local governments, this bill would impose a state-mandated local program.

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

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

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

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

1 SECTION 1. The Legislature finds and declares all of the
2 following:
3 (a) Mental health needs are the most common and disabling
4 medical conditions affecting children.
5 (b) Mental health needs in youth have increased in recent years
6 nationally and appear to be rising as a consequence of the current
7 COVID-related crisis.

(c) Based on national and state prevalence rates, between 620,000 and 1,240,000 of California's 6.2 million students enrolled in K-12 schools are estimated to have a mental health condition.

(d) Half of all lifetime mental health needs emerge before 14 years of age, and three-quarters before 24 years of age.

(e) Almost one in five youth report having seriously considered suicide in the past year.

(f) Suicide is the second leading cause of death for youth.

(g) Many children suffer without help. Approximately half to three-quarters do not receive mental health treatment or services. For children living in low-income households with limited English proficiency, unmet mental health needs are even greater.

(h) Other student groups, such as LGBTQ students and Muslim students experience high rates of bullying, harassment, and victimization. Muslim students are twice as likely as their peers to report they are bullied. LGBTQ students are twice as likely as average to report depression symptomology and are three times more likely to report suicidal ideation.

(i) Nationally, 22 percent of Latino youth have depressive symptoms, a rate higher than any minority group besides Native American youth. The United States Office of Minority Health has found that Latina adolescents have the highest rates of suicidal ideation and suicide attempt, and, while lower than Latinas, Latino adolescent males have higher rates of suicidal ideation and suicide attempt than their white peers.

(j) Students in foster care, African American students and Native American students are more likely to be suspended or expelled than other groups of students. African American, Native American, and Pacific Islander students are more than twice as likely as their peers to be chronically absent.

(k) Youth involvement in mental health programming leads to better quality services that are responsive to the needs of youth.

(*l*) To date, only one out of every seven California counties has established children or youth behavioral health advisory committees. This represents an unrealized opportunity to engage youth in the community planning process for mental health services for youth.

(m) Providing youth with opportunities to make meaningful contributions to their schools and communities through participation and leadership in various settings contributes to

positive youth development and is likely to support improved youth engagement with appropriate behavioral health services.

SEC. 2. Chapter 1.2 (commencing with Section 5625) is added to Part 2 of Division 5 of the Welfare and Institutions Code, to read:

Chapter 1.2. Youth Mental Health Boards

5625. (a) There is established within the California Health and Human Services Agency, or one of its member departments as determined by the Secretary of California Health and Human Services, the California Youth Mental Health Board (state board).

(b) The state board shall advise the Governor and Legislature on the challenges facing youth with mental health needs and determine opportunities for improvement.

(c) The state board shall have 15 members who are between 15 and 23 years of age and who are representative, to the extent possible, of California's population, based on race, ethnicity, gender identity, sexual orientation, and geographic distribution.

(d) (1) Two members of the state board shall be appointed by the Speaker of the Assembly, 2 members shall be appointed by the Senate President Pro Tempore, and 11 members shall be appointed by the Governor.

(2) In making appointments, the Governor shall ensure that at least half of the members are youth mental health consumers who are receiving, or have received, mental health services, or siblings or immediate family members of mental health consumers. Youth mental health consumers include persons who are diagnosed with serious emotional disturbances, serious mental illnesses, or substance use disorders.

(e) Members of the state board shall serve two-year terms and be appointed so that an equal number of appointments, to the extent possible, expire in each year.

(f)Members of the state board shall appoint a chairperson and chair-elect.

(g) The state board shall be supported by staff of the California Health and Human Services Agency, or its member departments, as determined by the secretary.

(h) The state board shall have the powers and authority necessary to carry out the duties imposed upon it by this section, including, but not limited to, all of the following:

(1) To advocate for effective, quality mental health and substance use disorder programs for youth.

(2) To review, assess, and make recommendations regarding all components of California's mental health and substance use disorder systems that serve youth and to report, as necessary, to the Governor and Legislature, the Superintendent of Public Instruction, state departments, local boards, and local programs.

(3) To review program performance in the delivery of mental health and substance use disorder services for youth.

(4) To recommend strategies and reforms to improve all of the following:

(A) Access to care.

(B) The quality of care.

(C) Outcomes achieved for youth.

(D) Programs and services, including, but not limited to, prevention and early intervention, treatment, crisis support, suicide prevention, and other programs and services, as determined by the state board.

(5) To conduct public hearings, perform site visits, convene meetings, form working groups, advisory committees, and subcommittees, and engage in other strategies necessary and convenient to support the purpose of this section.

(6) To seek and obtain information held by state and local agencies to support the goals of the state board.

(7) To employ administrative, technical, and other personnel necessary for the performance of its powers and duties, pursuant to the state civil service requirements and subject to the approval of the Department of Finance.

(8) To accept any federal funds granted, by act of Congress or executive order, for purposes within the purview of the state board, subject to the approval of the Department of Finance.

(9) To accept any gift, donation, bequest, or grant of funds from private and public agencies for any of the purposes within the purview of the state board, subject to the approval of the Department of Finance.

(10) To employ all other appropriate strategies necessary or convenient to enable it to fully and adequately perform its duties and exercise the powers expressly granted in this section.

5626. (a) (1) Each community mental health service shall have a local youth mental health board (board) consisting of eight or more members, as determined by the governing body, and appointed by the governing body, except that boards in counties with a population of fewer than 80,000 may have a minimum of five members.

(2) (A) The board shall serve in an advisory role to the county board of supervisors, governing bodies of school districts within the county, the county office of education, and other public entities and officials within the county, as determined by the board.

(B) Board membership shall include county residents between 15 and 23 years of age and should reflect the diversity of the population in the county, including race, ethnicity, sexual orientation and gender identity, to the extent possible.

(C) To the extent possible, half or more of the board membership shall be mental health consumers who are receiving, or have received, mental health services, or siblings or close family members of mental health consumers, as determined by the governing board.

(D) To the extent possible, half or more of the board members shall be enrolled in school in the county.

(3) In counties with a population of fewer than 80,000, at least two members shall be consumers who are receiving, or who have received, mental health services.

(b) The board, at its discretion, may meet concurrently with and advise the mental health board established pursuant to Section 5604 on matters pertaining to meeting the mental health needs of youth.

(c) The board is established to inform decisions by the county board of supervisors, school districts, the county office of education, and other governmental and nongovernmental bodies involved with the community mental health service, as determined by the board.

(d) The board shall review and evaluate the local public mental health system, pursuant to Section 5604.2, and advise the county and school district governing bodies on mental health services related to youth that are delivered by the local mental health agency

or local behavioral health agency, school districts, or others, as applicable.

(e) The term of each member of the board shall be for no less than two years and no more than three years. The governing body shall equitably stagger appointments so that an equal number of appointments, to the extent possible, expire in each year.

(f) If two or more local agencies jointly establish a community mental health service pursuant to Article 1 (commencing with Section 6500) of Chapter 5 of Division 7 of Title 1 of the Government Code, the board for the community mental health service shall consist of an additional five members for each additional agency, with equal representation from each local agency to the extent possible.

(g) A member of the board or the member's spouse, parent, or sibling shall not be a full-time or part-time employee of a county mental health service, an employee of the State Department of Health Care Services, or an employee or a member of the governing body of a mental health contract agency doing business in the local jurisdiction.

(h) Members of the board shall abstain from voting on any issue in which the member has a financial interest, as defined in Section 87103 of the Government Code.

(i) The board may be established as an advisory board or a commission, depending on the preference of the county.

5627. A local youth mental health advisory board shall be subject to the provisions of Chapter 9 (commencing with Section 54950) of Part 1 of Division 2 of Title 5 of the Government Code, relating to meetings of local agencies.

5628. (a) The local youth mental health board may do all of the following:

(1) Review and evaluate the community's youth mental health needs, services, and related challenges and opportunities, as determined by the board.

(2) Review county agreements affecting youth entered into pursuant to Section 5650. The board may make recommendations to the governing body regarding concerns identified within these agreements.

(3) Advise the governing body and the local mental health director as to any aspect of the local mental health program relating to youth. The board may request assistance from the local patients'

1 rights advocates, local agencies, the grand jury, and others when
2 reviewing and advising on mental health evaluations or services
3 provided in facilities with limited access.
4 (4) Review and advise on the procedures used to ensure youth
5 involvement at all stages of the mental health planning process for
6 the county's three-year program and expenditure plan, as required
7 by Section 5848.
8 (5) Submit an annual report to the county governing body,
9 school districts, and other local governing bodies, where relevant,
10 on the needs and performance of the county's mental health system
11 as it relates to the needs of youth, with recommendations for
12 improvement as needed.
13 (6) Review and comment on the county's performance outcome
14 data as it relates to youth and communicate its findings to the
15 California Behavioral Health Planning Council and the California
16 Mental Health Services Oversight and Accountability Commission.
17 (b) This section does not limit the ability of the governing body
18 to transfer additional duties or authority to a local youth mental
19 health board.
20 5629. (a) The board of supervisors shall assign staff to support
21 the local youth mental health board and pay, from any available
22 funds, the actual and necessary expenses of the members of the
23 local youth mental health board incurred incident to the
24 performance of their official duties and functions. The expenses
25 may include travel, lodging, childcare, and meals for the members
26 of a youth mental health board while on official business as
27 approved by the director of the local mental health program.
28 (b) The governing body shall provide a budget for the local
29 youth mental health board that is sufficient to facilitate the purpose,
30 duties, and responsibilities of the youth mental health board. To
31 the extent that funds are available for this purpose, the governing
32 body may use planning and administrative revenues identified in
33 subdivision (c) of Section 5892.
34 5630. The local youth mental health board shall develop bylaws
35 to be approved by the governing body that do all of the following:
36 (a) Establish the specific number of members on the youth
37 mental health board, consistent with subdivision (a) of Section
38 5626.
39 (b) Ensure that the composition of the local youth mental health
40 board represents and reflects the diversity and demographics of

1 the county as a whole, consistent with subdivision (a) of Section
2 5626, to the extent feasible.
3 (c) Establish that a quorum be one person more than half of the
4 appointed members.
5 (d) Establish that the chairperson of the local youth mental
6 health board be in consultation with the local mental health
7 director.
8 SEC. 3. If the Commission on State Mandates determines that
9 this act contains costs mandated by the state, reimbursement to
10 local agencies and school districts for those costs shall be made
11 pursuant to Part 7 (commencing with Section 17500) of Division
12 4 of Title 2 of the Government Code.

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MHSOAC
Mental Health Services
Oversight & Accountability Commission

Amendments to the Rules of Procedure

Filomena Yeroshek, Chief Counsel
February 17, 2021

WELLNESS • RECOVERY • RESILIENCE

Outline

- Brief background
- High level summary of changes to January 2020 proposal
- Commissioner questions
- Public comment
- Commissioner discussion
- Motion and vote

Background

- January 2020 Commission meeting - proposed amendments presented
- 12-month stakeholder engagement process
  - Written public comment
  - April 2020 MHSA Partners Forum meeting
  - September 2020 Subcommittee meeting
  - November 2020 proposed revisions posted
  - December 2, 2020 Subcommittee meeting scheduled
  - February 17, 2021 meeting

Stakeholder Concerns & Responses to Address

- Mission Statement and core values
- Bagley-Keene Open Meeting Act compliance
- Delegated Innovation Project approval
- Transparency and accountability
  - Delegated authority to advocate on legislation
  - Delegated contract authority
- Stakeholder outreach and engagement

Transparency and Accountability

- Contract authority (Rule 2.4) – amendment increase authority from $100K to $200K and from $200K to $400K for interagency agreements; with consent of Commission Chair and Vice Chair increases authority to $500k and to $750K for interagency agreements
- Stakeholder Concerns: lack of transparency and accountability in Commission contracts; no opportunity for public comment
- Response:
  - Public contract dashboard on website
  - Budget presentation 3 times during fiscal year

Outreach and Engagement

- Committee structure (Rule 6.1) – amendments make several changes to the committee structure, including authorizing but not requiring committees; designated seats on committees; and the term of the committee membership
- Stakeholder Concerns: Changes reduce public participation and influence on Commission decisions; and elimination of designated seats (2:2:2) goes against key principles of the MHSA
- Response:
  - Revised Rule 6.1: goal to have specified membership of 2:2:2; membership reflects demographic diversity and geographic diversity
- New Rule 5.1: broaden strategies of community outreach and engagement

Proposed Motion

- The Commission adopts the Rules of Procedure with the February 2021 amendments as presented.

