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Mental Health Services
Oversight & Accountability Commission

Commission Packet

Commission Teleconference Meeting
February 17, 2021
9:00 AM – 12:30 PM

Mental Health Services
Oversight & Accountability Commission
1325 J Street, Suite 1700, Sacramento, California 95814
Phone: (916) 445-8696 * Email: mhsoac@mhsoac.ca.gov * Website: www.mhsoac.ca.gov

Commission/Teleconference Meeting Notice

NOTICE IS HEREBY GIVEN that the Mental Health Services Oversight Accountability and Commission (the Commission) will conduct a **teleconference meeting on February 17, 2021**.

This meeting will be conducted pursuant to Governor Newsom's Executive Order N-29-20, issued March 17, 2020, which suspended certain provisions of the Bagley-Keene Open Meeting Act during the declared State of Emergency response to the COVID-19 pandemic. Consistent with the Executive Order, in order to promote and maximize social distancing and public health and safety, this meeting will be conducted by teleconference only. The locations from which Commissioners will participate are not listed on the agenda and are not open to the public. All members of the public shall have the right to offer comment at this public meeting as described in this Notice.

DATE: February 17, 2021

TIME: 9:00 a.m. – 12:30 p.m.

ZOOM ACCESS:

Link: https://zoom.us/j/97472260775
Dial-in Number: 408 638 0968
Meeting ID: 974 7226 0775
Passcode: 513141

Public Participation: The telephone lines of members of the public who dial into the meeting will initially be muted to prevent background noise from inadvertently disrupting the meeting. Phone lines will be unmuted during all portions of the meeting that are appropriate for public comment to allow members of the public to comment. Please see additional instructions below regarding Public Participation Procedures.

***The Commission is not responsible for unforeseen technical difficulties that may occur in the audio feed.**

PUBLIC PARTICIPATION PROCEDURES: All members of the public shall have the right to offer comment at this public meeting. The Commission Chair will indicate when a portion of the meeting is to be open for public comment. **Any member of the public wishing to comment during public comment periods must do the following:**

- **If joining by call-in, press *9 on the phone.** Pressing *9 will notify the meeting host that you wish to comment. You will be placed in line to comment in the order in which requests are received by the host. **When it is your turn to comment, the meeting host will unmute your line and announce the last three digits of your telephone number**. The Chair reserves the right to limit the time for comment. Members of the public should be prepared to complete their comments within 3 minutes or less time if a different time allotment is needed and announced by the Chair.

- **If joining by computer, press the raise hand icon on the control bar.** Pressing the *raise hand* will notify the meeting host that you wish to comment. You will be placed in line to

comment in the order in which requests are received by the host. **When it is your turn to comment, the meeting host will unmute your line and announce your name and ask if you'd like your video on**. The Chair reserves the right to limit the time for comment. Members of the public should be prepared to complete their comments within 3 minutes or less time if a different time allotment is needed and announced by the Chair.

Our Commitment to Excellence

The Commission's 2020-2023 Strategic Plan articulates three strategic goals:

1) Advance a shared vision for reducing the consequences of mental health needs and improving wellbeing – and promote the strategies, capacities and commitment required to realize that vision.
2) Advance data and analysis that will better describe desired outcomes; how resources and programs are attempting to improve those outcomes; and, elevate opportunities to transform and connect programs to improve results.
3) Catalyze improvement in state policy and community practice by (1) providing information and expertise; (2) facilitating networks and collaboratives; and, (3) identifying additional opportunities for continuous improvement and transformational change.

Our Commitment to Transparency

Per the Bagley-Keene Open Meeting Act, public meeting notices and agenda are available on the internet at www.mhsoac.ca.gov at least 10 days prior to the meeting. Further information regarding this meeting may be obtained by calling (916) 445-8696 or by emailing mhsoac@mhsoac.ca.gov

Our Commitment to Those with Disabilities

- Pursuant to the American with Disabilities Act, individuals who, because of a disability, need special assistance to participate in any Commission meeting or activities, may request assistance by calling (916) 445-8696 or by emailing mhsoac@mhsoac.ca.gov. Requests should be made one (1) week in advance whenever possible.

AGENDA

Lynne Ashbeck
Chair

Mara Madrigal-Weiss
Vice Chair

Commission Meeting Agenda

All matters listed as "Action" on this agenda, may be considered for action as listed. Any item not listed may not be considered at this meeting. Items on this agenda may be considered in any order at the discretion of the Chair.

9:00 AM **Call to Order and Welcome**

Chair Lynne Ashbeck will convene the Mental Health Services Oversight and Accountability Commission meeting and make announcements.

9:05 AM **Roll Call**

Roll call will be taken.

9:10 AM **General Public Comment**

General Public Comment is reserved for items not listed on the agenda. No debate nor action by the Commission is permitted on general public comments, as the law requires formal public notice prior to any deliberation or action on agenda items.

9:40 AM **Information**

1: Budget Overview

Presenter:

- **Norma Pate, Deputy Director**

The Commission will be presented with an update of the Governor's proposed budget for Fiscal Year 2021-2022, and a mid-year update of the Commission's current year budget.

- Public comment

10:10 AM **Action**

2: Legislative Priorities

Presenters:

- **Toby Ewing, Executive Director**
- **Norma Pate, Deputy Director**

The Commission will consider legislative and budget priorities related to Commission initiatives, including Senate Bill 224 (Portantino) for the current legislative session.

- Public comment
- Vote

10:40 AM **10 Minute Break**

10:50 AM **Action**

3: Amendments to the Rules of Procedure

Presenter:

- **Filomena Yeroshek, Chief Counsel**

The Commission will consider adopting amendments to its Rules of Procedure.

- Public comment
- Vote

12:00 PM **Information**

4: Staff Report

Presenters:

- **Toby Ewing, Executive Director**
- **Dawnté Early, Ph.D., Chief of Research and Evaluation**

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

- Public comment

12:30 PM **Adjournment**

AGENDA ITEM 1

Information

February 17, 2021 Commission Meeting

Budget Overview

Summary: The Commission will be presented with an update of the Governor's proposed budget for Fiscal Year 2021-2022, and a mid-year update of the Commission's current year budget.

Background: The Governor's Proposed Budget states that it will advance key priorities to make health care more affordable for all by providing more Californians with coverage and strengthening the health care system during the COVID-19 Pandemic. Priorities to improve parity between behavioral health services and physical health care include:

- Establishing an Office of Health Care Affordability and a system to better use health data to improve health outcomes and address health equity. The Office is charged with promoting investments in primary care and behavioral health (CHHS Page 95).

- Recasting the Office of Statewide Health Planning and Development and the proposed Office of Health Care Affordability under the umbrella of a Department of Health Care Affordability Infrastructure to focus on workforce development (CHHS Page 96).

- Improving outcomes and expanding access to preventative services through county behavioral health departments and schools (CHHS Page 101).

- Implementation of an incentive program through Medi-Cal managed care plans, in coordination with county behavioral health departments and schools (CHHS Page 101).

- Augmenting the Commission's Budget by $25 million one-time Mental Health Services Act Funds for the Mental Health Student Services Act Partnership Grant Program to expand partnerships between county mental health plans and school districts. In addition, a proposal to add $25 million on-going Proposition 98 General Funds for innovative partnerships with county behavioral health departments to support student mental health services (CHHS Pages 101-102).

- Extending for one additional fiscal year the 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 (CHHS Page 102).

- Making behavioral health benefits, more consistent and seamless, by revising behavioral health medical necessity, implementing payment reform, and working toward administrative integration through the California Advancing and Innovating Medi-Cal initiative (CHHS Page 102).

Establishing a grant program for counties to acquire and rehabilitate real-estate assets to expand the community continuum of behavioral health treatment resources (CHHS Page 103)

- Expanding the community treatment programs for the felony incompetent to stand trial population to drive improved outcomes for individuals with serious mental illness and reduce recidivism in this population (CHHS Page 103).

Mid-Year Update
The Commission will be provided with a presentation that includes the actual expenditures from Fiscal Year 2019-20, and estimated expenditures for Fiscal Year 2020-21.

Presenter: Norma Pate, Deputy Director

Enclosures (1): Health and Human Services Summary from the Governor's Proposed 2021-22 Budget

Handouts: (2) Budget Highlights and a PowerPoint will be made available at the Commission Meeting.

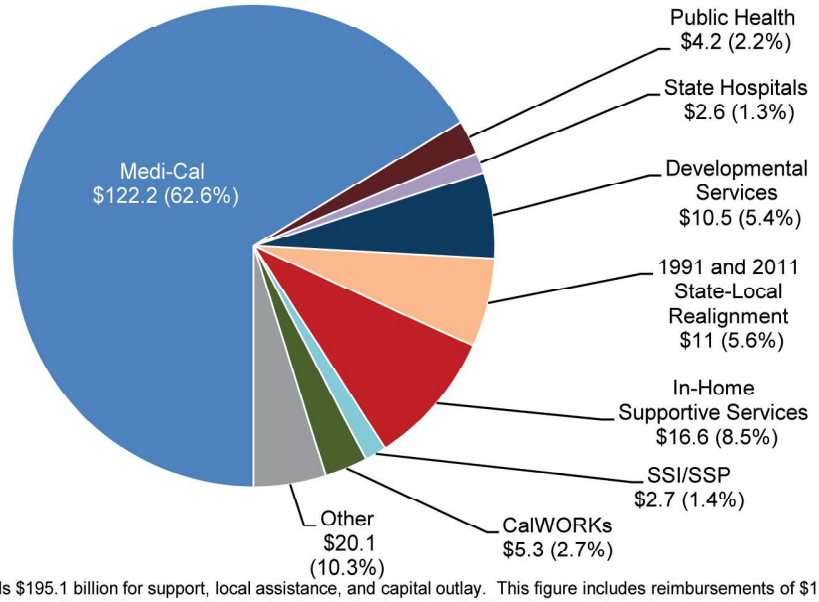
HEALTH AND HUMAN SERVICES

The Health and Human Services Agency oversees departments and state entities that provide health and social services to California's most vulnerable and at-risk residents. Along with the Governor's Office of Emergency Services, the Agency is leading the response to the COVID-19 Pandemic. The Budget includes $195.1 billion ($64.3 billion General Fund and $130.8 billion other funds) for all health and human services programs. This does not include all pandemic response costs. (See COVID-19 Pandemic Response Chapter for more details.)

The COVID-19 Pandemic is having a significant impact on the programs under the Health and Human Services Agency. The Budget assumes that the COVID-19 Pandemic emergency response continues at some level until December 2021. This includes the enhanced Federal Medical Assistance Percentage (FMAP) provided to support the state's Medi-Cal program.

To help address projected structural deficits, the 2020 Budget Act assumed the suspension of various health and human services investments effective July 1, 2021 and December 31, 2021. Given the improved revenue outlook in the short term, the Budget proposes to delay these suspensions by one year. These suspensions include, but are not limited to, Proposition 56 supplemental payment increases, reversing the 7-percent reduction in In-Home Supportive Services hours, and Developmental Services payment increases.

Health and Human Services Proposed 2021-22 Funding[1/]
All Funds
(Dollars in Billions)



[1/] Totals $195.1 billion for support, local assistance, and capital outlay. This figure includes reimbursements of $17.9 billion and excludes $305,000 in Proposition 98 funding in the Department of Developmental Services budget and county funds that do not flow through the state budget.
Note: Numbers may not add due to rounding.

Major Health and Human Services Program Caseloads

	2020-21 Revised	2021-22 Estimate	Change
Medi-Cal	13,970,800	15,603,800	1,633,000
California Children's Services (CCS)[1/]	14,571	14,571	0
CalWORKs	405,317	482,436	77,119
CalFresh	2,167,167	2,559,491	392,324
SSI/SSP (support for aged, blind, and disabled)	1,201,565	1,188,055	-13,510
Child Welfare Services[2/]	111,204	110,817	-387
Foster Care	56,923	57,899	976
Adoption Assistance	88,849	89,239	390
In-Home Supportive Services	570,411	592,829	22,418
Regional Centers	357,819	386,431	28,612
State Hospitals[3/]	6,162	6,361	199
Developmental Centers[4/]	322	322	0
Vocational Rehabilitation	108,000	108,000	0

[1/] Represents unduplicated quarterly caseload in the CCS Program. Does not include Medi-Cal CCS beneficiaries.
[2/] Represents Emergency Response, Family Maintenance, Family Reunification, and Permanent Placement service areas on a monthly basis. Due to transfers between each service area, cases may be reflected in more than one service area.
[3/] Represents the year-end population at State Hospitals, county Jail-Based Competency Treatment programs, and Kern Admission, Evaulation and Stabilization center.
[4/] Represents the year-end population.

MAKING HEALTH CARE MORE AFFORDABLE

More than ever, the COVID-19 Pandemic has underscored the need to expand coverage and increase affordability of health care for all. The state has made significant investments in recent years to expand coverage and increase the affordability of health care, including:

- Augmenting premium assistance for Covered California enrollees, making California the first state in the nation to provide additional state premium assistance for the middle class;
- Instituting a state individual mandate to stabilize the health insurance market;
- Expanding eligibility for no-cost Medi-Cal for persons aged 65 and older and persons with disabilities up to 138 percent of the federal poverty level;
- Extending Medi-Cal to income-eligible young adults regardless of immigration status;
- Addressing the high costs of prescription drugs;
- Restoring optional benefits (most were preventative services) and extending full-scope Medi-Cal coverage to new mothers with a maternal mental health diagnosis; and
- Expanding preventative services with a specific focus on screening for adverse childhood experiences.

These improvements are providing more Californians with coverage and strengthening the health care system during the COVID-19 Pandemic. Keeping people covered and healthy slows the growth of the average Californian's personal health care expenses and encourages the provision of preventative and primary care services.

The Budget takes additional steps to make health care more affordable, including establishing an Office of Health Care Affordability and a system to better use health data to improve health outcomes and address health equity.

OFFICE OF HEALTH CARE AFFORDABILITY

Improving the affordability of health coverage will benefit millions of working Californians, and this endeavor must be accompanied by efforts to address underlying cost drivers. The Budget builds on the Health Care Payment Database, which enables

the Office of Statewide Health Planning and Development to collect and analyze granular utilization and cost data.

Given the size and complexity of California's health care system, the Budget includes $11.2 million in 2021-22, $24.5 million in 2022-23, and $27.3 million in 2023-24 and ongoing from the Health Data and Planning Fund to establish the Office of Health Care Affordability.

This Office will be charged with increasing transparency on cost and quality, developing cost targets for the health care industry, enforcing compliance through financial penalties, and filling gaps in market oversight of transactions that may adversely impact market competition, prices, quality, access, and the total cost of care. In addition to lowering costs, the Office will promote health care workforce stability and training needs, report quality performance and equity metrics on the entire health care system, advance payment models that reward high-quality, cost-efficient care, and promote investments in primary care and behavioral health.

The Office of Statewide Health Planning and Development's programs for data assets and health care workforce development and the Office of Health Care Affordability's focus on health care cost containment present an opportunity for the Administration to better align these priorities. The Administration will submit a proposal in the spring recasting the Office of Statewide Health Planning and Development and the proposed Office of Health Care Affordability under the umbrella of a Department of Health Care Affordability and Infrastructure. The Department will be the dedicated entity within state government with subject matter expertise on health care affordability and infrastructure.

UTILIZING HEALTH INFORMATION EXCHANGE

It is imperative that the state expand the use of clinical and administrative data to better understand the health and social needs of individual patients in order to achieve high-quality, efficient, safe, and timely service delivery while improving outcomes. These goals can be accomplished by building and supporting the infrastructure and information systems to facilitate secure and appropriate exchange of electronic health information among health care providers.

Despite significant federal investment over the past 10 years for adoption of electronic health records and creation of health information exchanges, most patients' medical information, including clinical histories, medications, and test results, is stored on paper or across hundreds of disparate electronic health record systems. The goals of improved

health outcomes and affordability cannot be achieved without unified patient health records and digital infrastructure to support a more integrated provision of health and human services.

To further build on the promise of health information exchange, the Administration is interested in accelerating the utilization and integration of health information exchanges as part of a network that receives and integrates health data for all Californians. The building and operation of the network of exchanges will leverage existing investments in health information exchange and look for additional federal funding in alignment with federal interoperability rules. To do this the state must:

- Enable the right access to health information at the right time resulting in improved health and outcomes for all Californians;
- Identify and overcome the barriers to exchanging health information between public programs, as well as with California providers and consumers; and
- Engage consumers and their providers in managing medical, behavioral and social services through appropriate, streamlined access to electronic health information.

The Administration envisions an environment where health plans, hospitals, medical groups, testing laboratories, and nursing facilities—at a minimum, as a condition of participating in state health programs such as Medi-Cal, Covered California and CalPERS—contribute to, access, exchange, and make available data through the network of health information exchanges for every person.

IMPROVING HEALTH EQUITY

The COVID-19 Pandemic has exposed long-standing health inequities seen among people of color. The pandemic has also highlighted systemic racism and discrimination that has created social, economic, and health inequities contributing to disproportionately higher infection and mortality rates for both chronic and infectious diseases; and COVID-19 incidence has been disproportionate in Black, Latinx, and Pacific Islander populations. The higher prevalence of underlying health conditions such as diabetes, obesity, and hypertension among communities of color increases the likelihood of more severe outcomes.

California was the first state in the nation to implement a health equity metric as part of the Blueprint for a Safer Economy framework. The equity metric requires counties to demonstrate an improvement in COVID-19 test positivity rates in neighborhoods facing

the most severe impacts. Addressing differential infection rates in disadvantaged communities is critical to safely reopening California's economy.

Health equity has been a key focus of the Administration and the COVID-19 Pandemic has accelerated the need for additional action. The Budget builds on these efforts to address the need for a more culturally and linguistically competent and responsive health and social services system. The Budget proposes the following initiatives expressly addressing health inequities:

- Health Plan Equity and Quality Standards—This spring, the Administration will propose an investment for the Department of Managed Health Care, in collaboration with other entities, to establish a priority set of standard quality measures for full service and behavioral health plans, including quality and health equity benchmark standards, and to take enforcement actions against non-compliant health plans.
- Improving Equity Through Managed Care Plan Reprocurements—As Medi-Cal and Covered California managed care plan contracts come up for renewal, the Administration will work to include a focus on health disparities and cultural and language competency through health plan contractual language with a framework similar to the Blueprint equity metric.
- Analysis of COVID-19 Impacts—The Budget includes $1.7 million General Fund in 2021-22 and $154,000 General Fund in 2022-23 and ongoing for the California Health and Human Services Agency to conduct an analysis of the intersection of COVID-19, health disparities, and health equity to help inform any future response.
- Community Navigators—The Budget includes $5.3 million ($3.2 million General Fund) for the Department of Developmental Services to contract with family resource centers to implement a navigator model statewide. The navigator model would utilize parents of individuals in the regional center system to provide education on resources, advocacy, and mentorship to other parents of individuals being served by the regional center system. The purpose of navigators is to increase service authorization and utilization in diverse communities, furthering health equity within the developmental services system. Funding includes resources for a one-time independent evaluation focused on improving the effectiveness of existing disparity projects.

Addressing health disparities created by systemic racism and discrimination are also central to many of the other budget proposals described later in this Chapter. In addition, the Budget includes $4.1 million ($3.7 million General Fund) in 2021-22 and

$2.1 million ($1.6 million General Fund) ongoing for the Health and Human Services Agency to further reorient the administration of its programs through the use of data and the development of an equity dashboard.

ADDRESSING AGING IN CALIFORNIA

In June 2019, the Governor issued an executive order calling for a 10-year Master Plan for Aging to support aging well across the lifespan. California's 65 and over population is projected to grow to 8.5 million by 2030, nearly doubling from 2010 and increasing from 11.5 percent of the population to 20 percent. The Governor also established a Task Force on Alzheimer's Prevention and Preparedness, chaired by Former First Lady Maria Shriver, to tackle the policy and health challenges faced by the growing number of people living with dementia—more than 690,000 Californians have a diagnosis of Alzheimer's and more than 1.6 million people are responsible for providing care.

Nearly 80 percent of all Californians who have died from COVID-19 in 2020 were age 65 or older. Moreover, nearly 40 percent of all Californians who died from COVID-19 in 2020 were living in nursing homes; early data suggest people with dementia have experienced especially high rates of cases and death. Millions more older and at-risk adults remained home to stay healthy and, as a result, faced isolation and interruption to essential activities, including caregiving. Black, Latinx, and Pacific Islander older Californians have been disproportionately impacted by COVID-19.

The Budget recognizes the extraordinary challenges older Californians and their families face during the COVID-19 Pandemic, and proposes a range of investments to increase opportunities for Californians to age well over the next decade, including developing new strategies with the federal government to leverage Medicare to provide additional long-term services and supports.

The Governor will appoint a Senior Advisor on Aging, Disability and Alzheimer's to advance cross-Cabinet initiatives and partnerships between government, the private sector, and philanthropy, such as closing the digital divide, transportation options beyond driving, and caregiving workforce solutions, for Californians of all ages. The Budget includes a $5 million General Fund placeholder for spring proposals to further implement the Master Plan for Aging.

To drive innovation in top priorities identified in the Master Plan for Aging, the Budget makes the following targeted investments:

- Medicare Innovation and Integration—The Administration plans to submit a proposal in the spring for state operations to establish a new Office of Medicare Innovation and Integration that will explore strategies and models to strengthen and expand low- and middle-income Californians' access to high-quality services and supports, while developing new partnerships with the federal government.
- Expanded Facilities to Support Housing—The Budget includes $250 million one-time General Fund for the Department of Social Services to acquire and rehabilitate Adult Residential Facilities (ARF) and Residential Care Facilities for the Elderly (RCFE) with a specific focus on preserving and expanding housing for low-income seniors who are homeless or at risk of becoming homeless. See the Housing and Homelessness Chapter for more information.
- Aging and Disability Resource Connections (ADRC)—The Budget delays suspension of and expands ADRCs, or "No Wrong Door," networks currently serving approximately one-third of the state to serving the entire state. These centers provide people with "one stop" telephone and online access to information and assistance with aging, disability, and Alzheimer's, in multiple languages and with cultural competencies. The Budget provides $7.5 million in 2021-22, half-year funding of $5 million in 2022-23, and is subject to suspension on December 31, 2022.
- IHSS COVID-19 Back-up Provider System—The Budget includes $5.3 million one-time General Fund in 2021-22 to extend the back-up provider system and back-up provider wage differential to avoid disruptions to caregiving until December 2021. The Administration will evaluate the need of an IHSS provider backup system for severely impaired individuals as the state recovers from the effects of the COVID-19 Pandemic.
- Increased Geriatric Care Workforce—The Budget includes $3 million one-time General Fund for the Office of Statewide Health Planning and Development to grow and diversify the pipeline for the geriatric medicine workforce, as the increasing and diversifying numbers of older adults living longer lives require developing a larger and more diverse pool of health care workers with experience in geriatric medicine.

EQUITABLE PATH FORWARD ON ALZHEIMER'S

The Budget proposes a comprehensive and coordinated approach to Alzheimer's with an emphasis on communities of color and on women, who are disproportionately susceptible to the disease and the primary providers of caregiving. Investments to be administered by the Department of Public Health are five-pronged: $5 million one-time General Fund for a public education campaign on brain health; $4 million one-time

General Fund for new training and certification for caregivers; $2 million one-time General Fund for expanded training in standards of care for health care providers; $2 million one-time General Fund for grants to communities to become dementia-friendly; and $4 million one-time General Fund for research to strengthen California's leadership on disparities and equity in Alzheimer's.

ADDRESSING BEHAVIORAL HEALTH

The COVID-19 Pandemic is having a myriad of impacts on individuals and families. Stay at home orders, which have been necessary to save lives, have also increased isolation for seniors. Families have also struggled with schools closed to in-person instruction and children without many normal physical and social outlets. In addition, the COVID-19 Pandemic induced recession has left many households with increased worry about how they will maintain food and shelter. With this backdrop, the Administration is focused on improving outcomes and expanding access to preventative services through county behavioral health departments and schools. These efforts build on resources provided in the 2020 Budget Act for the Department of Managed Health Care's behavioral health-focused investigations and enforcement of commercial health plan compliance with parity laws.

STUDENT MENTAL HEALTH

COVID-19 stay-at-home orders and school closures have impacted students and caused additional stress and anxiety. Early identification and treatment through school-based, or school-linked, services can reduce emergency room visits, crisis situations, inpatient stays, placement in high-cost special education settings, and out of home placement.

The Budget includes one-time $400 million ($200 million General Fund), 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. This innovative effort seeks to build infrastructure, partnerships, and capacity statewide to increase the number of students receiving preventive and early intervention behavioral health services from schools, providers in schools, or school-based health centers.

Additionally, the Budget includes $25 million one-time Mental Health Services Fund, available over five years, for the Mental Health Services Oversight and Accountability Commission to augment the Mental Health Student Services Act Partnership Grant

Program, which funds partnerships between county mental health plans and school districts.

Further, the Budget includes $25 million ongoing Proposition 98 General Fund to fund innovative partnerships with county behavioral health departments to support student mental health services. This funding would be provided to local educational agencies as a match to funding in county Mental Health Services Act (MHSA) spending plans dedicated to the mental health needs of students. See the K-12 Education Chapter for additional information.

STRENGTHENING COUNTY BEHAVIORAL HEALTH

County behavioral health programs are supported by a combination of 2011 Realignment, MHSA, and other county funding sources, and are responsible for organizing and overseeing local mental health and substance use disorder programs, including specialty mental health for Medi-Cal and uninsured patients. Counties work with Medi-Cal managed care plans to deliver mild and moderate services and provide specialty mental health services not included in managed care plans. The Budget includes several different efforts to improve and add needed infrastructure to county behavioral health programs, including support for individuals acutely impacted by mental illness.

The COVID-19 Pandemic has necessitated changes in the demand for behavioral health services and the delivery of these benefits. Therefore, the Budget proposes statutory changes to extend flexibilities in county spending of local MHSA funds that were included in the 2020 Budget Act in response to the COVID-19 Pandemic for an additional fiscal year. The statutory changes authorize counties to spend down their local MHSA prudent reserves, as opposed to requesting county-by-county authority from the state. Further, the changes authorize counties to spend funds within the Community Services and Supports program component regardless of category restrictions to meet local needs. Lastly, the changes authorize counties to use their existing approved MHSA spending plans, if a new plan is delayed because of COVID-19-related reasons.

As discussed later in this chapter, the Administration is proposing the California Advancing and Innovating Medi-Cal (CalAIM) Initiative to make Medi-Cal, including behavioral health benefits, more consistent and seamless, by among other things, revising behavioral health medical necessity, implementing payment reform, and working toward administrative integration.

The Budget also includes $750 million one-time General Fund for competitive grants to counties to acquire and rehabilitate real estate assets to expand the community continuum of behavioral health treatment resources. These community resources are needed to address individuals experiencing a crisis and are a critical component of an overarching framework to solve and not just mitigate homelessness. The Administration is also exploring opportunities to repurpose relinquished adult jail bond financing to add to this effort. See the Criminal Justice Chapter for more information.

The Budget also proposes to greatly expand the community treatment programs for the felony incompetent to stand trial population. This includes a demonstration project that will streamline services to drive improved outcomes for individuals with serious mental illness and reduce recidivism in this population.

DEPARTMENT OF HEALTH CARE SERVICES

Medi-Cal, California's Medicaid program, is administered by the Department of Health Care Services. Medi-Cal is a public health care program that provides comprehensive health care services at no or low cost for low-income individuals. The federal government mandates that basic services be included in the program, including: physician services; family nurse practitioner services; nursing facility services; hospital inpatient and outpatient services; laboratory and radiology services; family planning; behavioral health; and early and periodic screening, diagnosis, and treatment services for children. In addition to these mandatory services, the state provides optional benefits such as outpatient drugs, adult dental services, home and community-based services, and medical equipment. The Department also operates the California Children's Services and the Primary and Rural Health programs, and oversees county-operated community mental health and substance use disorder programs.

The Medi-Cal budget is $117.9 billion ($22.5 billion General Fund) in 2020-21 and $122.2 billion ($28.4 billion General Fund) in 2021-22. The Budget assumes that caseload will increase approximately 10.1 percent from 2019-20 to 2020-21 and increase approximately 11.7 percent from 2020-21 to 2021-22. Medi-Cal is projected to cover approximately 15.6 million Californians, nearly 40 percent of the state's population, in 2021-22.

CALIFORNIA ADVANCING AND INNOVATING MEDI-CAL (CALAIM)

Medi-Cal has significantly expanded and changed over the last ten years, in large part due to California's implementation of the federal Patient Protection and Affordable Care Act. Since implementing the Act, the Department has undertaken many initiatives

and embarked on innovative demonstration projects to improve the beneficiary experience.

Today, some Medi-Cal enrollees may need to access six or more separate delivery systems, including managed care, fee-for-service, mental health, substance use disorder, dental, developmental, and/or In-Home Supportive Services. Fragmentation of service delivery increases the need for care coordination, increases complexity, and results in greater health inequities. To improve clinical outcomes and assist beneficiaries with navigating this complex system, the Department is seeking to better coordinate and integrate these delivery systems to achieve more equal health outcomes for all across the entire continuum of care.

To this end, the Department is launching CalAIM, which builds upon the critical successes of waiver demonstration programs such as Whole Person Care, the Coordinated Care Initiative, Health Homes, and public hospital system delivery transformation. CalAIM proposes to provide a wider array of services and supports for patients with complex and high needs.

CalAIM has three primary goals:

- Identify and manage member risk and need through whole person care approaches and addressing social determinants of health;
- Make Medi-Cal more consistent and seamless by reducing complexity and increasing flexibility; and
- Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform.

Transformation of the delivery system is necessary to improve outcomes for Medi-Cal beneficiaries as well as to achieve long-term cost avoidance. The reforms proposed through CalAIM represent a comprehensive approach to achieving these goals. These changes will position the state to better connect individuals—including children and youth in foster care, individuals experiencing homelessness, individuals with mental health challenges and substance use disorders, and individuals involved in the justice system—to the services they need. Attaining these goals will have significant impacts on individuals' health and quality of life and through iterative system transformation, will ultimately reduce healthcare costs over time.

To implement CalAIM effective January 1, 2022, the Budget includes $1.1 billion ($531.9 million General Fund) in 2021-22, growing to $1.5 billion ($755.5 million General Fund) in 2023-24.

This investment will provide for enhanced care management and in lieu of services, necessary infrastructure to expand whole person care approaches statewide, and build upon existing dental initiatives. Beginning in 2024-25, the Administration proposes to phase out infrastructure funding, resulting in ongoing costs of about $846.4 million ($423 million General Fund) per year.

This effort will be complemented by $750 million one-time General Fund for competitive grants to counties to acquire and rehabilitate real estate assets to expand the community continuum of behavioral health treatment resources. The Administration is also exploring opportunities to repurpose relinquished adult jail bond financing to add to these efforts. See the Criminal Justice Chapter for additional details.

Other Significant Adjustments:

- 2020-21 Budget—The Budget reflects lower expenditures in the Medi-Cal program of approximately $1.2 billion General Fund in 2020-21 compared with the 2020 Budget Act. The decrease is due primarily to reduced COVID-19 caseload costs, additional enhanced Federal Medical Assistance Percentage (FMAP), reduced costs associated with the state-only claiming adjustment, and additional Hospital Quality Assurance Fee (HQAF) savings. These reduced General Fund costs are partially offset by a one-time retroactive correction to managed care rates associated with dual-eligible beneficiaries and an increase in deferred federal fund claims.
- COVID-19 Medi-Cal Caseload Impacts—The Budget projects an average monthly caseload of 14 million beneficiaries in 2020-21 and 15.6 million beneficiaries in 2021-22, and includes $5.4 billion ($1.7 billion General Fund) in 2020-21 and $13.5 billion ($4.3 billion General Fund) in 2021-22 for increased caseload attributable to the COVID-19 Pandemic. Caseload is projected to peak at 16.1 million beneficiaries in January 2022, driven by the federal continuous coverage requirement related to the COVID-19 Public Health Emergency and the COVID-19 induced recession.
- Additional COVID-19 Impacts—The Budget includes net costs of $1.9 billion total funds ($2 billion General Fund savings) for COVID-19 impacts, including enhanced FMAP savings, vaccine administration costs, and federal waiver flexibilities. The

Budget assumes enhanced FMAP savings and flexibilities will remain in effect through the last quarter of calendar year 2021.

- State-Only Claiming Adjustment—The Budget includes $249.8 million General Fund in 2020-21 and $279.1 million General Fund in 2021-22 for retroactive and ongoing dental, pharmacy, and managed care, targeted case management, and behavioral health costs associated with state-only populations.
- Medi-Cal Rx—The Budget includes costs of $219.9 million ($70.2 million General Fund) in 2020-21 and savings of $612.7 million ($238.2 million General Fund) in 2021-22 associated with the carve-out of the Medi-Cal pharmacy benefit from managed care to fee-for-service, effective April 1, 2021. Full annual savings are projected to be approximately $1.2 billion ($419 million General Fund) by 2023-24.
- Reinstatement of Adult Acetaminophen and Cough/Cold Products—The Budget reflects annual savings of $21 million ($7.8 million General Fund) to reinstate over-the-counter adult acetaminophen and cough/cold products as covered Medi-Cal benefits effective July 1, 2021. Coverage of these products was temporarily reinstated effective March 1, 2020, as part of the state's federally approved COVID-19 waiver flexibilities.
- Medi-Cal Coverage of Continuous Glucose Monitors—The Budget includes $12 million ($4.2 million General Fund) in 2021-22 and ongoing to add continuous glucose monitors as a covered Medi-Cal benefit for adult individuals with type 1 diabetes, effective January 1, 2022. This proposal increases health equity.
- Telehealth Flexibilities in Medi-Cal—The Budget includes $94.8 million ($34 million General Fund) ongoing to expand and make permanent certain telehealth flexibilities authorized during COVID-19 for Medi-Cal providers, and to add remote patient monitoring as a new covered benefit, effective July 1, 2021. This effort will expand access to preventative services and improve health outcomes, thereby increasing health equity.
- County Administration—The Budget includes an ongoing increase of $65.4 million ($22.9 million General Fund) in 2021-22 for county eligibility determination activities based on growth in the California Consumer Price Index.

PROPOSITION 56 SUPPLEMENTAL PAYMENT PROGRAMS

Given an improved revenue outlook in the short term, the Budget delays the suspension of Proposition 56 programs by 12 months and includes a total of $3.2 billion ($275.3 million General Fund, $717.8 million Proposition 56 Fund, and $2.2 billion federal

funds) for these programs in 2021-22. (The Budget would have otherwise included $759.9 million General Fund savings if the suspensions were not delayed.) The General Fund partially supports supplemental payment programs at current levels now that program costs exceed declining tobacco tax revenues, due primarily to the assumed implementation of the ban on flavored tobacco and vaping products pursuant to Chapter 34, Statutes of 2020 (SB 793).

The Budget assumes Proposition 56 suspensions effective July 1, 2022, except for supplemental payments to intermediate care facilities for the developmentally disabled, freestanding pediatric subacute facilities, and Community Based Adult Services, which will be suspended December 31, 2022, due to the managed care calendar rate year. Payments for Women's Health, Family Planning, and the Loan Repayment Program are exempt from suspension. The Budget also proposes to exempt supplemental payments for the Behavioral Health Integration program, the AIDS waiver, Home Health, and Pediatric Day Health from suspension because they would not be deemed eligible by the federal government.

OTHER SUSPENDED PROGRAMS

Given an improved revenue outlook in the short term, the Budget proposes to delay suspensions by one year for the following:

- Medi-Cal Post-Partum Eligibility Extension—The Budget delays the suspension of Medi-Cal post-partum extended eligibility by 12 months to December 31, 2022, for a cost of $27.1 million General Fund in 2021-22.
- Medi-Cal Adult Optional Benefits Extension—The Budget includes $47 million ($15.6 million General Fund) in 2021-22 to delay by 12 months the suspension of audiology and speech therapy services, incontinence creams and washes, optician and optical lab services, and podiatric services to December 31, 2022.

DEPARTMENT OF SOCIAL SERVICES

The Department of Social Services (DSS) serves, aids, and protects needy and vulnerable children and adults in ways that strengthen and preserve families, encourage personal responsibility, and foster independence. The Department's major programs include CalWORKs, CalFresh, In-Home Supportive Services (IHSS), Supplemental Security Income/State Supplementary Payment (SSI/SSP), Child Welfare Services, Community Care Licensing, and Disability Determination. Beginning July 1, 2021, child care and nutrition programs will transition from the California

Department of Education (CDE) to DSS. The Budget includes $36.2 billion ($14.4 billion General Fund) for DSS programs in 2021-22.

Significant Adjustments:

- Food Banks—The Budget includes $30 million one-time General Fund above program base funding levels for the Department of Social Services to fund existing Emergency Food Assistance Program providers, food banks, tribes, and tribal organizations to mitigate increases in food needs among low-income and food-insecure populations. The recently enacted federal COVID-19 response and relief bill includes increased benefits for CalFresh and the Emergency Food Assistance Program.
- Supplemental Nutrition Benefit and Transitional Nutrition Benefit Programs Adjustment—The Budget includes $22.3 million ongoing General Fund to reflect adjusted benefit amounts mitigating the effects of the elimination of the SSI Cash-Out policy.
- California Food Assistance Program (CFAP) Emergency Allotments—The Budget includes $11.4 million one-time General Fund for CFAP households to receive the maximum allowable allotment based on household size.

CALIFORNIA WORK OPPORTUNITY AND RESPONSIBILITY TO KIDS

The CalWORKs program, California's version of the federal Temporary Assistance for Needy Families (TANF) program, provides temporary cash assistance to low-income families with children to meet basic needs. It also provides welfare-to-work services so that families may become self-sufficient. Eligibility requirements and benefit levels are established by the state. Counties have flexibility in program design, services, and funding to meet local needs.

Total TANF expenditures are $9.3 billion (state, local, and federal funds) in 2021-22. The amount budgeted includes $7.4 billion for CalWORKs program expenditures and $1.9 billion in other programs. Other programs include expenditures for Child Care, Child Welfare Services, Foster Care, Department of Developmental Services programs, the Statewide Automated Welfare System, Work Incentive Nutritional Supplement, California Community Colleges Child Care and Education Services, Cal Grants, and the Department of Child Support Services.

The average monthly CalWORKs caseload is estimated to be 482,436 families in 2021-22, a 19 percent increase from the revised 2020-21 projection. Prior to COVID-19, the

CalWORKs caseload had decreased every year since 2010-11. Due to the COVID-19 Pandemic's impact on the economy and initial spikes in caseload in the immediate months following the pandemic, the CalWORKs caseload was projected to grow significantly at the 2020 Budget Act. This caseload did not materialize likely due to expanded and extended unemployment insurance benefits and direct stimulus payments. The Budget includes revised caseload projections, driven by updated assumptions and the uncertainty surrounding further federal relief and duration of the public health emergency.

Significant Adjustments:

- CalWORKs Time on Aid Exemption—The Budget includes $46.1 million one-time General Fund (TANF) block grant funding to temporarily suspend any month in which CalWORKs aid or services are received from counting towards the CalWORKs 48-month time limit based on a good cause exemption due to the COVID-19 Pandemic.
- CalWORKs Grant Increase—The Budget reflects a 1.5-percent increase to CalWORKs Maximum Aid Payment levels, effective October 1, 2021, which is estimated to cost $50.1 million in 2021-22. These increased grant costs are funded entirely by the Child Poverty and Family Supplemental Support Subaccounts of the Local Revenue Fund.

IN-HOME SUPPORTIVE SERVICES

The IHSS program provides domestic and related services such as housework, transportation, and personal care services to eligible low-income aged, blind, and disabled persons. These services are provided to assist individuals to remain safely in their homes and prevent more costly institutionalization. The Budget includes $16.5 billion ($5.3 billion General Fund) for the IHSS program in 2021-22, a 10-percent increase in General Fund costs over the revised 2020-21 level. Average monthly caseload in this program is estimated to be 593,000 recipients in 2021-22, a 3.9-percent increase from the revised 2020-21 projection.

Significant Adjustments:

- IHSS Service Hours Restoration—The Budget includes $449.8 million General Fund in 2021-22 and $242.6 million General Fund in 2022-23 to reflect a delay in suspending the 7-percent across-the-board reduction to IHSS service hours. The increased funding for IHSS service hours is now proposed to be suspended on December 31, 2022. The suspension will be lifted if the Administration determines

through the 2022 Budget Act process that there is sufficient General Fund revenue to support all suspended programs in the subsequent two fiscal years.

- Minimum Wage—The Budget reflects $1.2 billion ($557.6 million General Fund) to support projected minimum wage increases to $14 per hour on January 1, 2021 and $15 per hour on January 1, 2022.
- IHSS County Administration—The Budget no longer assumes savings to hold county administration funding at the 2019-20 level, resulting in county administration costs being updated for 2021-22 to include $17.8 million General Fund to reflect caseload and Consumer Price Index adjustments.

SUPPLEMENTAL SECURITY INCOME/STATE SUPPLEMENTARY PAYMENT (SSI/SSP)

The federal SSI program provides a monthly cash benefit to eligible aged, blind, and disabled persons who meet the program's income and resource requirements. In California, the SSI payment is augmented with an SSP grant. These cash grants assist recipients with basic needs and living expenses. The federal Social Security Administration administers the SSI/SSP program, making eligibility determinations, computing grants, and issuing combined monthly checks to recipients. The state-only Cash Assistance Program for Immigrants (CAPI) provides monthly cash benefits to aged, blind, and disabled legal noncitizens who are ineligible for SSI/SSP due solely to their immigration status.

The Budget includes $2.69 billion General Fund in 2021-22 for the SSI/SSP program. This represents a 0.6-percent decrease from the revised 2020-21 level. The average monthly caseload in this program is estimated to be 1.18 million recipients in 2021-22, a 1.1-percent decrease from the 2020-21 projection. The SSI/SSP caseload consists of 69.4 percent persons with disabilities, 29.3 percent persons who are aged, and 1.4 percent blind.

Effective January 2021, the maximum SSI/SSP grant levels are $955 per month for individuals and $1,598 per month for couples. The projected growth in the Consumer Price Index is 2.2 percent for 2022. As a result, the maximum SSI/SSP monthly grant levels will increase by approximately $17 and $26 for individuals and couples, respectively, effective January 2021. CAPI benefits are equivalent to SSI/SSP benefits.

CHILDREN'S PROGRAMS

Child Welfare Services include family support and maltreatment prevention services, child protective services, foster care services, and adoptions. California's child welfare

system provides a continuum of services to children who are either at risk of or have suffered abuse and neglect. Program success is measured in terms of improving the safety, permanence, and well-being of children and families served. The Budget includes $700.1 million General Fund in 2021-22 for services to children and families in these programs, a decrease of $22.6 million General Fund, or 3.1 percent, compared to the 2020 Budget Act. When federal and 1991 and 2011 Realignment funds are included, total funding for children's programs is in excess of $8.9 billion in 2021-22. The net decrease is primarily attributable to decreased caseload under the Continuum of Care Reform and one-time funding related to child welfare services included in the 2020 Budget Act.

Significant Adjustments:

- COVID-19 Related Supports for Child Welfare Services—The Budget includes $61.1 million General Fund in 2021-22 to support services related to quarantine needs for foster youth and caregivers, temporary extension of assistance payments to emergency caregivers, support to Family Resource Centers, state–administered contracts for youth and family helplines, provision of laptops and cellular phones to foster youth, assistance to families with youth who are at-risk of entering foster care, and temporary provision of assistance payments to youth who turn 21 years of age while in extended foster care after April 17, 2020, through December 31, 2021, and for any nonminor dependent who met eligibility requirements for the Extended Foster Care program and lost their employment or has experienced a disruption in their education program resulting from COVID-19, and cannot otherwise meet any of the participation requirements.
- Federal Family First Prevention Services Act Implementation—The Budget includes $61.1 million ($42.7 million General Fund) to begin implementation of Part IV of the federal Family First Prevention Services Act (FFPSA). FFPSA Part IV sets out new criteria for non-foster home placement settings eligible for federal Title IV-E Foster Care maintenance payments.
- Child Welfare Workforce Development—The Budget includes $10.1 million ($5.9 million General Fund) ongoing to establish an additional child welfare social workers regional training academy in northern California (bringing the statewide total to five academies), increase ongoing training for social workers and supervisors, assess training effectiveness, and modernize how social worker training is monitored and used to inform workforce development planning.

- Delay Suspension of Various Children's Issues—The Budget proposes to extend the temporary augmentation to the Emergency Child Care Bridge Program, foster family agencies, Child Welfare Public Health Nursing Early Intervention Program, and the Family Urgent Response System from December 31, 2021, to December 31, 2022. Estimated costs to delay the suspension in 2021-22 are $54.5 million General Fund. The suspension will be lifted if the Administration determines through the 2022 Budget Act process that there is sufficient General Fund revenue to support all suspended programs in the subsequent two fiscal years.
- Youth Returning from Out of State—In partnership with the Legislature, $5.2 million one-time General Fund was allocated in December 2020 for the Department of Social Services to support youth in their transition back to California. These resources are supporting county capacity building and supportive services for the returned youth, COVID-related quarantine costs, and technical assistance to support counties in placing the returning youth.

IMMIGRATION SERVICES

The Department of Social Services funds qualified nonprofit organizations to provide immigration services to immigrants who reside in California via the unaccompanied undocumented minors and Immigration Services Funding programs. The Budget continues to include $75 million General Fund ongoing for immigration services.

Significant Adjustments:

- Rapid Response Program—The Budget includes $5 million one-time General Fund for the Rapid Response Program to support entities that provide critical assistance/ services to immigrants during emergent situations when federal funding is not available.

CHILD CARE

Since 2019, the state has invested approximately $400 million ongoing to expand early education and child care. The COVID-19 Pandemic has disrupted the child care system and federal funding has been critical to reducing long-term losses in this system. The Budget focuses on avoiding further loss in this system and builds on the recommendations made in the Master Plan for Early Learning and Care.

The 2020 Budget Act shifted early learning, child care and nutrition programs from the Department of Education to the Department of Social Services. This transition, which

becomes effective July 1, 2021, will align all child care programs within a single department in state government.

Significant Adjustments:

- State Operations—The Budget shifts $31.7 million ($0.9 million General Fund) and 185.7 positions from the Department of Education to the Department of Social Services to administer early learning, child care, and nutrition programs.
- Local Assistance—The Budget includes $3.1 billion ($1.3 billion General Fund) and shifts the following programs, including: General Child Care, Alternate Payment Programs, CalWORKs Stage 2 & Stage 3, Resource & Referral Programs, Migrant Child Care Program, Severely Disabled Program, California Child Care Initiative, Quality Improvement Activities, Local Planning Councils, and Child and Adult Care Food Program.
- COVID-19 Related Support—The Budget includes $55 million one-time General Fund to support child care providers' and families' needs as a result of the pandemic.

Updated Proposition 64 cannabis tax revenues will provide an additional $21.5 million for child care slots in 2020-21 and $44 million ongoing. These funds will provide for 4,700 new child care slots.

For the first time, the Administration has begun the collective bargaining process with Child Care Providers United representing child care providers to negotiate a memorandum of understanding that governs the payments made to these providers. The California Department of Human Resources is the Governor's designee to meet and confer regarding matters within the scope of representation. DSS will support bargaining and work to meet goals articulated in the Master Plan on Early Learning and Care.

RESPONDING TO THE IMMEDIATE NEEDS OF CHILD CARE PROVIDERS

While conclusive data continue to be collected on the impact of the COVID-19 Pandemic on the state's child care system, preliminary findings and anecdotal evidence suggest that the loss of capacity in the state has been significant. Regardless, many child care providers have gone to great lengths to continue to provide care to children in a safe environment, and have taken on the added responsibility of helping children in distance learning access their public school education. It is a priority for the Administration to support these providers to the greatest extent possible, to preserve the

existing system of care, and provide additional ongoing investments to improve and expand the system.

Despite significant fiscal limitations, the 2020 Budget Act preserved funding for early learning and care programs to the greatest extent possible, with a focus on serving the children of income-eligible essential workers. This included:

- Additional access to subsidized child care for children of essential workers
- Stipends for child care providers
- A funding hold harmless for child care providers that contract directly with the state and have to close for health and safety reasons
- Paid non-operational days when a provider accepting vouchers has to close for health and safety reasons
- Provider reimbursement at a child's maximum certified level of need for all providers accepting vouchers
- Family fee waivers for all families through August 31, 2020, with additional fee waivers for families eligible for, but not receiving, in-person care due to COVID-19, through June 30, 2021

The Administration took further action in October to provide $110 million to child care providers to reimburse them for the cost of waived family fees and extend the length of care for children of essential workers with temporary vouchers.

FEDERAL RELIEF

In late December, Congress passed a fifth stimulus bill, the Coronavirus Response and Relief Supplemental Appropriations Act that includes approximately $10.3 billion for child care and Early Start. The state is expected to receive approximately $1 billion. The 2020 Budget Act included language to guide the prioritization of additional federal funds as follows:

- Up to $100 million for providers accepting vouchers to extend access to child care for children of essential workers, at-risk children, and other eligible children
- Up to $90 million in child care provider stipends
- Up to $35 million to increase the number of paid non-operational days for providers accepting vouchers that must close for health and safety reasons

- Up to $30 million for reimbursing child care providers for family fees waived for families enrolled, but not receiving in-person care, from September 1, 2020, to June 30, 2021 (these costs were addressed by the Administration through the October action)
- Up to $30 million to increase capacity for up to two years for subsidized child care and preschool
- Up to $15 million to assist child care providers with the costs of re-opening

MASTER PLAN FOR EARLY LEARNING AND CARE

The 2019 Budget Act included $5 million one-time General Fund for a long-term roadmap to universal preschool and a comprehensive, quality, and affordable child care system. The Master Plan for Early Learning and Care was released on December 1, 2020, and provides recommendations and a multi-year plan for transforming the state's child care and early education systems. Specific to child care programs, the Master Plan's recommendations include:

- Streamlining program requirements to unify state child care program.
- Promoting school readiness by increasing access to high-quality preschool.
- Improving quality of care by enhancing educator competencies and providing affordable and accessible pathways for workforce advancement.
- Supporting equity by eliminating bias through practices and training, with specific focus on children with disabilities and dual language learners.
- Adopting a comprehensive reimbursement rate structure that considers care setting, costs associated with quality, characteristics of children served, and workforce competencies.
- Developing data infrastructure that supports the quality of care by aggregating data on the ways that families and educators experience the system.

Implementation of the Master Plan will require years of consistent investment and reform. The 2020 Budget Act began implementation of the Master Plan with funding dedicated to transition child care programs into a single agency. This transition improves the ability of state government to streamline and unify all early childhood services and eases the administration of child care provider collective bargaining, which began in late 2020. The Budget builds on this work by providing an increase of $44.3 million Cannabis Fund to expand access to child care vouchers for more than

4,500 children, with $21.5 million available starting in 2020-21. The K-12 Education chapter includes additional information about investments in early learning programs.

DEPARTMENT OF PUBLIC HEALTH

The Department of Public Health is charged with protecting and promoting the health and well-being of the people of California. The Budget includes $4.2 billion ($1.1 billion General Fund) in 2021-22 for the Department.

COVID-19 DISASTER RESPONSE

The Budget reflects over $1 billion in 2020-21 which represents state and federal support for emergency response measures including supporting enhanced laboratory capacity and testing, data-driven investigation, response and prevention, coordination with local partners, and the Valencia Branch Laboratory. This total mainly reflects emergency funds and federal grants processed as of late Fall 2020; additional anticipated current year funding as of the Governor's Budget is reflected elsewhere in the budget.

The Budget includes over $820 million in 2021-22 to continue and build on the emergency response measures described above.

Significant Adjustments:

- New Cannabis Department—The Budget proposes to transfer 119 positions and $29.0 million in 2021-22 from the Department of Public Health to support the consolidation of resources for the new Department of Cannabis Control.
- Licensing and Certification—The Budget includes $19.1 million for year three of the Los Angeles County contract and $4.5 million to support increased medical breach and caregiver investigation workload.
- Childhood Reading Augmentation—The Budget includes $5 million one-time General Fund for the Department of Public Health to provide books to low-income children to improve child development and literacy.

DEPARTMENT OF DEVELOPMENTAL SERVICES

The Department of Developmental Services (DDS) provides individuals with developmental disabilities a variety of services that allow them to live and work independently or in supported environments. California is the only state that provides

services to individuals with developmental disabilities as an entitlement. The Budget includes $10.5 billion ($6.5 billion General Fund) and estimates that approximately 386,753 individuals will receive developmental services by the end of 2021-22.

COVID-19 IMPACTS

The Budget includes $211.7 million ($150.4 million General Fund) to address COVID-19 impacts on the developmental services system. Funding supports utilization increases for purchase of services above base funding levels and direct response expenditures for surge capacity at the Fairview and Porterville Developmental Centers and other operating costs in state-operated facilities.

REGIONAL CENTER EMERGENCY RESPONSE

In the last five years, DDS has been impacted by various emergencies and disasters including wildfires, earthquakes, and public safety power shutoffs. The Budget includes $2 million ($1.4 million General Fund) ongoing for regional center emergency coordinators. Each regional center will receive a dedicated position to coordinate emergency preparedness, response, and recovery activities for DDS consumers.

Other Significant Adjustments:

- Youth Returning from Out-of-State Foster Care—The Budget includes ongoing $5.8 million ($3.5 million General Fund) for DDS to support approximately ten youth in their transition back to California. In partnership with the Legislature, one-time $2.9 million ($1.8 million General Fund) was allocated in December, 2020 for these purposes.
- Supplemental Rate Increase—The Budget includes $454.6 million ($261.2 million General Fund) in 2021-22 to continue the supplemental rate increases included in the 2019 and 2020 Budget Acts. The supplemental rate increases will be suspended on December 31, 2022. The suspension will be lifted if the Administration determines through the 2022 Budget Act process that there is sufficient General Fund revenue to support all suspended programs in the subsequent two fiscal years.
- Uniform Holiday Schedule—The Budget includes $55.9 million ($35.8 million General Fund) in 2021-22 to suspend implementation of the Uniform Holiday Schedule. The funding will be suspended on December 31, 2022. The suspension will be lifted if the Administration determines through the 2022 Budget Act process that there is sufficient General Fund revenue to support all suspended programs in the subsequent two fiscal years.

DEPARTMENT OF STATE HOSPITALS

The Department of State Hospitals (DSH) administers the state mental health hospital system, the Forensic Conditional Release Program, the Sex Offender Commitment Program, and the evaluation and treatment of judicially and civilly committed patients. The Budget includes $2.5 billion ($2.3 billion General Fund) in 2021-22 for support of the Department. The patient population is expected to reach 6,361 by the end of 2021-22, including patients receiving competency treatment in jail-based settings.

COVID-19 IMPACTS

The Budget includes $51.9 million one-time General Fund in 2021-22 to address the impacts of COVID-19 including, but not limited to, isolation and testing capacity at state hospitals, outside medical invoicing, and other supports for patients and employees. As an additional safeguard, and to provide for increased surge capacity, DSH has contractually secured a portion of the Norwalk facility to use as an alternate care site. Due to the recent increase in COVID-19 cases this facility was activated in mid-December to provide for additional isolation space at DSH-Patton hospital.

FELONY INCOMPETENT TO STAND TRIAL POPULATION

The Department continues to experience a growing number of incompetent to stand trial (IST) commitments who are referred from trial courts and are awaiting admission to the state hospital system, which has been further exacerbated by the COVID-19 Pandemic. The number of ISTs pending placement into the state hospital system was approximately 1,428 individuals in December 2020.

The Budget includes the followings proposals to address the number of ISTs pending placement by increasing local capacity to provide treatment, housing, and other necessary supports:

- Community Care Demonstration Project for Felony IST (CCDP-IST)—The Budget includes $233.2 million General Fund in 2021-22 and $136.4 million General Fund in 2022-23 and ongoing to contract with three counties to provide a continuum of services to felony ISTs in the county as opposed to state hospitals. This proposal seeks to demonstrate the effectiveness of streamlining services to drive improved outcomes for individuals with serious mental illness. This proposal is projected to serve up to 1,252 ISTs in the county continuum of care settings in 2021-22.

- Expansion of Community Based Restoration (CBR)—The Budget includes $9.8 million General Fund in 2020-21, $4.5 million General Fund in 2021-22, and $5 million General Fund in 2022-23 and ongoing to expand the current Los Angeles County CBR program beginning in 2020-21 and establish new CBR programs in additional counties in 2021-22. This proposal is projected to increase capacity by up to 250 beds in 2021-22.
- Reappropriation and Expansion of the IST Diversion Program—The Budget includes $46.4 million one-time General Fund, available over three years, to expand the current IST Diversion program in both current and new counties. Additionally, the Budget includes five-year limited-term funding of $1.2 million General Fund annually to support research and administration for the program. Further, the Budget authorizes the reappropriation of existing program funds set to expire in 2020-21.
- Expansion of the Jail-Based Competency Treatment Program—The Budget includes $785,000 General Fund in 2020-21 and $6.3 million General Fund in 2021-22 and ongoing to expand the Jail-Based Competency Treatment program to seven additional counties. This expansion is estimated to increase capacity by up to 31 beds in 2021-22.
- Forensic Conditional Release Program (CONREP) Mobile Forensic Assertive Community Treatment (FACT) Team—The Budget includes $5.6 million General Fund in 2021-22, $8 million General Fund in 2022-23 and 2023-24, and $8.2 million General Fund in 2024-25 and ongoing to implement a FACT team model within CONREP, in lieu of the typical centralized outpatient clinic model, to expand community-based treatment options for both ISTs and non-ISTs in counties and backfill State Hospital beds with IST patients. This expansion is estimated to increase capacity by up to 100 beds in 2021-22.
- CONREP Continuum of Care Expansion—The Budget includes $3.2 million General Fund in 2020-21 and $7.3 million General Fund in 2021-22 and ongoing to increase the step-down capacity in the community in order to transition more stable non-IST patients out of state hospital beds and backfill state hospital beds with IST patients. This expansion is estimated to increase capacity by up to 40 beds in 2021-22.

OTHER HEALTH AND HUMAN SERVICES ADJUSTMENTS

- Supporting Local Child Support Agency Administration—The Budget includes $24.9 million ($8.5 million General Fund) ongoing for local child support agencies to improve child support collections and services and $23.8 million ($8.1 million General

Fund) ongoing for local child support courts and state operations child support funding.

- Office of Youth and Community Restoration—The Budget includes $3.4 million General Fund in 2021-22 and $3.1 million ongoing General Fund to develop reports on youth outcomes in the juvenile justice system, staff a Child Welfare Council committee focused on improving outcomes for justice-involved youth, and create an Office Ombudsperson.
- Center for Data Insights and Innovation—The Budget proposes to consolidate existing resources to establish a Center for Data Insights and Innovation within the 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.

1991 AND 2011 REALIGNMENT

The programs for 1991 and 2011 Realignment are funded through two sources: state sales tax and vehicle license fees. These fund sources are projected to increase by 5.6 percent from 2019-20 to 2020-21 and decrease by 1.9 percent from 2020-21 to 2021-22.

2011 Realignment Estimate at 2021 Governor's Budget

($ millions)

	2019-20	2019-20 Growth	2020-21	2020-21 Growth	2021-22	2021-22 Growth
Law Enforcement Services	**$2,600.4**		**$2,633.8**		**$2,682.7**	
Trial Court Security Subaccount	558.2	0.0	567.0	$10.1	563.7	0.0
Enhancing Law Enforcement Activities Subaccount	489.9	$224.4	489.9	247.3	489.9	$210.7
Community Corrections Subaccount	1,344.7	0.0	1,366.0	75.9	1,408.3	0.0
District Attorney and Public Defender Subaccount	40.9	0.0	41.6	5.1	45.5	0.0
Juvenile Justice Subaccount	166.7	0.0	169.3	10.0	175.3	0.0
Youthful Offender Block Grant Special Account	*(157.5)*	-	*(160.0)*	*(9.4)*	*(165.6)*	-
Juvenile Reentry Grant Special Account	*(9.2)*	-	*(9.3)*	*(0.6)*	*(9.7)*	-
Growth, Law Enforcement Services		**224.4**		**348.4**	**0.0**	**210.7**
Mental Health	**$1,120.6**	0.0	**$1,120.6**	$9.4	**$1,120.6**	0.0
Support Services	**$3,825.1**		**$3,885.6**		**$3,969.3**	
Protective Services Subaccount	2,359.9	0.0	2,397.2	$84.6	2,423.9	0.0
Behavioral Health Subaccount	1,465.2	0.0	1,488.4	94.0	1,545.4	0.0
Women and Children's Residential Treatment Services	*(5.1)*		*(5.1)*		*(5.1)*	
Growth, Support Services		**0.0**		**188.0**	**0.0**	
Account Total and Growth	**$7,770.5**		**$8,176.4**		**$7,983.3**	
Revenue						
1.0625% Sales Tax	$7,050.2		$7,427.2		$7,276.7	
General Fund Backfill	6.0		12.0		6.0	
Motor Vehicle License Fee	747.3		749.0		788.1	
Revenue Total	**$7,770.5**		**$8,176.4**		**$7,983.3**	

This chart reflects estimates of the 2011 Realignment subaccount and growth allocations based on current revenue forecasts and in accordance with the formulas outlined in Chapter 40, Statutes of 2012 (SB 1020).

1991 Realignment Estimate at 2021 Governor's Budget

Dollars in Thousands

Amount	CalWORKs MOE	Health	Social Services	Mental Health	Family Support	Child Poverty	Totals
2019-20 State Fiscal Year							
Base Funding							
Sales Tax Account	$742,048	$-	$2,296,188	$-	$443,649	$102,919	$3,584,804
Vehicle License Fee Account	363,383	1,050,566	216,223	-	152,435	290,884	2,073,492
Subtotal Base	**$1,105,432**	**$1,050,566**	**$2,512,411**	**$-**	**$596,085**	**$393,803**	**$5,658,296**
Growth Funding							
Sales Tax Growth Account:	-	-	-	-	-	-	-
Caseload Subaccount	-	-	-	-	-	-	-
County Medical Services Growth Subaccount	-	-	-	-	-	-	-
General Growth Subaccount	-	-	-	-	-	-	-
Vehicle License Fee Growth Account	-	-	-	-	-	-	-
Subtotal Growth	**$-**	**$-**	**$-**	**$-**	**$-**	**$-**	**$-**
Total Realignment 2019-20[1/]	**$1,105,432**	**$1,050,566**	**$2,512,411**	**$-**	**$596,085**	**$393,803**	**$5,658,296**
2020-21 State Fiscal Year							
Base Funding							
Sales Tax Account	$742,048	$23,890	$2,296,188	$-	$419,759	$102,919	$3,584,804
Vehicle License Fee Account	363,383	1,016,414	216,223	-	186,586	290,884	2,073,492
Subtotal Base	**$1,105,432**	**$1,040,304**	**$2,512,411**	**$-**	**$606,346**	**$393,803**	**$5,658,296**
Growth Funding							
Sales Tax Growth Account:	$6,372	$21,182	$68,917	$36,594	-	$50,632	$183,698
Caseload Subaccount	-	-	(68,917)	-	-	-	(68,917)
County Medical Services Growth Subaccount	-	-	-	-	-	-	-
General Growth Subaccount	(6,372)	(21,182)	-	(36,594)	-	(50,632)	(114,780)
Vehicle License Fee Growth Account	8,747	29,077	-	50,233	-	69,503	157,559
Subtotal Growth	**$15,119**	**$50,259**	**$68,917**	**$86,826**	**$-**	**$120,135**	**$341,257**
Total Realignment 2020-21[1/]	**$1,120,551**	**$1,090,564**	**$2,581,328**	**$86,826**	**$606,346**	**$513,938**	**$5,999,553**
Change From Prior Year	*$15,119*	*$39,998*	*$68,917*	*$86,826*	*$10,262*	*$120,135*	*$341,257*
2021-22 State Fiscal Year							
Base Funding							
Sales Tax Account	$752,888	$-	$2,345,276	$25,545	$460,934	$152,263	$3,736,906
Vehicle License Fee Account	367,663	1,096,570	212,429	47,288	113,889	354,063	2,191,902
Subtotal Base	**$1,120,551**	**$1,096,570**	**$2,557,704**	**$72,833**	**$574,823**	**$506,327**	**$5,928,808**
Growth Funding							
Sales Tax Growth Account:	-	-	-	-	-	-	-
Caseload Subaccount	-	-	-	-	-	-	-
County Medical Services Growth Subaccount	-	-	-	-	-	-	-
General Growth Subaccount	-	-	-	-	-	-	-
Vehicle License Fee Growth Account	-	-	-	-	-	-	-
Subtotal Growth	**$-**	**$-**	**$-**	**$-**	**$-**	**$-**	**$-**
Total Realignment 2021-22[1/]	**$1,120,551**	**$1,096,570**	**$2,557,704**	**$72,833**	**$574,823**	**$506,327**	**$5,928,808**
Change From Prior Year	*$0*	*$6,005*	*-$23,624*	*-$13,993*	*-$31,523*	*-$7,611*	*-$70,745*

[1/] Excludes $14 million in Vehicle License Collection Account moneys not derived from realignment revenue sources.

AGENDA ITEM 2

Action

February 17, 2021 Commission Meeting

Legislative Priorities

Summary: The Commission will consider legislative and budget priorities related to Commission initiatives, including Senate Bill 224 (Portantino) for the current legislative session.

Background:

The Commission's portfolio of activities over the last few years have focused on improving youth access to mental health care and outcomes associated with that care. Those activities include Triage and Mental Health Student Services Act grants; Stiving for Zero, the state suicide prevention strategic plan, the report, *Every Young Heart and Mind: Schools as Centers of Wellness.*

Due to the pandemic, students that may not have experienced mental health symptoms are now facing mental health challenges, due to the isolation associated with distance learning, and not being able to connect with friends or teachers. Education about mental health creates awareness and empowers students to seek help and reduces the stigma associated with mental health challenges.

To ensure that students received the education needed to help empower students to seek help, Senator Portantino introduced Senate Bill 224, public instruction, mental health education that will ensure pupils receive mental health education in schools from qualified instructors.

Enclosed for your review is information regarding Senator Portantino's plan to provide education to students in schools during elementary, middle school and high school.

Presenter: Toby Ewing, Executive Director and Norma Pate, Deputy Director

Enclosures (2): Senate Bill 224, introduced on January 14, 2021 and Fact Sheet.

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:

SECTION 1. (a) The Legislature finds and declares all of the following:

(1) Mental health is critical to overall health, well-being, and academic success.

(2) Mental health challenges affect all age groups, races, ethnicities, and socioeconomic classes.

(3) Millions of Californians, including at least one in five youths, live with mental health challenges. Millions more are affected by the mental health challenges of someone else, such as a close friend or family member.

(4) Mental health education is one of the best ways to increase awareness and the seeking of help, while reducing the stigma associated with mental health challenges. The public education system is the most efficient and effective setting for providing this education to all youth.

(b) For the foregoing reasons, it is the intent of the Legislature in enacting this measure to ensure that all California pupils in grades 1 to 12, inclusive, have the opportunity to benefit from a comprehensive mental health education.

SEC. 2. Article 6 (commencing with Section 51925) is added to Chapter 5.5 of Part 28 of Division 4 of Title 2 of the Education 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

recognized as accurate and objective by professional organizations and agencies with expertise in the mental health field.

SEC. 3. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

O

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

AGENDA ITEM 3

Action

February 17, 2021 Commission Meeting

Amendments to the Rules of Procedure

Summary: The Commission will consider adoption of proposed amendments to its Rules of Procedure. These proposed amendments include proposals presented in January 2020 and revised amendments to ten rules, developed through a year-long stakeholder engagement process, that have been available for public consideration since November 2020.

Background:

The Commission's strategic planning process highlighted the need and opportunity to amend the Rules of Procedure, which were originally adopted in 2009 and last amended in March of 2016. In drafting the proposed amendments, staff reviewed rules from other boards and commissions in addition to documenting current Commission practices.

In January 2020, the Commission was presented with proposed amendments to the Rules of Procedure. Many of the proposed amendments presented are non-substantive and/or reflect current Commission practices. For your reference, the proposed rules presented in January 2020 are enclosed as Enclosure 4. At the January 2020 meeting the Commission instructed staff to bring the proposed amendments back after making further revisions to clarify some of the proposed amendments and to address public comments.

As a result of a 12-month stakeholder engagement process, staff revised the January 2020 proposal. The revised proposed amendments to the Commission's Rules of Procedure are enclosed as Enclosure 1.

Key Themes of Stakeholder Input:

The concerns shared during public engagement cover a range of specific provisions in the Rules of Procedures. More broadly, the conversations, and how the revised amendments address stakeholder concerns, are organized in three thematic areas:

Core Values of the MHSA

The Mental Health Services Act, as a citizen's initiative, was drafted and promoted by consumers, peers, family members, advocates, and practitioners. The MHSA has been implemented under the stewardship of those stakeholders whose voices are elevated and honored through designated membership on the Commission.

The amendments proposed in January 2020 incorporate the mission statement in the new strategic plan adopted by the Commission after an 18-month public strategic planning

process. Stakeholders voiced their concern that the new mission statement does not include some of the aspects of the MHSA's values that some stakeholders hold dear.

In response to the concerns, the draft revised amendments to the Rules incorporate into the Governance Philosophy section of the Rules some of the longstanding core values that are not part of the new mission statement, including "collaborating with clients, their families, and underserved communities; advancing strategies to eliminate disparities; and "promoting mental wellness and supporting recovery and resiliency."

In addition, the draft revised Rule 1.7 describing orientation for new Commissioners include a new requirement that the orientation include "the principles of recovery, consumer and family driven decision making, community collaboration, meaningful stakeholder outreach and engagement, and cultural competence and the imperative to reduce disparities." These are also core principles in the Commission's strategic plan.

Transparency and Accountability

The Mental Health Services Act anticipates that volunteer Commissioners would meet quarterly, and the operations of the Commission would be executed by a professional staff of civil servants under the leadership of an Executive Director who serves at the pleasure of the Commission and reports to and is accountable to the Commission.

Some stakeholders' concerns focused on two rules, Rules 2.4 and Rule 2.5, dealing with delegated authority of the Executive Director. The January 2020 proposed amendment to Rule 2.4 would have increased the Executive Director's authority to enter into contracts. It also would have allowed the Executive Director to enter into larger contracts upon the approval of the Commission Chair and Vice Chair. Concerns were raised that the new authority did not provide sufficient transparency or accountability.

To address these concerns, the draft revised Rule 2.4 adds a requirement that the Executive Director shall ensure information on all contracts, including contracts entered under delegated authority of Rule 2.4, be included in the Commission's public budget information on its website. Staff has developed phase one of this contract transparency tool/dashboard and it is posted on the Commission's website. This dashboard includes information on all active contracts dating back to Fiscal Year 2018-2019 with the contract number, the contractor name, amount, length, and brief description of each contract.

This contract transparency dashboard is consistent with and supported by the current transparency of the Commission's budget. The budget is presented to the Commission and the public three times during the fiscal year: at the beginning, midway, and at the end of the fiscal year. This budget presentation requirement is included in Rule 2.1.

The January 2020 proposed revisions of Rule 2.5 sought to clarify the Executive Director's role in responding to emerging legislative issues. The proposal would have included authorization for the Executive Director to advocate on legislation "when the legislation advances an informal or emerging position of the Commission after consultation with the Chair and Vice Chair." Concerns were raised about the "informal or emerging" language. In response to these concerns, the current proposed amendments to Rule 2.5 no longer includes this part of the January 2020 proposal.

Outreach and Engagement

The Commission's tradition of relying on stakeholder committees for public input has been significantly augmented by the expansion of other public engagement activities, including community forums, focus groups, listening sessions, site visits, use of surveys, Commission Subcommittees, and other approaches to gathering public input.

The January 2020 proposal, in recognition of these growing forms of community engagement, added a new rule (Rule 5.1) that specifies these broad and inclusive strategies of engagement.

The January proposal also aligned Rule 6.1, dealing with committees, with the Welfare and Institutions Code section 5845(d)(3) to state the Commission "may" rather than "shall" establish standing committees. Concern was voiced that this change would exclude stakeholder involvement in Commission decisions.

Committees are one of many effective means to ensure Commission decisions are made with robust stakeholder involvement. One of the most effective ways to engage with consumers, families, and members of diverse racial, ethnic, and cultural communities is to go to where they are. The inclusion of a new Rule 5.1 focusing on strategies to ensure broad and inclusive community outreach clearly states the Commission's commitment to broad, diverse, and inclusive engagement and consultation with community stakeholders.

The January 2020 proposal also sought to refine the committee membership requirements in Rule 6.1 by focusing on the expertise needed to advance the committee's goals. Concern was raised about the elimination of the requirement for two consumers, two family members, and two representatives of underserved ethnic and cultural communities. In response to stakeholder concerns, the proposed revision to Rule 6.1 provides that each committee should include at least two members who are consumers, two family members or caregivers, and two experts on reducing disparities. The revised Rule 6.1 also includes the requirement that committee members have the desired expertise and experience to advance the committee's goals. In addition, the revised Rule states that the Commission shall strive to ensure committee membership reflects the demographic diversity, including race, ethnicity, sexual orientation, and gender identity of California and geographic diversity.

Year-Long Stakeholder Engagement:

As mentioned above, over the last year, the Commission Chair and Vice Chair and staff have engaged stakeholders to understand their concerns about the January 2020 proposed amendments to the Rules of Procedure and to explore refinements to address those concerns.

Specifically, Commission Chair Ashbeck and Vice Chair Madrigal-Weiss met virtually with stakeholders at the MHSA Partners Forum in April 2020 and held a virtual public meeting of the Rules of Procedure Subcommittee in September 2020. The Subcommittee was scheduled to meet on December 2, 2020 to discuss staff recommended changes to the Rules of Procedure to address stakeholder concerns. The December 2nd meeting was postponed at the request of stakeholders and was not able to be rescheduled until February 17, 2021.

Throughout these public engagement meetings, stakeholders raised concerns about a range of specific provisions in the Rules of Procedures. The key themes of these concerns, and how staff recommends the proposed amendments address or mitigate those concerns, are highlighted below.

The specific concerns are documented in the enclosed table and displayed with the January 2020 proposal and suggested revisions with explanations (Enclosure 3). Also enclosed is a document (Enclosure 2) limited to the recommended revisions to the January proposals for the following rules:

- Governance Philosophy
- Rule 1.7 Commissioner Orientation
- Rule 2.1 Duties of the Executive Director
- Rule 2.4 Contract Authority
- Rule 2.5 Authority to Advocate on Legislation
- Rule 4.4 Agenda items
- Rule 4.11 Quorum
- Rule 4.12 Voting
- Rule 5.1 Public Outreach and Engagement
- Rule 6.1 Committee/Subcommittee/Other Multi-member Body Structure

Enclosures 2 and 3 in the packet for today's meeting were previously posted on the Commission's website and sent to the Commission's listserv in late November 2020 as part of the materials for the December 2nd Subcommittee meeting.

Enclosure 1 is the Rules of Procedures with the final proposed amendments for your considered adoption today. This document incorporates the revisions that are in Enclosure 2.

Enclosures (5): (1) Rules of Procedure with proposed February 2021 amendments (2) Proposed revisions to the January 2020 amendments; (3) Responses to written public comments on the January 2020 proposed amendments; (4) January 2020 proposed amendments to Rules of Procedure presented in January 2020; and (5) Stakeholder letters comment on the January 2020 proposal.

Handouts: A PowerPoint presentation will be provided at the meeting.

Enclosure 1

MHSOAC
Mental Health Services
Oversight and Accountability Commission

RULES OF PROCEDURE

Proposed February 2021 amendments

(New language is shown in underlined text and deleted language is shown in strikethrough text.)

TABLE OF CONTENTS

To be added when document is completed.

MISSION

The Mental Health Services Oversight and Accountability Commission works through partnerships to catalyze transformational change across systems and ensure everyone who needs mental health care has access to and receives effective and culturally competent care.

GOVERNANCE PHILOSOPHY

Integrity and sound stewardship in adherence to the Commission's Mission, Vision, and Core Principles are paramount in the governance of all Commission activities. The Commission will govern itself with an emphasis on the following:

a. Collaborating with clients, their families, and underserved communities
b. Advancing health equity and strategies to eliminate disparities
c. Promoting mental wellness and supporting recovery and resiliency
d. Advancing an objective understanding and incorporating diverse viewpoints
e. Making decisions in a transparent, responsive, and timely manner
f. Striving to improve results and outcomes
g. Elevating transformative vision and strategic leadership
h. Working collaboratively to drive system-scale improvements
i. Being proactive

~~Specifically~~:

~~a. The MHSOAC will cultivate a sense of group responsibility. The MHSOAC will be responsible for excellence in governing. The MHSOAC will use the expertise of individual members to enhance the ability of the MHSOAC~~.

~~b. The MHSOAC will direct evaluate, and inspire the organization through the careful establishing written policies, procedures and directives.~~

~~c. The MHSOAC will enforce upon itself the necessary discipline to govern with excellence, including preparation and regular attendance at meetings, thorough preparation by each member for each meeting, adherence to its policymaking principles, and respecting the roles~~.

~~d. Continual development of the MHSOAC will include orientating of new members in the Commission's governance policies and processes, periodic re-orientation of existing members, and regular discussion of process improvement~~.

~~e. The MHSOAC will regularly discuss and evaluate its performance and take steps to improve its effectiveness~~.