February 11, 2021

Lynne Ashbeck, Chair
Mara Madrigal-Weiss, Vice Chair
Mental Health Services Oversight and Accountability Commission
1325 J St., Suite 1700
Sacramento, CA 95814

Dear Chair Ashbeck and Vice Chair Madrigal-Weiss:

ACCESS and Cal Voices appreciates your efforts to propose staff recommendations for amendments to the proposed Rules of Procedure in response to stakeholder input, and with the goal of conforming those Rules to the foundational principles of the Mental Health Services Act (MHSA). However, we continue to have serious concerns that the proposed Rules of Procedure are not in alignment with the MHSA and do not promote meaningful stakeholder engagement.

We understand that the Commission's statutory duties have increased since inception of the Commission, requiring a greater time commitment by Commissioners. However, the requirements of the MHSA, including the requirement of extensive stakeholder involvement, have not changed. The solution to this is not to increase the authority of the Executive Director, but instead to fully utilize the knowledge and experience of Committees. In the past, Committees of the Commission have had significant involvement in assisting the Commission in accomplishing its goals. This active involvement by Committees must not only be revived, but it must be increased.

Although most of our initial concerns, outlined in our September 11, 2020 letter remain, we are choosing to focus this letter on our three main concerns, which are discussed in more detail below:

1. Contract authority of the Executive Director
2. Authority to approve Innovation projects
3. Committee structure

In addition, we urge the Commission to allow for time to address stakeholder comments received at the February 17th meeting, before immediately holding a full Commission vote directly following the stakeholder input. While we assume that you had the best of intentions in your scheduling of the vote, failure to allow time for Commission staff to review and consider public input received at the Rules of Procedure Stakeholder meeting not only leaves the clear impression that there is no intention for allowing such review and consideration to take place—this timeline makes it structurally impossible for Commission staff to do so. The requirement of extensive stakeholder involvement does not, and should not mean taking feedback as a mere "check-the-box" obligation. The lack of time allotted for serious consideration of the stakeholder feedback that will be gathered at the Rules of Procedure

Stakeholder meeting creates the appearance—intentional or not—that such feedback is not valued or respected, nor that it will be utilized in the way the MHSA intends.

The impression that stakeholder feedback is not valued is further demonstrated in the deletion of the sentence: "Public comment and stakeholder involvement at the committee level does not replace public comment at the Commission meetings" in the Public Comment section of the Rules of Procedure. The only purpose for deleting this sentence would be to further limit public comment. This intentional deletion can only be interpreted as the Commission not desiring and valuing stakeholder engagement at every level, as required by the MHSA.

Contract authority of the Executive Director

When voters passed Proposition 63 in 2004, the voter information pamphlet promised "strict accountability for funds". Furthermore, the MHSOAC is required to "ensure that the perspective and participation of diverse community members reflective of California populations and others suffering from severe mental illness and their family members is a significant factor in all of its decisions and recommendations" (WIC § 5846(d)). For those of us working in nonprofit organizations, or those receiving services within the Public Mental Health System, $750,000 or even $400,000 is a significant amount of taxpayer dollars distributed without public comment, or even any prior public knowledge.

While we understand the need for the Executive Director to make financial decisions necessary for the daily functioning of the Commission, such as telecommunications and lease agreements, we see no need for the Executive Director to have authority to enter into any contract up to (in some cases) $750,000. This authority goes far beyond simple agreements related to the business functions of the Commission, and opens the door to back-door contracts intended to fulfill the statutorily required work of the Commission.

Contracts related to the work of the Commission should be subject to public disclosure and comment to ensure they are in alignment with the foundations of the MHSA. An example of this is the current contract with Social Finance. Social Finance, while most likely a very competent organization, is headquartered outside of California, and thus does not have the deep knowledge of the MHSA that California organizations possess. A public process would have opened a discussion about whether these funds should be given to a California-based organization, and would have resulted in several qualified organizations from which to choose the best fit for the project.

Contracts related to the work of the Commission must also be subject to review by the full Commission. Again, referencing the Social Finance contract for $530,000, this contract was approved by the Commission as part of a vague motion where:

> The MHSOAC authorizes the Executive Director to enter into four contracts to support three multi-county collaboratives and one system-change project developed by the Commission's Innovation Incubator with an aggregate not to exceed $2,055,000.

There was no information provided to the Commission about who would receive these 4 contracts, and what the contracts are intended to accomplish. Again, $2,055,000 is a very large sum of public money, and each individual

contract should be reviewed by Commissioners to ensure that MHSA money is spent effectively and appropriately. At the time the Social Finance contract was executed, it was executed in violation of the Rules of Procedure which were in effect at the time.

Certainly, entering into a large contract constitutes a "decision" of the Commission, which should include the perspective and participation of community members. All contracts designed to complete significant portions of the Commission's authority should either be subject to a public bid process, or allow for public comment.

Authority to Approve Innovation Projects

While we understand the challenge of small counties in developing Innovation projects, we are strongly opposed to allowing blanket approvals of Innovation projects without any Commission review or public input. Innovation projects are uniquely designed and intended to promote learning. With this learning, comes challenges and the necessary evolution of Innovation plans. It is this learning which makes an Innovation project the least suitable MHSA project for blanket approvals. A county Innovation plan approved in prior years will most likely have undergone changes and evolution within that county to ensure its effectiveness. Allowing a new county to begin an Innovation project exactly as that project was approved, without considering the challenges faced by the prior county in implementing the project, and without considering the learning which has already taken place, defeats the purpose of an Innovation project; continual learning, evolution, and improvement.

Innovation Plans are also designed to address the unique needs of each county, needs which are determined by that community after a complete Community Planning Process (CPP). Allowing a county to implement an Innovation project from another county sidesteps the entire CPP, the foundation of the MHSA.

Again, we understand the challenges of small counties, but blanket approval of Innovation plans is contrary to the MHSA. There must be limitations on these approvals, including:

- Approvals must be limited to small counties
- Counties must demonstrate a complete Community Planning Process prior to approval
- Small counties must document and incorporate the learning which has taken place in all other counties who have implemented the Innovation Plan

We see no reason why all Innovations plans cannot at the very least be placed on the consent calendar. This allows for approval of non-controversial plans, while promoting discourse on all others.

Committee Structure

The duties of the Commission have increased over the past several years. However, this does not in any way negate the obligations of the Commission to conduct their business in open, public, and transparent forums. Historically, the Commission has included a number of active and involved committees which played a significant role in assisting the Commission with its work. These committees included an Evaluation Committee, a Measurements and Outcomes Committee, a Measurements and Outcomes Technical Resource Group, the Client

and Family Leadership Committee (CFLC), and the Cultural and Linguistic Competence Committee (CLCC). We urge you to not only continue with existing committees, but also to bring back the Evaluation and Outcomes Committees, and create an additional Innovations Committee to review Innovations Plans and a Community Planning Committee to assist counties with their Community Planning Processes by developing a model CPP process.

As history has proven, active and involved Committees hold the potential to effectively assist the Commission with its work, but this requires consistency in Committee rosters. A one-year term is not appropriate if a Committee is to be effective. Many projects continue beyond a year, or cross over between years, and the continual change in membership will prohibit progress. To preserve institutional knowledge, and ensure the effectiveness of Committees, we recommend a minimum of 2-year terms, with a rolling roster so that a maximum of half of Committee members are replaced in any given year. Moreover, standing Committees should be required by the Rules of Procedure, not as merely an option. We therefore urge you to retain the "shall" language in Section 6.1. Lastly, all standing Committees must meet regularly, have their decisions respected and considered by the Full Commission, and receive follow-through from Commission staff.

While Committees are valuable and under-utilized by the Commission, they are attended by fewer members of the public than full Commission meetings. We believe the deleted sentence from Section 4.13 , "Public comment and stakeholder involvement at the committee level does not replace public comment at Commission meetings", must remain in the rules of procedure to ensure adequate stakeholder involvement in the decisions of the Commission. Additionally, we have concerns that limiting stakeholder engagement in the decisions of the Commission risks the possibility of future Bagley-Keene violations.

Again, we appreciate your willingness to receive public comment on the Proposed Changes to the Rules of Procedure, and we respectfully ask that you take the time to meaningfully consider the stakeholder input received, and incorporate that comment into your final Rules of Procedure. As we stated previously—and cannot stress enough—holding a full Commission meeting immediately after the stakeholder meeting does not allow for any meaningful consideration of stakeholder input. We therefore strongly urge you to postpone this agenda item to a later meeting.

Sincerely,

Susan Gallagher, MMPA
Executive Director

February 12, 2021

Lynne Ashbeck
Chair
Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814

Dear Commissioner Ashbeck,

We remain grateful for your leadership to the Commission and your commitment to the community voice. At this time, we respectfully request that the Commission postpone any action items related to the proposed changes to the Rules of Procedure pending full and timely consideration of the feedback received from stakeholders at the stakeholder subcommittee meeting.

Stakeholder participation is a critical tenet of the MHSA and as such should be an integral part of all Commission activities. As the Rules of Procedure define and direct the operations and designations of Commissioners and staff, it is imperative that those impacted by these changes are provided with an opportunity to be a key player in that discussion. Any changes to these rules must be thoroughly considered for their impact on consumers and families, and the service delivery system as a whole. While there has been some engagement of community stakeholders, the statement that this has been a robust and ongoing effort is misleading.

After the proposed changes were released in January 2020, there was no further public action until a two hour meeting was held in September 2020. So, while we are happy to see this conversation continue, this very brief meeting scheduled to take place next week on February 17th, directly ahead of the Commission meeting is only the second publicly noticed subcommittee meeting. While we understand that COVID-19 had a significant impact on the Commission's operations, the minimal engagement of the community on this matter lies in stark contrast to the efforts of the Commission to engage community members on other issues and projects. This is most notably demonstrated when compared to the current PEI project that has already completed 5 community engagement sessions with another 5 scheduled in the next 6 weeks.

In December of 2020, the stakeholders requested a version of the Rules of Procedure with the two sets of the amendments combined, as two separate documents of proposed changes were unclear and confusing. Our stakeholder coalition had refrained from developing our comments in anticipation of a single, combined document. This second version was not made available until Monday, February 8th, 2021 after 5:00 p.m. At this week's 8:00 a.m. meeting, stakeholders will present their concerns regarding this second version. Holding a full Commission vote on the matter at the 9:00 a.m. meeting does not allow time for stakeholder concerns to be thoughtfully considered, and a third version be developed and in print (unless it

is already expected that the stakeholder meeting will result in no changes to the second version). Scheduling these meetings so close together leaves the clear impression that there is no intention of meaningful consideration of stakeholder input.

In consideration of these challenges, we respectfully request that the Commission delay any plans to finalize any changes during the upcoming MHSOAC meeting and instead take the time to outline a full and complete effort to support the needed review and discussion process to ensure transparency on such an important issue.

Sincerely,

<u>ORGANIZATIONS</u>

Dr. Lisa Pion-Berlin, ACHT, ACSW
President and Chief Executive Officer
Parents Anonymous® Inc.

Poshi Walker
LGBTQ Program Director
Cal Voices

Heidi Strunk
Executive Director
Mental Health America in California

Elia Gallardo
Director, Government Affairs
County Behavioral Health Directors Association

Susan Gallagher (ACCESS)
Executive Director
CalVoices

Eba Laye
Executive Director
Whole Systems Learning

Sarah Marxer
Evaluation and Policy Specialist II
Peers Envisioning & Engaging in Recovery Services (PEERS)

Liz Oseguera
Senior Policy Advocates
California Health+ Advocates

Sally Zinman
Executive Director
California Association of Mental Health Peer Run Organizations

Mandy Taylor, MSW *(she/her/hers)*
Behavioral Health Equity Manager
California LGBTQ Health and Human Services Network
A project of Health Access

Tiffany Elliott
Peer Personnel Program Manager
RI International

Stacie Hiramoto, MSW
Director
Racial and Ethnic Mental Health Disparities Coalition

Mel Mason
Executive Director
The Village Project

INDIVIDUALS

Alison Monroe
Family member of a person with serious mental illness
Oakland, CA

R. Bong Vergara, MSW/MA
Health Equity Advocate
Orange County

Laurel Benhamida
Mental Health Advocate for the Muslim Community
California

Lynne Gibbs
Advocate
Santa Barbara County

Lauren Rettagliata
Former Mental Health Commission Chair
Contra Costa County

Shelley Hoffman
Parent and Caregiver Advocate
Los Angeles County

Nicki King, Ph.D.
Mental Health Advocate
Yolo County

Mary Haffner
Mental Health Advocate
Ventura County

Mary Ann Bernard
Attorney and Mental Health Advocate
Sacramento County

Linda Mayo
Mother of Adult Twin Daughters with SMI
Stanislaus County

cc: All Members of the MHSOAC
Toby Ewing, Executive Director
Filomena Yeroshek, Chief Counsel

From: Geoff McLennan <gtmclennan@gmail.com>
Sent: Tuesday, February 16, 2021 12:06 PM
To: Shah, Sharmil@MHSOAC <Sharmil.Shah@mhsoac.ca.gov>
Subject: Fwd: Comments to Rules Procedures Meeting on 2/17, RE: subcommittee terms.