COMMISSIONERS

1.1 Terms of Commissioners

A. The Commission consists of 16 voting members: the Attorney General or designee; the Superintendent of Public Instructions or designee; the Chairperson of the Senate Committee on Health, the Chairperson of the Senate Committee on Human Services, or another member of the Senate selected by the President pro Tempore of the Senate; the Chairperson of the Assembly Committee on Health or another member of the Assembly selected by the Speaker of the Assembly; and twelve members appointed by the Governor to specified seats: two individuals with lived experiences, two family members, a physician specializing in alcohol and drug treatment, a mental health professional, a county sheriff, a superintendent of a school district, a representative of a labor organization, a representative of an employer with less than 500 employees, a representative of an employer with more than 500 employees, and a representative of a health care services plan or insurer. (Welfare and Institutions Code Section 5845)

B. ~~Pursuant to Welfare and Institutions Code Section 5845,~~ The term of each Commissioner is three years, to be staggered so that approximately one-third of the appointments expire in each year. A Commissioner may resign prior to the end of the Commissioner's term by submitting written notification to the appointing authority and sending a copy of the resignation to the Commission Chair and the Executive Director. A Commissioner who desires to serve after their term has expired shall notify the Commission Chair and the Executive Director in writing of their intention to serve until reappointed or replaced by a new appointee. ~~Members shall~~ Commissioners serve without compensation but ~~shall be~~ are reimbursed in accordance with the policy of the State of California for all actual and necessary expenses incurred in the performance of their duties. (Welfare and Institutions Code Section 5845)

~~If a Commissioner cannot attend a Commission meeting he or she will notify the Chair and the Executive Director of such absence in advance of the Commission meeting. If a Commissioner misses one (1) Commission meeting without notice or three (3) Commission meetings in a calendar year with notice the Chair shall notify the Commissioner and that Commissioner's appointing power in writing that the attendance record of the Commissioner be improved or that the Commissioner be replaced.~~

1.2 The Role of Commissioners

A. Commissioners are expected to work collectively to accomplish the Commission's goals as adopted by the Commission and to attend Commission meetings in person or via teleconference.

B. At the request of the Chair, Commissioners are expected to serve as a member of a committee, subcommittee, or other Commission body.

C. At the request of the Chair, Commissioners are expected to represent the Commission in meetings, conferences, testimony in public hearings, and other speaking engagements.

D. The Commissioner with the most seniority and present at the meeting is expected to preside at the Commission meeting when neither the Chair nor Vice Chair is available to run all or part of the meeting.

E. The best decisions come out of unpressured collegial deliberations and the Commission ~~MHSOAC~~ seeks to maintain an atmosphere where the Commissioners ~~or Committee members~~ can speak freely, explore ideas before becoming committed to positions and seek information from staff and other members. To the extent possible the Commission ~~MHSOAC~~ encourages members to come to meetings without having fixed or committed their positions in advance.

1.3 Chair

A. Election of the Chair

A.1. The Commission shall elect a Chair ~~shall be elected~~ at a ~~MHSOAC~~ Commission meeting preferably held in September but no later than during the last quarter of the calendar year. The Chair shall be elected by a majority of the ~~members of the MHSOAC~~ Commissioners present and voting consistent with the Rule 4.11A and shall assume all duties ~~and presides at all MHSOAC meetings~~ starting January 1, following the election. The Chair is elected to a one-year term. A Commissioner may be elected to serve more than one term as Chair. ~~The term of the Chair shall be one year each.~~

A.2. In the event more than two candidates are nominated for Chair and no candidate receives a majority of the votes cast, the balloting shall continue, and another vote taken between the two candidates receiving the highest number of votes.

B. Duties of the Chair

B.1. The Chair, with input from Commissioners and staff, sets the Commission's meeting agenda, prioritizing and scheduling agenda items as appropriate, and conducts the meetings.

B.2. The Chair appoints Commissioners to Commission subcommittees, committees, or other bodies as necessary to conduct the Commission's business.

B.3. The Chair provides guidance and direction to the Executive Director on Commission business, including but not limited to: (a) advocating on legislation consistent with Commission Rule 2.5; (b) approving Innovation projects consistent with Commission Rule 2.6; and (c) placing items on the Commission agenda consistent with Commission Rule 4.5.

B.4. In the event the Chair is unable to continue with the Chair's duties due to resignation, death, incapacity, or no longer being a member of the Commission, the Vice Chair shall assume all of the responsibilities of the Chair until a successor is elected. The election shall be held within 60 days of the vacancy.

1.4 Vice Chair

A. Election of the Vice Chair

A.1. The Commission shall elect the Vice Chair ~~shall be elected~~ at a ~~MHSOAC~~ Commission meeting preferably held in September but no later than during the last quarter of the calendar year. The Vice Chair shall be elected by a majority of the ~~members of the MHSOAC~~ Commissioners present and voting consistent with the Rule 4.11A and shall assume all duties ~~and presiding at all MHSOAC meetings~~ starting January 1, following the election. The Vice Chair is elected to a one-year term. A Commissioner may be elected to serve more than one term as Vice Chair.

A.2. In the event more than two candidates are nominated for Vice Chair, and no candidate receives a majority of the votes cast, the balloting shall continue, and another vote taken between the two candidates receiving the highest number of votes.

B. Duties of the Vice Chair

B.1. The Vice Chair fulfills the role of Chair and presides at meetings in the absence of the Chair.

B.2. In the event the Vice Chair is unable to continue with the Vice Chair's duties due to resignation, death, incapacity, or no longer being a member of the Commission, an election for a successor shall be held within 60 days of the vacancy.

B.3. When neither the Chair nor Vice Chair is available to run all or part of the meeting, e.g., both officers may be absent, need to leave the room, or are disqualified from discussion and action on an item due to conflict of interest, the ~~most senior~~ Commissioner with the most seniority on the Commission who is present shall preside at the meeting.

1.5 Commission Member Vacancy

~~Commissioners may leave office at the end of their term or sooner.~~ When a vacancy occurs on the Commission, a successor is selected by the appointing authority ~~power~~.

1.6 Compensation and Expenses

Commissioners, ~~staff, agendized presenters, and active Committee members~~ will be reimbursed in accordance with State per diem laws. Also, any reasonable business expenses incurred will be reimbursed as authorized by law ~~the Commission~~. ~~On a case by case basis the designee of a Committee member may also be reimbursed in accordance with the State per diem laws.~~

1.7 Training and Orientation

A. New Commissioners ~~members~~ shall within 30 days of being appointed receive ~~training and~~ orientation in: (1) Commission governance, policies and procedures, including the Commission's Strategic Plan, Mission Statement, Vision Statement, Core Principles, and governance philosophy; (2) Commission strategic directives; (3) Mental Health Services Act (MHSA) programs and issues, including the principles of recovery, consumer and family-driven decision making, community collaboration, meaningful stakeholder outreach and engagement, cultural competence and the imperative to reduce disparities; and (4) relevant laws and statutes.

B. At or before the orientation session, the new Commissioner ~~member~~ will receive the following documents:

1) The Bagley-Keene Open Meeting Act

2) Information on the Political Reform Act and how it affects Commissioners

3) The Commission's Conflict of Interest Code

4) The Commission's Rules of Procedure

5) List of Commission meeting dates and locations

6) Any other documents that may be helpful to the Commissioner to fulfill the Commissioner's responsibilities on the Commission

~~1) Listing of names, addresses, and contact information for the Commission members;~~

~~2) Listing of names and contact information for MHSOAC Staff~~

~~3) Copy of the Rules of Procedure~~

~~4) Brief history and overview of MHSOAC including mission, purpose statement, and Proposition 63~~

~~5) Information about the Political Reform Act and how it affects the Commissioners~~

~~6) Information about the travel reimbursement procedures~~

~~7) List of meeting dates and locations~~

~~8) Copy of the Bagley-Keene Open Meeting Act~~

~~9) Summary of Robert's Rules of Order~~

~~10) Copy of the following documents:~~

~~a) Mental Health Services Act Prevention and Early Intervention: County and State Level Policy Direction;~~

~~b) Recommendation to the MHSOAC for funding for Innovative Programs;~~

~~c) Eliminating Stigma and Discrimination Against Persons with Mental Health Disabilities;~~

~~d) Mental Health Services Oversight and Accountability Commission Report on Co-Occurring Disorders;~~

~~e) Mental Health Services Oversight and Accountability Commission Position Paper on Training and Education;~~

~~f) Any other policy paper adopted by the Commission~~

C. As required by Government Code Sections 11146 through 11146.4 and 12950.1, within six months of beginning service as a Commissioner and at least every two years thereafter, ~~members of the~~ Commissioners shall receive training on laws related to ethics, conflict of interest requirements, governmental transparency, open government, fair government processes, and sexual harassment and abusive conduct prevention.

1.8 Statement of Economic Interest – Form 700

Each Commissioner is required by the California Political Reform Act and the corresponding regulations to file a Statement of Economic Interests, Form 700: (1) within 30 days of being appointed; (2) on a yearly basis as prescribed by law; and (3) within 30 days of ending Commission membership.

1.9 Conflict of Interest

A. Presence of a conflict of interest prohibits Commissioners as public officials from participating in discussion about or taking action on an item. Provisions in California statutes, regulations, and case law define and provide guidelines related to conflict of interest. A Commissioner shall not make, participate in making, or in any way attempt to use ~~his or her~~ the Commissioner's official position to influence a Commission decision in which ~~he or she~~ the Commissioner knows or has reason to know the Commissioner has a financial interest (Government Code Section 87100). Additionally, Commissioners must be guided solely by the public interest, rather than by personal interest, when dealing with contracting in an official capacity (Government Code Section 1090 et seq.).

B. A Commissioner who has a financial conflict of interest ~~must~~ shall do the following:

1) Notify the Executive Director as soon as possible if any agenda item presents a potential conflict of interest. This will prepare the Chair to announce the Commissioner's nonparticipation in any discussion, deliberation or vote when the item comes up.

2) Publicly identify, in enough detail to be understood by the public, the financial interest that causes the conflict of interest or potential conflict of interest.

3) Recuse ~~himself or herself~~ themselves from discussing or voting on the matter or from attempting to use ~~his or her~~ their position to influence the decision.

~~The Commission will adopt for itself and adhere to an Incompatible Activities Policy.~~

1.10 Commission Representation

A. Every Commissioner ~~member of the MHSOAC has~~ retains the right to express ~~his or her~~ their opinion on any subject whenever the ~~member~~ Commissioner is acting as an individual and not on behalf of ~~or at the expense of~~ the Commission.

B. Commissioners who agree to represent the Commission ~~in meetings, conferences, testimony in public hearings, speaking engagement, etc,~~ and do so at the request of the Commission, ~~with or without reimbursement,~~ agree ~~also~~ to represent only the officially approved positions of the Commission or a complete and accurate presentation of issues under consideration by the Commission. Commissioners whose personal positions are in conflict with the Commission's official positions must represent either the Commission's positions only or decline the request to represent the Commission.

C. A Commissioner is considered to be acting officially on behalf of the Commission whenever ~~he or she~~ the Commissioner states or implies that ~~he or she~~ they are acting as a representative or member of the Commission, whenever the ~~member~~ Commissioner is authorized by the Commission to represent it, or the activity of the ~~member~~ Commissioner results in an expense ~~direct or indirect~~ to the Commission. ~~Examples of such expenses include but are not limited to compensation for travel, per diem, phone calls, postage, use of Commission stationary, or other materials produced or furnished by the Commission~~.

D. Nothing shall prevent ~~members of the~~ Commissioners from expressing their views as individuals in ~~regular or special meetings of the~~ Commission meetings or activities when these views bear directly upon policy issues under discussion.

EXECUTIVE DIRECTOR

2.1 Duties of the Executive Director

A. The Executive Director is appointed and discharged by the Commission ~~MHSOAC~~. The Executive Director acts under the authority of, and in accordance with direction from the Commission ~~MHSOAC. Commissioners should direct their requests for information or assistance from staff to the Executive Director.~~

B. The Executive Director represents the Commission and advances its goals by working with California's constitutional officers, federal, state and local agencies, national and international organizations, private sector leaders, and other stakeholders, including but not limited to, consumers, families, and representatives of diverse communities.

~~The Executive Director also serves as the Commission's liaison with, county commissions, other mental health associations and stakeholder groups~~.

C. The Executive Director presents to the Commission the annual budget and expenditures at the beginning of the fiscal year for Commission adoption, a mid-year expenditure report, and a close-of-year expenditure report.

D. The Executive Director fulfills the responsibilities set forth in the Executive Director's duty statement and implements the delegated authority specified in the Rules of Procedure.

~~a) Achieving the results set forth in the Multi-Year Strategic Plan of the MHSOAC within the appropriate and ethical standards of business conduct set by the Commission and the State of California;~~

~~b) Plan, organize, direct, and administer all activities, programs and functions of the MHSOAC;~~

~~c) Respond to direction from the Chair to develop ideas for programs and/or initiatives reflecting the MHSOAC's goals.~~

~~d) Direct the preparation of all reports to be submitted by the MHSOAC to the Governor and Legislature;~~

~~e) Direct the preparation of the MHSOAC's annual budget for review by the Chair and submission to the Department of Finance, and/or the Legislative Analyst;~~

~~f) Direct the implementation of all federal and state statutes and regulations and Commission policies that require action by staff, administer the civil service system (including hiring, evaluating and terminating all employees), attend meetings of the Commission and report on the general affairs of the Commission, and keep the Commission advised as to the needs of the MHSOAC.~~

2.2 Designation of Acting Executive Director

When the Executive Director is absent or otherwise unavailable to perform the duties set forth in these Rules of Procedure, ~~of the office~~ the Executive Director may designate in writing another person to act on the Executive Director's behalf. Within 24 hours of such delegation the Executive Director shall notify the Chair and Vice Chair of the delegation including the scope and duration of the delegation.

2.3 Evaluation of Executive Director

The Commission shall in closed session evaluate the Executive Director's performance on an annual basis. Prior to the closed session evaluation, the Chair and Vice Chair will provide the Executive Director with a performance review to be discussed in the closed session evaluation. The evaluation will be based on the ~~MHSOAC's accomplishment of the Commission's Multi-Year Strategic Plan;~~ performance goals and professional development objectives adopted ~~annually~~ by the Commission and the Executive Director's duty statement ~~developed and adopted by the Commission~~.

2.4 Contract Authority. ~~Pursuant to the MHSOAC Resolution adopted on March 24, 2011,~~

A. The Executive Director has the authority to take all actions necessary to enter into contracts on the Commission's behalf ~~of the MHSOAC~~ in the amount of ~~$100,000~~ $200,000 or less and to enter into Interagency Agreements in the amount of ~~$200,000~~ $400,000 or less.

B. The Executive Director, with the consent of the Chair and Vice Chair, has the authority to take all actions necessary to enter into contracts on the Commission's behalf in the amount of $200,001 and $500,000 and to enter into Interagency Agreements in the amount of $400.001 and $750,000.

C. The Executive Director shall ensure that information on all contracts that the Commission has entered into, including contracts under this Rule 2.4, is included in the Commission's publicly reported budget information.

2.5 Authority ~~of the Executive Director~~ to Advocate on Legislation.

A. The Commission is authorized to advise the Governor and Legislature regarding actions the State may take to improve the mental health care and services of Californians. As part of this authority, the Commission may advocate on legislation.

B. The Executive Director, or ~~his or her~~ the Executive Director's designee, is authorized on behalf of the ~~MHSOAC~~ Commission to advocate on legislation: (1) when the legislation ~~is consistent with~~ advances a formally established position of the Commission; ~~or~~ (2) at the direction of the Chair and when the legislation furthers the interest of the Commission; or (3) after full discussion with and at the direction from the full Commission.

C. The Executive Director shall give an update of all advocacy efforts, except confidential budget proposals, taken on behalf of the Commission at the next Commission meeting following the advocacy efforts.

2.6. Authority to Approve Innovation Projects.

A. The Executive Director, with the consent of the Commission Chair, is authorized to approve a county Innovation plan that meets any of the following conditions:

1) The county Innovation plan, plan extension or modification does not raise significant concerns or issues and includes total MHSA Innovation spending authority of $1,000,000 or less.
2) The county Innovation plan is substantially similar to a county Innovation proposal that has been approved by the Commission within the past three years, if in the judgement of the Executive Director,
    a) differences in the county Innovation proposal and a previously approved plan are not material to concerns raised by the Commission in its previous review and are non-substantive, and
    b) the new project furthers the ability of the previously approved Innovation plan to support statewide transformational change.

B. The Executive Director shall publicly report to the Commission, at the next Commission meeting ~~at the first available opportunity~~ any county Innovation plan approved by the Executive Director on behalf of the Commission under this delegated authority.

~~**2.6 Authority to Approve Additional Funding for Previously Approved Innovation Projects**~~

~~The Executive Director, or his or her designee, is authorized to approve a county's request to expend additional Mental Health Services funding in an amount not to exceed $500,000 or 15% of the total project, whichever is less, for an Innovation project that has been previously approved.~~

LEGAL COUNSEL

3.1 Duties of Chief Legal Counsel

A. Chief Counsel provides legal advice to the ~~MHSOAC~~ Commission and ~~The Chief Counsel~~ reports both to the ~~MHSOAC~~ Commission and to the Executive Director.

B. Chief Counsel is responsible for, among other things, advising staff regarding all relevant legal matters and supporting the legal inquiries and meeting activities of the ~~MHSOAC~~ Commission.

C. In situations where the Chief Counsel ~~would have~~ may have a conflict of interest, or where legal expertise outside the practice of Chief Counsel is imperative, the Commission may consult ~~consultation~~ with the office of the Attorney General or another state department ~~via an interagency agreement is available.~~

D. Counsel shall not provide legal counsel to members of the Commission except in their role as members of the ~~MHSOAC~~ Commission.

3.2 Hiring Chief Counsel

A. The Executive Director is responsible for hiring and discharging the Chief Counsel.

B. The Executive Director is responsible for evaluating the Chief Counsel's performance with input from the ~~MHSOAC~~ Commission and staff.

COMMISSION MEETINGS

4.1 Frequency of Meetings

A. ~~MHSOAC~~ Commission meetings are to be held as often as is necessary to enable the Commission to fully and adequately perform its duties, but ~~it shall not meet~~ not less than once each quarter. ~~at any time and location convenient to the public as it may deem appropriate~~. All meetings shall be open to the public pursuant to the Bagley-Keene Open Meeting Act.

B. The ~~MHSOAC~~ Commission meeting schedule for the ~~following~~ calendar year is approved in January of that calendar year.

4.2 Robert's Rules of Order

Robert's Rules of Order will be used as a guide at ~~the~~ Commission ~~and Committee~~ meetings.

4.3 Open Meetings

A. Commission meetings are subject to the Bagley-Keene Open Meeting Act set forth in Government Code Sections 11120 et seq.

B. The Bagley-Keene Open Meeting Act prohibits Commissioners from using direct communication, personal intermediaries, or technological devices to discuss, deliberate, or take action outside of an open meeting (Government Code Section 11122.5 (b)). Serial meetings are also prohibited. A serial meeting is a series of communications, each of which involves less than a quorum of the Commission, but which taken as a whole involves a majority of the Commission's members. (Government Code Section 11122.5)

~~The principal law that governs the meetings of the MHSOAC and its Committees is the Bagley-Keene Open Meeting Act which is set forth in Government Code Sections 11120 et seq.~~

~~**4.4 Serial Meetings**~~

~~4.5~~ 4.4 Agenda Items

A. A Commission meeting agenda may include action or information items.

B. Action items that are non-controversial or pro forma may be placed on the consent calendar. All items on the consent calendar are voted upon as one unit and are not voted upon as an individual item. At the meeting any Commissioner may ask that a matter be removed from the consent agenda and that request shall be effective without further action. If a matter is removed from the consent agenda it ~~shall~~ may be discussed at ~~a point~~ the same meeting or at a different Commission meeting as deemed appropriate by the Commission. There shall be no discussion or presentations made concerning items that remain on the consent agenda.

Staff prepares briefing materials on each agenda item and provides Commissioners with those materials in advance of the meeting. These materials provide Commissioners with a detailed description of a proposed course of action, background information, fiscal impact, the pros and cons of taking the action, and similar information for alternative actions.

~~4.6~~ 4.5 Request for Item to be Placed on the Agenda

A. Agenda items are placed on the Commission's meeting agenda with the approval of the Chair and Executive Director. The final meeting agenda is approved by the Chair and the Executive Director after consultation with the Chief Counsel.

B. Individual Commissioners wishing to place items on the agenda should contact the Chair or the Executive Director.

C. Members of the public wishing to place items on the agenda should contact Commission staff.

~~Agenda items shall only be placed on the Commission's agenda at the request of (1) a Committee of the MHSOAC; (2) a member of the MHSOAC; or (3) MHSOAC staff with the approval of the Executive Director. Members of the public wishing to place items on the agenda must go through one of the above~~.

~~Before agenda and meeting packets are finalized, they shall be reviewed by the Chair of the Commission, the Executive Director, Chief Counsel. The Chair of the Commission, the Executive Director, and the Operations Committee shall work together to develop and set the Commission agendas~~.

~~4.7~~ 4.6 Exhibits and Handouts

A. Agendized presenters who are not associated with the Commission may provide exhibits and handouts related to their presentation for distribution at the Commission meeting and are encouraged to submit them to the Commission at least two weeks before the meeting. Additionally, they are encouraged to provide the materials in an electronic format that meets federal and state accessibility standards.

B. The Commission will make the above-mentioned materials available to the public by publishing them on the Commission website in a format that meets federal and state accessibility standards. The Commission will also send a notice to the Commission's list-serve that the materials have been published on the website.

C. If the above-mentioned materials were received by the Commission within a reasonable time before the meeting date, the Commission will also make those materials available in printed format for public inspection on the day of the meeting.

~~Presenters may provide exhibits and handouts for distribution to the Commissioners. Presenters are encouraged to provide sixteen copies to the Commission office for distribution to the Commissioners and staff. Staff at least two weeks before the Commission meeting. Staff will post the material on the Commission website and notice of the posting will be emailed to the MHSOAC list-serve. The materials will also be made available to the public at the meeting.~~

~~4.8~~ 4.7 Public Agenda Notice ~~(PAN)~~

A. A public agenda notice of any Commission meeting must be ~~given and~~ made available on the Commission's website at www.MHSOAC.ca.gov, at least 10 calendar days before the meeting. The ~~PAN~~ public agenda notice will also be emailed to the ~~MHSOAC~~ Commission's list-serve. A copy of the public agenda notice will also be sent to any person who requests one in writing ~~it a PAN in writing must be sent a copy~~. (Government Code Section 11125).

B. The ~~PAN~~ public agenda notice of a Commission meeting must include the name, address, and telephone number of the individual who can provide additional information prior to the meeting and the address of the internet site where notices are posted. (Government Code Section 11125)

C. The ~~PAN~~ public agenda notice of a Commission meeting must also include a specific agenda for the meeting containing a brief description of the items of business to be transacted or discussed in either open or closed session. No agenda items may be added after the ten-day period begins, unless permitted by specific exceptions set forth in the Bagley-Keene Open Meeting Act. (Government Code Section 11125)

D. ~~Upon request by a person with a disability the PAN~~ The public agenda notice of a Commission meeting shall also be made available in appropriate alternative formats as required by Section 202 of the American with Disabilities Act of 1990 and the federal rules and regulations adopted in implementation thereof. The ~~PAN~~ public agenda notice shall include information regarding how, to whom, and by when a request for any disability-related modification or accommodation including auxiliary aids or services may be made by a person with a disability who requires these aids or services in order to participate in the public meeting. (Government Code Section 11125)

~~4.9~~ 4.8 Availability of Commission Meeting Materials

A. The ~~PAN~~ public agenda notice and all other materials distributed to the Commissioners prior to or at a Commission meeting are public records and as such are subject to disclosure, unless a recognized exemption applies under California Public Records Act, set forth in Government Code Sections 6250 et seq. or the Bagley-Keene Open Meeting Act set forth in Government Code Sections 11120 et seq. Commission meeting materials are available to the public at www.MHSOAC.ca.gov. ~~as attachments to the PAN~~ The Commission will also make meeting materials available for public inspection in printed format on the day of the meeting.

B. The Bagley-Keene Open Meeting Act provides that unless a specific exemption applies, materials ~~writings~~ pertaining to agenda items ~~that are public records and have been~~ distributed to the Commission by the staff or individual Commissioners prior to or during the meeting must be made available for public inspection at the meeting. Materials pertaining to agenda items ~~or if~~ prepared by a person other than staff or a Commissioner shall be made available after the meeting. In addition, the materials ~~writing~~ shall be distributed to all persons who request or have requested copies of the materials ~~writing~~ and will be ~~made~~ available on the ~~MHSOAC~~ Commission's website.

~~4.10~~ 4.9 Closed Sessions

A. Any closed session must be noted on the meeting agenda and properly noticed, citing the statutory authority or provision of the Bagley-Keene Open Meeting Act that authorizes the closed session. The Commission may only hold closed sessions for the reasons set forth in the Bagley-Keene Open Meeting Act. ~~Pursuant to the Bagley-Keene Open Meeting Act, the following matters may be properly conducted in closed session:~~

- ~~To consider the appointment, employment, evaluation of performance, discipline or dismissal, as well as to hear charges or complaints about a Commission employee's actions (Government Code Section 11126(a)(1)).~~
- ~~To confer with or receive advice from legal counsel regarding pending litigation when discussion in open session would prejudice the Commission's position in the litigation (Government Code Section 11126(e)(1)).~~

B. Prior to convening a closed session, the Chair must publicly announce those issues that will be considered in closed session (Government Code Section 11126.3). This can be done by a reference to the item as properly listed on the agenda. After the closed session has been completed, the ~~MHSOAC~~ Commission must reconvene in public prior to adjournment (Government Code Section 11126.3). If the closed session involved a decision to hire or fire an individual the Chair is required to report the action taken, and any roll call vote taken.

C. Chief Counsel will attend each closed session and keep and enter in a minute book a record of topics discussed and decisions made at the meeting. These minutes are confidential, maintained ~~in a sealed envelope~~ by Chief Counsel, and are discoverable only to the Commission itself or to a reviewing court. The minutes may, but need not, consist of a recording of the closed session. (Government Code Section 11126.1)

~~4.11~~ 4.10 Teleconference Meetings

Pursuant to the Bagley-Keene Open Meeting Act ~~provides that~~ the ~~MHSOAC~~ Commission ~~or committees~~ may hold a meeting by audio or audio-visual teleconference for the benefit of the public and the Commission ~~or committee~~. (Government Code Section 11123) All ~~PAN~~ public agenda notice requirements apply.

~~4.12~~ 4.11Quorum

A. A simple majority of the Commission's statutory membership shall constitute a quorum for the transaction of business. The Commission's statutory membership is 16 members making nine members a quorum. When a quorum is present, a simple majority of those present and voting may act to bind the Commission.

B. A meeting at which a quorum is initially present may continue, notwithstanding the withdrawal of Commissioners and the absence of a quorum. The only action that may be taken in the absence of a quorum is to fix the time to adjourn, recess, or take measures to obtain a quorum.

~~Every act or decision done or made by a majority of the Commissioners present at the meeting duly held at which a quorum is present, shall be regarded as binding. A meeting at which a quorum is initially present may continue to transact business, notwithstanding the withdrawal of Commissioners below a quorum, if any action taken is approved by at least a majority of the required quorum for the meeting.~~

~~4.13~~ 4.12Voting

A. After a motion is made, seconded, and public comment has been heard, the Commission may vote. A Commissioner must be present to vote.

B. A Commissioner ~~member~~ who is disqualified in a matter because of financial contributions, financial interest, or another conflict is not entitled to vote. The Commissioner is required to announce at the meeting that the Commissioner ~~he or she~~ will not participate and disclose the reasons for the disqualification on the record. This information is noted in the meeting minutes.

C. A Commissioner may "abstain" from voting, if the Commissioner ~~he or she~~ is entitled to participate but chooses not to. The reason for abstaining ~~participating~~ need not be disclosed on the record.

D. Prior to voting on a policy project report, the Commission shall consider the report in at least one meeting prior to the meeting at which the motion to approve is considered.

E. Approval of a policy project report by a subcommittee of the Commission constitutes the "first reading" of a policy project report.

F. The Commission may determine that the timely release of a policy project report is in the public interest and may vote to suspend this rule in order to approve a policy project report in a single meeting.

~~Any proposed policy item on the agenda, along with its corresponding language/documents, shall be presented for discussion at a Commission meeting at least one (1) meeting prior to the meeting at which the vote on the issue is taken.~~

~~The Commission may take action, by a simple majority, on an agenda item at the same meeting that the item is presented if the Commission deems that there exists a need to take action.~~

~~Approval of county MHSA Innovation Plans is exempt from this review schedule and may be voted upon at the Commission meeting at which they are first presented by staff and need not be posted 30 days before the meeting.~~

~~4.14~~ 4.13 Public Comment

A. Opportunity is provided for the public to address the Commission on agenda items. The Commission may adopt reasonable procedures so that members of the public have an

opportunity to directly address the Commission on each agenda item before the Commission. These procedures may include limiting the total amount of time allocated for public comment on a specific agenda item ~~particular issues~~ and for each individual speaker. (Government Code Section 11125.7)

B. If the agenda item has already been considered by a multi-member body ~~committee~~ composed exclusively of members of the Commission at a public meeting where interested members of the public were afforded the opportunity to address the multi-member body ~~committee~~ on the item, additional public comment opportunity at the Commission meeting need not be provided unless the item has been substantially changed since the multi-member body ~~committee~~ heard the item. (Government Code Section 11125.7)

C. Members of the public who wish to provide public comment at a meeting are encouraged to complete a public comment card but are not required to do so. ~~The meeting coordinator will request anyone planning to speak to complete a public comment card~~.

~~It is the policy of the Commission to vet issues as much as is practical through the MHSOAC standing committees before those issues are brought to the full Commission. It is the responsibility of the committee chair to engage stakeholder participation at the committee level and to report back to the full Commission. Public comment and stakeholder involvement at the committee level does not replace public comment at the Commission meetings.~~

~~4.15~~ 4.14 Access to Commission Meeting Sites

Commission meeting sites are accessible to people with disabilities and should also be accessible by public transportation. Those who need special assistance may contact the meeting coordinator listed on the public agenda notice of the meeting.

~~4.16~~ 4.15 Minutes and Motion Summaries

Minutes and motion summaries of each open session meeting are included in the meeting materials and posted on the Commission website at: www.MHSOAC.ca.gov. ~~distributed to Commissioners, the Executive Director, Chief Counsel, and selected staff for review. After review and Commission approval, minutes and motion summaries are published on the MHSOAC Commission website at: www.MHSOAC.ca.gov.~~

PUBLIC OUTREACH AND ENGAGEMENT

5.1 The Commission is committed to ensure the perspective and participation of diverse community members – those with lived experiences and their family members, community advocacy organizations, county behavioral health agencies - are a significant factor in the Commission's understanding, actions, decisions, and recommendations. The Commission ensures broad and inclusive community outreach and engagement through the following actions and other opportunities that may be identified going forward:

- Public meetings with open, informed, and transparent deliberation.
- Committee and subcommittee meetings that hear from community members and other subject matter experts to develop a shared understanding of the challenges and opportunities of topics specified by the Commission.
- Community forums that are organized to highlight and understand topics specified by the Commission and of concern to the community.
- Small group listening sessions to hear from individuals with lived experience on sensitive topics.
- Site visits that are organized to acquire first-hand knowledge and understanding of the challenges of specific topics and the existing efforts to address those challenges.
- Convening advisory bodies with expertise on topics specified by the Commission.
- Meetings with community-based organizations and local leaders.
- Use of surveys.

COMMITTEES/SUBCOMMITTEES/OTHER MULTI-MEMBER BODIES

~~5.1~~ 6.1 ~~Committee~~ Structure

A. The ~~MHSOAC~~ Commission ~~shall~~ may establish one or more ~~standing~~ committees as necessary to provide technical and professional expertise pursuant to Welfare and Institutions Code Section 5845 (d)(3)~~(d)(2)~~. Such committees provide guidance, review materials, and make recommendations to the ~~MHSOAC~~ Commission. ~~and, in rare instances, when given delegated authority by the Commission, make decisions on behalf of the MHSOAC~~.

A.1. The Commission Chair ~~elect~~ shall appoint a Chair and Vice Chair for each ~~standing~~ committee from among the Commission's membership who will assume their duties immediately upon appointment. ~~The Chair and Vice-chair for each standing Committee will assume his or her duties in January following the year he or she was appointed. Each year the Commission Chair may reappoint a Committee Chair and Vice-chair.~~

A.2. Each committee should have a maximum of 15 members. The committee chair and vice chair select committee members who have the desired expertise and experiences to advance the committee's goals. Committee members serve a one - year term unless that term is extended by the appointing authority. Each committee should include at lease two consumers, two family members or care givers of consumers, and two experts on reducing disparities. The Commission shall strive to ensure committee membership reflects the demographic diversity, including race,

ethnicity, sexual orientation, and gender identity of California; the geographic diversity of California, and includes members with lived experience with mental health and/or the mental health system of care.

~~Ideally each standing committee shall have a maximum of 15 members and shall include public membership. At least two shall be consumers, at least two shall be family members or care givers of consumers, and at least two shall be members of underserved ethnic and cultural communities. Public membership of each committee shall be selected by the committee Chair and Vice Chair. In their recruitment and appointment committee Chair and Vice Chair shall pay special attention to issues related to cultural diversity and competency. Commission staff and/or consultants will staff each committee.~~

A.3. The committee Chair may establish one or more multi-member body consisting of committee members in order to further the work of the committee.

A.4. If a committee member cannot attend a committee meeting the member shall notify the committee Chair and the committee staff member of such absence in advance of the committee meeting. If a committee member misses more than one committee meeting without notice or three committee meetings in a calendar year with notice, the committee Chair has discretion to decide whether it is in the best interest of the committee to have that committee member replaced.

~~The membership of each Committee will be confirmed every other year in odd numbered years at the January MHSOAC meeting. In the intervening time each Committee Chair has discretion to modify the Committee membership based upon the needs of the Committee.~~

~~The MHSOAC may establish an Operations Committee that is composed of the Chair or the Vice-chair of each standing Committee. The Commission Chair and Vice-chair are the Chair and Vice-chair of the Operations Committee. The Operations Committee is exempt from the public membership listed above and it is not authorized to take policy positions on behalf of the Commission unless the Commission specifically delegates such authority.~~ Convenience

B. The Commission may establish any multi-member body (e.g. committee, subcommittee, taskforce) consisting of Commissioners appointed by the Chair as necessary to support the work of the Commission.

~~5.3~~ 6.2 Bagley-Keene Open Meeting Act

A. Meetings of a committee, subcommittee, and multi-member body are subject to the Bagley-Keene Open Meeting Act set forth in Government Code Sections 11120 et seq. ~~The principal law that governs the meetings of the MHSOAC and its Committees is the Bagley-Keene Open Meeting Act which is set forth in Government Code Sections 11120 et seq.~~

B. A public agenda notice of a committee, subcommittee, or multi-member body meeting must be given and made available on the MHSOAC website at www.MHSOAC.ca.gov, at least 10 calendar days before the meeting. The public agenda notice will also be emailed to the Commission's list-serve. A copy of the public agenda notice will be sent to any person who requests it in writing. ~~a PAN in writing must be sent a copy.~~

C. The public agenda notice of a committee, subcommittee, or multi-member body meeting must include the name, address, and telephone number of the individual who can provide additional information prior to the meeting and the address of the internet site where notices are posted.

D. The public agenda notice of a committee, subcommittee, or multi-member body meeting must also include a specific agenda for the meeting containing a brief description of the items of business to be transacted or discussed. No agenda items may be added after the ten-day period begins, unless permitted by specific exceptions set forth in the Bagley-Keene Open Meeting Act. (Government Code Section 11125)

E. ~~Upon request by a person with a disability the PAN~~ The public agenda notice of a committee, subcommittee, or multi-member body meeting shall also be made available in appropriate alternative formats as required by Section 202 of the American with Disabilities Act of 1990 and the federal rules and regulations adopted in implementation thereof. The public agenda notice shall include information regarding how, to whom, and by when a request for any disability-related modification or accommodation including auxiliary aids or services may be made by a person with a disability who requires these aids or services in order to participate in the public meeting.

F. A committee, subcommittee, or other multi-member body may hold a meeting by audio or audio-visual teleconference (Government Code Sections 11123 and 11123.5). All public agenda notice requirements apply.

~~5.2~~ 6.3 Compensation and Expenses

~~Commissioners, staff~~ Active members of committees, subcommittees or any other multi-member body and agendized presenters ~~and active Committee members will be~~ are eligible to be reimbursed in accordance with State per diem laws. ~~Also, any reasonable business expenses incurred will be reimbursed as authorized by the Commission. On a case-by-case basis a Committee member designee may also be reimbursed in accordance with the State per diem laws.~~

~~5.4 Public Agenda Notice (PAN)~~

~~A Notice of any Committee meeting must be given and made available on the MHSOAC website at www.MHSOAC.ca.gov, at least ten (10) calendar days before the meeting. The PAN will also be emailed to the MHSOAC list-serve. Any person who requests a PAN in writing must be sent a copy. The notice must include:~~

- ~~Name, address, and telephone number of the individual who can provide additional information prior to the meeting~~

- ~~Address of the internet site where notices are posted~~
- ~~Specific agenda for the meeting containing a brief description of the items of business to be transacted or discussed.~~

~~Upon request by a person with a disability the PAN shall also be made available in appropriate alternative formats as required by Section 202 of the American with Disabilities Act of 1990 and the federal rules and regulations adopted in implementation thereof. The PAN shall include information regarding how, to whom, and by when a request for any disability-related modification or accommodation including auxiliary aids or services may be made by a person with a disability who requires these aids or services in order to participate in the public meeting.~~

~~WORKGROUPS~~

~~6.1 Establishment of Workgroups~~

~~The MHSOAC and its committees may establish workgroups, to focus on a specific dimension of the Commission or Committees' work. The workgroup is project focused with specific time limited deliverables.~~

~~The membership of the Workgroups will consist of a smaller body of Committee members who volunteer or are appointed by the Committee Chair and Vice-chair.~~

Enclosure 2

Mental Health Services
Oversight & Accountability Commission

Draft Revisions to the January 2020 Proposed Amendments to the Rules of Procedure

In response to public comment staff recommends the following changes to the proposed amendments. The proposed revisions are shown in underlined text for added language and strikethrough for deleted language.

- **Governance Philosophy**
  Add the following language to the governance philosophy to read:

  "Integrity and sound stewardship in adherence to the Commission's Mission, Vision, and Core Principles are paramount in the governance of all Commission activities. The Commission will govern itself with an emphasis on the following:

  a.) Collaborating with clients, their families, and underserved communities
  b.) Advancing health equity and strategies to eliminate disparities
  c.) Promoting mental wellness and supporting recovery and resiliency
  d.) Advancing an objective understanding and incorporating diverse viewpoints
  e.) Making decisions in a transparent, responsive and timely manner
  f.) Striving to improve results and outcomes
  g.) Elevating a transformative vision and strategic leadership
  h.) Working collaboratively to drive system-scale improvements
  i.) Being proactive

- **Rule 1.7 ~~Training and Orientation of Commissioners~~ Commissioner Orientation**
  Change the title of Rule 1.7 to "Commissioner Orientation" and revise paragraph A to read:

  A. "New Commissioners shall within 30 days of being appointed receive orientation in: (1) Commission governance, policies and procedures, including the Commission's Strategic Plan, Mission Statement, Vision Statement, Core Principles, and governance philosophy; (2) Commission strategic directives; (3) Mental Health Services Act (MHSA) programs and issues, including the principles of recovery, consumer and family-driven decision-making, community collaboration, meaningful stakeholder outreach and engagement, cultural competence and the imperative to reduce disparities; and (4) relevant laws and statues."

- **Rule 2.1 Duties of the Executive Director**
  Revise paragraph B to read:
  B. "The Executive Director represents the Commission and advances its goals by working with California's constitutional officers, federal, state, and local agencies, national and international organizations, private sector leaders, and other stakeholders, including but not limited to, consumers, families, and representatives of diverse communities."

- **Rule 2.4 Contract Authority**
  Add a new paragraph C to read:

  C. The Executive Director shall ensure that information on all contracts that the Commission has entered into, including contracts under this Rule 2.4, is included in the Commission's publicly reported budget information.

- **Rule 2.5 Authority to advocate on Legislation**
  Keep the original language of paragraph B (2) which was proposed to be revised in January and revise paragraph B to read:

  B. The Executive Director, or the Executive Director's designee, is authorized on behalf of the Commission to advocate on legislation: (1) when the legislation advances a formally established position of the Commission; (2) at the direction of the Chair and when the legislation furthers the interest of the Commission; or (3) after full discussion with and at the direction from the full Commission.

- **Rule 4.4 Agenda Items**
  Keep the following original paragraph that was proposed to be deleted in January:

  Staff prepares briefing materials on each agenda item and provides Commissioners with those materials in advance of the meeting. These materials provide Commissioners with a detailed description of a proposed course of action, background information, fiscal impact, the pros and cons of taking the action, and similar information for alternative actions.

- **Rule 4.11 Quorum**
  Revise paragraph A to read:

  A. A simple majority of the Commission's statutory membership shall constitute a quorum for the transaction of business. The Commission's statutory membership is 16 members making nine members a quorum. When a quorum is present, a simple majority of those present and voting may act to bind the Commission.
  B. A meeting at which a quorum is initially present may continue, notwithstanding the withdrawal of Commissioners and the absence of a quorum. The only action that may be taken in the absence of a quorum is to fix the time to adjourn, recess, or take measures to obtain a quorum.

- **Rule 4.12 Voting**
  Revise paragraph D and add new paragraphs E and F to read:

  D. Prior to voting on a policy project report, the Commission shall consider the report in at least one meeting prior to the meeting at which the motion to approve is considered. ~~This requirement shall not apply if the report was previously discussed in a public meeting of a Commission subcommittee and the subcommittee recommended Commission adoption of the report~~.

E. Approval of a policy project report by a subcommittee of the Commission constitutes the "first reading" of a policy project report.

F. The Commission may determine that the timely release of a policy project report is in the public interest and may vote to suspend this rule in order to approve a policy report in a single meeting.

- **Rule 5.1 Public Outreach and Engagement**
  Revise the section to add the following language to read:

  The Commission ~~seeks~~ is committed to ensure the perspective and participation of diverse community members – those with lived experiences and their family members, community and advocacy organizations, county behavioral health agencies - ~~and others with mental health challenges and their families~~ are a significant factor in the Commission's understanding, actions, decisions and recommendations. The Commission ensures broad and inclusive community outreach and engagement through the following actions and other opportunities that may be identified going forward:

  - Public ~~hearings~~ meetings ~~that have~~ with open, informed, and transparent deliberation
  - Committee and subcommittee meetings that hear from community members and other subject matter experts to develop a shared understanding of the challenges and opportunities of topics specified by the Commission
  - Community forums that are organized to highlight and understand topics specified by the Commission and of concern to the community
  - Small group listening sessions to hear from individuals with lived experience on sensitive topics
  - Site visits that are organized to acquire first-hand knowledge and understanding of the challenges of specific topics and the existing efforts to address those challenges
  - Convening advisory bodies with expertise on topics specified by the Commission
  - Meetings with community-based organizations and local leaders
  - Use of surveys

- **Rule 6.1 Committee/Subcommittee/Other Multi-member Body Structure**
  Rewrite paragraph A.2 to read:

  A.2 Each committee should have a maximum of 15 members. The committee chair and vice chair select committee members who have the desired expertise and experiences to advance the committee's goals. Committee members serve a one-year term unless that term is extended by the appointing authority. Each committee should include at least two consumers, two family members or care givers of consumers, and two experts on reducing disparities. The Commission shall strive to ensure committee membership reflects the demographic diversity, including race, ethnicity, sexual orientation, and gender identity of California; the geographic diversity of California; and includes members with lived experience with mental health and/or the mental health system of care.

Enclosure 3

Mental Health Services
Oversight & Accountability Commission

Responses to Written Public Comments on the January 2020 Proposed Amendments to the Rules of Procedure

Table 1: Mission Statement

Mission Statement	
The January 2020 proposed amendments to the Rules of Procedure incorporated the Mission Statement that was adopted by the Commission as part of the Strategic Plan following extensive public outreach. The Mission Statement is intended to be read in conjunction with the Vision Statement ("Wellbeing for All Californians") and the Commission's Core Principles (Wellness and Recovery; Client-Consumer and Family-Driven; Community Collaboration; Cultural Competency; and Integrated Service Delivery), both of which were also adopted as part of the Strategic Plan. The new Mission Statement: "The Mental Health Services Oversight and Accountability Commission works through partnerships to catalyze transformational change across systems and ensure everyone who needs mental health care has access to and receives effective and culturally competent care." The former Mission Statement: "The MHSOAC provides the vision and leadership, in collaboration with clients, their family members and underserved communities, to ensure an enhanced continuum of care for individuals at risk for and living with serious mental illness and their families by holding public systems accountable and by providing oversight, eliminating disparities, promoting mental wellness, supporting recovery and resiliency resulting in positive outcomes in California's community based mental health system.	
Public Comments Summary	**Response**
#1: PEERS in its April 3, 2020 letter, contends that: • The deleted language is fundamental to the promise of transforming the mental health system that is at the core of the MHSA • The deleted language emerged from collaborative work of many stakeholders, and reflects the broad and hard-won consensus among consumers, family members, providers, and policymakers	**Response to Comment #1 PEERS:** The Commission is committed to the core values of the MHSA and the critical partnership with consumers, their family members, and underserved communities. The concepts in the former Mission Statement are fundamental to the Commission's operation and are Core Principles in the Commission's Strategic Plan which includes consumer and family driven, wellness and recovery, and community collaboration, and cultural competency.

• The new Mission Statement does not ensure people with mental health challenges, family members, and underserved communities will be among the partnerships working with the OAC • The deletion of "eliminating disparities" represents back-sliding in this key area • "Promoting mental wellness, supporting recovery and resiliency" should not be deleted because this is a critical part of the transformational change promised by the MHSA.	The new Mission Statement was adopted in January 2020 after an 18-month public strategic planning process and thus it is not recommended to be changed now. However, the former Mission Statement contains principles important to the Commission and therefore, it is recommended that language from the former Mission Statement be added to the Governance Philosophy section of the Rules of Procedure. This preserves the critical components of the former Mission Statement and keeps the new Mission Statement adopted in the Strategic Plan.
#2: NAMI in its May 5, 2020 letter states: • NAMI opposes the deletion of the specific mention of clients and family members • The MHSA is client and family driven and the Commission should uphold this value of the Act and never alienate the individuals it serves.	**Response to Comment #2 NAMI:** • Same response as to Comments #1 and #2. • The Commission includes two clients and two family members as members.
#3: REMHDCO in its undated letter states: • NAMI opposes the deletion of the phrase, "in collaboration with clients, their family members and underserved communities" because the phrase is paramount to the purpose and operation of the Commission.	**Response to Comment #3 REMHDCO:** • Same response as to Comment #1.
#4: CalVoices in its September 11, 2020 letter states: • The original phrase, "in collaboration with clients, their family members and underserved communities" is vital to the Commission's purpose and operation as set forth in Welfare and Institutions Code §5846(d) and should be kept • The new Mission Statement does not accurately detail the statutory role of the Commission, which is to "provide oversight and accountability" and "not necessarily to catalyze transformational change" • The new Mission Statement does not uphold the General Standards in 9 CCR §3320.	**Response to Comment #4 CalVoices:** • Same response as to Comment #1. • Transforming change in the mental health system is a fundamental promise and premise of the MHSA. Working through partnerships to catalyze that transformational change is one of several ways the Commission fulfills its statutory role. • The General Standards in 9 CCR §3320 apply to counties and not to the Commission, however, they are included in the Commission's Strategic Plan as core principles.

#5: Californians advocating for the Seriously Mentally Ill (SMI) in its October 20, 2020 letter states: • The changes completely eliminate collaboration and removes the intent of MHSA funding for those with serious mental illness. The new mission statement omits the only groups eligible for MHSA services, and substitutes people who are not eligible for MHSA services, contrary to the intent of the voters in Proposition 63/MHSA.	**Response to Comment #5 California advocating for the Seriously Mentally Ill (SMI):** • Same response as to Comments #1 and #2. • The Mission Statement does not change the funding or the eligibility for services under the MHSA. The new Mission Statement states the Commission's commitment to ensuring everyone, including individuals with serious mental illness, have access to and receive effective and culturally competent care, consistent with the Commission's responsibility to provide oversight and accountability for the community mental health system as a whole. WIC section 5845 gives the Commission a wide range of authorities beyond the specific scope of the MHSA.

Table 2: Governance Philosophy

January 2020 Proposal & December 2020 Recommendation	
The January 2020 amendments propose changes to the Governance Philosophy by streamlining the language and making it action oriented. As part of streamlining, the examples of the Governance Philosophy in the current Rules of Procedure are proposed to be deleted. Below is the proposed Governance Philosophy. "Integrity and sound stewardship are paramount in the governance of all Commission activities. The Commission will govern itself with an emphasis on the following: a.) ~~Being~~ Advancing an objective understanding and incorporating diverse ~~diversity in~~ viewpoints b.) Making decisions in a transparent, responsive ~~an efficient~~ and timely manner c.) Striving to improve ~~for~~ results and outcomes d.) Elevating a transformative ~~Focusing on outward~~ vision and strategic leadership ~~and less on administrative detail~~ e.) Working ~~Using~~ collaboratively to drive system-scale improvements ~~rather than individual decisions making processes~~ f.) Being proactive ~~rather than reactive~~" ~~Specifically, …~~ **December 2020 Recommendation:** Add the language from the former Mission Statement and revise the Governance Philosophy section to read: "Integrity and sound stewardship in adherence to the Commission's Mission, Vision, and Core Principles are paramount in the governance of all Commission activities. The Commission will govern itself with an emphasis on the following: a) Collaborating with clients, their families, and underserved communities b) Advancing health equity and strategies to eliminate disparities c) Promoting mental wellness and supporting recovery and resiliency d) Advancing an objective understanding and incorporating diverse viewpoints e) Making decisions in a transparent, responsive and timely manner f) Striving to improve results and outcomes g) Elevating a transformative vision and strategic leadership h) Working collaboratively to drive system-scale improvements i) Being proactive	
Public Comments Summary	**Response**

Table 2: Governance Philosophy

#1: CalVoices in its September 11, 2020 letter states the current section documents key elements of the Commission's governance philosophy and should be retained.	**Response to Comment #1 CalVoices:** • The list of specifics is not necessary as they do not add substantive elements to the governance philosophy.

Table 3: Rule 1.1 Terms of Commissioners

January 2020 Proposal & December 2020 Recommendation	
The January 2020 amendments propose to delete the following paragraph from Rule 1.1. "If a Commissioner cannot attend a Commission meeting, he or she will notify the Chair and the Executive Director of such absence in advance of the Commission meeting. If a Commissioner misses one (1) Commission meeting without notice or three (3) Commission meetings in a calendar year with notice the Chair shall notify the Commissioner and that Commissioner's appointing power in writing that the attendance record of the Commissioner be improved or that the Commissioner be replaced." **December 2020 Recommendation:** No change to the January 2020 proposal	
Public Comments Summary	**Response**
#1: CalVoices in its September 11, 2020 letter opposes the deletion of the paragraph because: • Full Commissioner participation for each entire meeting is an essential element of the Commission's success because when Commissioners are absent they miss public input on items and the lack of diversity of Commissioner input is contrary to the statutory mandate of the different seats on the Commission.	**Response to Comment #1 CalVoices:** • The paragraph is proposed to be deleted because it is contrary to Commissioners' statutory term appointment set forth in WIC §5845. Per §5845 Commissioners are appointed for a term of three years. The purpose of a statutory specific term appointment is to provide independence and protect the appointee from possible political pressure from the appointing power.

Table 4: Rule 1.2 The Role of Commissioners

January 2020 Proposal & December 2020 Recommendation	
The January 2020 amendments propose to delete the following paragraph from Rule 1.2. "The best decisions come out of unpressured collegial deliberations. The Commission seeks to maintain an atmosphere where the Commissioners can speak freely, explore ideas before becoming committed to positions and seek information from staff and other members. To the extent possible the Commission encourages members to come to meetings without having fixed or committed their positions in advance." **December 2020 Recommendation:** No change to the January 2020 proposal	
Public Comment Summary	**Response**
#1: REMHDCO in its undated letter opposes the deletion, stating: • "Collegial deliberations (any deliberations) have been greatly reduced in recent years" and REMHDCO would like more dialogue and deliberations at either Committee meetings or Commission meetings.	**Response to Comment #1 REMHDCO:** • The paragraph was proposed to be deleted because it did not fit in a rule dealing with the "role" of Commissioners and the concepts are reflected in the Governance Philosophy. • Staff strongly disagrees with the comment regarding collegial deliberations. The MHSA sets an expectation that the Commission meet four times per year. The Commission in fact has been meeting 10 or more times per year for years. Due to COVID-19 and the need to meet via Zoom, the Commission's monthly meetings are shorter in length than the in-person meetings. Even in these shorter meetings there is a lot of collegial deliberations. A review of the minutes of the Commission meetings clearly show the deliberation among Commissioners are collegial and professional.
#2: CalVoices in its September 11, 2020 letter opposes the deletion because: • Commissioners are expected to attend meetings with open mind and without having pre-determined opinions. Collaboration necessitates meeting environment where collegial deliberations	**Response to Comment #2 CalVoices:** • Same as response to comment #1.

Table 4: Rule 1.2 The Role of Commissioners

take place and community input is meaningfully incorporated into decisions.	

Table 5: Rule 1.3B Duties of the Chair

January 2020 Proposal & December 2020 Recommendation	
The January 2020 amendments propose to add the following paragraph regarding the duties of the Chair. This language is not in the current Rule 1.3. "B. Duties of the Chair "The Chair, with input from Commissioners and staff, sets the Commission's meeting agenda, prioritizing and scheduling agenda items as appropriate, and conducts the meetings." **December 2020 Recommendation:** No change to the January 2020 proposal	
Public Comment Summary	**Response**
#1: REMHDCO in its undated letter proposes adding the following sentence to the end of the paragraph: "The Chair should also consider agenda items proposed by members of the public."	**Response to Comment #1 REMHDCO:** • The Chair already has discretion to consider any agenda items and this sentence proposed in the comment is not necessary.

Table 6: Rule 1.7A Training and Orientation

January 2020 Proposal & December 2020 Recommendation	
The January amendments propose the following non-substantive edits to paragraph A: "A. New Commissioners ~~members~~ shall within 30 days of being appointed receive ~~training and~~ orientation in: (1) Commission governance, policies and procedures; (2) Commission strategic directives; (3) Mental Health Services Act (MHSA) programs and issues; and (4) relevant laws and statues." **December 2020 Recommendation:** Change the title of Rule 1.7 to "Commissioner Orientation" and revise paragraph A to read as follows: "A. New Commissioners shall within 30 days of being appointed receive orientation in: (1) Commission governance, policies and procedures, including the Commission's Strategic Plan, Mission Statement, Vision Statement, Core Principles, and governance philosophy; (2) Commission strategic directives; (3) Mental Health Services Act (MHSA) programs and issues, including the principles of recovery, consumer and family-driven decision-making, community collaboration, meaningful stakeholder outreach and engagement, cultural competence, and the imperative to reduce disparities; and (4) relevant laws and statues."	
Public Comment Summary	**Response**
#1: REMHDCO in its undated letter proposes adding the following language to the end of paragraph A: "In addition, the new Commissioners will receive training on the important principles of the MHSA including but not limited to: • Recovery • Consumer and family driven; community collaboration • Meaningful stakeholder outreach and engagement • Cultural competence and reducing disparities • Prevention and Innovation."	**Response to Comment #1 REMHDCO:** • Staff recommends amending the rule consistent with the recommendation in the comment.
#2: CalVoices in its September 11, 2020 letter proposes adding the words, "General Standards" to item number 3.	**Response to Comment #2 CalVoices:** • The General Standards, regulations issued by the former Department of Mental Health apply to counties in their implementation of the MHSA. These standards, which are "community collaboration, cultural competence, client and family

Table 6: Rule 1.7A Training and Orientation

	driven, wellness, recovery and resilience focused, and integrated services experiences for clients and their families" are already covered in the orientation under number 3 because they are core principles of the Strategic Plan. They are also covered in item number 4, relevant laws and statutes.

Table 7: Rule 1.9 Conflict of Interest

January 2020 Proposal & December 2020 Recommendation	
The January amendments propose to delete the following sentence in Rule 1.9: "The Commission will adopt for itself and adhere to an Incompatible Activities Policy." **December 2020 Recommendation:** No change to the January 2020 proposal	
Public Comment Summary	**Response**
#1: CalVoices in its September 11, 2020 letter states: • It is "essential that public entities have a Conflict of Interest (or Incompatible Activities Policy) to protect the public's trust and inform Commissioners of activities or interests that may constitute a conflict of interest and compromise professional judgment."	**Response to Comment #1 CalVoices:** • The Commission has a Conflict of Interest Code and the Rules of Procedure do not propose to eliminate or change that Code. Contrary to the commenter's uses of the term, "Incompatible Activities Policy" interchangeably with "Conflict of Interest" policy, these are two different things. • The appointing power already requires Commissioners to sign an Incompatible Activities Policy. The requirement in the Rules of Procedure for an Incompatible Activities Policy was proposed to be deleted because it is duplicative.

Table 8: Rule 2.1 Duties of the Executive Director

January 2020 Proposal & December 2020 Recommendation	
The January amendments propose to change Rule 2.1 in relevant part as follows: "A. The Executive Director is appointed and discharged by the ~~MHSOAC~~ Commission. The Executive Director acts under the authority of, and in accordance with direction from the ~~MHSOAC~~ Commission. ~~Commissioners should direct their requests for information or assistance from staff to the Executive Director~~. B. The Executive Director represents the Commission and advances its goals by working with California's constitutional officers, federal, state, and local agencies, national and international organizations, private sector leaders, and other stakeholders." ~~The Executive Director also services as the Commission's liaison with, county commissions, other mental health associations and stakeholder groups~~. … **December 2020 Recommendation:** Amend paragraph B to add, "consumers, families, and diverse community stakeholders" to read as follows: "B. The Executive Director represents the Commission and advances its goals by working with California's constitutional officers, federal, state, and local agencies, national and international organizations, private sector leaders, and other stakeholders, including but not limited to consumers, families, and representatives of diverse communities."	
Public Comment Summary	**Response**
#1: REMHDCO in its undated letter proposes to revise paragraph B to read: "B. The Executive Director represents the Commission and advances its publicly approved goals by working with California's constitutional officers, federal, state, and local agencies, national and international organizations, private sector leaders, and especially community ~~other~~ stakeholders."	**Response to Comment #1 REMHDCO:** • See recommended change listed above.

#2: CalVoices in its September 11, 2020 letter states it does not support the proposed changes for the following reasons: • Replacing the word, "liaison" with the new language "contravenes the Bagley-Keene Act because the new language authorizes the Executive Director to bypass the public meeting process to effectuate policy" • Allowing the Executive Director to advance the Commission's goals "grants the Executive Director potentially unlimited power … without any Commission or public oversight."	**Response to Comment #2 CalVoices:** • The Bagley-Keene Act does not limit the role of staff to represent and implement the decisions of the state body. Contrary to the comment, Rule 2.1 does not authorize the Executive Director to bypass the public meeting process to effectuate policy: Paragraph B states the Executive Director "represents" the Commission. • Paragraph A of Rule 2.1 clearly states that the Executive Director "acts under the authority of and in accordance with direction from the Commission." Reading both Paragraphs A and B together it is clear that when the Executive Director "represents" the Commission per Paragraph B, the Executive Director does so under the limitations of Paragraph A. The Rule does not, as the comment contends, grant the Executive Director potentially unlimited power.

Table 9: Rule 2.4 Contract Authority

January 2020 Proposal & December 2020 Recommendation	
The January amendments propose to make the following changes to Rule 2.4: A. The Executive Director has the authority to take all actions necessary to enter into contracts on the Commission's behalf in the amount of ~~$100,000~~ $200,000 or less and to enter into Interagency Agreements in the amount of ~~$200,000~~ $400,000 or less. B. The Executive Director, with the consent of the Chair and Vice Chair, has the authority to take all actions necessary to enter into contracts on the Commission's behalf in the amount of $500,000 or less and to enter into Interagency Agreements in the amount of $750,000 or less. **December 2020 Recommendation:** Add a new paragraph C to read as follows: "C. The Executive Director shall ensure that information on all contracts that the Commission has entered into, including contracts under this Rule 2.4, is included will be included in the Commission's publicly reported budget information."	
Public Comment Summary	**Response**

Table 9: Rule 2.4 Contract Authority

#1: CASRA in its March 1, 2020 letter states it does not support the change because: • Authorizing the Executive Director to enter into contracts up to $750,000 without approval by the Commission or notice to the public reduces transparency and allows the Executive Director too much discretion on funding projects.	**Response to Comment #1 CASRA:** • There are two tiers of delegated authority and only the first tier (contracts of $200,000 or less and interagency agreements of $400,000 or less) provides the Executive Director sole delegated authority. • The second tier is a joint delegated authority with two Commissioners (the Chair and Vice Chair) and the Executive Director. Under this tier both the Chair and Vice Chair must consent before the Executive Director can enter into a contract of between $200,001 and $500,000 and Interagency Agreements of between $400,001 and $750,000. This requirement of consent from both the Chair and Vice Chair limits the Executive Director's discretion. • The above recommended change to this Rule will increase transparency and accountability by making information on all the contracts part of publicly reported budget information on the Commission's website.
#2: PEERS in its April 3, 2020 letter states it does not support the change because: • Doubling the dollar amount of contracts and Interagency Agreements reduces transparency and decreases opportunities for the public, consumers, family members, members of underserved communities, and Commissioners other than the Chair and Vice Chair to comment on and inform the decisions.	**Response to Comment #2 PEERS:** • Same as response to Comment #1
#3: NAMI in its May 5, 2020 letter states it opposes the increased authority of the Executive Director because: • It is unclear why it is necessary at this time to double the Executive Director's authority to make large financial commitments after only consulting the Chair and Vice Chair and it is unclear whether or how the proposed increase in the Executive	**Response to Comment #3 NAMI:** • Same as response to Comment #1 • The changes were made to correspond to the increased delegated authority that the Department of General Services (DGS) provided to other state entities, including boards and commissions.

Table 9: Rule 2.4 Contract Authority

Director's authority reflect the rules of other boards and commissions • The Commission should uphold its value of engaging consumers and family members in its decisions regarding such a large amount of taxpayer funds	
#4: REMHDCO in its undated letter states opposes the increase in the authority because: • The Commissioners and the public must be allowed to review and comment on what the Commission funds over $100,000 • The change reduces transparency and allows the Executive Director too much discretion on funding projects that do not necessarily have the support of the Commissioners or public stakeholders. This lack of transparency is not in line with the principles of the MHSA.	**Response to Comment #4 REMHDCO:** • Same as response to Comment #1
#5: CalVoices in its September 11, 2020 letter states it opposes the increased authority because: • Allowing the Executive Director to enter into contracts goes against the Bagley-Keene Act by allowing for actions to be taken outside of the public view. • It also goes against WIC 5846(d) that requires the Commission to ensure the perspective and participation of diverse community members is a significant factor in its decision because the rule allows the Executive Director to "unilaterally" enter into significant contrast "without participation by stakeholders". Also, the majority of the Commissioners will not be informed about the money they are required to oversee.	**Response to Comment #5 CalVoices:** • Same as response to Comment #1 • The comment implies that the Executive Director would not be authorized to enter into any contracts no matter the dollar amount. The Bagley-Keene Act does not limit the role of staff to represent and implement the decisions of the state body. The law recognizes there is a difference between the multi-member body and administrative staff of that body: The Attorney General has interpreted that a report drafted by staff is not the work of the multi-member body for purposes of the Public Records Act unless the draft is distributed to a majority of the multi-member body. It is unreasonable to argue that the administrative staff cannot act on behalf of the multi-member body.
#5: Californians Advocating for the Seriously Mentally Ill in its October 20, 2020 letter states:	**Response to Californians advocating for the Seriously Mentally Ill:** • Same as response to Comment #1

Table 9: Rule 2.4 Contract Authority

• Increasing Executive Director authorization over contracts undermines the transparency of the Commission's actions and minimizes stakeholder collaboration. The voice of individuals living with severe mental illness and their family members must continue to be considered when making decisions regarding the taxpayer revenues provided from the MHSA	

Table 10: Rule 2.5 Authority to Advocate on Legislation

January 2020 Proposal & December 2020 Recommendation
The January amendments propose to amend Rule 2.5 as follows: A. The Commission is authorized to advise the Governor and Legislature regarding actions the State may take to improve the mental health care and services of Californians. As part of this authority, the Commission may advocate on legislation. B. The Executive Director, or ~~his or her~~ the Executive Director's designee, is authorized on behalf of the ~~MHSOAC~~ Commission to advocate on legislation: (1) when the legislation ~~is consistent with~~ advances a formally established ~~an officially approved~~ position of the Commission; or (2) when the legislation advances an informal or emerging position of the Commission after consultation with the Chair and Vice Chair ~~at the direction of the Chair and when the legislation furthers the interest of the Commission~~. C. The Executive Director shall give an update of all advocacy efforts, except confidential budget proposals, taken on behalf of the Commission at the next Commission meeting following the advocacy efforts. **December 2020 Recommendations:** Keep the original language of paragraph B (2) which was proposed to be revised in January and add the following language to paragraph B to read: B. The Executive Director, or the Executive Director's designee, is authorized on behalf of the Commission to advocate on legislation: (1) when the legislation advances a formally established position of the Commission; (2) at the direction of the Chair and when the legislation furthers the interest of the Commission; or (3) after full discussion with and at the direction from the full Commission.

Table 10: Rule 2.5 Authority to Advocate on Legislation

Public Comment Summary	Response
#1: CASRA in its March 1, 2020 letter states it would support the change to allow the Executive Director to advocate on "informal or emerging positions" at the Legislature if the Commission adopts a statement of values and principles to guide any such position.	**Response to Comment #1 CASRA:** • See the recommendation above that removes the proposal authorizing the Executive Director to advocate on "informal or emerging positions."
#2: PEERS in its April 3, 2020 letter states it does not support the change because: • "Increasing" Executive Director's authority to advocate on legislation when "legislation advances an informal or emerging position after consultation with only the Chair and Vice Chair disempowers other members of the Commission…decreases transparency, and eliminates the public's opportunity to comment on these positions."	**Response to Comment #2 PEERS:** • Same response as to Comment #1
#3: NAMI in its May 5, 2020 letter states it opposes the change because: • Allowing the Executive Director authority to advocate on legislation without prior vetting by stakeholders lacks the value of transparency that the Commission holds as a top priority.	**Response to Comment #3 NAMI:** • Same response as to Comment #1
#4: REMHDCO in its undated letter states it opposes the change because: • "There should not be advocacy allowed by MHSOAC staff unless the public is allowed to comment on the legislation before the full Commission and the Commission votes on the legislation. It is not sufficient that only the Chair and Vice Chair are consulted." • In addition, REMHDCO opposes the addition of the language regarding "confidential budget proposal" stating, that the Executive Director "should not be commenting on budget proposals (e.g. WET funding) without Commission approval and	**Response to Comment #4 REMHDCO:** • Same response as to Comment #1 • The proposed change to this rule regarding confidential budget proposal is required to comply with orders from the Department of Finance. Budget proposals are considered integral part of the Governor's deliberation process and state agencies are required to keep them confidential until and unless the Governor releases the proposal to the Legislature as part of the Governor's budget. Once the Governor releases the Governor's budget that includes the specific budget proposal the proposal is no longer confidential.

Table 10: Rule 2.5 Authority to Advocate on Legislation

the Executive Director should give an update on all of his/her advocacy efforts."	• Current Rule 2.5 already requires the Executive Director to give an update on all advocacy efforts at the next Commission meeting following the advocacy efforts.
#5: CalVoices in its September 11, 2020 letter states it opposes the proposed changes that allow the Executive Director to advocate on legislation that the Commission has not publicly and officially adopted a position because: • It "contravenes the Bagley-Keene Act" because the "public has a right to participate and public comment in all decisions of the Commission." • The law mandates a diverse Commission of 16 appointed members to make formal decisions with public input. The Executive Director's role is to assist the Commission in accomplishing their formal positions, not in establishing his or her own positions." • Delete the exception for confidential budget proposals unless they are exempt from the Bagley-Keene Act.	**Response to Comment #5 CalVoices:** • Same response as to Comment #1 • See response in Table 9 regarding the Bagley-Keene Act not limiting the role of staff to represent and implement the decisions of the state body. • The Bagley-Keene Act exempts disclosure of information that is exempted by the Public Records Act (Gov Code §11125.1). Budget proposals fit under several sections of the Public Records Act §6254, which exempts disclosure of information that is protected under federal or state law, correspondence to Governor or employees of the Governor, and draft interagency memorandum. Budget proposals are considered draft interagency memorandum until and unless the Governor releases the proposal to the Legislature as part of the Governor's budget.

Table 11: Rule 2.6 Authority to Approve Innovation Projects

January 2020 Proposal & December 2020 Recommendation
The January amendments propose to amend Rule 2.6 to incorporate the language the Commission adopted at the May 2019 meeting. The only changes to the May 2019 version proposed in January 2020 is to paragraph B to read: B. The Executive Director shall publicly report to the Commission <u>at the next Commission meeting</u> ~~at the first available opportunity~~ any county Innovation plan approved by the Executive Director on behalf of the Commission under this delegated authority. **December 2020 Recommendations:** No change to the January 2020 proposal

Table 11: Rule 2.6 Authority to Approve Innovation Projects

Public Comment Summary	Response
#1: REMHDCO in its undated letter states it opposes Rule 2.6 because: • "This 'secret approval' does not allow community stakeholders from individual counites the opportunity to comment on their county's Innovation Plan." • Commissioners and public stakeholders should be allowed to be aware of and comment on programs or program changes of $1,000,000. • "Innovation Programs were not supposed to be considered 'innovative' if they were being implemented or administered in another county (unless there was a substantial difference in the new proposed plan.)"	**Response to Comment #1 REMHDCO:** • Community stakeholders from individual counties and from state level advocacy groups have multiple opportunities to comment on individual county Innovation plans. o First, under the MHSA and regulations counties are required to engage community stakeholders in a local program planning process (CPP). o Second, the Innovation plan is required to go through a 30-day public comment period at the local level. o Third, the Innovation plan is required to be reviewed at a hearing before the local mental health board and another hearing at the county Board of Supervisors. By the time the Innovation plan is presented to the Commission local community stakeholders have had months and sometimes years to review and comment on it. o Fourth, the Commission sends each Innovation plan to its stakeholder contractors and on its listserv twice for public comment: once when the Innovation plan is in draft and/or going through the local 30-day public comment period and a second time when the Innovation plan is final and submitted to the Commission for approval. • Neither the MHSA nor the Innovation regulations prohibit multiple counties from piloting an Innovation project. Under the Innovation regulations, projects are not eligible for Innovation funding if the approach has "already demonstrated its effectiveness." (9 CCR Section 3910)

Table 11: Rule 2.6 Authority to Approve Innovation Projects

#2: CalVoices in its September 11, 2020 letter states it opposes Rule 2.6 because: • The MHSA requires community collaboration and meaningful stakeholder input. Approval of any MHSA spending without public discourse and stakeholder input runs contrary to the MHSA. • Key statutory role of the Commission is approval of Innovation plans. The MHSA requires diverse Commission made up of 16 members with varied knowledge and different perspective. The decision making should not be delegated to a single person, especially one who is not a Commissioner.	**Response to Comment #2 CalVoices:** • Same response as to Comment #1 • The rule provides for a joint delegation to the Chair and the Executive Director. Contrary to the comment, the rule does not delegate to a single person who is not a Commissioner. The Chair, who was elected by the Commission, as chair, is required to consent to the Innovation approval.

Table 12: Rule 4.3 Open Meeting

January 2020 Proposal & December 2020 Recommendation	
The January amendments propose clarifying language and consolidates two rules into Rule 4.3. The relevant language is as follows: A. Commission meetings are subject to the Bagley-Keene Open Meeting Act set forth in Government Code Sections 11120 et seq. ~~The principal law that governs the meetings of the MHSOAC and its Committees is the Bagley-Keene Open Meeting Act which is set forth in Government Code Section 11120 et seq.~~ **December 2020 Recommendation:** No change to the January 2020 proposal	
Public Comment Summary	**Response**
#1: REMHDCO in its undated letter propose additional language to Rule 4.3 because it claims that the Commission "has sponsored events that included all Commissioners but was "invitation only" to the public and allowed only a limited number of public members chosen by staff to attend. The letter proposes the following new paragraph:	**Response to Comment #1 REMHDCO:** • The rules were re-organized and the new Rule 6.2 specifically provides that meetings of a committee, subcommittee and multi-member body are subject to the Bagley-Keene Open Meeting Act.

"All committee meetings of the MHSOAC whether those of a standing committee, special project, or ad-hoc committee are also subject to the Bagley-Keen (sic) Open Meeting Act. The MHSOAC shall not sponsor "invitation only" events that limit participation by public members to those chosen by the MHSOAC staff."	• The comment does not provide specific information about the "invitation only" event, however, the Commission follows the Bagley-Keene Act, which permits such events under specified circumstances. For example, the Innovation Fest at the Google campus was permitted under the Bagley-Keene Act because it was not a meeting as defined by the Act because less than a majority of Commissioners were present. (Govt. Code §11122.5)
#2: CalVoices in its September 11, 2020 letter "proposes additions to Rule 4.3 to comply with law" because it contends that in the past the Commission has hosted meetings which included Commissioners, but were "invitation only" to the public. The example cited is the meeting at Google to discuss the Innovation Incubator. The proposed language is: "A meeting occurs when a quorum of a body convenes, either serially or all together, in one place, to address issues under the body's jurisdiction. (§11122.5.) Obviously, a meeting would include a gathering where members were debating issues or voting on them. But a meeting also includes situations in which the body is merely receiving information. To the extent that a body received information under circumstances where the public is deprived of the opportunity to monitor the information provided, and either agree with it or challenge it, the open-meeting process is deficient."	**Response to Comment #2 CalVoices:** • Same response as to Comment #1

Table 13: Rule 4.4 Agenda Items

January 2020 Proposal & December 2020 Recommendation	
The January amendments propose to delete the following paragraph from Rule 4.4: "Staff prepares briefing materials on each agenda item and provides Commissioners with those materials in advance of the meeting. These materials provide Commissioners with a detailed description of a proposed course of action, background information, fiscal impact, the pros and cons of taking the action, and similar information for alternative actions." **December 2020 Recommendation:** Do not delete the language	
Public Comment Summary	**Response**
#1: CalVoices in its September 11, 2020 letter states it opposes the deletion of the paragraph because there is no reason to remove the language and the Commissioners should receive meeting materials in advance of the meeting including all the items in the paragraph.	**Response to Comment #1 CalVoices:** • See the recommendation above.

Table 14: Rule 4.5 Request for Items to be Placed on the Agenda

January 2020 Proposal & December 2020 Recommendation
The January amendments propose the following changes to Rule 4.5: A. Agenda items are placed on the Commission's meeting agenda with the approval of the Chair and Executive Director. The final meeting agenda is approved by the Chair and the Executive Director after consultation with the Chief Counsel. B. Individual Commissioners wishing to place items on the agenda should contact the Chair or the Executive Director. C. Members of the public wishing to place items on the agenda should contact Commission staff.

Table 14: Rule 4.5 Request for Items to be Placed on the Agenda

~~Agenda items shall only be placed on the Commission's agenda at the request of (1) a Committee of the MHSOAC; (2) a member of the MHSOAC; or (3) MHSOAC staff with the approval of the Executive Director. Members of the public wishing to place items on the agenda must go through one of the above.~~

~~Before agenda and meeting packets are finalized, they shall be reviewed by the Chair of the Commission, the Executive Director, Chief Counsel. The Chair of the Commission, the Executive Director, and the Operations Committee shall work together to develop and set the Commission agenda.~~

December 2020 Recommendation: No changes to the January 2020 proposal

Public Comment Summary	Response
#1: REMHDCO in its undated letter opposes the change and argues that: • A committee of the MHSOAC should be able to request that an item be put on the agenda. • A member of the public should be able to go to either any Commissioner or Commission staff (not just Commission staff) in order to get something placed on the agenda	**Response to Comment #1 REMHDCO:** • The rule does not change the public's access to the Commissioners, including the Chair. A committee member or a member of the public can still contact any Commissioner with a request.
#2: CalVoices in its September 11, 2020 letter states it opposes the language change contending: • The 16 member Commission should be responsible for determining the agenda items that Commission wishes to discuss. The role of the Executive Director should not be to determine agenda items, it should be to assist the 16 member Commission in reaching its own goals. • The public should be able to propose agenda items to be allowed or disallowed with a decision made by the full 16 member Commission because WIC 5846(d) requires the Commission to ensure the perspective and participation of diverse community members is a significant factor in all its decisions and recommendations.	**Response to Comment #2 CalVoices:** • Same response as to Comment #1 • Per Rules of Procedure, Rule 1.3B, the Chair, who is elected by the Commission, is the person who sets the agenda with input from Commissioners and staff. The Commission elects a Chair to take on certain responsibilities, including setting the agenda. This rule is consistent with Rule 1.3B. • It is unreasonable and inefficient to require the full Commission to decide on whether an item should be placed on the meeting agenda. The time spent on such deliberations could instead be spent on priorities, such as strategies to reduce disparities or improve outcomes for individuals with mental health needs.

Table 15: Rule 4.11 Quorum

January 2020 Proposal & December 2020 Recommendation
The January amendments proposed the following changes to Rule 4.11: A. A simple majority <u>of the Commission's statutory membership</u> shall constitute a quorum for the transaction of business. <u>The Commission's statutory membership is 16 members making nine members a quorum. A majority of the quorum (i.e. five members) may act to bind the Commission.</u> B. <u>A meeting at which a quorum is initially present may continue, notwithstanding the withdrawal of Commissioners and the absence of a quorum. The only action that may be taken in the absence of a quorum is to fix the time in which to adjourn, recess, or take measures to obtain a quorum.</u> ~~Every act or decision done or made by a majority of the Commissioners present at the meeting dully held at which a quorum is present, shall be regarded as binding. A meeting at which a quorum is initially present may continue to transact business, notwithstanding the withdrawal of Commissioners below a quorum, if any action taken is approved by at least a majority of the required quorum for the meeting.~~ **December 2020 Recommendation:** Add the following clarify language: A. A simple majority of the Commission's statutory membership shall constitute a quorum for the transaction of business. The Commission's statutory membership is 16 members making nine members a quorum. <u>When a quorum is present, a simple majority of those present and voting may act to bind the Commission</u>. B. A meeting at which a quorum is initially present may continue, notwithstanding the withdrawal of Commissioners and the absence of a quorum. The only action that may be taken in the absence of a quorum is to fix the time to adjourn, recess, or take measures to obtain a quorum.