Hi Sharmil,
Please forward this email along to Lynne Ashbeck for tomorrow's meeting, Rules & Procedures. I was not able to find an email for her.
Thanks,
Geoff McLennan

Dear Commissioners, Rules & Procedures Subcommittee,
I submit these comments in the event I can't attend the meeting tomorrow.
I've previously contacted staff and perhaps yourself regarding changes to the term of subcommittee appointments as proposed last year. As proposed and changed, the language would allow a one year term subject to extension to two years. This change should read just the opposite: a 2 year term extended by 1 year to 3 years or more. The reasons I suggest this amendment to the proposal are as follows:
1. Thank you to staff for proposing this change.
2. Within the context of any committee process, consideration should be given to the committee process as **learning to work together takes months, even years**. One year is clearly too short with perhaps the following considerations necessary for caring committee work:
a. **Education about the MHSOAC processes and procedures and state laws-** 1 year. Some may never understand some of the laws.
b. Establishing working relationships on the committee, such as leadership, trust, storming/forming/norming processes, communication, and informal needs takes a year and more. A cohesive policy body means working together and being very considerate, such as taking the time to understand and appreciate other peoples viewpoints. Have you ever worked on a committee when misunderstandings occur?
c. **Special consideration for client members**- those living with mental illness need patience and extra care at times as they may not be capable of attending meetings during a personal crisis, or may need extra time. It is likely that clients will need additional learning time as understanding communication processes (attachments clear, digital issues, video conferencing issues) can be problematic and frustrating for all. We do not all think alike and this takes extra time and patience. Extra time for clients will likely require up to 2 years for this learning curve of processes and procedures of the MHSOAC and the state laws.
d. **Special consideration for family members** who attend to and care for family SMI persons/clients. As a family member/caretaker for my sister for all of my life, I suggest considerable time for anyone on a committee, and particularly those of the MHSOAC. I take care of 2 seriously mentally ill persons and appreciate the challenges and time for caring. This can be upsetting, disruptive, and distracting just at home, and must be included when considering public service. Family members may be anxious about our MI loved ones, and even those we serve with. This takes extra time yet we embrace those caretakers.

My overall point is that **proposing a term of one year is not workable**, particularly for those members who live with mental illness and family members who care for those clients. I respectfully propose that we allow a two year term in consideration of those who live with and are caretakers or family members. Please share this with your committee member. Please bear in mind that I speak mainly from lived experience but also based on post graduate work in psychology and motivation in the workplace, and collaborative work on many boards/commissions/committees.
Time is love and we need to be extra generous with the committee process and those who need extra time.

Thank you, and pardon me if I seem disruptive.
Geoff McLennan

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Thanks, Geoff McLennan

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Mental Health Services Act (MHSA) Innovation Project Plan

County Name: San Mateo
Date submitted: 2/24/20
Project Title: PIONEERS (Pacific Islanders Organizing, Nurturing and Empowering Everyone to Rise and Serve) program
Total amount requested: $925,000 ($750K services; $100K admin; $75K eval)
Duration of project: 4 years

Section 1: Innovations Regulations Requirement Categories

GENERAL REQUIREMENT:

An Innovative Project must be defined by one of the following general criteria:

- ☑ **Introduces a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention**
- ☐ Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population
- ☐ 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
- ☐ Supports participation in a housing program designed to stabilize a person's living situation while also providing supportive services onsite

PRIMARY PURPOSE:

An Innovative Project must have a primary purpose that is developed and evaluated in relation to the chosen general requirement.

- ☑ **Increases access to mental health services to underserved groups**
- ☐ Increases the quality of mental health services, including measured outcomes
- ☐ Promotes interagency and community collaboration related to Mental Health Services or supports or outcomes
- ☐ Increases access to mental health services, including but not limited to, services provided through permanent supportive housing

Section 2: Project Overview

PRIMARY PROBLEM:

What primary problem or challenge are you trying to address? Please provide a brief narrative summary of the challenge or problem that you have identified and why it is important to solve for your community.

Native Hawaiian/Pacific Islanders & Mental Health
Communities of color represent 61% of San Mateo County's population and yet continue to be disproportionately impacted by negative health outcomes. Native Hawaiian/Pacific Islanders (NHPI) in San Mateo County (11,543)[1] account for the largest NHPI population in the Bay Area and are anticipated to double in size by 2040. Addressing behavioral health inequities impacting the NHPI community in a culturally relevant manner, is a priority for our County. NHPI value family, church and community. Interconnectedness plays a central role in NHPI identity and yet the NHPI community is often excluded from societal benefits as they experience some of the highest disparities across various health indicators. In San Mateo County:

- Specialty mental health service penetration rates are lowest for both youth (1.8%) and adult (2.6%) Asian/Pacific Islander racial group[2]. In fiscal year 18/19, our Behavioral Health and Recovery Services (BHRS) served 260 NHPI.
- NHPI youth in San Mateo County schools (grade 9, 11) reported the highest rates of depression related feelings and seriously considered attempting suicide in the previous year.[3]
- Pacific Islanders have one of the highest rates of uninsured at 19.8%[4].

The Mental Health Services Act is explicit in the legislation that developing culturally relevant strategies for underserved populations is a priority. This was core to the California Reducing Disparities Project (CRDP) project, an MHSA- funded project and the largest investment from a State, in the nation, to look into diverse community perspectives on mental health disparities. Most recently, the MHSOAC initiated Youth Innovation Project shared findings from their youth focus groups and online surveys. Not surprisingly, lack of cultural competence was identified as a priority along with increasing preventative mental health services in schools. Yet, there are minimal examples of effective NHPI specific programs that promote mental wellness and link the community to services.

Primary Problem: High rates of depression and suicidality amongst NHPI youth

[1] U.S. Census Bureau, 2018 estimates, https://www.census.gov/quickfacts/sanmateocountycalifornia
[2] Performance Outcomes Adult Specialty Mental Health Services Report, March 22, 2018, https://www.dhcs.ca.gov/provgovpart/pos/. Penetration rates are calculated by taking the number receiving services and dividing by total Medi-Cal eligible.
[3] Lucille Packard Foundation for Children's Health, Kidsdata.org
[4] Advancement Project California; RACE COUNTS, racecounts.org, 2017.

NHPI College-age Youth
College-aged youth are a critical group to engage in behavioral wellness and broader community impact. Many college students experience first onset of mental health and substance use issues during this time.[5] Three out of five college students experience overwhelming anxiety[6] yet, few seek services. This is exacerbated for youth from vulnerable cultural/ethnic families. Studies have found that students of color experience higher levels of mental health difficulties due to racial discrimination, stigma, tendency to not engage in help-seeking behaviors and lack of culturally relevant support services[7]. There is an association between mental health challenges and lower academic achievement and higher dropout rates, especially for ethnic/cultural minority groups. Among Pacific Islanders, 47% of Guamanians, 50% of Native Hawaiians, 54% of Tongans, and 58% of Samoans entered college, but leave without earning a degree.[8]

NHPI make up 1.7% (484) of the San Mateo District Community College student enrollment[9]. Specifically, for NHPI students, the gap between accessing behavioral health services on campus is the expectation that they would access services because they are in need - experiencing a challenge, crisis, or trauma. Understanding and supporting cultural identity is critical for college-age youth mental health.[10] A variety of studies show that ethnic minority college students may have fewer indirect experiences with help-seeking, such as knowing family members or close friends who have sought professional psychological services; may perceive on-campus psychological services as irrelevant and not culturally competent; and may not perceive health service utilization as an established cultural practice.

Need for Culturally Responsive Behavioral Health Services
NHPI's associate individuals with mental illness or mental health issues as sick or demon-possessed; they are extremely rooted in their faiths and believe serving God and prayer are the only cures for healing. This highly emphasized stigma forces NHPIs to internalize their emotions and just get over it when faced with mental health challenges. This stigma serves as an heirloom being passed down from generation to generation. For NHPI students, seeking and speaking to a counselor, therapist, or psychiatrist is such a foreign concept because NHPI families typically deal with their issues at home. Speaking to someone outside of their family unit is discouraged because of shame and dishonor to their family name.

Another factor is that there are few to no NHPI counselors, therapists, or psychiatrists. This same stands in regard to medical care and higher education. NHPIs often do not seem

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[5] National Council on Disability, Mental Health on College Campuses: Investments, Accommodations Needed to Address Student Needs, July 21, 2017

[6] American College Health Association, National College Health Assessment, https://www.acha.org/

[7] National Council on Disability, Mental Health on College Campuses: Investments, Accommodations Needed to Address Student Needs, July 21, 2017

[8] U.S. Census Bureau. American Community Survey Reports, 2010. The National Commission on Asian American and Pacific Islander Research in Education.

[9] California Community Colleges, Student Success Metrics, https://www.calpassplus.org/LaunchBoard/Student-Success-Metrics.aspx

[10] Srivastava, R., & Srivastava, R. (2018). Impact of Cultural Identity on Mental Health in Post-secondary Students. *International Journal of Mental Health and Addiction*, *17*(3), 520–530. doi: 10.1007/s11469-018-0025-3

themselves reflected in these professions enough to 1) imagine themselves in these types of professions 2) feel comfortable seeking services and 3) believe that these professions and services are not only for white people.

The current state of behavioral health services is not meeting the needs of the NHPI community because the services are designed without the NHPI community in mind. NHPIs are expected to utilize behavioral health services simply because they are available when in actuality they do not connect, resonate, nor appeal to the community.

NHPI Leadership Development
There is a lack of investment in personal and professional leadership development of NHPI to champion solutions for healthier outcomes for their community. Improving behavioral health services in a culturally responsive way for NHPIs begins with investing in NHPI young leaders. Young people are plugged into their families, respective churches, schools, sports, student groups, and often are responsible for caring for their elderly family members. This population of NHPIs have the potential to be the change agents in demystifying and dismantling mental illness and mental health stigma in their community.

The investment can fund intentional programming designed by and for NHPI youth to promote linkages, awareness and education about behavioral and emotional health that is culturally relevant to NHPI students, and lead to both 1) developing NHPI leaders in the community, including potentially a pipeline of NHPIs into the public behavioral health field to that could help transform culturally responsive behavioral health care services, and 2) begin shifting the cultural norms of NHPI community to support their emotional wellbeing and behavioral health outcomes.

San Mateo County Public Health Chronic Disease and Injury Prevention previously sponsored a leadership development program with San Mateo High School NHPI youth. It was through these sessions that the need for trauma-informed emotional wellbeing-focused spaces was critical to developing resilient youth NHPI leaders. An NHPI student disclosed that they were seeing a therapist in secret because they did not want to be ostracized by their family. Unfortunately, their visits did not last. NHPIs would rather suffer in silence than bear the weight of shame because fear of being vulnerable, feeling exposed, and losing face among their families and communities.

An NHPI leadership program focused on higher education eventually had to designate a separate space for students to decompress, take a break, and process because the material being covered brought up a lot of past traumas and triggers that have not been addressed. It was a lot for NHPI students to hold on to and process while in that space. Thereafter, that space became a staple in the program. After the program finished, NHPI students would express their need for that space once they were back in their everyday routines.

PROPOSED PROJECT

Describe the INN Project you are proposing.

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

The proposed project, Pacific Islanders Organizing, Nurturing, and Empowering Everyone to Rise and Serve (PIONEERS) provides a culturally relevant behavioral health program for NHPI college-age youth that prioritizes the mental wellbeing of students and their respective communities through empowerment, leadership and advocacy. There is no behavioral health prevention program focused specifically on NHPI college-age youth; ***the innovation will offer a culturally responsive behavioral health prevention program for the NHPI community.***

The PIONEERS program will increase access to behavioral health services for NHPI college-age youth by 1) addressing mental health challenges 2) increasing awareness about the importance of emotional health; 3) building the capacity of NHPI advocates for behavioral health; and 4) improving culturally competent services and treatment for NHPI students on college campuses.