Public Comment Summary	Response
#1: REMHDCO in its undated letter states it supports the new rule.	In response to Commissioners' discussion at the January 2020 meeting staff recommends the above clarifying language.

Table 16: Rule 4.12 Voting

January 2020 Proposal & December 2020 Recommendation
The January amendments propose the following relevant changes to Rule 4.12: The following paragraph D was proposed to be added: "D. Prior to voting on a policy project report, the Commission shall consider the report in at least one meeting prior to the meeting at which the motion to approve is considered. This requirement shall not apply if the report was previously discussed in a public meeting of a Commission subcommittee and the subcommittee recommended Commission adoption of the report." The following paragraphs were proposed to be deleted: ~~"Any proposed policy item on the agenda, along with its corresponding language/documents, shall be presented for discussion at a Commission meeting at least one (1) meeting prior to the meeting at which the vote on the issue is taken.~~ ~~The Commission may take action, by a simple majority, on an agenda item at the same meeting that the item is presented if the Commission deems that there exists a need to take action."~~ **December 2020 Recommendation:** Revise paragraph D of Rule 4.12 by deleting the last sentence and adding two new paragraphs as follows: D. Prior to voting on a policy project report, the Commission shall consider the report in at least one meeting prior to the meeting at which the motion to approve is considered. ~~This requirement shall not apply if the report was previously discussed in a public meeting of a Commission subcommittee and the subcommittee recommended Commission adoption of the report.~~ E. Approval of a policy project report by a subcommittee of the Commission constitutes the "first reading" of a policy project report. F. The Commission may determine that the timely release of a policy project report is in the public interest and may vote to suspend this rule in order to approve a policy report in a single meeting.

Public Comment Summary	Response
#1: REMHDCO in its undated letter states it opposes the new paragraph especially the second sentence and opposes the deletion of the first paragraph. The letter contends that:	**Response to Comment #1 REMHDCO:** • The term, "policy item" is too vague and ambiguous and could result in every agenda item requiring at least one meeting prior

Table 16: Rule 4.12 Voting

• Any policy item and not just policy project report should be subject to at least one meeting prior to the meeting at which it is voted. • Subcommittee meetings are not sufficient because some Subcommittee meetings have been held in places that are not easily accessible to a large number of members of the public and state level advocates (e.g. Redding, Riverside, Monterey).	to the meeting at which the motion to approve is considered (first and second read). • Subcommittee meetings are held in different regions of California to give local stakeholders, a majority of whom cannot travel to Sacramento, the opportunity to provide input to the Commission's work.
#2: CalVoices in its September 11, 2020 letter states it opposes the language change because: • "All" items, not just "policy" items unless "truly urgent" should be presented during at least two Commission meetings to allow for full discussion and public input. • The change limits the role of the 16 member Commission by leaving them out of valuable discussion and public input. Under WIC 5846(d) which requires the Commission to ensure the perspective and participation of diverse community members is a significant factor in all if its decision, requires the 16 member Commission hear the public comment and incorporate it into their decision. • Client stakeholders have transportation barriers which limit their travel to OAC subcommittee meetings. Discussion at subcommittees should not take the place of public discussion at two meetings of the full 16 member Commission.	**Response to Comment #2 CalVoices:** • Same response as to Comment #1 • It is not reasonable for "all" items to be discussed at two Commission meetings. The proposed changes to the rule do not limit the role of the Commission nor limit consideration of public comment from diverse communities. The Commission can and does have valuable discussion in a single meeting in which it considers the public input.

Table 17: Rule 4.13 Public Comment

January 2020 Proposal & December 2020 Recommendation	
The January amendment proposes the following relevant change to Rule 4.13: The following paragraph is proposed to be deleted: ~~It is the policy of the Commission to vet issues as much as practical through the MHSOAC standing committees before those issues are brought to the full Commission. It is the responsibility of the committee chair to engage stakeholder participation at the committee level and to report back to the full Commission. Public comment and stakeholder involvement at the committee level does not replace public comment at the Commission meeting.~~ The following changes were proposed to paragraph B: B. If the agenda item has already been considered by a subcommittee or committee composed exclusively of members of the Commission at a public meeting where interested members of the public were afforded the opportunity to address the subcommittee or committee on the item, additional public comment opportunity at the Commission need not be provided unless the item has been substantially changed since the subcommittee or committee heard the item (Government Code Section 11125.7) **December 2020 Recommendation:** No change to the January 2020 proposal	
Public Comment Summary	**Response**
#1: CASRA in its March 1, 2020 letter states it opposes the paragraph B that allows the Commission to vote on an agenda item without public comment (if that item was considered at a prior committee meeting) because: • There are serious challenges to stakeholder involvement in decision-making and stakeholders should be offered the opportunity to comment prior to any vote on a substantive issue.	**Response to Comment #1CASRA:** • Paragraph B in Rule 4.13 conforms to the Bagley-Keene Open Meeting Act. The rationale for this provision of the Bagley-Keene Act is that the public had an opportunity to comment on the issue and the issue was not substantially changed therefore there was nothing new to comment on.

Table 17: Rule 4.13 Public Comment

#2: REMHDCO in its undated letter states it opposes the deletion of the paragraph because: • The deleted language reflects the "heart and soul of the MHSA stakeholder engagement and participation in all the Commission activities and decisions." • The standing committees served as a place for important issues to be discussed in dialogue with Commissioners instead of 2-3 minute one-way public comments at the Commission meetings. Removing the language removes the underlying protection for meaningful stakeholder involvement with the MHSOAC.	**Response to Comment #2 REMHDCO:** • Committee discussion is important, but it is not sufficient for meaningful stakeholder engagement in Commission decisions. The January 2020 version proposes a new rule, Rule 5.1 that provides much broader and more inclusive strategies of public outreach and engagement, which includes committee meetings as well as community forums and listening sessions, etc.
#3: CalVoices in its September 11, 2020 letter states it opposes the language in paragraph B because: • The change limits the role of the 16 member Commission by leaving them out of valuable discussion and public input. Under WIC 5846(d) which requires the Commission to ensure the perspective and participation of diverse community members is a significant factor in all if its decision, requires the 16 member Commission hear the public comment and incorporate it into their decision. • The proposed changes to paragraph B to add, "subcommittee" is not in accordance with Government Code 11125.7 because the Government Code uses the term "committee" only. • The deleted text should remain a foundation of the Commission's procedure. Public comment and stakeholder involvement at the committee level should provide an additional level of public comment but not lessen the amount of public comment at the 16 member Commission meeting.	**Response to Comment #3 CalVoices:** • Same response as for Comment #1 and the same responses to the comments on Rule 4.12. • The key operative part of section Government Code section 11125.7 is that the subgroup is "composed exclusively by members" of the state body. The label on the multi-member group is not dispositive. The dispositive component is that the group is composed exclusively by Commissioners, which under this rule it is.

Table 18: Rule 5.1 Public Outreach and Engagement

January 2020 Proposal & December 2020 Recommendation
The January amendments proposed to add a new Rule 5.1 to read as follows: The Commission seeks to ensure the perspective and participation of diverse community members and others with mental health challenges and their families are a significant factor in the Commission's decisions and recommendations. The Commission ensures this through: • Public hearings that have open, informed, and transparent deliberation • Committee and subcommittee meetings that hear from community members and other subject matter experts to develop a shared understanding of the challenges and opportunities of topics specified by the Commission • Community forums and listening sessions that are organized to highlight and understand topics specified by the Commission • Site visits that are organized to acquire first-hand knowledge and understanding of the challenges of specific topics and the existing efforts to address those challenges. **December 2020 Recommendation:** Revise the language to read: "The Commission ~~seeks~~ is committed to ensure the perspective and participation of diverse community members – those with lived experiences and their family members, community and advocacy organizations, county behavioral health agencies - ~~and others with mental health challenges and their families~~ are a significant factor in the Commission's understanding, actions, decisions and recommendations. The Commission ensures broad and inclusive community outreach and engagement through the following actions and other opportunities that may be identified going forward: • Public ~~hearings~~ meetings ~~that have~~ with open, informed, and transparent deliberation • Committee and subcommittee meetings that hear from community members and other subject matter experts to develop a shared understanding of the challenges and opportunities of topics specified by the Commission • Community forums that are organized to highlight and understand topics specified by the Commission and of concern to the community • Small group listening sessions to hear from individuals with lived experience on sensitive topics • Site visits that are organized to acquire first-hand knowledge and understanding of the challenges of specific topics and the existing efforts to address those challenges • Convening advisory bodies with expertise on topics specified by the Commission • Meetings with community-based organizations and local leaders • Use of surveys

Table 18: Rule 5.1 Public Outreach and Engagement

Public Comment Summary	Response
#1 REMHDCO in its undated letter proposes adding the following additional language: "Testimony from state level mental health advocates, including recipients of stakeholder advocacy grants administered by the MHSOAC, who are encouraged to attend all Commission meetings to give voice to their respective communities."	**Response to Comment #1 REMHDCO:** • The language proposed by the comment is already covered in the Rule.
#2: CalVoices in its September 11, 2020 letter states it would support this rule with the following changes: • Replacing "the Commission's" with, "all of its" referring to the Commission's decisions in the first sentence • Replacing the word, "hearing" with the word, "meeting" in the first bullet.	**Response to Comment #2 CalVoices:** • See the above recommendations

Table 19: Rule 6.1 Committee/Subcommittee/Other Multi-member Body Structure

January 2020 Proposal & December 2020 Recommendation
The January amendments propose the following relevant changes to Rule 6.1: A. The ~~MHSOAC~~ Commission ~~shall~~ may establish one or more standing committees as necessary to provide technical and professional expertise pursuant to Welfare and Institutions Code Section 5845(d)(3) … A.2. ~~Ideally~~ Each ~~standing~~ committee shall have a maximum of 15 members and ~~shall~~ may include public membership. Public membership of each committee shall be selected by the committee Chair and Vice Chair for a one-year term. Of this public membership, the committee Chair and Vice Chair shall seek individuals with the desired expertise who are consumers, family members or care givers of consumers, and members of underserved ethnic and cultural communities. ~~at least two shall be consumers, at least two shall be family members or care givers of consumers, and at least two shall be members of underserved ethnic and cultural communities. Public membership of each committee shall be selected by the committee Chair and Vice Chair~~. In their recruitment and appointment of committee members,

Table 19: Rule 6.1 Committee/Subcommittee/Other Multi-member Body Structure

committee Chair and Vice Chair shall pay special attention to issues related to cultural diversity and competency and the needed expertise to support the committee's goals. Commission staff and/or consultants will staff each committee.

December 2020 Recommendation: Change paragraph 2A to read:

A.2. "Each committee should have a maximum of 15 members. The committee chair and vice chair select committee members who have the desired expertise and experiences to advance the committee's goals. Committee members serve a one-year term unless that term is extended by the appointing authority. Each committee should include at least two consumers, two family members or care givers of consumers, and two experts on reducing disparities. The Commission shall strive to ensure committee membership reflects the demographic diversity, including race, ethnicity, sexual orientation, and gender identity of California; the geographic diversity of California; and includes members with lived experience with mental health and/or the mental health system of care.

Public Comment Summary	Response
#1: CASRA in its March 1, 2020 letter states it oppose the changes to paragraphs A and A.2. • Comment on paragraph A: CASRA states it does not support the removal of the requirement of the Commission to establish committees because it believes a robust committee structure is the key to ensuring that policy issues and decision are made based on full exploration and discussion of the topic. • Comment on paragraph A.2A, CASRA states: o it does not support the removal of the requirement for public members to be appointed to Commission committees stating the MHSA is very explicit about the need for government to collaborate and consult with community stakeholders and the most effective strategy to support such involvement is through participation in committees. o it opposes the removal of the requirement for consumers, family members, and members of racial, ethnic and cultural communities be appointed to committees because it is imperative that a significant effort be made to include representatives of these constituencies. The letter	**Response to Comment #1 CASRA:** • The change in paragraph A from "shall" to "may" conforms with the language in WIC 5845(d)(3) which authorizes the Commission to establish committees but does not require it. Committees are one of many effective means to ensure policy issues and decisions are made based on full exploration and discussion. The Commission is committed to support community stakeholder involvement and the new Rule 5.1 specifies all the many ways the Commission ensures robust stakeholder involvement, including committee meetings and public membership in committees. • The Commission is committed to broad, diverse, and inclusive engagement and consultation with community stakeholders. The Commission collaborates and consults with community stakeholders in many ways: Committee membership is only one of those ways. One of the most effective ways to engage and obtain community input is to go to the community. In addition, to having committee meetings, the Commission is engaging with consumers, family members, and members of racial, ethnic and

Table 19: Rule 6.1 Committee/Subcommittee/Other Multi-member Body Structure

acknowledges that it is sometimes very difficult as many potential participants do not have the time and/or support to attend meetings.	cultural communities through focus groups, community forums, site visits, and listening sessions in their communities. • See the above recommendation regarding the committee membership including consumers, family members, and members of diverse racial, ethnic and cultural communities.
#2: PEERS in its April 3, 2020 letter states it opposes the changes to both paragraphs A and A.2. • Comment on paragraph A: PEERS states that eliminating the requirement to establish committees reduces opportunities for the public to influence the Commission's decisions. The letter also states that PEERS believes the involvement of a wide range of stakeholders increases the quality of decision making and committee meetings that allow for an open exchange of ideas is an important mechanism for increasing the quality of decisions. • Comment on paragraph A2: PEERS states the removing of the requirement for public membership and the requirement of at least two consumers, at least two family members or caregivers, and at least two members of underserved ethnic and cultural communities is a major step backwards in the MHSA promise of transforming California's mental health system to one that supports the wellness, recovery, and resilience of all Californians	**Response to Comment #2 PEERS:** • Same response as to Comment #1
#3: NAMI in its May 5, 2020 letter states it opposes the changes to both paragraphs A and A.2: • Comment on paragraph A: NAMI states that this change will reduce public participation and transparency. The letter states NAMI is concerned that it will reduce opportunities for stakeholders to provide timely input to the Commission staff and members. The letter further states that committees play an important function to any board or commission and participants are able to lend important expertise in a more rich and meaningful way than what is usually afforded during "public comment" periods at formal commission meetings.	**Response to Comment #3 NAMI:** • Same response as to Comment #1 • The rule does not change the access to staff or to Commissioners. The Commission has expanded the opportunities for stakeholders to provide timely input through the changes reflected in the new Rule 5.1 that expands the types of strategies the Commission is using to obtain input including community forums, listening sessions, site visits in addition to committee meetings. • People with lived experiences come from all walks of life. Mental health needs touches people from every profession, every social-economic background, every age, and every education level.

Table 19: Rule 6.1 Committee/Subcommittee/Other Multi-member Body Structure

• Comment on paragraph A.2: NAMI states in its letter that requiring "needed expertise" "devalues the expertise and contributions that can be made from people with lived experience who may not possess formal education, training, or degrees in the behavioral health field."	Having committee members who have the desired expertise for the committee acknowledges this important fact and helps reduce stigma associated with mental illness. The desired expertise will defer with the committee.
#4: REMHDCO in its undated letter states it opposes the changes to both paragraphs A and A2. • Comment on paragraph A: The letter contends the most effective way for the Commission to engage community stakeholders is through regular and ad-hoc committee meetings that allow robust and open dialogue with knowledgeable and diverse stakeholders. • Comment on paragraph A.2: The letter contends that the MHSA is very explicit about being consumer and family driven and for government to collaborate and consult with community stakeholders. It further states that having a committee with no community members is not in line with the most important principles of the MHSA and is like having a recovery team without having the consumer or family member on it. As to the minimum number of consumers, family members, members of underserved racial and cultural communities was instituted as a safeguard to ensure the work and decisions of the committee would be consumer and family driven and culturally competent.	**Response to Comment #4 REMHDCO:** • Same response as to Comments #1 and #3
#5: **CalVoices** in its September 11, 2020 letter opposes the changes to paragraph A.2, stating: • The MHSA requires 16 member Commission to accomplish a lot of work on a volunteer basis and for this reason the committees comprised of the public and commissioners have historically been highly utilized by the Commission to assist the Commission meet	**Response to Comment #5 CalVoices:** • Same response as to Comments #1 and #3

Table 19: Rule 6.1 Committee/Subcommittee/Other Multi-member Body Structure

its goals. Public members have the unique expertise and time to commit to meetings. • Committees are an effective way for the Commission to engage a broad range of community stakeholders • The requirement for specific committee membership ensures committees are client and family driven and culturally competent in accordance with the MHSA General Standards (9 CCR §3320)	

Enclosure 4

RULES OF PROCEDURE

Proposed January 2020 amendments

(New language is shown in underlined text and deleted language is shown in strikethrough text.)

MHSOAC

Mental Health Services
Oversight and Accountability Commission

TABLE OF CONTENTS

To be added when document is completed.

MISSION

The Mental Health Services Oversight and Accountability Commission works through partnerships to catalyze transformational change across systems and ensure everyone who needs mental health care has access to and receives effective and culturally competent care.

~~The MHSOAC provides the vision and leadership, in collaboration with clients, their family members and underserved communities, to ensure an enhanced continuum of care for individuals at risk for and living with serious mental illness and their families by holding public systems accountable and by providing oversight, eliminating disparities, promoting mental wellness, supporting recovery and resiliency resulting in positive outcomes in California's community based mental health system.~~

GOVERNANCE PHILOSOPHY

Integrity and sound stewardship are paramount in the governance of all Commission activities. The Commission ~~MHSOAC~~ will govern itself with an emphasis on the following:

a.) ~~Being~~ Advancing an objective understanding and incorporating diverse ~~diversity in~~ viewpoints;
b.) Making decisions in a transparent, responsive ~~an efficient~~ and timely manner;
c.) Striving to improve ~~for~~ results and outcomes;
d.) Elevating transformative ~~Focusing on outward~~ vision and strategic leadership ~~and less on administrative detail~~;
e.) Working ~~Using~~ collaboratively to drive system-scale improvements ~~rather than individual decisions-making processes~~;
f.) Being proactive ~~rather than reactive~~

~~Specifically~~:

~~a. The MHSOAC will cultivate a sense of group responsibility. The MHSOAC will be responsible for excellence in governing. The MHSOAC will use the expertise of individual members to enhance the ability of the MHSOAC.~~

~~b. The MHSOAC will direct evaluate, and inspire the organization through the careful establishing written policies, procedures and directives.~~

~~c. The MHSOAC will enforce upon itself the necessary discipline to govern with excellence, including preparation and regular attendance at meetings, thorough preparation by each member for each meeting, adherence to its policymaking principles, and respecting the roles.~~

~~d. Continual development of the MHSOAC will include orientating of new members in the Commission's governance policies and processes, periodic re-orientation of existing members, and regular discussion of process improvement~~.

~~e. The MHSOAC will regularly discuss and evaluate its performance and take steps to improve its effectiveness~~.

COMMISSIONERS

1.1 Terms of Commissioners

A. The Commission consists of 16 voting members: the Attorney General or designee; the Superintendent of Public Instructions or designee; the Chairperson of the Senate Committee on Health, the Chairperson of the Senate Committee on Human Services, or another member of the Senate selected by the President pro Tempore of the Senate; the Chairperson of the Assembly Committee on Health or another member of the Assembly selected by the Speaker of the Assembly; and twelve members appointed by the Governor to specified seats: two individuals with lived experiences, two family members, a physician specializing in alcohol and drug treatment, a mental health professional, a county sheriff, a superintendent of a school district, a representative of a labor organization, a representative of an employer with less than 500 employees, a representative of an employer with more than 500 employees, and a representative of a health care services plan or insurer. (Welfare and Institutions Code Section 5845)

B. ~~Pursuant to Welfare and Institutions Code Section 5845,~~ The term of each Commissioner ~~member shall be~~ is three years, to be staggered so that approximately one-third of the appointments expire in each year. A Commissioner may resign prior to the end of the Commissioner's term by submitting written notification to the appointing authority and sending a copy of the resignation to the Commission Chair and the Executive Director. A Commissioner who desires to serve after their term has expired shall notify the Commission Chair and the Executive Director in writing of their intention to serve until reappointed or replaced by a new appointee. ~~Members shall~~ Commissioners serve without compensation but ~~shall be~~ are reimbursed in accordance with the policy of the State of California for all actual and necessary expenses incurred in the performance of their duties. (Welfare and Institutions Code Section 5845)

~~If a Commissioner cannot attend a Commission meeting he or she will notify the Chair and the Executive Director of such absence in advance of the Commission meeting. If a Commissioner misses one (1) Commission meeting without notice or three (3) Commission meetings in a calendar year with notice the Chair shall notify the Commissioner and that Commissioner's appointing power in writing that the attendance record of the Commissioner be improved or that the Commissioner be replaced.~~

1.2 The Role of Commissioners

A. Commissioners are expected to work collectively to accomplish the Commission's goals as adopted by the Commission and to attend Commission meetings in person or via teleconference.

B. At the request of the Chair, Commissioners are expected to serve as a member of a committee, subcommittee, or other Commission body.

C. At the request of the Chair, Commissioners are expected to represent the Commission in meetings, conferences, testimony in public hearings, and other speaking engagements.

D. The Commissioner with the most seniority and present at the meeting is expected to preside at the Commission meeting when neither the Chair nor Vice Chair is available to run all or part of the meeting.

- ~~Represent the MHSOAC outside Commission meetings~~
- ~~Provide knowledge and expertise to guide Commission policy-making~~
- ~~Attend Commission meetings throughout the state~~
- ~~Serve as a member of at least one MHSOAC Committee~~
- ~~Attend, in person or via teleconference, meetings of any MHSOAC Committee of which they are a member~~
- ~~Work collectively to accomplish the goals of the MHSOAC as set forth in its Multi-Year Strategic Plan and/or the yearly Work Plan~~

~~The best decisions come out of unpressured collegial deliberations and the MHSOAC seeks to maintain an atmosphere where the Commission or Committee members can speak freely, explore ideas before becoming committed to positions and seek information from staff and other members. To the extent possible the MHSOAC encourages members to come to meetings without having fixed or committed their positions in advance.~~

1.3 Chair

A. Election of the Chair

A.1. The Commission shall elect a Chair ~~shall be elected~~ at a ~~MHSOAC~~ Commission meeting preferably held in September but no later than during the last quarter of the calendar year. The Chair shall be elected by a majority of the Commissioners present and voting consistent with the Rule 4.11A ~~members of the MHSOAC~~ and shall assume all duties ~~and presides at all MHSOAC meetings~~ starting January 1, following ~~January~~ the election. The Chair is elected to a one-year term. A Commissioner may be elected to serve more than one term as Chair. ~~The term of the Chair shall be one year each~~.

A.2. In the event more than two candidates are nominated for Chair and no candidate receives a majority of the votes cast, the balloting shall continue, and another vote taken between the two candidates receiving the highest number of votes.

B. Duties of the Chair

B.1. The Chair, with input from Commissioners and staff, sets the Commission's meeting agenda, prioritizing and scheduling agenda items as appropriate, and conducts the meetings.

B.2. The Chair appoints Commissioners to Commission subcommittees, committees, or other bodies as necessary to conduct the Commission's business.

B.3. The Chair provides guidance and direction to the Executive Director on Commission business, including but not limited to: (a) advocating on legislation consistent with Commission Rule 2.5; (b) approving Innovation projects consistent with Commission Rule 2.6; and (c) placing items on the Commission agenda consistent with Commission Rule 4.5.

B.4. In the event the Chair is unable to continue with the Chair's duties due to resignation, death, incapacity, or no longer being a member of the Commission, ~~of the Chair~~ the Vice Chair shall assume all of the responsibilities of the Chair until a successor is elected. The election shall be held within 60 days of the vacancy ~~after resignation, death~~.

1.4 Vice Chair

A. Election of the Vice Chair

A.1. The Commission shall elect the Vice Chair ~~shall be elected~~ at a ~~MHSOAC~~ Commission meeting preferably held in September but no later than during the last quarter of the calendar year. The Vice Chair shall be elected by a majority of the Commissioners present and voting consistent with the Rule 4.11A ~~members of the MHSOAC~~ and shall assume all duties ~~and presides at all MHSOAC meetings~~ starting January 1, following ~~January~~ the election. The Vice Chair is elected to a one-year term. A Commissioner may be elected to serve more than one term as Vice Chair.

A.2. In the event more than two candidates are nominated for Vice Chair, and no candidate receives a majority of the votes cast, the balloting shall continue, and another vote taken between the two candidates receiving the highest number of votes.

B. Duties of the Vice Chair

B.1. The Vice Chair fulfills the role of Chair and presides at meetings in the absence of the Chair.

B.2. In the event the Vice Chair is unable to continue with the Vice Chair's duties due to resignation, death, incapacity, or no longer being a member of the Commission, an election for a successor shall be held within 60 days of the vacancy.

B.3. When neither the Chair nor Vice Chair is available to run all or part of the meeting, e.g., both officers may be absent, need to leave the room, or are disqualified from discussion and action on an item due to conflict of interest, the ~~most senior~~ Commissioner with the most seniority on the Commission who is present shall preside at the meeting.

1.5 Commission Member Vacancy

~~Commissioners may leave office at the end of their term or sooner.~~ When a vacancy occurs on the Commission, a successor is selected by the appointing authority ~~power~~.

1.6 Compensation and Expenses

Commissioners, ~~staff, agendized presenters, and active Committee members~~ will be reimbursed in accordance with State per diem laws. Also, any reasonable business expenses incurred will be reimbursed as authorized by law ~~the Commission~~. ~~On a case-by-case basis the designee of a Committee member may also be reimbursed in accordance with the State per diem laws.~~

1.7 Training and Orientation

A. New Commissioners ~~members~~ shall within 30 days of being appointed receive ~~training and~~ orientation in: (1) Commission governance, policies and procedures; (2) Commission strategic directives; (3) Mental Health Services Act (MHSA) programs and issues; and (4) relevant laws and statutes.

B. At or before the orientation session, the new Commissioner ~~member~~ will receive the following documents:

1) The Bagley-Keene Open Meeting Act

2) Information on the Political Reform Act and how it affects Commissioners

3) The Commission's Conflict of Interest Code

4) The Commission's Rules of Procedure

5) List of Commission meeting dates and locations

6) Any other documents that may be helpful to the Commissioner to fulfill the Commissioner's responsibilities on the Commission

~~1) Listing of names, addresses, and contact information for the Commission members;~~

~~2) Listing of names and contact information for MHSOAC Staff~~

~~3) Copy of the Rules of Procedure~~

~~4) Brief history and overview of MHSOAC including mission, purpose statement, and Proposition 63~~

~~5) Information about the Political Reform Act and how it affects the Commissioners~~

~~6) Information about the travel reimbursement procedures~~

~~7) List of meeting dates and locations~~

~~8) Copy of the Bagley-Keene Open Meeting Act~~

~~9) Summary of Robert's Rules of Order~~

~~10) Copy of the following documents:~~

~~a) Mental Health Services Act Prevention and Early Intervention: County and State Level Policy Direction;~~

~~b) Recommendation to the MHSOAC for funding for Innovative Programs;~~

~~c) Eliminating Stigma and Discrimination Against Persons with Mental Health Disabilities;~~

~~d) Mental Health Services Oversight and Accountability Commission Report on Co-Occurring Disorders;~~

~~e) Mental Health Services Oversight and Accountability Commission Position Paper on Training and Education;~~

~~f) Any other policy paper adopted by the Commission~~

C. As required by Government Code Sections 11146 through 11146.4 and 12950.1, within six months of beginning service as a ~~member of the~~ Commissioner and at least every two years thereafter, ~~members of the~~ Commissioners shall receive training on laws related to ethics, conflict of interest requirements, governmental transparency, open government, ~~and~~ fair government processes, and sexual harassment and abusive conduct prevention.

1.8 Statement of Economic Interest – Form 700

Each Commissioner is required by the California Political Reform Act and the corresponding regulations to file a Statement of Economic Interests, Form 700: (1) within 30 days of being appointed; (2) on a yearly basis as prescribed by law; and (3) within 30 days of ending Commission membership.

1.9 Conflict of Interest

A. Presence of a conflict of interest prohibits Commissioners ~~(~~as public officials~~)~~ from participating in discussion about or taking action on an item. Provisions in California statutes, regulations, and case law define and provide guidelines related to conflict of

interest. A Commissioner shall not make, participate in making, or in any way attempt to use ~~his or her~~ the Commissioner's official position to influence a Commission decision in which ~~he or she~~ the Commissioner knows or has reason to know ~~he or she~~ the Commissioner has a financial interest (Government Code Section 87100). Additionally, Commissioners must be guided solely by the public interest, rather than by personal interest, when dealing with contracting in an official capacity (Government Code Section 1090 et seq.).

B. A Commissioner who has a financial conflict of interest shall ~~must~~ do the following:

1) Notify the Executive Director as soon as possible if any agenda item presents a potential conflict of interest. This will prepare the Chair to announce the Commissioner's nonparticipation in any discussion, deliberation or vote when the item comes up.

2) Publicly identify, in enough detail to be understood by the public, the financial interest that causes the conflict of interest or potential conflict of interest.

3) Recuse ~~himself or herself~~ themselves from discussing or voting on the matter or from attempting to use ~~his or her~~ their position to influence the decision.

~~The Commission will adopt for itself and adhere to an Incompatible Activities Policy.~~

1.10 Commission Representation

A. Every Commissioner ~~member of the MHSOAC has~~ retains the right to express ~~his or her~~ their opinion on any subject whenever the ~~member~~ Commissioner is acting as an individual and not on behalf of ~~or at the expense of~~ the Commission.

B. Commissioners who agree to represent the Commission ~~in meetings, conferences, testimony in public hearings, speaking engagement, etc,~~ and do so at the request of the Commission, ~~with or without reimbursement,~~ agree ~~also~~ to represent only the officially approved positions of the Commission or a complete and accurate presentation of issues under consideration by the Commission. Commissioners whose personal positions are in conflict with the Commission's official positions must represent either the Commission's positions only or decline the request to represent the Commission.

C. A Commissioner is considered to be acting officially on behalf of the Commission whenever ~~he or she~~ the Commissioner states or implies that ~~he or she is~~ they are acting as a representative or member of the Commission, whenever the ~~member~~ Commissioner is authorized by the Commission to represent it, or the activity of the ~~member~~ Commissioner results in an expense~~, direct or indirect~~ to the Commission. ~~Examples of such expenses include but are not limited to compensation for travel, per diem, phone calls, postage, use of Commission stationary, or other materials produced or furnished by the Commission~~.

D. Nothing shall prevent ~~members of the~~ Commissioners from expressing their views as individuals in ~~regular or special meetings of the~~ Commission meetings or activities when these views bear directly upon policy issues under discussion.

EXECUTIVE DIRECTOR

2.1 Duties of the Executive Director

A. The Executive Director is appointed and discharged by the Commission ~~MHSOAC~~. The Executive Director acts under the authority of, and in accordance with direction from the Commission ~~MHSOAC~~. ~~Commissioners should direct their requests for information or assistance from staff to the Executive Director.~~

B. The Executive Director represents the Commission and advances its goals by working with California's constitutional officers, federal, state and local agencies, national and international organizations, private sector leaders, and other stakeholders.

~~The Executive Director also serves as the Commission's liaison with, county commissions, other mental health associations and stakeholder groups~~.

C. The Executive Director presents to the Commission the annual budget and expenditures at the beginning of the fiscal year for Commission adoption, a mid-year expenditure report, and a close-of-year expenditure report.

D. The Executive Director fulfills the responsibilities set forth in the Executive Director's duty statement and implements the delegated authority specified in the Rules of Procedure.

~~a) Achieving the results set forth in the Multi-Year Strategic Plan of the MHSOAC within the appropriate and ethical standards of business conduct set by the Commission and the State of California;~~

~~b) Plan, organize, direct, and administer all activities, programs and functions of the MHSOAC;~~

~~c) Respond to direction from the Chair to develop ideas for programs and/or initiatives reflecting the MHSOAC's goals.~~

~~d) Direct the preparation of all reports to be submitted by the MHSOAC to the Governor and Legislature;~~

~~e) Direct the preparation of the MHSOAC's annual budget for review by the Chair and submission to the Department of Finance, and/or the Legislative Analyst;~~

~~f) Direct the implementation of all federal and state statutes and regulations and Commission policies that require action by staff, administer the civil service system (including hiring, evaluating and terminating all employees), attend meetings of the Commission and report on the general affairs of the Commission, and keep the Commission advised as to the needs of the MHSOAC.~~

2.2 Designation of Acting Executive Director

When the Executive Director is absent or otherwise unavailable to perform the duties set forth in these Rules of Procedure ~~of the office~~, the Executive Director may designate in writing another person to act on the Executive Director's behalf. Within 24 hours of such delegation the Executive Director shall notify the Chair and Vice Chair of the delegation including the scope and duration of the delegation.

2.3 Evaluation of Executive Director

The Commission shall in closed session evaluate the Executive Director's performance on an annual basis. Prior to the closed session evaluation, the Chair and Vice Chair will provide the Executive Director with a performance review to be discussed in the closed session evaluation. The evaluation will be based on the ~~MHSOAC's accomplishment of the Commission's Multi-Year Strategic Plan;~~ performance goals and professional development objectives adopted ~~annually~~ by the Commission and the Executive Director's duty statement ~~developed and adopted by the Commission~~.

2.4 Contract Authority. ~~Pursuant to the MHSOAC Resolution adopted on March 24, 2011,~~

A. The Executive Director has the authority to take all actions necessary to enter into contracts on the Commission's behalf ~~of the MHSOAC~~ in the amount of ~~$100,000~~ $200,000 or less and to enter into Interagency Agreements in the amount of ~~$200,000~~ $400,000 or less. ~~The Executive Director may delegate to subordinates any of the authority delegated to the Executive Director by the MHSOAC. Within 24 hours of such delegation the Executive Director shall notify the MHSOAC Chair and Vice Chair~~.

B. The Executive Director, with the consent of the Chair and Vice Chair, has the authority to take all actions necessary to enter into contracts on the Commission's behalf in the amount of $500,000 or less and to enter into Interagency Agreements in the amount of $750,000 or less.

2.5 Authority ~~of the Executive Director~~ to Advocate on Legislation.

A. The Commission is authorized to advise the Governor and Legislature regarding actions the State may take to improve the mental health care and services of Californians. As part of this authority, the Commission may advocate on legislation.

B. The Executive Director, or ~~his or her~~ the Executive Director's designee, is authorized on behalf of the ~~MHSOAC~~ Commission to advocate on legislation: (1) when the legislation ~~is consistent with~~ advances a formally established ~~an officially approved~~ position of the Commission; or (2) when the legislation advances an informal or emerging position of the Commission after consultation with the Chair and Vice Chair. ~~at the direction of the Chair and when the legislation furthers the interest of the Commission~~.

C. The Executive Director shall give an update of all advocacy efforts, except confidential budget proposals, taken on behalf of the Commission at the next Commission meeting following the advocacy efforts.

2.6. Authority to Approve Innovation Projects.

A. The Executive Director, with the consent of the Commission Chair, is authorized to approve a county Innovation plan that meets any of the following conditions:

1) The county Innovation plan, plan extension or modification does not raise significant concerns or issues and includes total MHSA Innovation spending authority of $1,000,000 or less.
2) The county Innovation plan is substantially similar to a county Innovation proposal that has been approved by the Commission within the past three years, if in the judgement of the Executive Director,
    a) differences in the county Innovation proposal and a previously approved plan are not material to concerns raised by the Commission in its previous review and are non-substantive, and
    b) the new project furthers the ability of the previously approved Innovation plan to support statewide transformational change.

B. The Executive Director shall publicly report to the Commission, at the next Commission meeting ~~at the first available opportunity~~, any county Innovation plan approved by the Executive Director on behalf of the Commission under this delegated authority.

~~**2.6 Authority to Approve Additional Funding for Previously Approved Innovation Projects**~~

~~The Executive Director, or his or her designee, is authorized to approve a county's request to expend additional Mental Health Services funding in an amount not to exceed $500,000 or 15% of the total project, whichever is less, for an Innovation project that has been previously approved.~~

LEGAL COUNSEL

3.1 Duties of Chief Legal Counsel

A. Chief Counsel provides legal advice to the ~~MHSOAC~~ Commission and ~~The Chief Counsel~~ reports both to the ~~MHSOAC~~ Commission and to the Executive Director.

B. Chief Counsel is responsible for, among other things, advising staff regarding all relevant legal matters and supporting the legal inquiries and meeting activities of the ~~MHSOAC~~ Commission.

C. In situations where the Chief Counsel ~~would have~~ may have a conflict of interest, or where legal expertise outside the practice of Chief Counsel is imperative, the Commission may consult ~~consultation~~ with the office of the Attorney General or another state department. ~~via an interagency agreement is available.~~

D. Counsel shall not provide legal counsel to members of the Commission except in their role as members of the ~~MHSOAC~~ Commission.

3.2 Hiring Chief Counsel

A. The Executive Director is responsible for hiring and discharging the Chief Counsel.

B. The Executive Director is responsible for evaluating the Chief Counsel's performance with input from the ~~MHSOAC~~ Commission and staff.

COMMISSION MEETINGS

4.1 Frequency of Meetings

A. ~~MHSOAC~~ Commission meetings are to be held as often as is necessary to enable the Commission to fully and adequately perform its duties, but ~~it shall not meet~~ not less than once each quarter. ~~at any time and location convenient to the public as it may deem appropriate~~. All meetings shall be open to the public pursuant to the Bagley-Keene Open Meeting Act.

B. The ~~MHSOAC~~ Commission meeting schedule for the ~~following~~ calendar year is approved ~~prior to~~ in January of that calendar year.

4.2 Robert's Rules of Order

Robert's Rules of Order will be used as a guide at ~~the~~ Commission ~~and Committee~~ meetings.

4.3 Open Meetings

A. Commission meetings are subject to the Bagley-Keene Open Meeting Act set forth in Government Code Sections 11120 et seq.

~~The principal law that governs the meetings of the MHSOAC and its Committees is the Bagley-Keene Open Meeting Act which is set forth in Government Code Sections 11120 et seq.~~

~~**4.4 Serial Meetings**~~

B. The Bagley-Keene Open Meeting Act prohibits ~~the MHSOAC~~ Commissioners from using direct communication, personal intermediaries, or technological devices to discuss, deliberate, or take action outside of an open meeting (Government Code Section 11122.5 (b)). Serial meetings are also prohibited. A serial meeting is a series of communications, each of which involves less than a quorum of the Commission, but which taken as a whole involves a majority of the Commission's members. (Government Code Section 11122.5 ~~11121~~).

~~4.5~~ 4.4 Agenda Items

A. A Commission meeting agenda may include action or information items.

B. Action items that are non-controversial or pro forma may be placed on the consent calendar. All items on the consent calendar are voted upon as one unit and are not voted upon as an individual item. At the meeting any Commissioner may ask that a matter be removed from the consent agenda and that request shall be effective without further action. If a matter is removed from the consent agenda it ~~shall~~ may be discussed at ~~a point in~~ the same meeting or at a different Commission meeting as deemed appropriate by the Commission. There shall be no discussion or presentations made concerning items that remain on the consent agenda.