The PIONEERS program will target NHPI college-age youth and run by a community-based behavioral health provider to support linkages to direct treatment for youth who may need it. The CalMHSA Student Mental Health Program (SMHP), a statewide PEI initiative funded by MHSA, set out to improve student mental health across all 114 community college campuses, awarded 30 campus-based grants to expand and enhance the capacity to address the mental health PEI needs of their students, faculty, and staff. A formal evaluation of these programs by RAND Corporation found that campuses are in critical need of direct services and referrals to county and community agencies are often met with limited (or temporary) resources. The proposed project will also develop a new partnership in San Mateo County between San Mateo County Community Colleges, Behavioral Health and Recovery Services and community-based behavioral health providers, which will be core to supporting a much needed service on campuses.

Cultural responsiveness

Two identified barriers to accessing care for NHPI youth are 1) behavioral health stigma and 2) the cultural humility necessary to work with NHPI youth regarding behavioral health. Educating the campus about suicide, mental illness, and emotional wellbeing cannot be a cookie-cutter approach; educating the campus about all things behavioral health must be equitable and relevant to the population served.

The three local campuses of the San Mateo County Community College District (SMCCCD), Skyline College, College of San Mateo, and Cañada College, were examined to determine the level of mental health services and resources available to students on campus. Each campus had standard personal counseling offices staffed with licensed mental health professionals. All three campuses clearly defined that students need to make an appointment, counseling sessions are brief, and are limited to the academic calendar. Each campus had different resources available: drop-in center; wellness center; mental health peer educators; and educational trainings and workshops. Not one campus had any specific efforts on campus focused on vulnerable

ethnic populations. The closest program was a peer-to-peer support service offered at College of San Mateo. The services and resources are open to all and do not focus on any specific ethnic group.

Based on research outside of San Mateo County, Universities in California offer more mental health resources. California State University, Long Beach has a program called Project OCEAN (On-Campus Emergency Assistance Network) that was federally funded by Substance Abuse and Mental Health Services Administration (SAMHSA) between 2008-11, MHSA PEI funded through CalMHSA between 2012-14 and was permanently institutionalized in 2014 through Student Affairs based on impact of the program. Project OCEAN's is a peer education program that supports the mental health concerns of all students.

The CalMHSA SMHP initiative made significant momentum around stigma reduction and mental health awareness on college campuses, and yet, the programs did not look at cultural disparities and needs of some of the most vulnerable youth. The proposed project was developed by the BHRS Office of Diversity and Equity, Pacific Islander Initiative with culture responsiveness at the core and throughout each phase of the project and community input in the process. The PIONEERS program will include culturally focused strategies with the goal of participants developing protective factors for NHPI college-age youth as they understand cultural and mental health connections and develop leadership skills.

Leadership and community advocacy

Individual focused behavioral health prevention programs alone can develop protective factors for youth and linkages to needed behavioral health supports. A comprehensive approach integrating social and community-level strategies can have an exponential impact on behavioral health outcomes. It is well documented that improving behavioral health outcomes requires broader approaches that consider social determinants of health including community and social context (social integration, support systems, community engagement). Pertinently, the NHPI community embraces a collectivist culture, a prevention approach that integrates developing youth NHPI leaders (and hopefully contributors to a transformed behavioral health workforce) and giving back to their communities, especially given the broad health disparities impacting NHPI, is not only smart practice but culturally relevant.

Based on final research outside of the United States, there is a plethora of mental health content for NHPI in Aotearoa/New Zealand. Le Va (www.leva.co.nz). Le Va is ran by NHPI professionals who prioritize mental health, provide education and trainings for the NHPI community on how to work with the NHPI community, and build the capacity of NHPI's to thrive in the health and disability workforce. There is nothing like Le Va that exists in the U.S. for NHPI's.

The proposed project (PIONEERS Program) will consist of 4 key components:

1) YOUTH ADVISORY CIRCLE

- An advisory circle of NHPI college-age youth and the Pacific Islander Initiative will be recruited early in the project start-up phase. The advisory circle will inform all aspects of the PIONEERS program including the final program curriculum, activities, outreach strategies, evaluation and dissemination of the findings. While all current components of the project where developed based on learnings from youth themselves through other community leadership development and behavioral health spaces, youth will continue to play a critical role in the evolution of this project.

2) PIONEER INSTITUTE

- The 5-day PIONEER program provides cultural education alongside discussions and discoveries of self, identity, history, community, mental health, issues, institutions, policies, and other topics that develop young leaders' knowledge, skills, and network.
- Pending review and input from the youth advisory circle for the project, some of the topics addressed in the 5-day PIONEER curriculum may include:
    - **Lifelines:** Pacific Islanders' lineage a common history and more importantly share genealogy with one another. This connectedness is foundational to the way Pacific Islanders relate to one another, a bond that predates Western interruption. As communities continue to grow in the United States, they are also dispersed across the country diminishing bonds that once held families and nations together. Sharing one's journey and story is the first step to learning about one another and sparking warmth that can only be reignited when embracing kin.
    - **Migration Stories:** The exploration of the current state of the Pacific Islander community in the U.S. needs to start with the genesis of the community in this country. That starts at the inception of the idea to cut the umbilical cord from the motherland in the pursuit of a greater source of life for future generations. The stories of the migrant generation hold the visions that brought them thousands of miles across the ocean; stories, and therefore visions, that are nearly lost on the current generation. Hearing these stories breathe life back into these visions as parents and elders pass these stories to the students. Allowing students time to share their story with their peer, then visualize it on paper, gives them time to think more deeply about their individual story while drawing a bond with their peer's journey. The process of comparison automatically sets the stage for contrasting the visions in their stories to their current experiences. This prepares students' minds for further exploration of issues in the Pacific Islander communities.
    - **Community Memberships:** Part of understanding oneself is to understand where we belong and that isn't limited to our families. Belonging is wherever we place ourselves in any given situation at any given time. These assignments are determined by personal values and belief systems. These groupings are often socially constructed according

to societal expectations and norms. Understanding where we assign ourselves; how we prioritize those assignments; and recognizing the privileges and constraints that they come with affords a greater understanding of others while opening up the possibilities for acceptance and embrace of those different from ourselves.

- **Power of Resistance:** Leaders like Nat Turner, Sojourner Truth, and Marcus Garvey resisted and revolted against the disdain of Black people by White oppressors. Nat Turner was the first slave to lead a rebellion; Sojourner Truth escaped slavery and became an abolitionist; Marcus Garvey was a Black Nationalist. These leaders paved the way for future leaders such as Dr. Martin Luther King, Jr., Malcolm X, and Angela Davis. As Pacific Islanders, our people suffered oppression through colonization of our homelands. Many of our islands were occupied by military forces, used for atomic bomb testing, or stolen for its natural resources. Resistance has been something our ancestors demonstrated even before migrating to the United States. When Hawaiian language was banned in 1896, Queen Liliuokalani and the Hawaiian people snuck letters to each other written in Hawaiian language wrapped in flowers; when Lauaki Namulauulu Mamoe established the Mau a Pule, a resistance group against German rule, he was exiled from his homeland to Saipan; when Tupua Tamasese led a peaceful march in Samoa, he was killed by German forces. Leaders of our islands understood the necessity of having a voice, the power in organizing and standing together, the importance of resisting what they felt was wrong! Many died in the resistance that is now part of our legacy as Pacific Islanders.
- **Mana Room:** Mana is a term used in Polynesia, Melanesia, and Micronesia that is the foundation of our world view. Mana is a form of spiritual energy; healing energy; powerful energy; a sacred force existing in the universe. Mana is positive energy transmitted through land, the environment, sacred objects, and people.

3) MANA SESSIONS

- PIONEER Mana Sessions will be provided once a month in the fall. These sessions provide safe space to decompress, engage in group discussions centered around mental health and wellness, and skills building workshops.

4) FORWARD MOVEMENT PROJECTS

- Identify opportunities to give back or be of service to their community; lead workshops and discussions with high/middle school students and the broader community. Apply knowledge acquired from PIONEERS to determine what students' needs are, develop workshops, and provide it for them.

Project implementation activities

- Hire NHPI staff that have experience and rapport serving the NHPI community in San Mateo County and represent the different neighborhoods across the county with high NHPI population.
- Work with faculty and campus staff to set up the program schedule and get any infrastructure needed in place prior to launch
- Recruit advisory circle of NHPI college-age youth and the Pacific Islander Initiative to inform the program curriculum, activities, outreach strategies, implementation and evaluation.
- Work with the advisory circle to finalize the PIONEERS program.
- Identify potential community opportunities and NHPI leaders and partners to support PIONEERS' youth in their forward movement project.
- Work with evaluators to set up a continuous feedback process, evaluation tools and plan.
- Conduct outreach to engage NHPI college-age youth from both on-campus and the community.
- Launch the first cohort of NHPI student PIONEERS.

B) Identify which of the three project general requirements specified above [per CCR, Title 9, Sect. 3910(a)] the project will implement.

☑ **Increases access to mental health services to underserved groups**

C) Briefly explain how you have determined that your selected approach is appropriate.

The planning of the PIONEERS program has involved stakeholders from the system of care and the community, including NHPI youth. The idea was brought forward by the Pacific Islander Initiative (PII), a collaborative of providers, community leaders, clients/family members. PII stakeholders have been working on the idea for years prior to applying for innovation funds taking into account learnings from a previous youth leadership development program and deep understanding of the cultural barriers to accessing behavioral health care services. Based on a comprehensive review of published literature, web-based searches, the following were identified as key considerations for the project activities and approach:

1. **NHPI College-Age Youth** - There is a need for promising sustainable practices that address the mental health needs of NHPI college-age youth.
2. **Cultural Relevance** - Cultural identification and responsiveness is critical for the mental health of NHPI youth as they explore the opposing values of two cultures.
3. **Health Disparities** – Significant disparities in quality of life and behavioral health outcomes exist for NHPI communities.

These findings were used as supporting evidence for the proposed interventions and selected approach for this project. Appendix 1. Theory of Change illustrates the pathways between these five key considerations, the interventions or activities, expected outcomes, and learning objectives.

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

An NHPI Peer Counselor will engage NHPI youth on local college campuses. In FY 2017- 2018, there were 484 NHPI youth enrolled in San Mateo District Community Colleges and about 450 NHPI youth in grades 9-12. The expected annual reach is:

- 45 NHPI college-age youth engage in PIONEER program services
  - 90% develop protective factors (cultural and mental health awareness, self-identity and coping skills)
  - 90% attitudes and knowledge towards mental health improve
  - 80% youth mental health improves (suicide ideation, anxiety, depression)
  - 90% NHPI youth referred to behavioral health services; 85% follow through and engage in services

- 30 NHPI community youth engaged through the program's community advocacy component
  - 90% of all NHPI youth attitudes and knowledge towards mental health improve
  - 90% reduced stigma and improved awareness

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 PIONEERS program will target NHPI college-age youth. While data is limited for this community, we know that the NHPI community experiences some of the highest disparities across various health indicators. The Census Bureau reports that 17.6% of the NHPI community lived below poverty, compared to a national poverty rate of 11.7% for Asians and 11.6% for Whites.

RESEARCH ON INN COMPONENT

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

The key differences with the proposed project compared to other college mental health programs include:

- Cultural responsiveness to NHPI youth
- Community advocacy connection as NHPI college-age youth engage in broader NHPI community impact

B) Describe the efforts made to investigate existing models or approaches close to what you're proposing. Have you identified gaps in the literature or existing practice that your project would seek to address? Please provide citations and links to where you have gathered this information.

A comprehensive online and literature search was conducted for

- College mental health programs and lessons learned (online)
- Best practices for college mental health strategies (literature)
- Need for culturally responsive college mental health programs (literature)

Gaps in the literature and practice	Proposed intervention
No culturally specific, comprehensive college mental health programs for NHPI community. Culturally relevant outreach and engagement strategies (peer educators, cultural events) but a cookie-cutter approach to mental health.	The proposed project will incorporate cultural responsiveness into every phase and aspect of the program.
Community colleges and two-year institutions experience greater challenges, than 4-year universities, with providing mental health services.	The proposed project will develop a new partnership between community colleges and, county and community behavioral health providers.
No examples of college mental health programs that consider NHPI social determinants of behavioral health outcomes.	The proposed project will empower NHPI youth to get involved in a community advocacy project.

- CalMHSA – market research
- RAND Corporation, https://www.rand.org
- SAMSHA Programs, https://www.samhsa.gov/behavioral-health-equity/aanhpi
- Lucille Packard Foundation for Children's Health, https://www.kidsdata.org
- Asian & Pacific Islander American Health Forum, https://www.apiahf.org
- National Asian American Pacific Islander Mental Health Association, http://naapimha.org
- U.S. Census Bureau, 2018 estimates, https://www.census.gov/quickfacts/sanmateocountycalifornia
- Performance Outcomes Adult Specialty Mental Health Services Report, March 22, 2018, https://www.dhcs.ca.gov/provgovpart/pos/. Penetration rates are calculated by taking the number receiving services and dividing by total Medi-Cal eligible.
- Advancement Project California; RACE COUNTS, https://www.racecounts.org, 2017.
- National Council on Disability, Mental Health on College Campuses: Investments, Accommodations Needed to Address Student Needs, July 21, 2017
- American College Health Association, National College Health Assessment, https://www.acha.org/
- National Council on Disability, Mental Health on College Campuses: Investments, Accommodations Needed to Address Student Needs, July 21, 2017
- U.S. Census Bureau. American Community Survey Reports, 2010. The National Commission on Asian American and Pacific Islander Research in Education.
- California Community Colleges, Student Success Metrics, https://www.calpassplus.org/LaunchBoard/Student-Success-Metrics.aspx
- Srivastava, R., & Srivastava, R. (2018). Impact of Cultural Identity on Mental Health in Post-secondary Students. International Journal of Mental Health and Addiction, 17(3), 520–530. doi: 10.1007/s11469-018-0025-3

LEARNING GOALS/PROJECT AIMS

The broad objective of the Innovative Component of the MHSA is to incentivize learning that contributes to the expansion of effective practices in the mental health system. Describe your learning goals/specific aims and how you hope to contribute to the expansion of effective practices.

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?

Learning Goal #1 - Mental Health Outcomes

- Does the PIONEER program improve mental health outcomes for NHPI college-age youth?

- Does a culturally relevant college and community focused intervention improve access to behavioral health services for NHPI college-age youth?

- Does integration of leadership and community advocacy improve quality of life outcomes for NHPI?

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

As stated prior, the two key differences with the proposed project include:

- Cultural responsiveness to NHPI youth *(Learning Goal #1 and #2)*
- Community advocacy connection as NHPI college-age youth engage in broader NHPI community impact *(Learning Goal #3)*

The learning goals are directly connected to the needs, strategies (including the approaches that are new in the proposed project) and outputs as depicted in Appendix 1. Theory of Change.

EVALUATION OR LEARNING PLAN

For each of your learning goals or specific aims, describe the approach you will take to determine whether the goal or objective was met. Specifically, please identify how each goal will be measured and the proposed data you intend on using.

An independent evaluation consultant will be contracted and monitored by the MHSA Manager in collaboration with the BHRS program monitor and the Aging and Adult Services program coordinator to formally evaluate the innovation project. The following depicts a rough evaluation plan given that the consultant will be hired after the project is approved.

Learning Goal #1 -Mental Health Outcomes

- Does the PIONEER program improve mental health outcomes for NHPI college-age youth?

Due to unavailable baseline data specific to NHPI youth mental health outcomes, the following indicators will be collected as a baseline and tracked throughout the project to inform Learning Goal #1. Measures and methods could include:

- Number of NHPI college-age youth that engage in PIONEER program services
    - Percent of youth whose mental health improves (suicide ideation, anxiety, depression), as determined by pre/post screening.

Additionally, occasional interviews or planned focus groups with students that engage with the PIONEERS program can help us determine the **level of satisfaction** and narrative for the impact this project may have on NHPI student's **emotional health**. Demographics of youth that engage will also be collected.

Learning Goal #2 - Access

- Does a culturally relevant college and community focused intervention improve access to behavioral health services for NHPI college-age youth?

Some baseline data exists, while other indicators will be collected as a baseline and tracked throughout the project to inform Learning Goal #2. Measures and methods could include:

- Number of NHPI college-age youth referred to behavioral health services
- Percentage that follow through and engage in services (some baseline data available through BHRS)
- Percent develop cultural pride and sense of belonging, as determined by pre/post survey
- Percent decreased stigma and increased knowledge about available behavioral health resources, as determined by pre/post survey.

Additionally, the same occasional interviews or planned focus groups with youth that engage with the PIONEERS program (mentioned above) can include questions about **cultural awareness** determine the level of impact on **attitudes and behaviors towards mental health** and service utilization.

Learning Goal #3 - Capacity Building

- Does integration of leadership and community advocacy improve quality of life outcomes for NHPI?

The NHPI community embraces a collectivist culture, a prevention approach that integrates NHPI youth leadership and giving back to their communities, especially given the broad health disparities impacting NHPI, can have broad positive health outcomes. Due to unavailable baseline data specific to NHPI youth, the following indicators will be collected as a baseline and tracked throughout the project to inform Learning Goal #3. Measures and methods could include:

- Number of NHPI college-age youth engaged through the program's community advocacy component.

Pre/post surveys to determine:

- Improved protective factors (cultural and mental health awareness, self-identity and coping skills) of both community and youth participants
- Improved leadership skills (confidence, concrete tools, etc.)
- Improved educational outcomes (i.e. graduating with a degree)

Additionally, occasional interviews or planned focus groups with students and community youth that engage with the PIONEERS program can help us determine the **level of satisfaction** and narrative for the **impact on quality of life** , including educational goals. Pre- and post- to assess **protective factors**, internal strengths and external supports across several contexts: personal, peers, family, school, and community.

Section 3: Additional Information for Regulatory Requirements

CONTRACTING

If you expect to contract out the INN project and/or project evaluation, what project resources will be applied to managing the County's relationship to the contractor(s)? How will the County ensure quality as well as regulatory compliance in these contracted relationships?

All BHRS service agreements (contracts, MOU's) are monitored by a BHRS Manager that has the subject matter expertise. Contract monitors check-in at least monthly with service providers to review challenges, successes, troubleshoot and stay up-to-date on the progress of the project. Additionally, reporting deliverables are set in place in the agreements and linked to invoicing. Payments of services are contingent on the reporting. Evaluation contracts are monitored in a similar fashion by the MHSA Manager in collaboration with the assigned BHRS Manager.

COMMUNITY PROGRAM PLANNING

Please describe the County's Community Program Planning (CPP) process for the Innovative Project, encompassing inclusion of stakeholders, representatives of unserved or under- served populations, and individuals who reflect the cultural, ethnic and racial diversity of the County's community.

In San Mateo, the CPP process for Innovation Projects begins with the development of the MHSA Three -Year Plan. A comprehensive community needs assessment process determines the gaps, needs and priorities for services, which are used as the basis for the development of Innovation projects. Appendix 2 illustrates and describes the Three-Year Plan CPP process for San Mateo County.

Between February and March 2019, a broad solicitation of innovation ideas was launched. Both a flyer and an MHSA Innovation Idea Form were circulated through various means:

- Flyers are sent to/placed at County facilities, as well as other venues like family resource centers and community-based organizations;
- Announcements at numerous internal and external community meetings;
- Announcements at program activities engaging diverse families and communities (Parent Project, Health Ambassador Program, Lived Experience Academy, etc.);
- E-mails disseminating information to over 1,500 community members and partners;
- Word of mouth on the part of committed staff and active stakeholders,
- Postings on a dedicated MHSA webpage smchealth.org/bhrs/mhsa, the BHRS Wellness Matters bi-monthly e-journal and the BHRS Blog www.smcbhrsblog.org
- MHSA Innovation brainstorming sessions held with groups that requested it (Lived Experience Workgroup, MHSARC Older Adult Committee).

The MHSA Innovation Idea Form requested narrative on the proposed idea/project and information to ensure the idea meets the requirements for Innovation funding. Additionally, in San Mateo County we had the requirement that the idea address the MHSA Three-Year Plan prioritized needs:

- Engagement and integration of older adults across services and prevention activities
- Culturally relevant outreach and service delivery
- Integration of peer/family supports across services and prevention activities
- Integration of co-occurring practices across services and prevention activities
- Engagement services for transition-age youth (mentoring, education, peer support)
- Broader housing options to support individuals across the continuum of care

We received 35 MHSA Innovation Idea Forms, which speaks to the need for innovation in serving some of our most vulnerable communities' needs. All submitted ideas were pre-screened against the Innovation requirements, twenty-one were moved forward to an MHSA Innovation Selection Committee. The committee was made up of diverse clients, family members, community service providers and staff. All projects were reviewed and prioritized by the committee and included an Impact/Effort assessment and scoring. Five proposed Innovation ideas moved forward to develop into full Innovation project proposals for approval by the Mental Health Oversight and Accountability Commission (MHSOAC).

On October 2, 2019, the MHSA Steering Committee met to review the 5 project ideas and provide comment and considerations for the projects. The MHSARC voted to open the 30-day public comment period and reviewed MHSOAC comments, during the public hearing and closing of the public comment period on November 6, 2019. No other substantive comments were received. All comments are included in Appendix 3.

MHSA GENERAL STANDARDS

Using specific examples, briefly describe how your INN Project reflects, and is consistent with, all potentially applicable MHSA General Standards listed below as set forth in Title 9 California Code of Regulations, Section 3320 (Please refer to the MHSOAC Innovation Review Tool for definitions of and references for each of the General Standards.) If one or more general standards could not be applied to your INN Project, please explain why.

A) Community Collaboration

The proposed project will require partnerships for success, between NHPI college-age youth, Community Colleges, County BHRS, and community behavioral health services. The planning of the PIONEERS program has involved stakeholders from the system of care and the community, including youth. The idea was brought forward by the Pacific Islander Initiative (PII), a collaborative of providers, community leaders, clients/family members including youth. The collaboration with PII will continue through implementation in an advisory role to the project.

B) Cultural Competency

The entire project is rooted in cultural values and the understanding that cultural shapes mental health. Programming will leverage the collectivist culture of the NHPI community.

C) Client/Family-Driven

As mentioned above, PII will continue to play a role in the implementation of this project. This program is a prevention strategy targeting individuals that have not been diagnosed with a mental health condition. Clients and family members will be engaged in an advisory capacity through the PII or as independent member of an advisory board. The Mental Health Substance Abuse and Recovery Commission Older Adult Committee, which is made up of clients, family members and providers will be an ideal resource for this role. The evaluation contractor will gather input on the evaluation questions and strategies, develop quarterly progress reports to share preliminary findings and gather input from the advisory group.

D) Wellness, Recovery, and Resilience-Focused

Supporting wellness, recovery and resilience is accomplished through relationships and social networks, flexibility, respect and responsiveness, and taking a wholistic approach that considers overall health, stable housing, independence, etc. These principles are key to the strategies of the proposed project including hiring peer mental health workers that have experience serving the NHPI community in San Mateo County to conduct the programming, focusing on stigma reduction and trust building conversations and a process that aims to creating safe spaces and reduce stigma and shame.

E) Integrated Service Experience for Clients and Families
A request for proposal process will select the service provider that will own the contract for these services. Pre-launch planning and ongoing collaboration will be critical to offering an integrated service experience for recipients. PIONEERS program peers will need to be well-informed on the full range of services at BHRS and the community and build relationships with gatekeepers to ensure a coordinated referral and warm hand-off process.

CULTURAL COMPETENCE AND STAKEHOLDER INVOLVEMENT IN EVALUATION

Explain how you plan to ensure that the Project evaluation is culturally competent and includes meaningful stakeholder participation.

As mentioned earlier, the evaluation contractor will engage an advisory group of diverse clients, family members and providers to gather input on the evaluation questions, strategies and on quarterly progress reports. Cultural and language demographics will be collected and analyzed as part of the quarterly reports to ensure equal access to services among racial/ethnic, cultural, and linguistic populations or communities. The quarterly reports will be used to inform and adjust as needed the direction, outreach strategies and activities.

INNOVATION PROJECT SUSTAINABILITY AND CONTINUITY OF CARE

Briefly describe how the County will decide whether it will continue with the INN project in its entirety or keep particular elements of the INN project without utilizing INN Funds following project completion. Will individuals with serious mental illness receive services from the proposed project? If yes, describe how you plan to protect and provide continuity of care for these individuals upon project completion.

The advisory group will be engaged in the evaluation and adjustments of the project. In addition, the MHSA Steering Committee will be a venue for vetting next steps with diverse stakeholders. If the evaluation indicates that the proposed project is an effective means of increasing access to behavioral health services for at risk older adults and there is availability of Prevention and Early Intervention (PEI) funding, a proposal of continuation would be brought to the MHSA Steering Committee and the Mental Health and Substance Abuse Recovery Commission for approval and to a 30-day public comment process to secure ongoing PEI funding. Contractors will be asked to develop a sustainability plan as part of their project proposal.