~~Information items consist of presentations made to Commissioners to give background to an issue, an update, or may be in response to a Commissioner's inquiry. Since all agenda items are subject to action by the Commission there may be information items upon which the Commission decides to take action.~~

~~Staff prepares briefing materials on each agenda item and provides Commissioners with those materials in advance of the meeting. These materials provide Commissioners with a detailed description of a proposed course of action, background information, fiscal impact, the pros and cons of taking the action, and similar information for alternative actions.~~

~~4.6~~ 4.5 Request for Item to be Placed on the Agenda

A. Agenda items are placed on the Commission's meeting agenda with the approval of the Chair and Executive Director. The final meeting agenda is approved by the Chair and the Executive Director after consultation with the Chief Counsel.

B. Individual Commissioners wishing to place items on the agenda should contact the Chair or the Executive Director.

C. Members of the public wishing to place items on the agenda should contact Commission staff.

~~Agenda items shall only be placed on the Commission's agenda at the request of (1) a Committee of the MHSOAC; (2) a member of the MHSOAC; or (3) MHSOAC staff with the approval of the Executive Director. Members of the public wishing to place items on the agenda must go through one of the above~~.

~~Before agenda and meeting packets are finalized, they shall be reviewed by the Chair of the Commission, the Executive Director, Chief Counsel. The Chair of the Commission, the Executive Director, and the Operations Committee shall work together to develop and set the Commission agendas~~.

~~4.7~~ 4.6 Exhibits and Handouts

A. Agendized presenters who are not associated with the Commission may provide exhibits and handouts related to their presentation for distribution at the Commission meeting and are encouraged to submit them to the Commission at least two weeks before the meeting.

Additionally, they are encouraged to provide the materials in an electronic format that meets federal and state accessibility standards.

B. The Commission will make the above-mentioned materials available to the public by publishing them on the Commission website in a format that meets federal and state accessibility standards. The Commission will also send a notice to the Commission's list-serve that the materials have been published on the website.

C. If the above-mentioned materials were received by the Commission within a reasonable time before the meeting date, the Commission will also make those materials available in printed format for public inspection on the day of the meeting.

~~Presenters may provide exhibits and handouts for distribution to the Commissioners. Presenters are encouraged to provide sixteen copies to the Commission office for distribution to the Commissioners and staff. Staff at least two weeks before the Commission meeting. Staff will post the material on the Commission website and notice of the posting will be emailed to the MHSOAC list-serve. The materials will also be made available to the public at the meeting.~~

~~4.8~~ 4.7 Public Agenda Notice ~~(PAN)~~

A. A public agenda notice of any Commission meeting must be ~~given and~~ made available on the Commission's website at www.MHSOAC.ca.gov, at least 10 calendar days before the meeting. The ~~PAN~~ public agenda notice will also be emailed to the ~~MHSOAC~~ Commission's list-serve. A copy of the public agenda notice will also be sent to any person who requests one in writing ~~it a PAN in writing must be sent a copy~~ (Government Code Section 11125).

B. The ~~PAN~~ public agenda notice of a Commission meeting must include the name, address, and telephone number of the individual who can provide additional information prior to the meeting and the address of the internet site where notices are posted (Government Code Section 11125).

C. The ~~PAN~~ public agenda notice of a Commission meeting must also include a specific agenda for the meeting containing a brief description of the items of business to be transacted or discussed in either open or closed session. No agenda items may be added after the ten-day period begins, unless permitted by specific exceptions set forth in the Bagley-Keene Open Meeting Act (Government Code Section 11125).

D. ~~Upon request by a person with a disability the PAN~~ The public agenda notice of a Commission meeting shall also be made available in appropriate alternative formats as required by Section 202 of the American with Disabilities Act of 1990 and the federal rules and regulations adopted in implementation thereof. The ~~PAN~~ public agenda notice shall include information regarding how, to whom, and by when a request for any disability-related modification or accommodation including auxiliary aids or services may be made by a person with a disability who requires these aids or services in order to participate in the public meeting (Government Code Section 11125).

~~4.9~~ 4.8 Availability of Commission Meeting Materials

A. ~~PANs~~ The public agenda notice and all other materials distributed to the Commissioners prior to or at a Commission meeting are public records and as such are subject to disclosure, unless a recognized exemption applies under California Public Records Act, set forth in Government Code Sections 6250 et seq. or the Bagley-Keene Open Meeting Act set forth in Government Code Sections 11120 et seq. Commission meeting materials are available to the public at www.MHSOAC.ca.gov ~~as attachments to the PAN~~. The Commission will also make meeting materials ~~are also~~ available for public inspection in printed format on the day of the meeting.

B. The Bagley-Keene Open Meeting Act provides that unless a specific exemption applies, materials ~~writings~~ pertaining to agenda items ~~that are public records and have been~~ distributed to the Commission by the staff or individual Commissioners prior to or during the meeting must be made available for public inspection at the meeting. Materials pertaining to agenda items ~~or if~~ prepared by a ~~some~~ person other than staff or a Commissioner shall be made available after the meeting. In addition, the materials ~~writing~~ shall be distributed to all persons who request or have requested copies of the materials ~~writings~~ and will be ~~made~~ available on the ~~MHSOAC~~ Commission's website.

~~4.10~~ 4.9Closed Sessions

A. Any closed session must be noted on the meeting agenda and properly noticed, citing the statutory authority or provision of the Bagley-Keene Open Meeting Act that authorizes the ~~particular~~ closed session. The Commission may only hold closed sessions for the reasons set forth in the Bagley-Keene Open Meeting Act. ~~Pursuant to the Bagley-Keene Open Meeting Act, the following matters may be properly conducted in closed session:~~

- ~~To consider the appointment, employment, evaluation of performance, discipline or dismissal, as well as to hear charges or complaints about a Commission employee's actions (Government Code Section 11126(a)(1)).~~
- ~~To confer with or receive advice from legal counsel regarding pending litigation when discussion in open session would prejudice the Commission's position in the litigation (Government Code Section 11126(e)(1)).~~

B. Prior to convening a closed session, the Chair must publicly announce those issues that will be considered in closed session (Government Code Section 11126.3). This can be done by a reference to the item as properly listed on the agenda. After the closed session has been completed, the ~~MHSOAC~~ Commission must reconvene in public prior to adjournment (Government Code Section 11126.3). If the closed session involved a decision to hire or fire an individual the Chair is required to report the action taken, and any roll call vote taken.

C. Chief Counsel will attend each closed session and keep and enter in a minute book a record of topics discussed and decisions made at the meeting. These minutes are confidential, maintained ~~in a sealed envelope~~ by Chief Counsel, and are discoverable

only to the Commission itself or to a reviewing court. The minutes may, but need not, consist of a recording of the closed session. (Government Code Section 11126.1)

~~4.11~~ 4.10 Teleconference Meetings

Pursuant to the Bagley-Keene Open Meeting Act ~~provides that~~ the ~~MHSOAC~~ Commission ~~or committees~~ may hold a meeting by audio or audio-visual teleconference for the benefit of the public and the Commission ~~or committee~~ (Government Code Section 11123). All ~~PAN~~ public agenda notice requirements apply.

~~4.12~~ 4.11Quorum

A. A simple majority of the Commission's statutory membership shall constitute a quorum for the transaction of business. The Commission's statutory membership is 16 members making nine members a quorum. A majority of the quorum (i.e. five members) may act to bind the Commission.

B. A meeting at which a quorum is initially present may continue, notwithstanding the withdrawal of Commissioners and the absence of a quorum. The only action that may be taken in the absence of a quorum is to fix the time in which to adjourn, recess, or take measures to obtain a quorum.

~~Every act or decision done or made by a majority of the Commissioners present at the meeting duly held at which a quorum is present, shall be regarded as binding. A meeting at which a quorum is initially present may continue to transact business, notwithstanding the withdrawal of Commissioners below a quorum, if any action taken is approved by at least a majority of the required quorum for the meeting.~~

~~4.13~~ 4.12Voting

A. After a motion is made, seconded, and public comment has been heard, the Commission may vote. A Commissioner must be present to vote.

B. A Commissioner ~~member~~ who is disqualified in a matter because of financial contributions, financial interest, or another conflict is not entitled to vote. The Commissioner is required to announce at the meeting that the Commissioner ~~he or she~~ "will not participate" and disclose the reasons for the disqualification on the record. This information is noted in the meeting minutes.

C. A Commissioner may "abstain" from voting, if the Commissioner ~~he or she~~ is entitled to participate but chooses not to. The reason for abstaining ~~not participating~~ need not be disclosed on the record.

D. Prior to voting on a policy project report, the Commission shall consider the report in at least one meeting prior to the meeting at which the motion to approve is considered. This requirement shall not apply if the report was previously discussed in a public meeting of a Commission subcommittee and the subcommittee recommended Commission adoption of the report.

~~Any proposed policy item on the agenda, along with its corresponding language/documents, shall be presented for discussion at a Commission meeting at least one (1) meeting prior to the meeting at which the vote on the issue is taken.~~

~~The Commission may take action, by a simple majority, on an agenda item at the same meeting that the item is presented if the Commission deems that there exists a need to take action.~~

~~Approval of county MHSA Innovation Plans is exempt from this review schedule and may be voted upon at the Commission meeting at which they are first presented by staff and need not be posted 30 days before the meeting.~~

~~4.14~~ 4.13Public Comment

A. Opportunity is provided for the public to address the Commission on agenda items. The Commission may adopt reasonable procedures so that members of the public have an opportunity to directly address the Commission on each agenda item before the Commission. These procedures may include limiting the total amount of time allocated for public comment on a specific agenda item ~~particular issues~~ and for each individual speaker. (Government Code Section 11125.7)

B. If the agenda item has already been considered by a subcommittee or committee composed exclusively of members of the Commission at a public meeting where interested members of the public were afforded the opportunity to address the subcommittee or committee on the item, additional public comment opportunity at the Commission meeting need not be provided unless the item has been substantially changed since the subcommittee or committee heard the item. (Government Code Section 11125.7)

C. Members of the public who wish to provide public comment at a meeting are encouraged to complete a public comment card but are not required to do so. ~~The meeting coordinator will request anyone planning to speak to complete a public comment card~~.

~~It is the policy of the Commission to vet issues as much as is practical through the MHSOAC standing committees before those issues are brought to the full Commission. It is the responsibility of the committee chair to engage stakeholder participation at the committee level and to report back to the full Commission. Public comment and stakeholder involvement at the committee level does not replace public comment at the Commission meetings.~~

~~4.15~~ 4.14 Access to Commission Meeting Sites

Commission meeting sites are accessible to people with disabilities and should also be accessible by public transportation. Those who need special assistance may contact the meeting coordinator listed on the public agenda notice of the meeting.

~~4.16~~ 4.15 Minutes and Motion Summaries

Minutes and motion summaries of each open session meeting are included in the meeting materials and posted on the Commission website at: www.MHSOAC.ca.gov. ~~distributed to Commissioners, the Executive Director, Chief Counsel, and selected staff for review~~. ~~After review and Commission approval, minutes and motion summaries are published on the MHSOAC Commission website at: www.MHSOAC.ca.gov.~~

PUBLIC OUTREACH AND ENGAGEMENT

5.1 The Commission seeks to ensure the perspective and participation of diverse community members and others with mental health challenges and their families are a significant factor in the Commission's decisions and recommendations. The Commission ensures this through:

- Public hearings that have open, informed, and transparent deliberation.
- Committee and subcommittee meetings that hear from community members and other subject matter experts to develop a shared understanding of the challenges and opportunities of topics specified by the Commission.
- Community forums and listening sessions that are organized to highlight and understand topics specified by the Commission.
- Site visits that are organized to acquire first-hand knowledge and understanding of the challenges of specific topics and the existing efforts to address those challenges.

COMMITTEES/SUBCOMMITTEES/OTHER MULTI-MEMBER BODIES

6.1 ~~5.1~~ ~~Committee~~ Structure

A. The ~~MHSOAC~~ Commission ~~shall~~ may establish one or more ~~standing~~ committees as necessary to provide technical and professional expertise pursuant to Welfare and Institutions Code Section 5845 (d)~~(2)~~(3). Such committees provide guidance, review materials, and make recommendations to the ~~MHSOAC~~ Commission and, in rare instances, when given explicit and written delegated authority by the ~~MHSOAC~~ Commission, make decisions on behalf of the ~~MHSOAC~~ Commission.

A.1. The Commission Chair~~-elect~~ shall appoint a Chair and Vice Chair for each ~~standing~~ committee from among the Commission's membership who will assume their duties immediately upon appointment. ~~The Chair and Vice-chair for each standing Committee will assume his or her duties in January following the year he or she was appointed. Each year the Commission Chair may reappoint a Committee Chair and Vice-chair.~~

A.2. ~~Ideally~~ Each ~~standing~~ committee shall have a maximum of 15 members and may ~~shall~~ include public membership. Public membership of each committee shall be selected by the committee Chair and Vice Chair for a one-year term. Of this public membership, the committee Chair and Vice Chair shall seek individuals with the desired expertise who are consumers, family members or care givers of consumers, and members of underserved ethnic and cultural communities. ~~at least two shall be consumers, at least two shall be family members or care givers of consumers, and at least two shall be members of underserved ethnic and cultural communities. Public membership of each committee shall be selected by the committee Chair and Vice Chair.~~ In their recruitment and appointment of committee members, committee Chair and Vice Chair shall pay special attention to issues related to cultural diversity and competency and the needed expertise to support the committee's goals. Commission staff and/or consultants will staff each committee.

A.3. The committee Chair may establish one or more multi-member body consisting of committee members in order to further the work of the committee.

A.4. If a committee member cannot attend a committee meeting the member shall notify the committee Chair and the committee staff member of such absence in advance of the committee meeting. If a committee member misses more than one committee meeting without notice or three committee meetings in a calendar year with notice, the committee Chair has discretion to decide whether it is in the best interest of the committee to have that committee member replaced.

~~The membership of each Committee will be confirmed every other year in odd numbered years at the January MHSOAC meeting. In the intervening time each Committee Chair has discretion to modify the Committee membership based upon the needs of the Committee.~~

~~The MHSOAC may establish an Operations Committee that is composed of the Chair or the Vice-chair of each standing Committee. The Commission Chair and Vice-chair are the Chair and Vice-chair of the Operations Committee. The Operations Committee is exempt from the public membership listed above and it is not authorized to take policy positions on behalf of the Commission unless the Commission specifically delegates such authority.~~ Convenience

B. The Commission may establish any multi-member body (e.g. committee, subcommittee, taskforce) consisting of Commissioners appointed by the Chair as necessary to support the work of the Commission.

6.2 ~~5.4~~ Bagley-Keene Open Meeting Act

A. Meetings of a committee, subcommittee, and multi-member body are subject to the Bagley-Keene Open Meeting Act set forth in Government Code Sections 11120 et seq. ~~The principal law that governs the meetings of the MHSOAC and its Committees is the~~

~~Bagley-Keene Open Meeting Act which is set forth in Government Code Sections 11120 et seq.~~

B. A public agenda notice of a committee, subcommittee, or multi-member body meeting must be given and made available on the MHSOAC website at www.MHSOAC.ca.gov, at least 10 calendar days before the meeting. The public agenda notice will also be emailed to the Commission's list-serve. A copy of the public agenda notice will be sent to any person who requests it in writing ~~a PAN in writing must be sent a copy~~.

C. The public agenda notice of a committee, subcommittee, or multi-member body meeting must include the name, address, and telephone number of the individual who can provide additional information prior to the meeting and the address of the internet site where notices are posted.

D. The public agenda notice of a committee, subcommittee, or multi-member body meeting must also include a specific agenda for the meeting containing a brief description of the items of business to be transacted or discussed. No agenda items may be added after the ten-day period begins, unless permitted by specific exceptions set forth in the Bagley-Keene Open Meeting Act. (Government Code Section 11125)

E. ~~Upon request by a person with a disability the PAN~~ The public agenda notice of a committee, subcommittee, or multi-member body meeting shall also be made available in appropriate alternative formats as required by Section 202 of the American with Disabilities Act of 1990 and the federal rules and regulations adopted in implementation thereof. The ~~PAN~~ public agenda notice shall include information regarding how, to whom, and by when a request for any disability-related modification or accommodation including auxiliary aids or services may be made by a person with a disability who requires these aids or services in order to participate in the public meeting.

F. A committee, subcommittee, or other multi-member body may hold a meeting by audio or audio-visual teleconference (Government Code Sections 11123 and 11123.5). All public agenda notice requirements apply.

6.3 ~~5.3~~ Compensation and Expenses

~~Commissioners, staff,~~ Active members of committees, subcommittees or any other multi-member body and agendized presenters ~~and active Committee members will be~~ are eligible to be reimbursed in accordance with State per diem laws. ~~Also, any reasonable business expenses incurred will be reimbursed as authorized by the Commission. On a case-by-case basis a Committee member designee may also be reimbursed in accordance with the State per diem laws.~~

~~5.4 Public Agenda Notice (PAN)~~

~~A Notice of any Committee meeting must be given and made available on the MHSOAC website at www.MHSOAC.ca.gov, at least ten (10) calendar days before the meeting. The PAN will also be emailed to the MHSOAC list-serve. Any person who requests a PAN in writing must be sent a copy. The notice must include:~~

- Name, address, and telephone number of the individual who can provide additional information prior to the meeting
- Address of the internet site where notices are posted
- Specific agenda for the meeting containing a brief description of the items of business to be transacted or discussed.

Upon request by a person with a disability the PAN shall also be made available in appropriate alternative formats as required by Section 202 of the American with Disabilities Act of 1990 and the federal rules and regulations adopted in implementation thereof. The PAN shall include information regarding how, to whom, and by when a request for any disability-related modification or accommodation including auxiliary aids or services may be made by a person with a disability who requires these aids or services in order to participate in the public meeting.

WORKGROUPS

6.1 Establishment of Workgroups

The MHSOAC and its committees may establish workgroups, to focus on a specific dimension of the Commission or Committees' work. The workgroup is project focused with specific time limited deliverables.

The membership of the Workgroups will consist of a smaller body of Committee members who volunteer or are appointed by the Committee Chair and Vice-chair.

Enclosure 5

P.O. Box 388, 815 Marina Vista, Suite D, Martinez, CA 94553
Email: casra@casra.org
Phone: (925) 229-2300
Fax: (925) 229-9088
www.casra.org

March 1, 2020

Mental Health Oversight and Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814

RE: CASRA Opposition to Proposed Changes to Rules of Procedure

On behalf of the members of the California Association of Social Rehabilitation Agencies (CASRA), we wish to respectfully express our opposition to the January 2020 proposed changes.

I. *Increase the authority of the Executive Director to enter into contracts up to $750,000 without approval by the Commission or notice to the public.* We do not support this change. The proposed changes reduce transparency and allows the Executive Director too much discretion on funding projects.
II. *Allow the Executive Director to advocate an "informal or emerging position" at the Legislature without approval of the full commission.* We would support this change if the Commission adopts a statement of values and principles to guide any such position.
III. *Allow the Commission to vote on an agenda item without public comment (if that item was considered at a prior committee meeting.* We do not support this change. There are serious challenges to stakeholder involvement in decision-making and we believe that stakeholders should be offered the opportunity to comment prior to any vote on a substantive issue.
IV. *Remove the requirement of the Commission to establish committees.* We do not support this change. We believe that a robust committee structure is the key to ensuring that policy issues and decisions are made based on a full exploration and discussion of the topic.
V. *Remove the requirement for members of the public to be appointed to Commission committees.* We do not support this change. The MHSA is very explicit about the need for government to collaborate and consult with community stakeholders. The most effective strategy to support such involvement is through participation in committees.
VI. *Remove the requirement for consumers, family members and members of racial, ethnic and cultural communities to be appointed to committees.* If the Commission is going to utilize a committee structure, it is imperative that a significant effort be made to include representatives of these constituencies. However, we do acknowledge that this is sometimes very difficult as many potential participants do not have the time and/or support to attend meetings.

We appreciate your consideration of our point of view. If you have any questions, please contact me at betty@casra.org or 925-212-3824.

Sincerely,

Betty Dahlquist

Betty Dahlquist, MSW, CPRP
Executive Director

"A Diagnosis is Not a Destiny"

Enclosure 5

PEERS, 333 Hegenberger Road, Suite 250, Oakland, CA 94621
http://www.peersnet.org; Telephone: (510) 832-7337; Fax: (510) 452-1645

April 3, 2020

Commissioner Ashbeck, Chair
Commissioner Madrigal-Weiss, Vice Chair
Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814

Dear Commissioners Ashbeck and Madrigal-Weiss:

We appreciate the opportunity to comment on Proposed Changes to the MHSOAC Rules of Procedure. Peers Envisioning and Engaging in Recovery Services (PEERS) is a consumer-run mental health organization with a mission of eliminating mental health stigma through support groups, workshops, and community outreach. We serve a diverse group of people with mental health experiences, primarily low-income transition-age youth, adults, and older adults of color in Alameda County.

Our primary concern is that many of the proposed changes to the Rules of Procedure, regardless of the intention, will diminish opportunities for meaningful involvement of mental health consumers, family members, and underserved communities. Consensus about the requirement that these three groups be involved in decision-making at every level is a key principle of the Mental Health Services Act, and continues to be critical to ensuring that the MHSOAC lives up to the promise of transforming California's mental health system to one that supports the wellness, recovery, and resilience of all Californians.

Below are the proposed changes to the MHSOAC's Rules of Procedure that PEERS does not support:

1) Changes to the Mission (p.1 of the Proposed January 2020 amendments to Rules of Procedure):

The proposed revision of the mission statement removes language that we see as critical to the mission of the OAC. This language emerged from the collaborative work of many stakeholders and reflects the broad — and hard-won —consensus among consumers, family members, providers, and policymakers that was forged in the Prop 63 process. This language is fundamental to the promise of transforming the mental health system that is at the core of the Mental Health Services Act.

a) Deletion of "in collaboration with clients, their family members and underserved communities:" The naming of each of these three groups in the mission ensures that each is a critical partner in the work of the MHSOAC. The proposed language of "partnerships" does not ensure that people with mental health challenges, family members, and underserved communities will be among the partnerships. Long experience has shown that unless these groups are specifically named, we often are excluded from such partnerships. We contend that the full partnership of people with mental health challenges, family members, and underserved communities is a fundamental part of system transformation.

b) Deletion of "eliminating disparities:" The proposed mission statement does not mention disparities and refers only to "effective and culturally competent care." Such care is necessary, but not sufficient to eliminate disparities. The causes of disparities in mental health are complex and related to multiple inequities in the social determinants of health. Failing to state that eliminating disparities is part of the mission of the MHSOAC represents back-sliding in this key area.

c) Deletion of "promoting mental wellness, supporting recovery and resiliency:" Including explicit language that names wellness, recovery, and resilience in the MHSOAC's mission is a critical part of "transformational change across systems." Language that specifies the direction of such change or transformation is essential to ensuring that the system is changed in ways that are consistent with the vision of the many stakeholders who jointly created the Mental Health Services Act — in particular with the vision and experience of the consumer movement.

2) Decreasing opportunities for stakeholder involvement in contracting, advocacy on legislation, and approval of Innovation projects (p.9-10 of the Proposed January 2020 amendments to Rules of Procedure):

a) Doubling the dollar amount of contracts and Interagency Agreements that the Executive Director may enter into on the Commission's behalf (2.4.A) and allowing the Executive Director to enter into contracts up to $500,000 and Interagency Agreements of up to $750,000 with only the consent of the Chair and Vice Chair (2.4.B) reduce transparency and decrease opportunities for the public, consumers, family members, members of underserved communities, and even Commissioners other than the Chair and Vice Chair, to comment on and inform those decisions.

b) Increasing the authority of the Executive Director (2.5.B) to advocate on legislation on behalf of the Commission "when the legislation advances an informal or emerging position" after consultation with only the Chair and Vice Chair disempowers members of the Commission other than the Chair and Vice Chair, decreases transparency, and eliminates the public's opportunity to comment on these positions.

c) Granting the Executive Director the authority to approve Innovation projects or plans of up to $1,000,000 with only the consent of the Commission Chair (2.6.A) deprives the public of the opportunity to comment on these projects and plans and decreases transparency.

3) Decreasing requirements for the involvement of consumers, family members, and members of underserved ethnic and cultural communities in committees (p. 17-18):

   a) Eliminating the requirement of the Commission to establish committees (6.1.A) reduces opportunities for the public to influence the Commission's decisions. We strongly believe that the involvement of a wide range of stakeholders, including those most affected (people with mental health challenges and their families, including those who are currently unserved, underserved, or inappropriately served) increases the quality of decision making. Committee meetings that allow for an open exchange of ideas is an important mechanism for increasing the quality of decisions.

   b) Removing the requirement that committees include public membership and removing the requirement that at least two members be consumers, at least two members be family members or caregivers of consumers, and at least two be members of underserved ethnic and cultural communities (6.1.A.2) is a major step backward. Consensus about the requirement that these three groups be involved in committees was another key principle of the Mental Health Services Act, and continues to be critical to ensuring that the MHSOAC lives up to the promise of transforming California's mental health system to one that supports the wellness, recovery, and resilience of all Californians.

Thank you for considering these concerns.

Sincerely,

Vanetta Johnson
Executive Director
PEERS

Enclosure 5

REMHDCO
Racial and Ethnic Mental Health Disparities Coalition

Summary of Analysis of MHSOAC's Proposed Changes to "Rules of Procedure"

REMHDCO considers the following the most serious of the proposed changes to the MHSOAC's Rules of Procedure. REMHDCO does not support changes proposed by staff that:

- Increase the authority of the Executive Director to enter into contracts up to $750,000 without approval by the Commission or notice to the public.

Rule 2.4 Contract Authority. (Page 9 of the MHSOAC Draft) REMHDCO believes that the Commissioners and the public must be allowed to review and comment on what the Commissions funds over $100,000 (the current limit). The proposed changes reduce transparency, and allows the Executive Director too much discretion on funding projects that do not necessarily have the support of the other Commissioners or public stakeholders. This is not in line with the principles of the MHSA and is not the type of systems change that REMHDCO supports.

- Allow the Executive Director to advocate an "informal or emerging position" at the Legislature without approval of the full Commission.

Rule 2.5 Authority of the Executive Director to Advocate on Legislation (Page 9 of the MHSOAC Draft) This new language grants authorization to the Executive Director (or designee) to advocate on legislation that advances a formally established position of the Commission, but also when the legislation advances "*an informal or emerging position of the Commission*" after consultation with the Chair and Vice Chair. What constitutes "an informal or emerging position"? MHSOAC staff should not advocate positions on bills unless the public is allowed to comment on the legislation before the full Commission, and the Commission votes to adopt a position on the legislation. It is not sufficient that only the Chair and Vice Chair are consulted.

- Allow the Commission to vote on an agenda item without public comment (if that item was considered at a prior committee meeting).

Rule ~~4.13~~ 4.12 Voting and Rule ~~4.14~~. 4.13 Public Comment (Pages 15 and 16 of the MHSOAC Draft) There have been times when Commission subcommittee meetings have been held in

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places that are not easily accessible to a large number of members of the public and state level advocates (e.g. Redding, Riverside, Monterey). There should always be opportunity for public stakeholders to comment on a report with significant policy recommendations or policy implications before the Commission takes a vote on that report.

- Remove the requirement of the Commission to establish committees.

Rule ~~6.1~~ 5.1 ~~Committee~~ Structure A. (Page 17 of the MHSOAC Draft) The most effective way for the Commission to engage community stakeholders is through regular and ad-hoc committee meetings that allow robust and open dialogue with knowledgeable and diverse public stakeholders. Both the number of standing committees and the quality of committee meetings have declined in recent years. The solution is not to weaken the policy or rule, but to restore previous committees and improve upon the current committee practices of the MHSOAC.

- Remove the requirement for members of the public to be appointed to Commission committees.

Rule 6.1 5.1 Committee Structure A.2. (Page 18 of the MHSOAC Draft) The language that removes the requirement for public membership on committee is absolutely unacceptable. The MHSA is very explicit about being consumer and family driven, and for government to collaborate and consult with community stakeholders. Having an MHSOAC committee with no community members is a step backwards and not in line with the basic and most important principles the MHSA. It is akin to having a Full Service Partnership or recovery team without having the consumer (or when appropriate, family members) on it. Please see the additional information on the Bagley-Keene Open Meeting Act in the analysis by ACCESS of Cal Voices.

- Remove the requirement for consumers, family members, and members of racial, ethnic, and cultural communities to be appointed to committees.

Rule 6.1 5.1 Committee Structure A.2. Although this section directs the Chair and Vice Chair to seek specified stakeholders for public membership, this comes directly after the proposed change that *does not require public members on any committee*. So this applies only if it is decided that a committee will have public members in the first place.

Further, REMHDCO strongly objects to removing the specific number of consumers, family members, and members of underserved racial and cultural communities required on each committee. A minimum number of participants from each special population was instituted as a safeguard to ensure that the work and the decisions of any MHSOAC committee would be *consumer and family driven, and culturally competent*. All work of the commission should take reducing disparities strongly into consideration and this is unlikely to happen unless representatives from those racial, ethnic, and LGBTQ communities are on every committee.

Enclosure 5

REMHDCO Analysis of Proposed Changes to the MHSOAC "Rules of Procedure" in Order of Location in the Document

1. Change to Mission statement.
2. Rule 1.2 The Role of Commissioners
3. Rule 1.3 Chair B. Duties of the Chair
4. Rule 1.7 Training and Orientation
5. Rule 2.1 Duties of the Executive Director
6.* Rule 2.4 Contract Authority
7.* Rule 2.5 Authority of the Executive Director to Advocate on Legislation
8. Rule 2.6 Authority to Approve Innovation Projects
9. Rule 4.3 Open Meetings
10. Rule ~~4.6~~ 4.5 Request for Item to be Placed on the Agenda
11. Rule 4.12 4.11Quorum
12.* Rule 4.13 4.12Voting
13.* Rule 4.14 4.13Public Comment
14. Rule 5.1 PUBLIC OUTREACH AND ENGAGEMENT
15.* Rule 6.1 5.1 Committee Structure

*Denotes priority or of greater importance

1. **Change to Mission statement.**
   REMHDCO does not support some proposed changes.
   Page 1

   The OAC's proposed change removes the explicit language that "the MHSOAC provides vision and leadership, ***in collaboration with clients, their family members and underserved communities***…..

   We believe that the Commission needs to keep this language in its mission statement as "*working with clients, their family members and underserved communities"* is paramount to the purpose and operation of the Commission.

   Commission staff's proposed change:

The Mental Health Services Oversight and Accountability Commission works through partnerships to catalyze transformational change across systems and ensure everyone who needs mental health care has access to and receives effective and culturally competent care.

~~The MHSOAC provides the vision and leadership, in collaboration with clients, their family members and underserved communities, to ensure an enhanced continuum of care for individuals at risk for and living with serious mental illness and their families by holding public systems accountable and by providing oversight, eliminating disparities, promoting mental wellness, supporting recovery and resiliency resulting in positive outcomes in California's community based mental health system.~~

2. **Rule 1.2 The Role of Commissioners**
   Question the removal of some existing language.
   Page 3

   Commission staff's recommended changes:
   ~~The best decisions come out of unpressured collegial deliberations and the MHSOAC seeks to maintain an atmosphere where the Commission or Committee members can speak freely, explore ideas before becoming committed to positions and seek information from staff and other members. To the extent possible the MHSOAC encourages members to come to meetings without having fixed or committed their positions in advance.~~

   Why is the above language being proposed for removal? Collegial deliberations (any deliberations) have been greatly reduced in recent years. REMHDCO would like to see more dialogue and deliberations at either Committee meetings or Commission meetings.

3. **Rule 1.3 Chair B. Duties of the Chair**
   REMHDCO proposes changes to the new language. (See italicized language.)
   Page 4

   B. Duties of the Chair

   B.1. The Chair, with input from Commissioners and staff, sets the Commission's meeting agenda, prioritizing and scheduling agenda items as appropriate, and conducts the meetings. ***The Chair should also consider agenda items proposed by members of the public.***

   In the past, there was a regular conference call between the Chair, any members of the Commission who wished to participate, any members of the public that wished to participate, and the Executive Director to develop the agenda items for each meeting. While REMHDCO is not proposing that this practice be re-instated, REMHDCO does propose changes to "*Section*

4.5 Request for Item to be Placed on the Agenda" (page 12) and adding the language above would conform to our proposed changes.

4. **Rule 1.7 Training and Orientation**
   REMHDCO proposes additions to this section.
   Page 5

   Commission Staff's proposed language:
   A. New Commissioners ~~members~~ shall within 30 days of being appointed receive training and orientation in: (1) Commission governance, policies and procedures; (2) Commission strategic directives; (3) Mental Health Services Act (MHSA) programs and issues; and (4) relevant laws and statutes.

   REMHDCO additional proposed language:
   B. In addition, the new Commissioners will receive training on the important principles of the MHSA including but not limited to:
   - Recovery
   - Consumer and family driven; community collaboration
   - Meaningful stakeholder outreach and engagement
   - Cultural competence and reducing disparities
   - Prevention and Innovation

   Representatives of the stakeholder advocacy contracts could be responsible for providing this training. All MHSOAC staff should also receive training on these principles.

5. **Rule 2.1 Duties of the Executive Director**
   REMHDCO recommends additional language to the proposed new language
   Page 8

   Commission Staff's proposed changes:
   B. The Executive Director represents the Commission and advances its goals by working with California's constitutional officers, federal, state and local agencies, national and international organizations, private sector leaders, and other stakeholders.

   ~~The Executive Director also serves as the Commission's liaison with, county commissions, other mental health associations and stakeholder groups.~~
   REMHDCO's proposed additions to the above language:

   B. The Executive Director represents the Commission and advances its *publicly approved* goals by working with California's constitutional officers, federal, state and local agencies,

national and international organizations, private sector leaders, and *especially community* ~~other~~ stakeholders.

6. Rule 2.4 Contract Authority

REMHDCO strongly opposes all the proposed changes to this section.
Page 9

Proposed language by the MHSOAC staff:

A. The Executive Director has the authority to take all actions necessary to enter into contracts on the Commission's behalf ~~of the MHSOAC~~ in the amount of ~~$100,000~~ $200,000 or less and to enter into Interagency Agreements in the amount of ~~$200,000~~ $400,000 or less. ~~The Executive Director may delegate to subordinates any of the authority delegated to the Executive Director by the MHSOAC. Within 24 hours of such delegation the Executive Director shall notify the MHSOAC Chair and Vice Chair.~~

B. The Executive Director, with the consent of the Chair and Vice Chair, has the authority to take all actions necessary to enter into contracts on the Commission's behalf in the amount of $500,000 or less and to enter into Interagency Agreements in the amount of $750,000 or less.

REMHDCO believes that the Commissioners and the public must be allowed to review and comment on what the Commissions funds over $100,000. The staff's proposed changes reduce transparency, and allows the Executive Director too much discretion on funding projects that do not necessarily have the support of the other Commissioners or public stakeholders. This is not in line with the principles of the MHSA and is not the type of systems change that REMHDCO supports.

7. Rule 2.5 Authority ~~of the Executive Director~~ to Advocate on Legislation

REMHDCO strongly opposes some of the proposed changes.
Page 9

Proposed language by the MHSOAC staff that REMHDCO opposes:

B. The Executive Director, or ~~his or her~~ the Executive Director's designee, is authorized on behalf of the ~~MHSOAC~~ Commission to advocate on legislation: (1) when the legislation is ~~consistent with~~ advances a formally established ~~an officially approved~~ position of the Commission; or (2) when the legislation advances an informal or emerging position of the Commission after consultation with the Chair and Vice Chair. ~~at the direction of the Chair and when the legislation furthers the interest of the Commission.~~

This new language grants authorization to the Executive Director (or designee) to advocate on legislation that advances a formally established

position of the Commission, but also when the legislation advances "*an informal or emerging position of the Commission*" after consultation with the Chair and Vice Chair. What constitutes "an informal or emerging position"? There should not be advocacy allowed by MHSOAC staff unless the public is allowed to comment on the legislation before the full Commission, and the Commission votes on the legislation. It is not sufficient that only the Chair and Vice Chair are consulted.

C. The Executive Director shall give an update of all advocacy efforts, except confidential budget proposals, taken on behalf of the Commission at the next Commission meeting following the advocacy efforts.

REMHDCO also opposes the addition of the language regarding "confidential budget proposals". The Executive Director should not be commenting on budget proposals (e.g. WET funding) without Commission approval and the Executive Director should give an update of all his/her advocacy efforts at the Capitol to the Commission at its regular public meeting.

8. **Rule 2.6 Authority to Approve Innovation Projects**
   REMHDCO does not support this new language.
   Page 10

   This secret approval does not allow community stakeholders from individual counties the opportunity to comment on their county's Innovation Plan. Commissioners and public stakeholders should be allowed to be aware of and comment on program or program change of $1,000,000. Further, Innovation Programs were not supposed to be considered "innovative" if they were being implemented or administered in another county (unless there was a substantial difference in the new proposed plan.)

9. **Rule 4.3 Open Meetings**
   REMHDCO proposes additional language to this section.
   Page 11

   C. All committee meetings of the MHSOAC whether those of a standing committee, special project, or ad-hoc committee are also subject to the Bagley-Keen Open Meeting Act. The

MHSOAC shall not sponsor "invitation only" events that limit participation by public members to those chosen by the MHSOAC staff.

The MHSOAC has sponsored events that included all Commissioners but was "invitation only" to the public and allowed only a limited number of public members chosen by staff to attend.

10. Rule ~~4.6~~ 4.5 Request for Item to be Placed on the Agenda

REMHDCO supports the original language

Page 12

Proposed changes by MHSOAC staff:

C. Members of the public wishing to place items on the agenda should contact Commission staff.

~~Agenda items shall only be placed on the Commission's agenda at the request of (1) a Committee of the MHSOAC; (2) a member of the MHSOAC; or (3) MHSOAC staff with the approval of the Executive Director. Members of the public wishing to place items on the agenda must go through one of the above.~~

A Committee of the MHSOAC should be able to request that an item be put on the agenda. A member of the public should be able to go to either any Commissioner or Commission staff (not just Commission staff) in order to get something placed on the agenda.

11. Rule ~~4.12~~ 4.11 Quorum

REMHDCO supports the changes to this section.

Page 15

The new language proposed by the MHSOAC staff specifies that a majority of the quorum (i.e. five members) may act to bind the Commission; and that the only action that may be taken in the absence of a quorum is to fix the time in which to adjourn, recess, or take measures to obtain a quorum.

Previously, the Commission operated that once a quorum was established at a meeting, votes could be taken and in effect no matter how many members left the meeting. This allowed the Commission to take votes on important matters (including those involving millions of dollars) when there were *as few as two members present*.

12. Rule ~~4.13~~ 4.12 Voting

REMHDCO does not support the proposed additional language.
Page 15

MHSOAC Staff recommended changes:

D. Prior to voting on a policy project report, the Commission shall consider the report in at least one meeting prior to the meeting at which the motion to approve is considered. This requirement shall not apply if the report was previously discussed in a public meeting of a Commission subcommittee and the subcommittee recommended Commission adoption of the report.

~~Any proposed policy item on the agenda, along with its corresponding language/documents, shall be presented for discussion at a Commission meeting at least one (1) meeting prior to the meeting at which the vote on the issue is taken.~~

REMHDCO is particularly concerned about the addition of the second sentence (*This requirement shall not apply…)* and the removal of the second paragraph above. It is not clear what the difference is between a "policy project report" and a "policy item". It seems that *any policy item*, not just reports, should be subject to being considered at least one meeting prior to the meeting at which it is voted on.

Many community stakeholders believe in the last several years, significant policy items have not always been presented for a discussion at the Commission at least one meeting prior to the meeting at which the vote was taken. We do not condone changing this rule to correspond to the practice – we want the practice to conform to this important rule, and that the rule should remain.

Furthermore, there have been times when Commission subcommittee meetings have been held in places that are not easily accessible to a large number of members of the public and state level advocates (e.g. Redding, Riverside, Monterey). There should be opportunity for stakeholders and the public to comment on a report with significant policy recommendations or implications before the Commission takes a vote on the report. It is difficult to imagine why allowing for additional public comment would be a problem.

13. Rule ~~4.14~~ 4.13 Public Comment

REMHDCO strongly opposes two changes to this section.

Page 16

B. If the agenda item has already been considered by a subcommittee or committee composed exclusively of members of the Commission at a public meeting where interested members of the public were afforded the opportunity to address the subcommittee or committee on the item, additional public comment opportunity at the Commission meeting need not be provided unless the item has been substantially changed since the subcommittee or committee heard the item. (Government Code Section 11125.7)

REMHDCO believes that public comment should always be allowed on any item that comes before the Commission, unless the item is for information only. It is not clear in the language above whether disallowing public comment (for items heard at a previous meeting) pertains to items that may be taken up for a vote, or just informational items. This needs to be made clear. Also, who determines what constitutes "substantially changed"?

~~C. It is the policy of the Commission to vet issues as much as is practical through the MHSOAC standing committees before those issues are brought to the full Commission. It is the responsibility of the committee chair to engage stakeholder participation at the committee level and to report back to the full Commission. Public comment and stakeholder involvement at the committee level does not replace public comment at the Commission meetings.~~

REMHDCO strongly objects to the language above being removed from the Rules of Procedure. This language reflects the heart and soul of the MHSA – stakeholder engagement and participation in all the Commission activities and decisions. REMHDCO regrets that most of the standing committees of the MHSOAC have been dismantled because they served as a place where the important issues were discussed and community stakeholders were able to dialogue with Commissioners and MHSOAC staff instead of the 2-3 minute one-way public comments at the Commission meetings. Taking this language out of the Rules of Procedure removes the underlying protection for meaningful stakeholder involvement with the MHSOAC.

14. Rule 5.1 PUBLIC OUTREACH AND ENGAGEMENT

REMHDCO proposes additional language to this section. (See language in italics)

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The Commission seeks to ensure the perspective and participation of diverse community members and others with mental health challenges and their families are a significant factor in the Commission's decisions and recommendations. The Commission ensures this through:

- Public hearings that have open, informed, and transparent deliberation.
- Committee and subcommittee meetings that hear from community members and other subject matter experts to develop a shared understanding of the challenges and opportunities of topics specified by the Commission.
- Community forums and listening sessions that are organized to highlight and understand topics specified by the Commission.
- Site visits that are organized to acquire first-hand knowledge and understanding of the challenges of specific topics and the existing efforts to address those challenges.
- ***Testimony from state level mental health advocates, including recipients of stakeholder advocacy grants administered by the MHSOAC, who are encouraged to attend all Commission meetings to give voice to their respective communities.***

REMHDCO believes that all the stakeholder advocacy grants administered by the MHSOAC should specify and pay for advocacy on behalf of their communities at state level meetings and forums regarding the MHSA, including the Commission meetings.

15. Rule ~~6.1~~ 5.1 ~~Committee~~ Structure

REMHDCO strongly objects to the proposed changes in this section.

Pages 17-18

MHSOAC Staff recommended changes:

A. The ~~MHSOAC~~ Commission ~~shall~~ may establish one or more ~~standing~~ committees as necessary to provide technical and professional expertise pursuant to Welfare and Institutions Code Section 5845 (d)(2)(3).

This change removes the requirement of the Commission to have committees, including standing committees. The most effective way for the Commission to engage community stakeholders is through regular and ad-hoc committee meetings that allow robust and open dialogue with knowledgeable and diverse stakeholders. Both the number of standing

committees and the quality of committee meetings have declined in recent years. The solution is not to weaken the policy or rule, but to restore previous committees and improve upon the current practice.

A.2. Ideally Each ~~standing~~ committee shall have a maximum of 15 members and may ~~shall~~ include public membership.

This language removes the requirement for public membership on committees. This proposed change is absolutely unacceptable. The MHSA is very explicit about being consumer and family driven, and for government to collaborate and consult with community stakeholders. Having an MHSOAC committee with no community members is a step backwards and not in line with the basic and most important principles the MHSA. It is akin to having a recovery team without having the consumer or family members on it. Please see the additional information on the Bagley-Keene Open Meeting Act in the analysis by ACCESS of Cal Voices.

Public membership of each committee shall be selected by the committee Chair and Vice Chair for a one-year term. Of this public membership, the committee Chair and Vice Chair shall seek individuals with the desired expertise who are consumers, family members or care givers of consumers, and members of underserved ethnic and cultural communities. ~~at least two shall be consumers, at least two shall be family members or care givers of consumers, and at least two shall be members of underserved ethnic and cultural communities. Public membership of each committee shall be selected by the committee Chair and Vice Chair.~~

Although this directs the Chair and Vice Chair to seek specified stakeholders for public membership, this comes directly after the proposed change that *does not require public members on any committee*. So this applies only if it is decided that a committee will have public members in the first place.

REMHDCO strongly objects to removing the specific number of consumers, family members, and members of underserved racial and cultural communities required on each committee. A minimum number was instituted as a safeguard to ensure that the work and the decisions of any MHSOAC committee would be *consumer and family driven, and culturally competent*. All work of the commission should take reducing disparities strongly into consideration and this is unlikely to happen unless representatives from those racial, ethnic, and LGBTQ communities are on every committee.

Enclosure 5

In their recruitment and appointment of committee members, committee Chair and Vice Chair shall pay special attention to issues related to cultural diversity and competency and the needed expertise to support the committee's goals. Commission staff and/or consultants will staff each committee.

REMHDCO believes adding the language about the public committee members having the "competency and needed expertise to support the committee's goals" is not necessary and implies that the public members might be appointed as unqualified tokens.

Enclosure 5

NAMI California
National Alliance on Mental Illness

TO: Mental Health Services Oversight and Accountability Commission

FROM: Jessica Cruz, CEO, National Alliance on Mental Illness - California

DATE: May 5, 2020

SUBJECT: Proposed Changes to the MHSOAC's Rules of Procedure – Concerns

On behalf of the National Alliance on Mental Illness California (NAMI-CA), I am writing to share our perspective on the Mental Health Services Oversight and Accountability Commission (MHSOAC) January 2020 proposed changes to its "Rules of Procedure."

As you know, NAMI-CA is the statewide affiliate of the country's largest mental health advocacy organization, the National Alliance on Mental Illness. Our 19,000 members and 62 affiliates include many people living with serious mental illnesses, their families, and supporters. NAMI-CA advocates on their behalf, providing education and support to its members and the broader community.

NAMI-CA is concerned that some of the proposed changes to the MHSOAC's Rules of Procedure undermine the Commission's long-held pursuit of the perspectives of people living with serious mental illness and their families. The development of these proposed changes were made without the input of long-standing clients and families and stakeholders. Below you will find an outline of our concerns:

1. **Increasing the Authority of the Executive Director**

    - As outlined on page 9 of the MHSOAC draft of the proposed changes to its Rules of Procedure, the Commission is considering doubling the Executive Director's authority to contract with external organizations. With the consent of the Commission's Chair and Vice Chair, the Executive Director could execute contracts expending up to $750,000.
    - Additionally, the proposed changes would authorize the Executive Director to provide direct advocacy on legislation after consultation with the Commission Chair and Vice Chair.

    NAMI CA opposes increased authority of the Executive Director.

    - While we appreciate the pragmatism of empowering an Executive Director to make financial decisions necessary for the day-to-day operations of an organization, it is unclear *why* it is necessary at this time to double the Executive Director's authority to make large financial commitments on behalf of the Commission after only consulting with the Chair and Vice Chair.
    - NAMI California is aware of the MHSOAC's ongoing commitment to and organizational vision that the voice of the public – including individuals with lived experience and their family members — be considered when the MHSOAC makes decisions about its use of taxpayer revenues provided from the Mental Health

Services Fund. Therefore, we suggest that the Commission uphold its value of engaging consumers and family members in its decision utilizing such a large amount of taxpayer funds.

- It is unclear from the material shared by the Commission during their presentation of the proposed changes whether or how the proposed increase of Executive Director authority for expenditure of funds and legislative advocacy reflect the rules staff indicate they reviewed from other boards and commissions in California.
- The Commission and its Executive Director should be driven by the stakeholders it represents. Allowing the Executive Director authority to advocate on legislation without prior vetting by stakeholders lacks the value of transparency that the Commission holds as a top priority.

2. **New Mission of the Commission:** NAMI California is alarmed that the Commission would consider deleting collaboration with clients, their family members, and underserved communities from your mission statement:

   - Current Mission Statement: *"The MHSOAC provides the vision and leadership, in collaboration with clients, their family members and underserved communities, to ensure an enhanced continuum of care for individuals at risk for and living with serious mental illness and their families by holding public systems accountable and by providing oversight, eliminating disparities, promoting mental wellness, supporting recovery and resiliency resulting in positive outcomes in California's community based mental health system."*
   - Proposed Mission Statement: *"The Mental Health Services Oversight and Accountability Commission works through partnerships to catalyze transformational change across systems and ensure everyone who needs mental health care has access to and receives effective and culturally competent care."*

   NAMI CA opposes the changes to the mission, eliminating the specific mention of clients and family members.

   - The Mental Health Services Act is client and family driven. The Commission should uphold this value of the Act and *never* alienate the individuals that it serves.

3. **Committee Structure:** NAMI California is concerned that the following proposed changes to the Commission's committee structure and composition (Rule 6.1 Committee Structure) will also have the effect of reducing public participation and transparency:

   - Proposed changes would simply *authorize* the Commission – rather than require – to establish standing committees. Committees provide guidance, review materials, and make recommendations to the Commission. We are concerned that this change will reduce opportunities for stakeholders (including clients and family members with lived experience) to provide timely input to the Commission staff and members. Committees play an important function to any board or commission, and participants are able to lend important expertise in a more rich and meaningful way than what is usually afforded during "public comment" periods at formal commission meetings.
   - Proposed changes to the membership of committees removes an explicit

requirement to include two each of consumers, family members, and members of underserved ethnic and cultural communities. Additionally, the proposed language requires emphasizes “needed expertise” and requires that any consumer, family member, or member of underserved ethnic and cultural committees bring “needed” (read: subject matter) expertise. This devalues the expertise and contributions that can be made from people with lived experience who may not possess formal education, training, or degrees in the behavioral health field. Again, “client and family driven” is a hallmark value of the Mental Health Services Act. These proposed changes are counterintuitive to that value.

- Proposed changes to the term of committee members would reduce from a two-year term to a one-year term. Since the Commission’s committees have tended to meet infrequently, giving committee members one year to serve will mean they have less time to become grounded in the work, provide input, and contribute meaningfully to tasks and projects.

NAMI CA opposes the elimination of the Committees.

- These Committees provides the Commission with a bridge to the populations they serve. Eliminating these Committees will silence of the voices of the communities the Act serves.

The proposed changes to the Rules of Procedure directly contradict the core values of the Commission to uphold the Act by providing transparency, leading decisions based on stakeholder input, including hearing from those impacted most severely by mental illness (clients and families). Eliminating the voices of the community and consolidating the power of decisions within the Commission and MHSOAC staff falls outside of the purpose of the Act.

NAMI-CA urges the MHSOAC to reject the proposal to increase the authority of its Executive Director, Chair, and Vice Chair to consult only with one another when making decisions about projects of up to $750,000, to advocate in the legislature without any opportunity for public consideration and comment, and to modify the Commission’s mission and committee structure in ways that undermine public participation.

We look forward to a robust stakeholder convening to discuss these changes. Please feel free to contact me with any questions you may have. I can be reached at 916-567-0163.

Respectfully,

Jessica Cruz, MPA/HS
CEO
NAMI California

Enclosure 5

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September 11, 2020

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

RE: Proposed Changes to the MHSOAC's Rules of Procedure—Request for a Stakeholder Process

Dear Commissioners,

Cal Voices and its advocacy program, ACCESS California, greatly respect the work of the MHSOAC in improving the lives of people with lived experience while upholding the values of the Mental Health Services Act. However, we write to you today to express our concerns with the January 2020 proposed changes to your Rules of Procedure.

Cal Voices is California's oldest peer run mental health advocacy organization in California, and ACCESS California is our statewide consumer-led stakeholder advocacy program. ACCESS' mission is to strengthen and expand local and statewide client/consumer advocacy in California's Public Mental Health System through individual and community empowerment. Our ongoing research, data collection and evaluation, legislative and policy analysis, advocacy, education, training, outreach, and engagement activities implement strategies to elevate the voices, identify the needs, and increase genuine public participation of client/consumer stakeholders to drive truly transformative change.

As you are aware, the Mental Health Services Act (MHSA) requires unprecedented levels of stakeholder involvement within all facets of the Public Mental Health System whenever MHSA funds are utilized. In keeping with this mandate, the MHSOAC is required to incorporate the perspective of diverse community members, including those with lived experience, in all of its decisions and activities.[i]

Cal Voices is concerned that some of the proposed changes to the MHSOAC's Rules of Procedure bypass the public processes mandated by the Bagley-Keene Act, and circumvent the strong stakeholder involvement required by the MHSA. Additionally, Cal Voices believes that some of the proposed changes remove statutorily delegated decision-making responsibility from the 16 member Commission, and may inappropriately confer that responsibility on MHSOAC staff. Our detailed concerns are attached to this letter as Attachment A.

We respectfully request that all changes to the MHSOAC's Rules of Procedure be subject to a meaningful, robust, and inclusive public stakeholder process. Please feel free to contact me with any questions.

Sincerely,

Susan Gallagher, MMPA
Executive Director

[i] 9 CCR § 5846(d)

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Attachment A

ACCESS' COMMENTS ON MHSOAC PROPOSED RULES OF PROCEDURE CHANGES

SUMMARY: While we appreciate the Commission's efforts in updating the Rules of Procedure, we believe that, taken as a whole, some of the proposed changes to the Rules of Procedure run contrary to the spirit of the MHSA, risk limiting public participation in the activities of the Commission, and do not fully comply with the Bagley-Keene act and other statutes which govern the activities of the Commission. **We would strongly recommend that a public process be implemented, so that a full and complete public discussion can be undertaken** before any changes are made to the Rules of Procedure**.**

Our comments regarding the proposed changes to the Rules of Procedure are based in large part, but not entirely, on the following statutes and guidances:

1. The Bagley-Keene Act, Government Code Section 11120-1113, (emphasis added):

> 11120: It is the public policy of this state that public agencies exist to aid in the conduct of the people's business and the proceedings of public agencies be conducted openly so that the public may remain informed.
>
> In enacting this article, the Legislature finds and declares that it is the intent of the law that their actions be taken openly and that their deliberations be conducted openly.
>
> **The people of this State do not yield their sovereignty to the agencies which serve**
>
> **right to decide what is good for the people to know and what is not good for them to know.** The people insist on remaining informed so that they may retain control over the

2. In its public guide to the Bagley-Keene Act, the California Attorney General states (emphasis added):

> If efficiency were the top priority, the Legislature would create a department and then permit the department head to make decisions. **However, when the Legislature creates a multimember board, it makes a different value judgment. Rather than striving strictly for efficiency, it concludes that there is a higher value to having a group of individuals with a variety of experiences, backgrounds and viewpoints come together to develop a consensus. Consensus is developed through debate, deliberation and give and take**. This process can sometimes take a long time and is very different in character than the individual-decision-maker model. [ii]

3. Welfare and Institutions Code § 5846(d) (emphasis added):

> The commission shall ensure that the perspective and **participation of diverse community members** reflective of California populations and others suffering from severe mental illness

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and their family members is a **significant factor in all of its decisions and recommendations**.

ACCESS Comments on Proposed Changes to the Rules of Procedure

-Page 1-

Original Language:

The MHSOAC provides the vision and leadership, in collaboration with clients, their family members and underserved communities, to ensure an enhanced continuum of care for individuals at risk for and living with serious mental illness and their families by holding public systems accountable and by providing oversight, eliminating disparities, promoting mental wellness, supporting recovery and resiliency resulting in positive outcomes in California's community based mental health system.

Proposed Language:

MISSION

The Mental Health Services Oversight and Accountability Commission works through partnerships to catalyze transformational change across systems and ensure everyone who needs mental health care has access to and receives effective and culturally competent care.

ACCESS Position:

ACCESS strongly believes that the original mission statement should remain in effect for the following reasons:

1. Welfare & Institutions Code § 5846(d) requires the Commission to "ensure that the perspective and participation of diverse community members…is a significant factor in all of its decisions and recommendations. The original language "in collaboration with clients, their family members and underserved communities", is vital to the purpose and operation of the Commission and therefore should remain in the mission statement.

2. The Commission was created specifically to **provide oversight and accountability** to the public mental health system, not necessarily to catalyze transformational change. The original mission statement language accurately details the statutory role of the Commission (WIC § 5845)[iii].

3. Inherent in the requirement to provide oversight and accountability is the necessity to uphold the 5 General Standards of the MHSA. These General Standards are directly stated in the original mission statement, and absent from the proposed changes.

4. The Oxford Dictionary defines a Mission Statement as "a formal summary of the aims and values of a company, organization, or individual". A mission statement should be the foundation which guides all of an entity's activities, and thus should reflect the key statutory components upon which the Commission was established.

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5. While we recognize that this updated Mission Statement originated with the most recent draft Strategic Plan, we also recommend that the draft Strategic Plan be amended with the original mission statement.

-Page 1-

Proposed Removal of the Following Language:

GOVERNANCE PHILOSOPHY

Specifically:

a. The MHSOAC will cultivate a sense of group responsibility. The MHSOAC will be responsible for excellence in governing. The MHSOAC will use the expertise of individual members to enhance the ability of the MHSOAC.

b. The MHSOAC will direct evaluate, and inspire the organization through the careful establishing written policies, procedures and directives.

c. The MHSOAC will enforce upon itself the necessary discipline to govern with excellence, including preparation and regular attendance at meetings, thorough preparation by each member for each meeting, adherence to its policymaking principles, and respecting the roles.

d. Continual development of the MHSOAC will include orientating of new members in the Commission's governance policies and processes, periodic reorientation of existing members, and regular discussion of process improvement.

e. The MHSOAC will regularly discuss and evaluate its performance and take steps to improve its effectiveness.

ACCESS is opposed to this change: This section documents key elements of the Commission's Governance Philosophy and should be retained.

-Page 2-

Rule 1.1 Terms of Commissioners
Proposed Removal of the Following Language:

If a Commissioner cannot attend a Commission meeting he or she will notify the Chair and the Executive Director of such absence in advance of the Commission meeting. If a Commissioner misses one (1) Commission meeting without notice or three (3) Commission meetings in a calendar year with notice the Chair shall notify the Commissioner and that Commissioner's appointing power in writing that the attendance record of the Commissioner be improved or that the Commissioner be replaced.

ACCESS opposes removal of this language: Full Commissioner participation for each entire meeting is an essential element of the Commission's success. ACCESS opposes removal of this language, and instead encourages enforcement of this section for the following reasons:

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1. A review of the past 10 in-person Commission meeting minutes reveals that **one Commissioner has attended zero of the past 10 meetings**, one Commissioner has attended only 3 meetings, 2 Commissioners have attended 5 meetings, 3 Commissioners have attended 6 meetings, and 3 Commissioners have attended 7, with only 2 Commissioners attending all 10 meetings.

2. Non-urgent agenda items are placed on the agenda for discussion and public comment for two consecutive Commission meetings, to allow for adequate public input and Commission discussion. When Commissioners are regularly absent, or leave meetings early, they miss this valuable input, which is intended to ensure that Commission decisions reflect the public's feedback.

3. Welfare & Institutions Code § 5845(a) specifies the stakeholder groups that are required to be represented on the Commission. This broad stakeholder representation is vital to ensure that Commission decisions reflect the stakeholders who are impacted by Commission decisions. When Commissioners are absent, the lack of diversity of Commissioner input is contrary to the statutory mandate.

-Page 3-

Rule 1.2 The Role of Commissioners

Proposed Removal of the Following Language:

The best decisions come out of unpressured collegial deliberations and the MHSOAC seeks to maintain an atmosphere where the Commission or Committee members can speak freely, explore ideas before becoming committed to positions and seek information from staff and other members. To the extent possible the MHSOAC encourages members to come to meetings without having fixed or committed their positions in advance.

ACCESS recommends that this language remain in the Rules of Procedure. The Commissioners are expected to attend meetings with an open mind and without having pre-determined opinions. Community Collaboration necessitates a meeting environment where collegial deliberations take place and where community input is meaningfully incorporated into decisions.

-Page 5-

Rule 1.7 Training and Orientation

ACCESS proposes additional language to this section.

Commission Staff's Proposed language:

New Commissioners members shall within 30 days of being appointed receive training and orientation in: (1) Commission governance, policies and procedures; (2) Commission strategic directives; (3) Mental Health Services Act (MHSA) programs and issues; and (4) relevant laws and statutes.

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ACCESS' proposed additional language (highlighted and underlined):

New Commissioners members shall within 30 days of being appointed receive training and orientation in: (1) Commission governance, policies and procedures; (2) Commission strategic directives; (3) Mental Health Services Act (MHSA) programs, General Standards, and issues; and (4) relevant laws and statutes.

Reasoning: The Commission is charged with upholding the vision and General Standards of the MHSA. For this reason, it is imperative the Commissioners are adequately trained in the 6 General Standards (Community Collaboration, Cultural Competence, Client- and Family-Driven Services, Wellness, Recovery, and Resiliency, and Integrated Service Experiences)[iv].

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Rule 1.9 Conflict of Interest

Proposed Removal of the Following Language:

The Commission will adopt for itself and adhere to an Incompatible Activities Policy.

ACCESS is opposed to the removal of this language.

Reasoning: It is essential that public entities have a Conflict of Interest (or Incompatible Activities Policy). Conflict of Interest Policies are necessary to protect the public's trust and to inform Commissioners of the activities or interests which may constitute a conflict of interest, and thus risk compromising one's professional judgment.

-Page 8-

Rule 2.1 Duties of the Executive Director

Proposed Replacement of the Following Language:

~~The Executive Director also serves as the Commission's liaison with, county commissions, other mental health associations and stakeholder groups.~~

With this Language:

B. The Executive Director represents the Commission and advances its goals by working with California's constitutional officers, federal, state and local agencies, national and international organizations, private sector leaders, and other stakeholders.

ACCESS does not support this proposed change.

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Reasoning:

1. Removing the word "liaison" and replacing it with the proposed language contravenes the Bagley-Keene Act. The Commission's 16 members are charged with reviewing and approving policy after full deliberation at a public meeting. This proposed language change provides the Executive Director with authority to bypass the public meeting process to effectuate policy.

2. This language risks providing the Executive Director with excessive authority. The Executive Director is charged with recommending policy to the Commission for their review and approval. Allowing the Executive Director to "advance [the Commission's] goals" is overly broad and grants the Executive Director potentially unlimited power to draft, support, or oppose policies without any Commission or public oversight.

-Page 9-

Rule 2.4 Contract Authority

Proposed Language Change:

A. The Executive Director has the authority to take all actions necessary to enter into contracts on the Commission's behalf of the MHSOAC in the amount of ~~$100,000~~ $200,000 or less and to enter into Interagency Agreements in the amount of ~~$200,000~~ $400,000 or less. ~~The Executive Director may delegate to subordinates any of the authority delegated to the Executive Director by the MHSOAC. Within 24 hours of such delegation the Executive Director shall notify the MHSOAC Chair and Vice Chair.~~

B. The Executive Director, with the consent of the Chair and Vice Chair, has the authority to take all actions necessary to enter into contracts on the Commission's behalf in the amount of $500,000 or less and to enter into Interagency Agreements in the amount of $750,000 or less.

ACCESS is strongly opposed to these changes.

Reasoning:

1. The Bagley-Keene Act **requires** that government business be conducted in open and public forums, especially when it relates to the spending of public money. Allowing the Director to enter into contracts goes against the Bagley-Keene Act by allowing for actions to be taken outside of the public view.

2. Welfare & Institutions Code § 5846(d) requires the Commission to "ensure that the perspective and participation of diverse community members…is a significant factor in all of its decisions and recommendations. Allowing the Director to unilaterally enter into significant contracts goes against statute by not allowing participation by stakeholders.

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3. The 16 Commissioners have been designated to oversee the spending of MHSA dollars. Increasing the contract authority of the Director will result in the majority of the Commissioners not informed about the money they are required to oversee.

-Page 9-

Proposed New Language:*

Rule 2.5 Authority ~~of the Executive Director~~ to Advocate on Legislation

A. The Commission is authorized to advise the Governor and Legislature regarding actions the State may take to improve the mental health care and services of Californians. As part of this authority, the Commission may advocate on legislation.

B. The Executive Director, or ~~his or her~~ the Executive Director's designee, is authorized on behalf of the ~~MHSOAC~~ Commission to advocate on legislation: (1) when the legislation ~~is consistent with~~ advances a formally established ~~an officially approved~~ position of the Commission; or (2) when the legislation advances an informal or emerging position of the Commission after consultation with the Chair and Vice Chair. ~~at the direction of the Chair and when the legislation furthers the interest of the Commission.~~

C. The Executive Director shall give an update of all advocacy efforts, except confidential budget proposals, taken on behalf of the Commission at the next Commission meeting following the advocacy efforts.

*Note: This appears as *changed* language in the draft 2020 Rules of Procedure, but nothing from this section is included in the previous Rules of Procedure, thus it is proposed new language.

ACCESS is opposed to the yellow highlighted language, and believes that subsection C should be strengthened.

Reasoning:

1. The Bagley-Keene Act was written to preserve the public's right of access and participation to the activities of governmental bodies. Allowing the Director to advocate on legislation for which the Commission has not publicly and officially adopted a position contravenes the Bagley-Keene Act. The public has a right to participation and public comment in all decisions of the Commission.

2. The law mandates a diverse Commission of 16 appointed members who make formal decisions with the public's input. The Executive Director's role is to assist the Commission in accomplishing their formal positions, not in establishing his or her own positions.

3. Is there statutory language exempting confidential budget proposals from the protections of the Bagley-Keene Act? If not, this language should be removed.

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4. Subsection C. should be strengthened to require a log or list of all advocacy meetings the Director has held, and all legislative and policy proposals that s/he has advocated on.

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Proposed new language:

Rule 2.6. Authority to Approve Innovation Plans

A. The Executive Director, with the consent of the Commission Chair, is authorized to approve a county Innovation plan that meets any of the following conditions:

1) The county Innovation plan, plan extension or modification does not raise significant concerns or issues and includes total MHSA Innovation spending authority of $1,000,000 or less.

2) The county Innovation plan is substantially similar to a county Innovation proposal that has been approved by the Commission within the past three years, if in the judgement of the Executive Director,

a) differences in the county Innovation proposal and a previously approved plan are not material to concerns raised by the Commission in its previous review and are non-substantive, and

b) the new project furthers the ability of the previously approved Innovation plan to support statewide transformational change.

B. The Executive Director shall publicly report to the Commission, at the next Commission meeting at the first available opportunity, any county Innovation plan approved by the Executive Director on behalf of the Commission under this delegated authority.

ACCESS is strongly opposed to the addition of this language:

Reasoning:

1. The MHSA requires community collaboration and meaningful stakeholder input. Clients who receive the services are the most informed about proposed services, and most knowledgeable about issues and challenges of proposed services. Approval of any MHSA spending without public discourse and stakeholder input runs contrary to the MHSA.

2. A key statutory role of the 16 member Commission is approval of Innovation Plans[v]. The MHSA requires a diverse Commission made up of 16 individuals with varied knowledge and different perspectives. Their decision making should not be delegated to a single person, especially one who is not a Commissioner.

3. The 16 member Commission is also charged with oversight and evaluation of MHSA programs. Innovation plans are, by definition, designed to create learning about what works and what doesn't work. The mere fact that an Innovation plan was approved in the past, does not necessarily mean that it is an effective plan and should automatically be approved for another county. In fact, the opposite may be true. Innovation plans that have been active should be evaluated by the 16

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member Commission for effectiveness and outcomes to determine which Innovation programs are successful, and which ones should be changed or edited.

4. The Bagley-Keene Act was written to preserve the public's right of access and participation to the activities of governmental bodies. Allowing the Director to approve Innovation plans contravenes the Bagley-Keene Act by bypassing public comment. The public has a right to participation and public comment in all decisions of the Commission.

-Page 10-

Proposed changed language:

Rule 4.3 Open Meetings

A. Commission meetings are subject to the Bagley-Keene Open Meeting Act set forth in Government Code Sections 11120 et seq.

ACCESS proposes additions to this language to comply with law:

Reasoning: All meetings of the MHSOAC and its Committees are subject to the Bagley-Keene Open Meeting Act. According to the California Attorney General:

> A meeting occurs when a quorum of a body convenes, either serially or all together, in one place, to address issues under the body's jurisdiction. (§ 11122.5.) Obviously, a meeting would include a gathering where members were debating issues or voting on them. But a meeting also includes situations in which the body is merely receiving information. To the extent that a body receives information under circumstances where the public is deprived of the opportunity to monitor the information provided, and either agree with it or challenge it, the open-meeting process is deficient. [vi]

In the past, the Commission has hosted meetings which included Commissioners, but were "invitation only" to the public. Because these meetings are not made public, we do not know how often they occur, but one example was a meeting at Google to discuss the Innovation Incubator. This meeting was discussing relevant Commission business that the public should have been invited to.

-Pages 11,12-

Proposed language removal:

Rule 4.4 Agenda Items

~~Staff prepares briefing materials on each agenda item and provides Commissioners with those materials in advance of the meeting. These materials provide Commissioners with a detailed description of a proposed course of action, background information, fiscal impact, the pros and cons of taking the action, and similar information for alternative actions.~~

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ACCESS supports retaining this language.

Reasoning: There is no reason to remove this language. The Commissioners should absolutely receive meeting materials in advance of the meeting, including all of the items included in the language above.

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Proposed language changes:

Rule 4.5 Request for an Item to be Placed on the Agenda

A. Agenda items are placed on the Commission's meeting agenda with the approval of the Chair and Executive Director. The final meeting agenda is approved by the Chair and the Executive Director after consultation with the Chief Counsel.

B. Individual Commissioners wishing to place items on the agenda should contact the Chair or the Executive Director.

C. Members of the public wishing to place items on the agenda should contact Commission staff.

~~Agenda items shall only be placed on the Commission's agenda at the request of (1) a Committee of the MHSOAC; (2) a member of the MHSOAC; or (3) MHSOAC staff with the approval of the Executive Director. Members of the public wishing to place items on the agenda must go through one of the above.~~

~~Before agenda and meeting packets are finalized, they shall be reviewed by the Chair of the Commission, the Executive Director, Chief Counsel. The Chair of the Commission, the Executive Director, and the Operations Committee shall work together to develop and set the Commission agendas.~~

ACCESS opposes this language change.

Reasoning:

1. The 16 member Commission should be responsible for determining the agenda items that the Commission wishes to discuss. The role of the Executive Director should not be to determine agenda items, it should be to assist the 16 member Commission in reaching its own goals.

2. These language changes do not support the diverse public input that is required by WIC § 5846(d), which requires the Commission to "ensure that the perspective and participation of diverse community members…is a significant factor in all of its decisions and recommendations. The public should be able to propose agenda items to be either allowed or disallowed with a decision made by the full 16 member Commission.

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Proposed language changes:

Rule 4.12 Voting

D. Prior to voting on a policy project report, the Commission shall consider the report in at least one meeting prior to the meeting at which the motion to approve is considered. This requirement shall not apply if the report was previously discussed in a public meeting of a Commission subcommittee and the subcommittee recommended Commission adoption of the report.

~~Any proposed policy item on the agenda, along with its corresponding language/documents, shall be presented for discussion at a Commission meeting at least one (1) meeting prior to the meeting at which the vote on the issue is taken.~~

ACCESS opposes the proposed language change.

Reasoning:

1. ACCESS is opposed to the language change of "policy item", to the much more limiting term of "policy project report". All items, with the exception of truly urgent items, should be presented during at least two Commission meetings to allow for full discussion and public input. A policy project report limits this rule to very specific agenda items.

2. This rule change limits the role of the 16 member Commission, by leaving them out of valuable discussion and public input regarding important policy items. Public input, as required by WIC § 5846(d), which requires the Commission to "ensure that the perspective and participation of diverse community members…is a significant factor in all of its decisions and recommendations, requires that the 16 Commission members hear the public comment and incorporate it into their decisions. This cannot happen if items are not fully vetted within full Commission meetings.

3. Client stakeholders have numerous transportation barriers which limit their travel to OAC subcommittee meetings. Without financial travel assistance, they are often forced to limit their participation to full Commission meetings. While ACCESS fully supports the discussion of policy items at subcommittee meetings, this discussion should not take the place of public discussion at two meetings of the full 16 member Commission.

Proposed language changes:

Rule 4.13 Public Comment

B. If the agenda item has already been considered by a subcommittee or committee composed exclusively of members of the Commission at a public meeting where interested members of the public were afforded the opportunity to address the subcommittee or committee on the item, additional public comment opportunity at the Commission meeting need not be provided unless the

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item has been substantially changed since the subcommittee or committee heard the item. (Government Code Section 11125.7)

~~It is the policy of the Commission to vet issues as much as is practical through the MHSOAC standing committees before those issues are brought to the full Commission. It is the responsibility of the committee chair to engage stakeholder participation at the committee level and to report back to the full Commission. Public comment and stakeholder involvement at the committee level does not replace public comment at the Commission meetings.~~

ACCESS opposes the proposed language change.

Reasoning:

1. This rule change limits the role of the 16 member Commission, by leaving them out of valuable discussion and public input regarding important policy items. Public input, as required by WIC § 5846(d), which requires the Commission to "ensure that the perspective and participation of diverse community members…is a significant factor in all of its decisions and recommendations", requires that the 16 Commission members hear the public comment and incorporate it into their decisions. This cannot happen if items are not fully vetted within full Commission meetings.

2. The proposed language in Section B (above) cites Government Code §11125.7. However, the addition of the word "subcommittee" in the above section is NOT in accordance with Government Code §11125.7, and is in fact contrary to the Code. The Code specifically refers to "a committee composed exclusively of members of the Commission".

2. The stricken language should remain a foundation of the Commission's procedure, and thus should remain within the Rules of Procedure. Public comment and stakeholder involvement at the committee level should provide an additional level of public comment, but should not lessen the amount of public comment at the 16 member Commission meetings.

-Page 16-

Proposed additional language:

Rule 5.1 Public Outreach and Engagement

The Commission seeks to ensure the perspective and participation of diverse community members and others with mental health challenges and their families are a significant factor in the Commission's decisions and recommendations. The Commission ensures this through:

- Public hearings that have open, informed, and transparent deliberation.
- Committee and subcommittee meetings that hear from community members and other subject matter experts to develop a shared understanding of the challenges and opportunities of topics specified by the Commission.
- Community forums and listening sessions that are organized to highlight and understand topics specified by the Commission.

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- Site visits that are organized to acquire first-hand knowledge and understanding of the challenges of specific topics and the existing efforts to address those challenges.

ACCESS would support this language, with the following change:

The Commission seeks to ensure the perspective and participation of diverse community members and others with mental health challenges and their families are a significant factor in all of its ~~the Commission's~~ decisions and recommendations. The Commission ensures this through:

- Public meetings ~~hearings~~ that have open, informed, and transparent deliberation.

Reasoning:

Public comment at Committee meetings, Subcommittee meetings, or any other public forums ***does not*** replace public comment at full Commission meetings. The language in the Rules of Procedure must correctly mirror the language of the Welfare and Institutions Code, which requires an active and engaged 16 member Commission that makes decisions independent of the Executive Director or any other single or independent source.

-Pages 17,18-

Proposed changes:

Rule 6.1 ~~Committee~~ Structure

A.2. ~~Ideally~~ Each standing committee shall have a maximum of 15 members and may ~~shall~~ include public membership. Public membership of each committee shall be selected by the committee Chair and Vice Chair for a one-year term. Of this public membership, the committee Chair and Vice Chair shall seek individuals with the desired expertise who are consumers, family members or care givers of consumers, and members of underserved ethnic and cultural communities. ~~at least two shall be consumers, at least two shall be family members or care givers of consumers, and at least two shall be members of underserved ethnic and cultural communities. Public membership of each committee shall be selected by the committee Chair and Vice Chair.~~

ACCESS is opposed to this language change.

Reasoning:

1. The MHSA requires the 16 member Commission to accomplish a great deal of work on a volunteer basis. For this reason, Committees comprised of the public and Commissioners have historically been highly utilized by the 16 member Commission to assist the Commission in meeting its goals. Members of the public not only have unique expertise to assist the 16 Commissioners, they also have the time to commit to additional meetings. Additionally, the Committees are an effective way for the Commission to engage a broad range of community stakeholders, in addition to those who are able to attend Commission meetings.

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2. The language requiring specific committee membership (i.e. 2 consumers, 2 family members, etc.) should remain in the Rules of Procedure. This language ensures that Committees are client and family driven and culturally competent, in accordance with the MHSA General Standards (9 CCR § 3320).

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i http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=GOV&sectionNum=11120.

ii https://oag.ca.gov/sites/all/files/agweb/pdfs/publications/bagleykeene2004_ada.pdf p.2

iiihttps://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=WIC&division=5.&title=&part=3.7.&chapter=&article=

iv 9 CCR § 3320

https://govt.westlaw.com/calregs/Document/I74D73AD0D45311DEB97CF67CD0B99467?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default)

v Welfare and Institutions Code § 5830 (e) https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=WIC&division=5.&title=&part=3.7.&chapter=&article=

vi https://oag.ca.gov/sites/all/files/agweb/pdfs/publications/bagleykeene2004_ada.pdf p.5

Enclosure 5

September 11, 2020

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,

The undersigned mental health organizations appreciate your work on the Mental Health Services Oversight and Accountability Commission (MHSOAC) and your dedication to improving the lives of people with lived experience. We thank you for listening to our concerns about the MHSOAC Rules of Procedure and creating a subcommittee to receive stakeholder feedback regarding proposed changes to those rules.

We write to you today with two specific requests regarding the stakeholder process to solicit feedback on revising the Rules of Procedure, with the hope that these requests will be discussed at the Subcommittee Meeting on September 14, 2020:

Enclosure 5

1. Develop a process to ensure that the full document is discussed publicly

The Rules of Procedure is a comprehensive document which directs all aspects of MHSOAC governance and procedures, and for this reason is possibly the most important document of the Commission. Stakeholder concerns with the proposed changes encompass all aspects of this document, and therefore cannot be fully discussed in a single meeting. We respectfully request that the proposed changes undergo a full stakeholder process, similar to the process that was undertaken to develop the MHSOAC Strategic Plan, including multiple meetings and the opportunity for a robust and meaningful discussion of all the proposed changes.