COMMUNICATION AND DISSEMINATION PLAN

Describe how you plan to communicate results, newly demonstrated successful practices, and lessons learned from your INN Project.

A) How do you plan to disseminate information to stakeholders within your county and (if applicable) to other counties? How will program

participants or other stakeholders be involved in communication efforts?

MHSA implementation is very much a part of BHRS' day-to-day business. Information is shared, and input collected with a diverse group of stakeholders, on an ongoing basis. All MHSA information is made available to stakeholders on the the MHSA webpage, www.smchealth.org/bhrs/mhsa. The site includes a subscription feature to receive an email notification when the website is updated with MHSA developments, meetings and opportunities for input. This is currently at over 1,500 subscribers.

The BHRS's e-journal, Wellness Matters is published the first Wednesday of every other month and distributed electronically to county wide partners and stakeholders, and serves as an information dissemination and educational tool, with a standing column written by the County's MHSA Manager. The BHRS Blog also provides a forum for sharing and disseminating information broadly. In addition, presentations and ongoing progress reports are provided by BHRS, and input is sought on an ongoing basis at the monthly Mental Health and Substance Abuse and Recovery Commission meeting at the MHSA Steering Committee meeting; at meetings with community partners and advocates; and internally with staff.

Opportunities to present at statewide conferences will also be sought.

B) KEYWORDS for search: Please list up to 5 keywords or phrases for this project that someone interested in your project might use to find it in a search.

- NHPI Youth Behavioral Health
- NHPI College Behavioral Health Program
- Culturally Responsive Behavioral Health Prevention

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH
& RECOVERY SERVICES

TIMELINE

A) Specify the expected start date and end date of your INN Project
April 1, 2020 – December 31, 2023

B) Specify the total timeframe (duration) of the INN Project
4 years

- BHRS administrative project start-up through June 30, 2020
- 3 years of project implementation July 1, 2020 through June 30, 2023
- Final evaluation report due December 31, 2023

C) Include a project timeline that specifies key activities, milestones, and deliverables.

The timeline will be negotiated and finalized with the contracted partner agency and may change during implementation:

April 1, 2020 – June 30, 2020

- BHRS Administrative startup activities – RFP and contract negotiations

July 1, 2020 – September 30, 2020

- Project startup activities – establish/formalize agreements as needed (with colleges, other providers), establish advisory group, hire staff, set up infrastructure for implementation/evaluation and referral system and resources
- Evaluator to meet with contractor, advisory group and BHRS staff to discuss evaluation plan and tools

October 1, 2020 – December 31, 2020

- Onboarding of staff – training, relationship building, networking
- Determine schedule of programming, finalize promotional materials, referral resources and tools
- Evaluation plan finalized including data collection and input tools

January 1, 2021 – June 30, 2021

- Promotion and recruitment begin
- Data tracking and collection begins
- First evaluation quarterly report January 1, 2021 – March 31, 2021 presented to advisory group for input, adjustments to strategies, tools and resources, based on operational learnings to-date and quantitative data available.

July 1, 2021 – December 31, 2021

- Qualitative data collection begins (interviews, focus groups, etc.)
- Sustainability planning begins
- Continue promotion, programming, referrals and warm hand-offs
- Continue evaluation quarterly reports to request input and determine adjustments, as

needed

January 1, 2022 – June 30, 2022

- Continue sustainability planning
- Continue promotion, programming, referrals and warm hand-offs
- Continue evaluation activities and quarterly reports to request input and determine adjustments, as needed

July 1, 2022 – December 31, 2022

- Initial sustainability plan presented
- Engage MHSA Steering Committee and MHSARC on issue of continuation of the project with non-INN funds
- Determine if PEI dollars will be available to fund all or portions of the project
- Continue promotion, programming, referrals and warm hand-offs
- Continue evaluation activities and quarterly reports to request input and determine adjustments, as needed

January 1, 2023 – June 30, 2023

- Sustainability plan finalized
- Continue promotion, programming, referrals and warm hand-offs
- Continue evaluation activities and quarterly reports to request input and determine adjustments, as needed

July 1, 2023 – December 31, 2023

- Complete evaluation analysis and report
- Disseminate final findings and evaluation report

Section 4: INN Project Budget and Source of Expenditures

INN PROJECT BUDGET AND SOURCE OF EXPENDITURES

The next three sections identify how the MHSA funds are being utilized:

- **A)** BUDGET NARRATIVE (Specifics about how money is being spent for the development of this project)
- **B)** BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY (Identification of expenses of the project by funding category and fiscal year)
- **C)** BUDGET CONTEXT (if MHSA funds are being leveraged with other funding sources)

BUDGET NARRATIVE

Provide a brief budget narrative to explain how the total budget is appropriate for the described INN project. The goal of the narrative should be to provide the interested reader with both an overview of the total project and enough detail to understand the proposed project structure. Ideally, the narrative would include an explanation of amounts budgeted to ensure/support stakeholder involvement (For example, "$5000 for annual involvement stipends for stakeholder representatives, for 3 years: Total $15,000") and identify the key personnel and contracted roles and responsibilities that will be involved in the project (For example, "Project coordinator, full-time; Statistical consultant, part-time; 2 Research assistants, part-time…"). Please include a discussion of administration expenses (direct and indirect) and evaluation expenses associated with this project. Please consider amounts associated with developing, refining, piloting and evaluating the proposed project and the dissemination of the Innovative project results.

The total Innovation funding request for 3.9 years is $925,000, which will be allocated as follows:

Service Contract: $750,000
- $250,000 for FY 20/21
- $250,000 for FY 21/22
- $250,000 for FY 22/23

Evaluation (10%): $75,000
- $30,000 for FY 20/21
- $20,000 for FY 21/22
- $20,000 for FY 22/23
- $5,000 For FY 23/24

Administration (15%): $100,000
- $20,000 for FY 19/20
- $30,000 for FY 20/21
- $30,000 for FY 21/22
- $20,000 for FY 22/23

Direct Costs will total $750,000 over a three-year term and includes all contractor expenses related to delivering the services (salaries and benefits, program supplies, rent/utilities, mileage, transportation of clients, translation services, subcontracts for outreach, etc.).

Indirect Costs will total $150,000
- $75,000 for the evaluation contract with the final report will be due by December 31, 2024. The evaluation contract includes developing a plan, supporting data collection, data analysis and submitting annual reports to the MHSOAC.
- $100,000 for BHRS county business, contract monitoring, fiscal tracking, IT support, and oversight of the innovation project

Federal Financial Participation (FFP) there is no anticipated FFP. **Other Funding** N/A

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY*							
EXPENDITURES							
PERSONNEL COSTS (salaries, wages, benefits)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
1.	Salaries						
2.	Direct Costs						
3.	Indirect Costs	$20,000	$30,000	$30,000	$20,000		$100,000
4.	**Total Personnel Costs**	**$20,000**	**$30,000**	**$30,000**	**$20,000**		**$100,000**
OPERATING COSTS		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/34**	**TOTAL**
5.	Direct Costs						
6.	Indirect Costs						
7.	Total Operating Costs						
NON RECURRING COSTS (equipment, technology)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
8.							
9.							
10.	**Total Non-recurring costs**						
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		$250,000	$250,000	$250,000		$750,000
12.	Indirect Costs		$30,000	$20,000	$20,000	$5,000	$75,000
13.	**Total Consultant Costs**		**$280,000**	**$270,000**	**$270,000**	**$5,000**	**$825,000**
OTHER EXPENDITURES (please explain in budget narrative)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
14.							
15.							
16.	**Total Other Expenditures**						
BUDGET TOTALS							
Personnel (line 1)							
Direct Costs (add lines 2, 5 and 11 from above)			$250,000	$250,000	$250,000		$750,000
Indirect Costs (add lines 3, 6 and 12 from above)		$20,000	$60,000	$50,000	$40,000	$5,000	$175,000
Non-recurring costs (line 10)							
Other Expenditures (line 16)							
TOTAL INNOVATION BUDGET		**$20,000**	**$246,000**	**$246,000**	**$231,000**	**$12,000**	**$925,000**

*For a complete definition of direct and indirect costs, please use DHCS Information Notice 14-033. This notice aligns with the federal definition for direct/indirect costs.

BUDGET CONTEXT - 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**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
1.	Innovative MHSA Funds	$20,000	$280,000	$280,000	$270,000		$850,000
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Administration**	**$20,000**	**$280,000**	**$280,000**	**$270,000**		**$850,000**
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		$30,000	$20,000	$20,000	$5,000	$75,000
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Evaluation**		**$30,000**	**$20,000**	**$20,000**	**$5,000**	**$75,000**
TOTAL:							
C.	**Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
1.	Innovative MHSA Funds	$20,000	$310,000	$300,000	$290,000	$5,000	$925,000
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Expenditures**	**$20,000**	**$310,000**	**$300,000**	**$290,000**	**$5,000**	**$925,000**
*If “Other funding” is included, please explain.							

Appendix 1. Theory of Change

Theory of Change

Primary Problem: High rates of depression and suicidality amongst NHPI youth

Key Considerations (from the literature)

College Youth Mental Health
College-aged youth often experience first onset or worsening of mental health and substance use issues; this is exacerbated for NHPI and students of color due to discrimination, stigma, self-identity and lack of culturally relevant services.

Cultural Relevance
There is a lack of culturally relevant strategies on college campuses for supporting NHPI youth mental health.

Health Disparities
Significant disparities in health and behavioral health outcomes exist for NHPI communities; broader approaches that consider social determinants are key

Interventions

On-Campus Programming
Services will be provided primarily on-campus to support stigma reduction and participation of NHPI youth in college. Students will lead mental health dialogues, awareness, etc. in the community to allow for broader impact and reach of NHPI youth.

PIONEERS program will provide:
Cultural Education as it relates to wellness and mental health
Mana Group Sessions for peer discussions centered on wellness and mental health

Community Advocacy to impact broader changes for NPHI community. College students will lead community discussions and at high-middle schools, conduct community health advocacy or capacity building efforts, etc.

Outcomes

Stigma Reduction
45 NHPI college students engage in program services
30 NHPI community youth engaged with the program
90% college student participants develop protective factors (cultural and behavioral health awareness, self-identity and coping skills)
90% NHPI youth attitudes towards and knowledge about behavioral health improve.

Youth Mental Health
Decreased mental health challenges (suicide ideation, anxiety, depression)
90% NHPI youth referred to behavioral health services; **85%** engage in services

Community Mental Wellness
90% reduced stigma and improved awareness

Learning Objectives

Learning Goal #1
Does the PIONEER program improve mental health knowledge and decrease stigma for NHPI college-age youth?

Learning Goal #2
Does contextualizing culture with mental health improve attitude and behavior of NHPI college-age youth towards behavioral health service utilization?

Learning Goal #3
Does a culturally relevant college and community focused intervention improve access to behavioral health services for NHPI?

MHSA INN Primary Purpose

Increased access to behavioral health services

Appendix 2. Community Planning Process for MHSA Three-Year Plan

San Mateo County Mental Health Services Act

Three-Year Plan FY 2017-2020

Community Program planning (CPP) process

In December 2016, a comprehensive Community Program Planning (CPP) process to develop the MHSA Three-Year Plan was kicked off by our local mental health board, the Mental Health and Substance Use Recovery Commission (MHSARC). Planning was led by the MHSA Manager and the Director of BHRS along with the MHSARC and the MHSA Steering Committee.

A draft CPP process was presented to and vetted by the MHSARC. The MHSARC was asked for their input and comments on the process and what other stakeholder groups should we be reaching out to in each of the CPP Phases.

STAKEHOLDERS INVOLVED

Input was sought from twenty nine diverse groups and vulnerable populations to include perspectives of different backgrounds and interests including geographical, ethnic, cultural and

social economic, providers and recipients of behavioral health care services and other sectors, clients and their family members. See the full list of input sessions below.

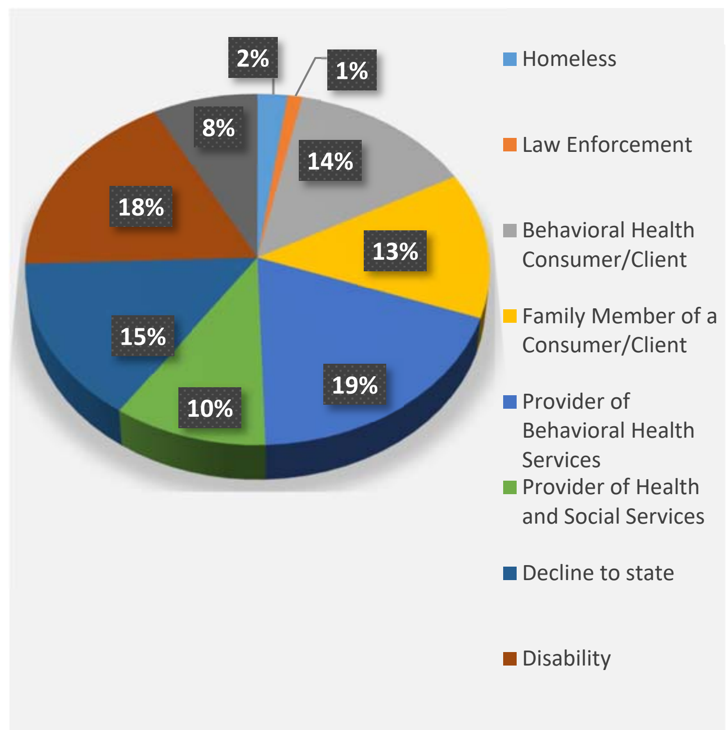
Additionally, a Pre-Launch session was held with clients/consumers hosted by the Peer Recovery Collaborative, a collaborative of peer-run agencies including California Clubhouse, Heart and Soul and Voice of Recovery. At this session information was presented and shared to help prepare clients/consumers for the CPP Launch session where they would be providing input and public comment. Discussion items included, 1) Background on MHSA; 2) What to expect at the CPP Launch session; and 2) How to prepare a public comment.

Extensive outreach was conducted to promote two key public meetings, the CPP Launch Session on March 13, 2017 and the CPP Prioritization Session on April 26, 2017. Flyers were made available in English, Spanish, Chinese, Tagalog, Tongan and Samoan. Stipends to consumers/clients and their family members, language interpretation, child care for families and refreshments were provided at each of these sessions.

Over 270 participated in the sessions, 156 demographic sheets were collected and of these 37% identified as clients/consumers and family members and 36 stipends were provided.

The majority of participants at these two public meetings (64%) represented central and south geographical areas of the county. There are institutional barriers to accessing and attending centrally located public meetings (trust, transportation, cultural and language, etc.). In an effort to account for this, two additional Community Prioritization Sessions were conducted in East Palo Alto and the Coastside. In the future, we will add a community session in the north part of the county as well.

Represented Groups



Input Sessions

Date	Stakeholder Group
12/7/16	**MHSARC and MHSA Steering Committee (Input on CPP Process)**
2/15/17	MHSARC Adult Committee
2/15/17	NAMI Board Meeting
2/16/17	Filipino Mental Health Initiative
2/21/17	Coastside Community Service Area
2/21/17	Northwest Community Service Area
3/1/17	MHSARC Older Adult Committee
3/2/17	Central Community Service Area
3/2/17	Peer Recovery Collaborative
3/3/17	Diversity and Equity Council
3/3/17	Northwest School-Based Mental Health Collaborative
3/7/17	Pacific Islander Initiative
3/7/17	Coastside School-Based Mental Health Collaborative
3/8/17	AOD Change Agents/CARE Committee
3/9/17	**Peer Recovery Collaborative (Pre-Launch Session)**
3/9/17	East Palo Alto Community Service Area
3/9/17	Central School Collaborative
3/13/17	**MHSA Steering Committee (CPP Launch)**
3/14/17	African American Community Initiative
3/16/17	Ravenswood School-Based Mental Health Collaborative
3/17/17	South Community Service Area and Child/Youth Committee
3/23/17	Chinese Health Initiative
3/23/17	Northeast School-Based Mental Health Collaborative
3/28/17	Latino Collaborative
4/10/17	Coastside Youth Advisory Committee
4/11/17	Spirituality Initiative
4/13/17	**East Palo Alto (Community Prioritization Session)**
4/18/17	**Coastside (Community Prioritization Session)**
4/19/17	MHSARC Child and Youth Committee
4/20/17	Native American Initiative
4/20/17	Contractor's Association
4/21/17	Latino Immigrant Parent Group
4/24/17	Veterans
4/25/17	TAY recipients of services
4/26/17	**MHSA Steering Committee (CPP Prioritization)**

PHASE 1. NEEDS ANALYSIS

To build off of the previous Community Program Planning (CPP) process in FY 2014/15, stakeholders including clients, family members, community partners and organizations were asked to think about current services as they relate to the gaps in services identified in FY 2014/15 (listed below), specific service categories and populations served to identify any additional gaps in services:

- Cultural humility and stigma
- Timely access
- Services for peers and families
- Services for adults and older adults
- Early intervention
- Services for children and TAY
- Co-occurring services
- Criminal justice involvement

For Phase I and the initial input sessions, stakeholders where asked the following questions, based on the priority gaps identified in previous years for continuity:

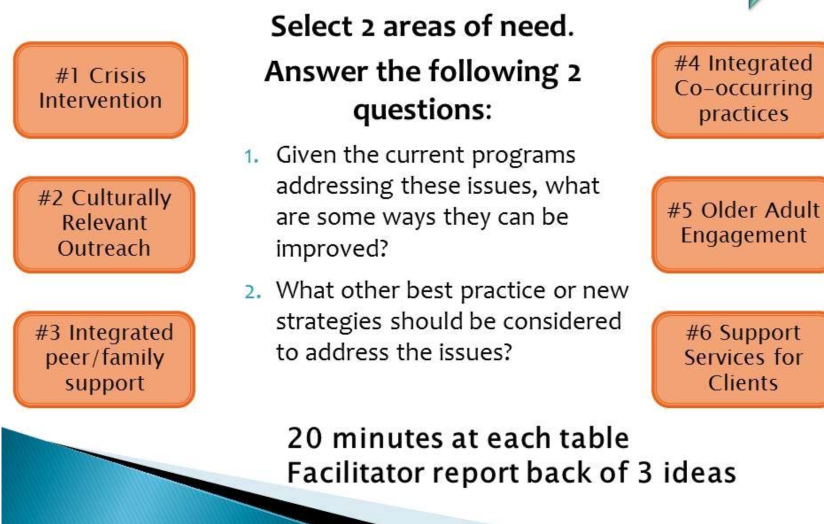
- From your perpective, do these MHSA services effectively [e.g. serve the cultural and linguistic needs of your target communities, address timely access for your target communities, serve the behavioral healthcare needs of clients and families, etc.]? What's working well? What improvements are needed?
  Probes: Do these services address principles of wellness and recovery? stigma?
- Are current collaborations effective in reaching and serving target communities? What is working well? What's missing?

All comments received up to the date of the CPP Launch Session on March 13th were grouped into themes and presented at the CPP Launch. Additional input was sought regarding both the needs/service gaps and whether there were any voices (or communities) missing from the Needs Analysis phase. The CPP Launch Session was a joint MHSARC and MHSA Steering Committee meeting and included a facilitated community input. Agenda items included 1) an MHSA Housing proposal for use of unencumbered housing funds 2) public comment from clients, families and community members on priority needs and gaps in mental health services, and 3) breakout groups to begin developing strategies to address the key needs/ service gaps identified. About 120 clients, families, community members and stakeholders attended the CPP Launch Session.

PHASE 2. STRATEGY DEVELOPMENT

The Strategy Development Phase was kicked off at the CPP Launch Session on March 13, 2017. Findings from the initial input sessions were shared at the CPP Launch Session including relevant strategy ideas.

From the San Mateo County Mental Health Services Act Three-Year Program and Expenditure Plan FY 17-18 through FY 19-20 & Annual Update FY 17-18



While the above six need/gaps in services were identified, there was also an overarching theme that arose from the input sessions, which brought to surface common questions in MHSA planning: do we build upon existing MHSA-funded programs or do we create new programs? Input session participants identified the need to consider both. It has been 10 years since the inception of MHSA and most programs have not received additional resources (aside from Cost of Living increases to the contracts) to expand services and/or clients served, especially for those programs that are resulting in positive behavioral health outcomes.

Three key next steps for the CPP process were identified at the CPP Launch Session:

- Additional input sessions with vulnerable populations and key stakeholders identified.
- Additional strategy development sessions in isolated and higher need communities, in particular East Palo Alto and the Coastside/South Coast region.
- Follow up meetings with all MHSA-funded programs to identify priority program challenges, needs and possible strategies to address these.

PHASE 3. PLAN DEVELOPMENT

The final Phase of the CPP Process was kicked off at the CPP Prioritization Session on April 26, 2017. The meeting goals were three-fold:

1. Present strategy recommendations, results from the Community Input Sessions and prepared public comments in support of each recommendation.
2. Provide meeting participants the opportunity to bring forward any additional strategy recommendations and to prioritize the additional recommendations.
3. Prioritize across all strategies proposed (MHSA Steering Committee only) to help identify the recommendations to include in the MHSA Three-Year Plan.

Appendix 3. Public Comments

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH
& RECOVERY SERVICES

Mental Health Services Act (MHSA) Steering Committee

Wednesday, October 2, 2019 / 4:00 – 5:30 PM
County Health Campus, Room 100, 225 37th Ave. San Mateo, CA 94403

NOTES – MHSA INNOVATIONS

1. Welcome & Background 4:05pm

2. MHSA One-Time Funds 4:10pm

3. MHSA Innovations (INN) Breakout Activity 4:40pm
    - Innovation funding allows for pilot projects that:
        - Introduce a new practice
        - Make changes to existing practices
        - Apply promising non-behavioral health practices
    - A new cycle of funding was launched in January, received 35 ideas, 20 were reviewed by a Selection Committee and 5 ideas moved forward, we will hear about these ideas today.

      MHSARC Motion:
      Vote to open a 30-day public comment period for the MHSA Innovation Project Proposals

        - Isabelle opened the motion
        - Chris seconded the motion
        - Unanimous vote to open 30-day public comment period

    - Innovation Project Proposals - Input Activity
        - Select 2 projects you want to learn about (20 min each)
        - Hear from folks who proposed the ideas
        - Ask questions, what do you believe is important to consider in the project
        - At each presentation you will receive a Theory of Change as a reference that identifies key considerations from the literature that supports the interventions
        - Pick two presentations you would like to learn more about

INN Breakout - Comments

- PIONEERS College-Age PI Mental Health
    - How will you sustain it after 3 years?
        - Community colleges if project is successful
    - What are some of the activities that will address mental health? Be sure to communicate how the mental health component is implemented in the program
        - All activities are centered around mental health

Please continue to provide public comments through November 6, 2019

- Email: mhsa@smcgov.org
- Phone: Doris Estremera, MHSA Manager (650) 573-2889
- Mail: 310 Harbor Blvd, Bldg E, Belmont CA 94002
- Optional Public Comment Form available on line at www.smcgov.org/mhsa

4. Adjourn 5:30pm

Next Mental Health and Substance Abuse Recovery Commission (MHSARC) Meeting
Closing of 30-day public comment period for MHSA Innovation Projects and Plan to Spend Available One-Time Funds:

November 6, 2019 from 3:30-5:00pm
County Health Campus, Room 100, 225 37th Ave. San Mateo

STAFF ANALYSIS— San Mateo County

Innovation (INN) Project Name:	**PIONEERS (Pacific Islanders Organizing, Nurturing and Empowering Everyone to Rise and Serve) program**
Total INN Funding Requested:	**$925,000**
Duration of INN Project:	**Four Years**
MHSOAC consideration of INN Project:	**November 2020**

Review History:

Approved by the County Board of Supervisors:	April 7, 2020
Mental Health Board Hearing:	November 6, 2019
Public Comment Period:	October 5 – November 6, 2019
County submitted INN Project:	February 24, 2020
Date Project Shared with Stakeholders:	October 24, 2019 and July 1, 2020

Project Introduction:

San Mateo County is requesting up to $925,000 of Innovation spending authority to provide prevention and early intervention services through a culturally relevant behavioral health program for Native Hawaiian and Pacific Islander (NHPI) college-age youth that prioritizes the mental wellbeing of students and their respective communities through empowerment, leadership and advocacy.

The Pacific Islanders Organizing, Nurturing, and Empowering Everyone to Rise and Serve (PIONEERS) program will increase access to behavioral health services for NHPI college-age youth by 1) addressing mental health challenges 2) increasing awareness about the importance of emotional health; 3) building the capacity of NHPI advocates for behavioral health; and 4) improving culturally competent services and treatment for NHPI students on college campuses.

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

This project has selected the following primary purpose:
Will increase access to mental health services to underserved groups by providing culturally responsive approaches to engaging and addressing NHPI youth behavioral health needs.

This project meets INN criteria by *introducing a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention* by offering a culturally responsive mental health-focused program for college-age NHPI youth that includes community advocacy connection for NHPI youth.

What is the Problem?

The County presents that three out of five college students experience overwhelming anxiety with few seeking services. Youth from vulnerable cultural/ethnic families may experience higher levels of mental health difficulties due to racial discrimination, and stigma. In addition, there is an association between mental health challenges and lower academic achievement and higher dropout rates. The County presents data showing "[a]mong Pacific Islanders, 47% of Guamanians, 50% of Native Hawaiians, 54% of Tongans, and 58% of Samoans entered college, but leave without earning a degree".

Within the three community college campuses in San Mateo County, there are standard counseling services and a drop-in center available but no outreach efforts specific to vulnerable ethnic populations.

In San Mateo County, specialty mental health service penetration rates are lowest for both youth (1.8%) and adults (2.6%) identifying in the Asian/Pacific Islander racial group. In addition, Pacific Islanders have one of the highest uninsured rates at 19.8%.

While the County does not present current data showing specific unmet mental health needs of college-age youth, they do provide numbers showing that San Mateo County reports high rates of depression and suicidality amongst NHPI youth in both 9th and 11th grade. NHPI youth in 9th grade and 11th grade reported the highest rates of depression related feelings among their peers[1]. Considering the barriers listed below, it is likely that these mental health symptoms continue after high school.

Identified barriers to accessing care for NHPI youth include:

- High rates of behavioral health stigma. For students, seeking and speaking to a counselor, therapist, or psychiatrist can be difficult because it is understood that NHPI families typically deal with their issues at home.
- Minimal examples of effective NHPI specific programs that promote mental wellness and link the community to services.
- There is a lack of investment in personal and professional leadership development of NHPI to champion solutions for healthier outcomes for their community.
- There are few to no NHPI counselors, therapists, or psychiatrists. Cultural humility is necessary to work with NHPI youth regarding behavioral health.

The County suggests that the current state of behavioral health services is not meeting the needs of the NHPI community because the services are designed

[1] https://www.kidsdata.org/region/4/san-mateo-county/results?fmt=144,943,533,535,534,140,141

without the NHPI community in mind and that improving behavioral health services in a culturally responsive way for NHPIs, begins with investing in NHPI young leaders.

How this Innovation project addresses this problem:

The proposed project seeks to provide a culturally relevant behavioral health prevention program for NHPI college-age youth that prioritizes the mental wellbeing of students and their respective communities through empowerment, leadership and advocacy. The County states they lack a behavioral health prevention program focused specifically on NHPI college-age youth and that the proposed innovation will offer a culturally responsive, behavioral health prevention program for the NHPI community.

San Mateo County seeks to build upon what they learned from a public health sponsored leadership development program with San Mateo High School NHPI youth and from a program focused on higher education. *Two key learnings emerged: 1) the need for trauma-informed emotional wellbeing-focused spaces was critical to developing resilient youth NHPI leaders and 2) students need a separate space to decompress, take a break, and process.*

The PIONEERS program will begin by developing a new partnership in San Mateo County between San Mateo County Community Colleges, NHPI college-age youth, Behavioral Health and Recovery Services and community-based behavioral health providers. The County will be contracting out the project activities to a community-based provider through a service contract. The community-based provider will be experienced in serving the NHPI community in San Mateo County and will include a *strong peer leadership focus to conducting the programming.*

PIONEERS programming includes 4 key components:

- Youth Advisory Circle- An advisory circle of NHPI college-age youth and the Pacific Islander Initiative will be recruited early in the project start-up phase. The advisory circle will inform all aspects of the PIONEERS program including the final program curriculum, activities, outreach strategies, evaluation and dissemination of the findings
- Pioneer Institute- The 5-day PIONEER program provides cultural education alongside discussions and discoveries of self, identity, history, community, mental health, issues, institutions, policies, and other topics that develop young leaders' knowledge, skills, and network. Curriculum to be informed by advisory circle.
- Mana Sessions- PIONEER Mana Sessions will be provided once a month in the fall. These sessions provide safe space to decompress, engage in group discussions centered around mental health and wellness, and skills building workshops.
- Forward Movement Projects- Identify opportunities to give back or be of service to their community; lead workshops and discussions with high/middle school students and the broader community. Apply knowledge acquired from PIONEERS to determine what students' needs are, develop workshops, and provide it for them.

The 4 key program components are in line with recommendations made in the California Reducing Disparities Project Strategic Plan to Reduce Mental Health Disparities. Specifically, goals 3 and 4 of the strategic plan aim to "increase the capacity of and empower unserved, underserved, and inappropriately served communities" and "develop, fund, and demonstrate the effectiveness of population-specific and tailored programs[2]".

County may wish to comment on whether they have any active CRDP projects or are partnering with any CRDP providers.

The Forward Movement Project component also links NPHI college-age students with NPHI middle/high school students through designing and providing workshops. This connection may help reduce stigma and increase likelihood of high school students connecting to services when they are needed.

The County also reminds us that the CalMHSA Student Mental Health Program, a statewide PEI initiative funded by MHSA, set out to improve student mental health across all 114 community college campuses. A formal evaluation of these programs by RAND Corporation found that campuses are in critical need of direct services and referrals to county and community agencies are often met with limited (or temporary) resources**. This Innovation project seeks to test one model of linkage between NHPI students and community services.**

Community Planning Process (*see pgs 15-17 and 27-34 of project plan for detailed CPP)*

Local Level

The idea for the PIONEERS project was brought forward by the Pacific Islander Initiative (PII), a collaborative of providers, community leaders, clients/family members including youth. The collaboration with PII will continue through implementation in an advisory role to the project.

The proposed innovation plan was posted for public comment beginning October 5, 2019 and concluded on November 6, 2019. A mental health board hearing was conducted on November 9, 2019 and was approved by the Board of Supervisors on April 7, 2020.

The County reports holding 29 community planning meetings during the development of the 2017-2020 three-year plan of which ***at least seven were with school-based committees or groups with children and youth representatives*.**

Public comments received during community planning breakout sessions are summarized with responses on page 34 of full plan.

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[2] https://cpehn.org/sites/default/files/crdp_executive_summary_english.pdf

Commission Level

Commission staff originally shared this project with its six stakeholder contractors and the listserv on October 24, 2019 while the County was in their 30-day public comment period and comments were to be directed to the County. The final version of this project was again shared with stakeholders July 1, 2020.

Comments received in response to Commission sharing plan with stakeholder contractors and the listserv are listed below.

Comment: Attempt should be made to co-locate the Pioneer and Cultural Cafe project because there are overlapping interests in both, such as counseling, interpreters, and professional staffing.

County response:

Thank you for the recommendation. Collaboration across our community prevention efforts is so valuable and will continue to be a priority for the two Health Equity Initiatives that proposed these projects. While there may be similar goals in terms of prevention and early intervention for youth, the cultural responsiveness of each of these projects is unique to the populations being served. The projects will not have direct mental health services, there will be a robust referral network that connects youth to systems of care, including behavioral health counseling.

The PIONEER program is focused on Native Hawaiian and Pacific Islander (NHPI) college-age youth across San Mateo County and is proposing strategies that would explore mental health needs as impacted and related to NHPI culture. The Cultural Café is focusing on Filipino/a/x youth in the northern part of the county and the strategies are rooted in cultural identification and Filipino/a/x values. This is exactly what makes these projects innovative, the cultural-specific considerations to addressing unmet mental health needs. Relevant research has supported the importance of strategies that address diverse needs of ethnic subgroups.

Comment:

All projects should attempt to share and collaborate with regional Islander communities in the Bay Area. This is paramount because these are state funds.

County response:

Thank you for your comment. It is part of the Pacific Islander (PI) Initiative's process to collaborate regionally because NHPI communities are spread across the region. The PI Initiative will continue to build a collaborative of NHPI that are currently working in communities and in educational institutions. The PI Initiative will ensure that there is regional collaboration as appropriate, especially given that this project is working with community colleges in San Mateo County which attract NHPI youth from across the Bay

Area. Additionally, the Pacific Islander Initiative that proposed the PIONEER program has representation in regional NHPI efforts.

Comment: A critical question is how does the county define Islanders? Who may be excluded? My understanding is there are over 100 separate Islander cultures in the South Pacific depending on the geographic region. For example, are there Islanders that will be excluded? Personal identity and wellness is critical, so this must be carefully clarified. I would suggest cultural experts such as Dean Lan of APSEA be contacted to confirm this point.

County response: The definition of "Islanders" is based upon the federal identification of Native Hawaiians and Pacific Islanders (NHPI). NHPI are defined having origins of Polynesian, Melanesian, or Micronesian descent. The intent of this space is to be inclusive to NHPI and non-NHPI, however the framing of the work would be addressed through the lens of NHPI.

Comment: Will the Pioneer program possibly hire students seeking psychology and behavioral science degrees at that campus? I think it should.

County response: One of the hopes of the Pacific Islander Initiative is that if there is interest in the field of study in psychology and behavioral science among NHPI students that they will have opportunities to work with staff and/or community leaders. Staff and community leaders may be able to link students to opportunities available within the county to gain experience. This is a great consideration that the initiative has in mind.

Comment: Peer jobs should be developed and offered to all students.

County response: We agree with the importance of connecting youth to peer positions and while not the focus, both of these projects could have a meaningful impact to behavioral health career pathways.

Comment: Efforts should be made to include other Bay Area Islander students as is practical.

County response: Yes, this is inherent in the collaboration with community colleges, which attract NHPI students from across the Bay Area region.

<u>Learning Objectives and Evaluation:</u> (*see pgs 12-14 of project plan for details)*

Annually, San Mateo County expects to reach 45 NHPI college-age youth to engage in PIONEER program services and 30 NHPI community youth to engage through the program's community advocacy component.

To guide their evaluation, San Mateo has posed three learning questions focused on outcomes, access and capacity building:

<u>Mental Health Outcomes</u>

- Does the PIONEER program improve mental health outcomes for NHPI college-age youth?

  - Measures and methods could include:
    - Number of NHPI college-age youth that engage in PIONEER program services
    - Percent of youth whose mental health improves (suicide ideation, anxiety, depression), as determined by pre/post screening
    - Interviews or planned focus groups with students to help determine the level of satisfaction and narrative for the impact this project may have on NHPI student's emotional health
    - Demographics of youth that engage

Access

- Does a culturally relevant college and community focused intervention improve access to behavioral health services for NHPI college-age youth?
  - Measures and methods could include:
    - Number of NHPI college-age youth referred to behavioral health services
    - Percentage that follow through and engage in services (some baseline data available through BHRS)
    - Percentage that develop cultural pride and sense of belonging, as determined by pre/post survey
    - Percentage that report decreased stigma and increased knowledge about available behavioral health resources, as determined by pre/post survey
    - Interviews or planned focus groups with students to determine the level of impact on attitudes and behaviors towards mental health and service utilization

Capacity Building

- Does integration of leadership and community advocacy improve quality of life outcomes for NHPI?
  - Measures and methods could include:
    - Number of NHPI college-age youth engaged through the program's community advocacy component
  - Pre/post surveys to determine:
    - Improved protective factors of both community and youth participants
    - Improved leadership skills
    - Improved educational outcomes

An independent evaluation consultant will be contracted and monitored by County staff to formally evaluate the innovation project.

County may wish to consider in addition to measuring the quantitative metrics to also look at measuring more qualitative metrics such as the impact on people's lives.

<u>The Budget</u> (*see pgs 21-23 for detailed project budget)*

The County is requesting authorization to spend up to $925,000 in MHSA Innovation funding for this project over a period of 4 years.

- County administration costs total $100,000 (11%) and include contract monitoring, fiscal tracking, IT support and general oversight.
- Evaluation costs total $75,000 (8%) and will be completed by a contractor.
- Direct contractor costs total $750,000 include expenses related to delivering services over a three-year period:
    - Salaries and benefits (including paid peer positions)
    - Program supplies
    - Rent/utilities
    - Mileage
    - Translation services
    - Subcontract for outreach

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

Client and Family Leadership Committee (CFLC) and
Cultural and Linguistic Competency Committee (CLCC)

2021 Meeting Calendar

Client and Family Leadership Committee		
DATE	TIME	LOCATION
March 18th	1-3pm	Zoom
April 15th	1-3pm	Zoom
June 17th	1-3pm	TBD
August 19th	1-3pm	TBD
October 21st	1-3pm	TBD
December 9th	1-3pm	TBD

Cultural and Linguistic Competency Committee		
DATE	TIME	LOCATION
March 11th	2-4pm	Zoom
May 13th	2-4pm	Zoom
July 8th	2-4pm	TBD
September 9th	2-4pm	TBD