2. Develop a process to finalize the Rules of Procedure which mirrors the regulatory process

We view the MHSOAC Rules of Procedure as a governing document akin to governmental regulations, and thus we believe it should undergo a process similar to the rulemaking process. The rulemaking process involves public notice of proposed regulations followed by a public comment period. The rulemaking agency then considers all public comment and revises the regulations as necessary. When regulations are revised significantly, they are again subject to public comment. In addition, the rulemaking agency responds to all public comment either by making the requested changes, or by explaining their reasons for not incorporating the comment. With this process in mind, and after robust and meaningful discussions with members of the public, we request that all proposed changes be posted publicly for stakeholder comment. Due to the length, breadth, and importance of the Rules of Procedure, we request this process occur in steps, with the possibility that there may be a need for more than one revision, public posting, and explanation for why some requested changes or comments were not incorporated. A final draft with all changes and explanations should also be publicly posted, and an opportunity for public comment during a full MHSOAC meeting be made before final adoption of the revised Rules of Procedure by the Commissioners.

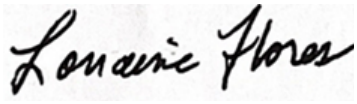
The MHSOAC should be a model for the robust stakeholder engagement required by the MHSA. As the organization statutorily delegated to provide oversight and accountability for many aspects of the MHSA, it is imperative that the MHSOAC be the leader in robust and meaningful stakeholder involvement.

Thank you again for hearing our concerns and creating a subcommittee to receive stakeholder input.

Sincerely,

Susan Gallagher, MMPA
Executive Director
Cal Voices

Enclosure 5



Lorraine Flores
Chair
California Behavioral Health Planning Council

Linda Tenerowicz
California Pan Ethnic Health Network

Liz Osegura

Liz Osegura
California Primary Care Association/California Health + Advocates

Poshi Walker

Poshi Walker, MSW
#Out4MentalHealth

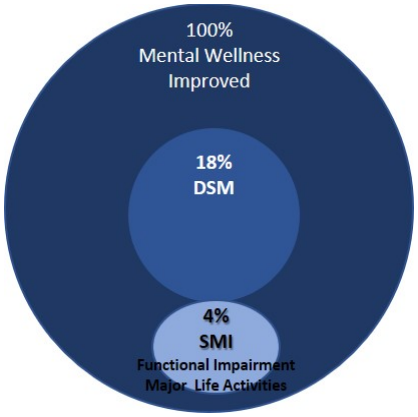
Interim Executive Director
PEERS

Stacie Hiramoto, MSW
Racial & Ethnic Mental Health Disparities Coalition (REMHDCO)

Lori Litel

Lori Litel
Executive Director
United Parents

Enclosure 5



To: Mental Health Services Oversight and Accountability Commission

From: Californians advocating for the Seriously Mentally Ill (SMI)

Date: October 20, 2020

RE: Proposed Changes to the MHSOAC's Rules of Procedure: MissionStatement and 2.4 Contract Authority

The signatures below represent concerned ***Californians Advocating for the Seriously Mentally Ill***, family members, professionals and consumers who focus on advocacy of 4% of those with mental illness depicted in the embedded chart: **SMI**

Along with NAMI California, we wish to express our strong opposition to the proposed changes to the Mission Statement and to section 2.4 Contract Authority.

Mission Statement

MISSION

The Mental Health Services Oversight and Accountability Commission works through partnerships to catalyze transformational change across systems and ensure everyone who needs mental health care has access to and receives effective and culturally competent care.

~~The MHSOAC provides the vision and leadership, in collaboration with clients, their family members and underserved communities, to ensure an enhanced continuum of care for individuals at risk for and living with serious mental illness and their families by holding public systems accountable and by providing oversight, eliminating disparities, promoting mental wellness, supporting recovery and resiliency resulting in positive outcomes in California's community based mental health system.~~

As family members and stakeholders, we believe the proposed changes completely eliminates collaboration, and removes the intent of MHSA funding for those with serious mental illness. The current Mission Statement incorporates the only groups eligible for MHSA services: "individuals at risk for and living with serious mental illness and their families." The proposed mission statement omits them entirely, substituting people who are NOT eligible for MHSA services, contrary to the intent of the voters in Prop. 63/MHSA. This is unacceptable.

2.4 Contract Authority. Pursuant to the MHSOAC Resolution adopted on March 24, 2011,

A. The Executive Director has the authority to take all actions necessary to enter into contracts on the Commission's behalf ~~of the MHSOAC~~ in the amount of ~~$100,000~~ $200,000 or less and to enter into Interagency Agreements in the amount of ~~$200,000~~ $400,000 or less. ~~The Executive Director may delegate to subordinates any of the authority delegated to the Executive Director by the MHSOAC. Within 24 hours of such delegation the Executive Director shall notify the MHSOAC Chair and Vice Chair.~~

Enclosure 5

B. The Executive Director, with the consent of the Chair and Vice Chair, has the authority to take all actions necessary to enter into contracts on the Commission's behalf in the amount of $500,000 or less and to enter into Interagency Agreements in the amount of $750,000 or less.

We believe increasing Executive Director authorization over contracts undermines the transparency of the Commission's actions and minimizes stakeholder collaboration. The voice of individuals living with severe mental illness and their family members must continue to be considered when making decisions regarding the taxpayer revenues provided from the Mental Health Services Act.

Respectfully,

Linda Mayo, NAMI & MHSA Stakeholder Stanislaus County, mother of SMI

Kartar Diamond, Orange County, SMI Advocate

Mark Gale, NAMI Greater Los Angeles County, Criminal Justice Chair

Shelley Hoffman, SMI Advocate, Caregiver Support Group Facilitator

Dale Milfay, mother of SMI San Francisco, outreach coordinator for Northern Ca. Committee on Psych Resources

Jeffrey Hayden, President/CEO of Hayden Consultation Services, Inc.Committee Member, Advocacy Steering Committee, National Alliance on Mental Illness (NAMI) – Ventura County

Lauren Rettagliata, SMI Advocate, Contra Costa County, Housing That Heals

Teresa Pasquini, SMI Advocate, Contra Costa County, Housing That Heals

Lois Loofbourrow, SMI Advocate

Fred Martin, Jr., SMI Advocate

Alison Morantz, James and Nancy Kelso Professor of Law, Stanford Law School

Wade Brynelson

Nancy Brynelson,Retired, CSU Center for the Advancement of Reading and Writing

Susan Levi, NAMI SFV VP

Lynne Gibbs, Chair, NAMI SBCO Public Policy Committee, and a mental health California advocate

Linda L. Mimms, M.A. Public Policy, Duke University, California Advocates,
Serious Mental Illness/Brain Disorders Advocate,
NSSC (National Shattering Silence Coalition),
SARDAA (Schizophrenia and Related Disorders Alliance of America),
NAMI (National Alliance on Mental Illness)

Enclosure 5

Rhonda Allen, SMI Advocate, NAMI Stanislaus
lease add my name to this letter, thank you

Carol Stanchfield, MS, LMFT Director of ACT & AOT Services, TPCP

Virginia A. Garr
SMI advocate, NAMI member, and member of American Foundation for Suicide Prevention

Anna Penido, Los Angeles
(mother of 2 young men with SMI)

Cheryl Perkins, SMI Advocate

Patricia Fontana-Narell
Family Advocate, Voices of Mothers

AGENDA ITEM 4

Information

February 17, 2021 Commission Meeting

Staff Report Out

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

Presenter:

- Toby Ewing, Executive Director, MHSOAC
- Dawnté Early, Ph.D., Chief of Research and Evaluation

Enclosures (6): (1) MHSSA Background Summary; (2) California Student Mental Health Implementation Guide; (3) Evaluation Dashboard; (4) Innovation Dashboard; (5) Calendar of Tentative Agenda Items; (6) Department of Health Care Services Revenue and Expenditure Reports Status Update

Handouts: None

Mental Health Services
Oversight & Accountability Commission

MHSSA Background:

The Mental Health Services Oversight & Accountability Commission (MHSOAC) administers the Senate Bill 82 Investment in Mental Health Wellness Act which provides local assistance funds to expand mental health crisis services. The Commission recognizes that the effects of mental health crises are evident on school campuses and that reaching pupils in the school setting is practical for a first point of contact for mental, behavioral, and substance use disorder services for youth. Schools provide an opportunity for early identification and early intervention to address behavioral health issues that can undermine learning and health development.

Improved access to mental health services is foundational to supporting children and youth develop into healthy resilient adults. Comprehensive models and integrated services that are tailored to individual and family needs, have the best chance of improving health and academic outcomes. The Mental Health Services Act is intended to foster stronger school-community mental health partnerships that can leverage resources to help students succeed by authorizing counties and local educational agencies to enter into partnerships to create programs that include targeted interventions for pupils with identified social-emotional, behavioral, and academic needs. School-community mental health partnerships offer an opportunity to reach children and youth in an environment where they are comfortable and that is accessible.

The MHSOAC makes Triage funding available to counties through a competitive grant process to expand access to services for children and youth. In 2017, the MHSOAC released SB 82 funds, with 50 percent of those funds dedicated to children and youth aged 21 and under. Additionally, the MHSOAC set aside approximately $20 million for four School-County Collaboration Triage grants with the aim of 1) providing school-based crisis intervention services for children experiencing or at risk of experiencing a mental health crisis and their families/caregivers, and 2) supporting the development of partnerships between behavioral health departments and educational entities.

Under that funding program Humboldt County, Placer County, Tulare County Office of Education, and California Association of Health and Education Linked Professions Joint Powers Authority in San Bernardino was awarded $5.3 million over four years. The four School-County partnership programs are supporting strategies to 1) build and strengthen partnerships between education and community mental health, 2) support school-based and community-based strategies to improve access to care, and 3) enhance crisis services that are responsive to the needs of children and youth, all with particular recognition of the educational needs of children and youth.

In addition to the four School-County partnership grantees, the MHSOAC awarded Triage contracts to counties to operate school-based Triage programs in Berkeley, Humboldt, Riverside, Sacramento, and San Luis Obispo.

As a result of the high-level of response to the school-county collaboration RFA and the implementation of school-based programs through the Triage RFA, the Legislature passed and the Governor signed the 2019 Budget Bill, Senate Bill 75, which included the Mental Health Student Services Act (MHSSA) to establish mental health partnerships between County Mental Health or Behavioral Health Departments and educational entities.

Categories of Funding:

During planning sessions, stakeholders raised concerns that communities with existing partnerships may have an advantage in responding to a Request for Application (RFA) compared to those with no existing partnership. In response to those concerns, in November 2019 the Commission approved the outline of the RFA which would make available $75 million in funding from four fiscal years, setting aside $5 million for implementation and evaluation, with program funding available in two categories: 1) funding for counties with existing school mental health partnerships ($45 million) and 2) funding for counties developing new or emerging partnerships ($30 million).

20 counties applied for Category 1 funding, 10 of which were awarded grants in April 2020. 18 counties applied for Category 2 funding and 8 additional grants will be awarded at the Commission's August 2020 meeting.

Grant Awards Breakdown:

The table on the following page includes a breakdown of the 38 county partnerships that applied for the MHSSA grants, including the 18 which were awarded and the 20 which were not awarded:

Applicant County Name	Size	Category	Awarded (18)	Not Awarded (20)
Amador	Small	2		X
Calaveras	Small	2	X	
Contra Costa	Large	2		X
Fresno	Large	1	X	
Glenn	Small	1		X
Humboldt	Small	1	X	
Imperial	Small	2		X
Kern	Large	1	X	
Lake	Small	1		X
Los Angeles	Large	1		X
Madera	Small	2	X	
Marin	Medium	1		X
Mariposa	Small	1		X
Mendocino	Small	1	X	
Monterey	Medium	1		X
Nevada	Small	2		X
Orange	Large	1	X	
Placer	Medium	1	X	
Riverside	Large	2		X
Sacramento	Large	1		X
San Bernardino	Large	1		X
San Diego	Large	1		X
San Francisco	Large	1		X
San Luis Obispo	Medium	1	X	
San Mateo	Large	2	X	
Santa Barbara	Medium	2	X	
Santa Clara	Large	2	X	
Santa Cruz	Medium	2		X
Shasta	Small	2		X
Solano	Medium	1	X	
Sonoma	Medium	2		X
Sutter-Yuba	Small	2		X
Tehama	Small	2	X	
Trinity-Modoc	Small	2	X	
Tulare	Medium	1	X	
Tuolumne	Small	2		X
Ventura	Large	1	X	
Yolo	Medium	2	X	

Category 1 Awardees (10):

Humboldt	Total Funds Received: $2.5 million	Partnerships: • Humbodlt County Department of Health and Human Services – Children's Mental Health • Humboldt County Office of Education • All 32 school districts in Humboldt County which include all public and charter schools in Humboldt County

Summary of Services:
The Humboldt Bridges to Success (HBTS) program was established in 2018 and funded with a MHSOAC grant. This program created school-based mental health crisis-triage teams for all five regions of Humboldt County, and created a sixth team that specializes in mental health service for the 0-5 age group, enabling each regional team to provide the services and supports which best meet their community's unique cultural and geographic differences. MHSSA funds will be used to hire additional direct service personnel, fund HBTS program evaluation, and help sustain the project for approximately two additional years. The HBTS program is currently staffed by 17 positions, all of which are direct care staff. Grant funds will be used to increase program staffing by six and increase the supervising mental health clinician and a peer position to full-time.

The primary goal of HBTS is to provide school-based mental health intervention and support to students, in crisis or at risk of crisis. The program increases access to mental health services by providing intervention and services in locations that are easily accessible to students and their families. These staff work alongside other school personnel to:

- Identify students in need of support
- Determine and provide an appropriate, limited duration intervention or interventions
- Determine if the intervention was successful
- If successful, slowly discontinue the intervention and continue to monitor the student, or
- If necessary, assist the student in accessing more intensive, longer term services and supports

Mendocino	Total Funds Received: $2.5 million	Partnerships: • Mendocino Health and Human Services Agency, Behavioral Health and Recovery Services • Mendocino County Office of Education • Special Education Local Plan Area • Seven school districts including Anderson Valley, Fort Bragg Unified, Laytonville, Manchester, Potter Valley Community, Ukiah Unified, and Willits Unified • Three charter schools including Eel River, River Oak and Willits Elementary

Summary of Services:
The Mendocino County Student Services partnership is led by Mendocino County Behavioral Health and includes the Mendocino County Office of Education, behavioral health service providers, and school districts. The partnership delivers an array of services to students and their families through therapists, counselors, and other case managers working on-site at schools and through services offered in the community by established behavioral health providers in Mendocino County, including the Mendocino County Youth Project, Redwood Community Services, Redwood Quality Management Company, and Tapestry Family Services. MHSSA funds will be used to better bolster and expand existing services to Mendocino County students and their families. This includes linking and strengthening existing mental health services to better meet student's mental health needs, and enhance awareness, prevention and early intervention.

Grant funds will be used to increase program staffing by six and will apply for a Healthy Minds Alliance AmeriCorps to increase capacity to address mental health needs in the community. Service providers support the goals, mission, and vision of the partnership through:

- Outreach and engagement to students and families
- Screening for mental health concerns and assessing student needs and strengths
- Brief treatment and intervention
- Coodinating services and resources outside the school and help students access community resources and mental health services
- Follow-up with students, families, and community providers
- Crisis intervention
- Providing support and collateral services to teachers in responding to students' mental health concerns
- Identifying needs of family members and providing referrals and linkages to services and community resources
- Providing group mental health services to students

Placer	Total Funds Received: $4 million	Partnerships: • Placer County Children's System of Care • Placer County Office of Education • Special Education Local Plan Area • Four school districts including Auburn Union, Placer Hills Union, Colfax Elementary, and Placer Union High School

Summary of Services:

For 31 years, Placer county has had a System of Care structure called the System Management Advocacy Resource Team (SMART), which is focused on the key outcomes for Placer County for children and families to be safe, healthy, at home, in school, and out of trouble. MHSSA funds will be used to broaden Placer County's existing System of Care partnership with school-based programs, increased staff, and expanded access on school campuses to a continuum of services and supports for children and their families, by creating and sustaining a Wellness Center at each of four school sites.

Each Wellness Center will not only be a program, but also a physical space on campus where staff will be co-located. It will be a mental health resource and provider site where students and their families can access prevention, early intervention, intensive, and crisis mental health services and referrals. It is also where school staff can access the program for training, consultation and increased mental health literacy.

Grant funds will be used to hire four Mental Health Specialists and three Family and Youth Community Liaisons to provide services at the Wellness Centers, which will also utilize existing school-based mental health staff, who will be reallocated and trained. In addition to the array of school based mental health services offered by the new Wellness Program, the Wellness staff will:

- Assist students and families with linkage to community-based referrals
- Help families initially access services and support the ongoing use of services
- Provide mental health education to school staff
- Partner with teachers to infuse social emtoional learning and mental health content into their curricula
- Engage parents and families to reduce complicating factors that impact mental wellbeing, such as food and housing insecurity, access to health care, and employment

Staff will also merge into the community for family and student support, including providing trainings for families in places where they live and work, and will blend into the school community providing presentations in classrooms and responding to mental health needs throughout the campus.

San Luis Obispo	Total Funds Received: $4 million	Partnerships: • County of San Luis Obispo Behavioral Health Department • San Luis Obispo County Office of Education • Six school districts including Lucia Mar, Paso Robles, San Luis Coastal, San Miguel, Shandon, and Templeton

Summary of Services:

The County of San Luis Obispo Middle School Comprehensive Partnership was established to build school and community cultures which promote social-emotional development, eliminate stigma, and provide access to care for students with mental health challenges. It established the Middle School Comprehensive Program to build collaborative teams at six of the counties middle schools. While 12 middle schools submitted proposals, funding limits dictated that only six schools could be supported.

Currently, MHSA funds support a lead behavioral health specialist, a youth development specialist, and a family advocate on each school's team, and each school provides its counselors, administrators, nurse, and faculty to form a multidisciplinary team to help identify and care for students at the earliest stage of risk.

MHSSA funds will be used to expand this partnership to provide the other six middle schools with the Program. The expanded partnership will build collaborative teams with the goal of increasing access to mental health services, reducing risk, and increasing protective factors.

Grant funds will be used to hire nine staff, including five Behavioral Health staff, and three Family Advocates, who will provide the following services:

- On-campus prevention, screening, early intervention, counseling, and referral
- On-campus youth development activities and engagement, including stigma reduction activities and education
- Mental health assessments and treatments
- Bilingual case management services to families

By expanding the Program to the six new middle school sites, the county will be able to make a significant countywide impact on increasing mental health outcomes, including access to care and protective factors for vulnerable populations, reduced stigma and negative outcomes stemming from social-emotional challenges and school failure.

Solano	Total Funds Received: $4 million	Partnerships: • Solano County Behavioral Health • Solano County Office of Education • Six school districts including Benicia, Dixon, Fairfield-Suisun, Travis, Vacaville, and Vallejo City

Summary of Services:

The Solano County Student Wellness Partnership between Solano County Behavioral Health Division and Local Education Agencies supports the social-emotional wellbeing, learning, and resilience of Solano County's children and youth by providing a full continuum of school-based mental health, and community resources to all K-12 students. This partnership has led to the ongoing development of a growing network of culturally responsive school Wellness Centers across the county in K-12 and adult education sites.

The Student Wellness Partnership project will further enhance the efforts made to address critical gaps in school-based programming by significantly increasing the capacity of educators and school staff to identify and respond to mental health needs, and increasing timely access to mental health services for students at risk of dropping out and/or high-risk youth. It will also significantly improve the crisis response provided to K-12 students in schools in several Solano County school districts.

MHSSA funds will be used to support four full-time and 13 part-time school-based clinical positions, to provide direct school-based mental health and crisis services. School districts will participate in either of two service tracks:

- Track 1: Training and Technical Assistance (six school districts)
  - Trainings will be offered to teachers, classified staff, parents, classes, and student/peers, according to the individual needs of each district
  - Trainings will primarily be offered on local school campuses
- Track 2: Direct Services and Crisis Response (three school districts)
  - Provision of screenings and/or assessments for students who need ongoing mental health services
  - Crisis response, including phone triage, in-person crisis evaluation, crisis intervention and planning
  - Enhanced support groups and wellness/resilience services provided by interns at Wellness Centers
  - Pilot implementation of peer model that leveraged parent liaisons to provide support for families impacted by a child/youth experiencing a crisis and/or being at risk of drop-out
  - Universal screening of incoming kindergartener's (Dixon only)

Tulare	Total Funds Received: $4 million	Partnerships: • Tulare County Mental Health • Tulare County Office of Education • 44 school districts • Valley Life Charter

Summary of Services:

The Tulare County Mental Health and Tulare County Office of Education partnership focuses on meeting the mental health needs of students throughout the community. This partnership is in the second year of implementing the School-County Collaboration Triage Grant, which has several key components, including the placement of Triage Social Workers in 48 schools across the county, providing mindfulness training to students, and providing numerous trainings related to supporting youth mental wellness and suicide prevention to schools, families, community members, and mental health professionals. MHSSA funds will be used to expand the current program and includes hiring additional Triage Social Workers to serve additional schools throughout Tulare County.

Grant funds will be used to hire ten staff, including six Triage Social Workers and two Mental Health Clinicians. The Triage Social Workers will become part of the school community and provide services on school campuses, as well as provide services and support to families in their homes and community settings, including:

- Identify families in need of services and supports, including assessment, parenting support, family intervention services, linkage, and referrals to community services
- Teach mindfulness to children and adolescents using the K-12 Mindful Schools Curriculum
- Implement Coping and Support Training to target middle and high school-aged youth to build self-esteem, monitor and set goals, decision making and personal control
- Collaborate with mental health prevention and early intervention programs that serve the region and provide targeted early intervention services

Grant funds will also be used to:

- Support the development of a collaborative system to provide training, support, and assistance to local pediatrician's offices to screen children using the Adverse Childhood Experiences screener
- Form a new partnership with Tulare County Probation and provide a free Triage Social Worker for two days a week to provide social work services to youth who are currently incarcerated or recently released
- Expand the Peer Support Specialists component
- Expand the Mental Wellness Training team

Fresno	Total Funds Received: $6 million	Partnerships: • Fresno County Department of Behavioral Health • Fresno County Superintendent of Schools • 32 school districts

Summary of Services:
In 2016, the Fresno County Department of Behavioral Health and the Fresno County Superintendent of Schools formed the All 4 Youth Partnership, whose mission is to create an integrated system of care that ensures all children in Fresno County have access to behavioral health services to support their social, emotional, and behavioral needs and to promote a positive healthy environment. All 4 Youth works to expand mental health treatment and prevention and early intervention services for youth at school, home, and community locations in Fresno County.

MHSSA funds will be used to expand prevention and early intervention services for youth aged 0-22 throughout Fresno County. The partnership will expand its current model of care to serve more youth with mental illness and their families through a strengths-based, person-centered approach that focuses on prevention and early intervention, and connects youth with needed therapeutic services through the existing All 4 Youth Hubs.

Grant funds will be used for the construction and facilities improvements to develop four new, school-adjacent Wellness Centers in areas of the county with high-need and where the All 4 Youth Partnership has been unable to acquire facility space. Grant funds will also be used to hire 12 staff (Family Partners) over four years. 21 staff will be utilized as "in kind."

Through the Wellness Centers the Partnership will:

- Provide accessible information and host trainings to increase student, family, school staff, and community knowledge about trauma and mental health
- Provide mental health prevention and intervention services in accessible locations including schools, the community and a home
- Promote mental health for all and reduce stigma around mental health to increase the likelihood of accessing services
- Provide strategies and training for comprehensive self-care for families, students, and school staff, and
- Collaborate with schools and districts to extend the implementation of their *Natural School Mental Health Curriculum: Guidance and Best Practices for States, Districts, and Schools* to families and communities

Kern	Total Funds Received: $6 million	Partnerships: • Kern County Behavioral Health & Recovery Services • Kern County Superintendent of Schools • Five school districts including Bakersfield City, Greenfield Union, Kern County Superintendent of Schools Alternative Education, Kern High, Panama Buena Vista Union

Summary of Services:

The Kern County Network for Children, established in 1992 by the Kern County Behavioral Health & Recovery Services and the Kern County Superintendent of Schools, developed the Kern Youth Resiliency Partnership (KYRP), to expand school community partnerships in Kern County. KYRP is designed to provide targeted campus-based mental health services that will build resiliency, improve school connectedness and attendance, and increase access to mental health services for the most at-risk youth in Kern County.

MHSSA funds will be utilized to implement a Multi-tiered System of Support mental health approach designed to increase access to mental health services by establishing new mentoring programs, offering school-based after-hours mental health services, and improving the cross-agency continuum of care:

- Tier 1 includes early intervention and monitoring
- Tier 2 includes Americorps Mentoring
- Tier 3 includes dedicated mental health team that will provide services to foster and homeless students

Grant funds will be used to hire qualified mental health teams and provide direct targeted services at five school districts in Kern County. Each mental health team includes a LCSW/LMFT, Case Manager, and Substance Abuse Counselor. 14 staff will be hired in year 1, increasing to 17 in year 4, and include the mental health teams as well as AmeriCorps Mentors. Mental health teams provide the following services:

- Screen foster and homeless youth for ACEs
- Pilot a universal screening tool for all students
- Pilot a screening tool to assess PreK-3rd grade
- Ensure that Check In/Check Out rapid response intervention to support academics, behavior and social and emotional health is implementing with fidelity
- Screen students using a Biopsychosocial Assessment in addition to the PHQ9, GAD 7 and Columbia Suicide Rating Scale
- Provide school-based therapeutic services for youth and families (during school and after-hours)
- Substance abuse counseling and case management services

Peer support is an integral component of the program and includes cross-age peer-to-peer mentoring as well as AmeriCorps Mentoring for foster and homeless youth.

Orange	Total Funds Received: $6 million	Partnerships: • Orange County Health Care Agency • Orange County Department of Education • 29 school districts • Oxford Preparatory Academy

Summary of Services:
Since 2010, there has been an existing partnership between the Orange County Department of Education (OCD), which serves as the County Office of Education, and the Orange County Health Care Agency (HCA) Behavioral Health Services (BHS). In addition, there is a service agreement with Santa Ana Unified School District. OCD provides Positive Behavioral Intervention and Supports and Violence Prevention Education Services as a broad range of personalized social development services that are culturally and linguistically appropriate. OCD also provides clinicians and case managers to schools in Santa Ana Unified School District to provide professional development for teachers on mental health issues, to provide school-based individual group and family therapy, and to facilitate student support groups. The HCA BHS administers a full continuum of mental health services including prevention and early intervention services, outpatient treatment, residential treatment, and crisis services.

MHSSA funds will be used to implement an educational-health partnership approach to improve collaboration between the educational and behavioral health systems to provide and coordinate mental health services and linkages, as well as train school staff on mental health topics.

Grant funds will be used to hire seven regional Mental Health Student Services Coordinators to provide and coordinate an array of prevention, education/training, early intervention, and intensive services to help fill existing gaps in connecting students and families to mental health services. The Coordinators will collaborate with school staff and families to facilitate coordination of care and linkages to this continuum of care. Coordinators will provide services, including, but not limited to:

- Provide ongoing coordination of partnerships between HCA BHS, districts, schools, and community providers
- Conduct needs assessments with districts in their region to customize needed services and trainings for students, parents, and school staff
- Develop communication pathways, monitor activities and needs and adjust activities based on evolving district needs surrounding mental health services and trainings
- Identify regional resources and serve as the “regional expert” of mental health services
- Coordinate and/or provide education and training for teachers, students, parents, and families on mental health issues
- Coordinate and support student wellness team members in a regional collaborative

Continued

Orange Continued

- Provide care coordination to facilitate access to mental health resources and trainings for parents and caregivers of at-risk students, including serving as a liaison with districts to educate parents and students at high risk about mental health resources and trainings, and coordinate partnerships with community agencies

- Facilitate targeted outreach and improved access to services for at-risk students
- Coordinate and provide targeted outreach and linkage to students identified as high risk
- Coordinate and provide intensified outreach and linkage to services for students who are identified as being in crisis
- Provide and coordinate professional development in districts for teachers on mental health topics
- Facilitate and coordinate trainer of trainer opportunities for district and school staff

Ventura	Total Funds Received: $6 million	Partnerships: • Ventura County Behavioral Health Department • Ventura County Office of Education • Five school districts including Fillmore, Moorpark, Oxnard, Santa Paula, and Ventura • Valley Life Charter

Summary of Services:

The Ventura County Mental Health Services in Schools Partnership was established in 2012 between the Ventura County Behavioral Health Department and the Ventura County Office of Education. Its mission is to provide service strategies in schools that increase early identification of mental health needs, reduce access barriers, prevent mental health issues from becoming severe and disabling, and facilitate linkages to ongoing and sustained services. The partnership provides mental health and support services for Ventura County's students with special education needs, as well as for additional populations of youth at highest risk of mental health care needs, and has continued to expand services and incorporate a continuum of school-based mental health services by establishing projects in 15 of the county's 20 school districts.

Using MHSSA funds, the Ventura County Wellness Center Program is being established to augment the partnership's mission. The Wellness Centers will be designed to be a "safe haven" for students, including those with mental health needs, to access services in a recovery-focused environment. They will be located in eight high schools within five school districts. These high schools have the greatest need for services and have available space to dedicate to the program. The Wellness Centers will reduce access barriers (e.g., transportation, cost, and stigma) and improve mental health and educational outcomes. Services provided through the Wellness Centers will specifically address suicide prevention, drop-out prevention, placement assistance and service planning for students in need of ongoing services, and outreach to high-risk youth.

Grant funds will be used to hire staff and contractors including Wellness Coordinators, Wellness Clinicians and Wellness Peers. A Wellness Coordinator will oversee all activities within each Wellness Center, including:

- Provide mental health screenings and counseling
- Provide mental health education and training
- Coordinate early intervention services/short-term counseling
- Support crisis intervention as indicated
- Develop and implement the school-based communications program
- Provide ongoing supervision and program management of Wellness Peers
- Maintain service data to support program evaluation, and
- Arrange brief interventions for alcohol and drug offenses
- Refer students with more intensive mental health needs to the assigned clinician to provide linkages to care providers and a more complete evaluation and assessment

Category 2 Awardees (8):

Calaveras	Total Funds Received: $2.5 million	Partnerships: • Calaveras County Health and Human Services Agency/Behavioral Health Division • Calaveras County Office of Education • Four school districts including Bret Hart Union, Calaveras Unified, Mark Twain Union Elementary, and Vallecito Union • Mountain Oaks Charter

Summary of Services:

The vision of the County-Educational Entities partnership is for a continuum for student mental health services on elementary campuses that will have three tiers: (1) Proposed: Mental Health Wellness Centers at elementary schools and other programs in middle and high schools (2) Current: The Calaveras Care Team for families with complex issues that require a coordinated approach (3) Current: Crisis protocols and processes that keep students in trauma-informed care from the time they are identified on campus to the time they are hospitalized (or safety planned, or incarcerated). The Program Plan will add to, and complete, the components, which have already been put into place. The intent is to develop an infrastructure that allows the clinical service providers to be on elementary school campuses where they are needed, when they are needed for students, while offering staff support and parent education for all campuses.

Grant funds will be used to staff and operate Mental Health Wellness Centers on elementary school campuses, including hiring two Licensed Clinicians, three Mental Health Specialists, two Supervising Licensed Clinicians, and a Program Evaluator. Sierra Child and Family Services, a non-profit community-based agency, is selected as a partner in the program because they have experience operating school based mental health programs in El Dorado County Union High School District. There are already multiple services provided on the school campus, and the Wellness Center staff will be able to link students to those services as appropriate for the student. Specifics for the program include:

- Teams, assigned to a specific school site, that will consist of a supervising licensed clinician, a licensed clinician, and a family specialist
- All students are eligible to participate in the services offered by the Wellness Center, regardless of their financial/insurance status
- Students referred to the team (by staff, teachers, family/parents) will receive individual assessment and treatment as needed, when deemed appropriate by the Supervising Clinician
- Services to students may include crisis support, brief mental health assessments, outreach and engagement, linkage/navigation to community services, therapy (includes DBT), activities/skills training to emphasize self-care, and mental health awareness
- When not working directly with students, the teams/members will: provide mental health trainings for school staff; provide mental health classes to students, parents, and the community; work with student leadership and student mentors on mental health issues, supports, communication; make connections with other services providers/services
- When needed, a team/member will respond to behavioral/mental health crisis on campus

Madera	Total Funds Received: $2.5 million	Partnerships: • Madera County Behavioral Health Services • Madera County Office of Education • 10 school districts • Three charter schools including Sherman Thomas, Western Sierra, and Ezequiel Alvarado

Summary of Services:

The Madera County Youth Behavioral Health Collaborative provides increased access to mental health and behavioral health services in the school, home and community to students throughout Madera County who are identified as in need of mental health support and intervention. The goals of the partnership are to:

- Increase access to behavioral health services in locations that are easily accessible to students and their families
- Emphasize preventive and early intervention services that maximize the healthy development of children and minimize the long-term need for public resources
- Provide case management services to children and families with multiple needs
- Enhance crisis services that are responsive to the needs of children and youth
- Facilitate linkages and access to a continuum of ongoing and sustained services for students with identified social-emotional, behavioral and academic needs
- Identify gaps in services to targeted populations

The program will address two county-wide needs (1) navigation and case management services for students and families and (2) additional capacity to assist with new interventions before calling school resource officers or law enforcement to conduct an assessment for a 5150 hold. Grant funds will be used to contract with Camarena Health, the county's largest community health care provider, to hire three Behavioral Health Community Navigators (BHCN), two Licensed Clinical Social Workers (LCSW), and a Program Coordinator.

Each BHCN will be assigned to one of three regions within the county. They will ensure the students and their families are able to access the available resources and treatment options, coordinate care, and serve as a liaison to the school staff to ensure that students have the school-based support services they need to successfully return to and remain in class. The LCSWs will be deployed throughout the county to provide responsive additional capacity during an initial student crisis. Whenever possible, they will use interactive video and audio technology to provide support to school staff to de-escalate stressful situations and to develop preventative measures before a 5150 referral is made. Tele-mental health services will be a key service delivery strategy for this program, both to efficiently and effectively cover the geographic range of the mostly-rural county and to address potential social-distancing requirements brought about by COVID-19.

Tehama	Total Funds Received: $2.5 million	Partnerships: • Tehama County Health Services Agency - Behavioral Health Services • Tehama County Department of Education • Seven school districts including Corning Union High, Corning Elementary, Evergreen Union, Gerber Union Elementary, Lassen View Union Elementary, Red Bluff Elementary, and Red Bluff Joint Union High • Reeds Creek Elementary School

Summary of Services:

The Tehama County Student Services Collaborative (TCSSC) is a new partnership including the Tehama County Department of Education, Tehama County Health Services Agency, and multiple schools within Tehama County. The partnership will use a Strategic Prevention Process for implementation of the TCSSC project. Universal screening, assessment, implementation of Social Emotional skills, and professional development will occur throughout the four years of the grant cycle. All schools participating in the collaborative will establish or update their facilities to develop a Social Emotional Wellness Center on campus.

Grant funds will be used to hire staff, provide trainings, and make facilities improvements to Wellness Centers. Three Mental Health Wellness Clinicians will be hired to provide direct service to students, collaborate with teams, and provide professional development. A Mental Health and Wellness Clinician Coordinator will support data collection, analysis, and program implementation. The community partners Empower Tehama, Expect More Tehama, and First 5 Tehama will also be engaged with the plan.

The project implementation includes the following:

- All children ages 0-5 in Tehama County will have an ASQ or ASQ-SE and transition meeting prior to entering Kindergarten
- All grades K-3 and 4-6 will participate in Mind Up Curriculum to build Social Emotional wellness and self-regulatory skills
- Universal screening will occur at LEA's and mental health partners using the CANS
- Why Try curriculum will be implemented for grades 6-8
- Grades 9-12 will implement Botvin Life Skills
- All schools and partners will participate in professional development on Trauma Informed Practices and Adverse Childhood Experiences (ACEs)
- All schools will be trained in Applied Suicide Intervention Skills Training (ASIST)
- Use of peer partners in schools through programs such as Club Live, STATUS, and Leadership to build a student network whose emphasis is on mental health wellness

Trinity-Modoc	Total Funds Received: $2.5 million	Partnerships: • Trinity County Behavioral Health Services • Trinity County Office of Education (TCOE) • Modoc County Office of Education (MCOE) • 12 school districts • California Heritage Youth Build Academy (CHYBA)

Summary of Services:
This new partnership with Trinity County Behavioral Health, Trinity County Office of Education, CHYBA, all Trinity County school districts, and the Modoc County Office of Education will bring wellness liaisons to schools to assist students with their mental health conditions, and to train staff in early detection and intervention. By providing personnel and peer support, this partnership will create linkages through the wellness liaisons between students, the triage team, community partners, and mental health providers.

The partnership will contract with Pathways to Success and will be assisted by the Pathways to Success Implementation Team (Implementation Team), which will implement their directives and manage the program. In addition, each school district in Trinity County, Modoc County, and CHYBA will have representation on the team to provide region specific feedback and guidance.
The Implementation Team will be composed of 23 members including:

- 18 School Liaison/Counseling Technicians
- 3 School Social Workers/Clinicians
- 1 Program Director
- 1 Program Director Administrative Assistant

The Social Worker/Clinicians and School Liaison/Counseling Technicians will be based at the schools and will directly serve students in schools (and other settings when directly working with preschoolers and families).

Social Worker/Clinicians will primarily provide direct services to students requiring mental health interventions. School Liaison/Counseling Technicians will provide students, parents, and staff with information and referrals to support students' success and will assist students with academic, attendance, and/or behavioral issues including implementing student disciplinary services and assisting parents and students in locating services (e.g. counseling, resource and intervention referrals) to increase student success.

All services will be provided on school campuses to include, but not be limited to trauma “toxic stress” informed strategies, suicide prevention and crisis teams, drop-out prevention, placement assistance and service plans for students who need ongoing services.

Santa Barbara	Total Funds Received: $4 million	Partnership Entities: • Santa Barbara County Department of Behavioral Wellness • Santa Barbara County Education Office • 20 school districts

Summary of Services:
The collaborative partnership between the Santa Barbara County Office of Education and County of Santa Barbara Behavioral Health Services will ensure seamless linkages to prevention and intervention resources, including securing appropriate levels of behavioral health services for County youth and their families. The design of the program is heavily centered on providing students and their families with access to Navigators and program Clinicians to facilitated access to mental health services.

Grant funds will be used to hire personnel to support mental health prevention, early intervention and crisis response activities, including coverage during the summer months, by providing direct services, making direct referrals to services and coordinating mental health training, educational opportunities and presentations to all stakeholders. Personnel hired include a Project Manager, a Research Evaluator, two Clinicians, and six contracted Navigators.

Navigators and Clinicians will have direct contacts for "warm hand-offs" to Behavioral Wellness and community mental health providers. The Project Manager will work with mental health and healthcare providers to increase awareness of the Program and ensure direct lines of communication are established and proper procedures are in place to share necessary information for comprehensive case management provided by Navigators. Additionally, students, school staff and parents will be provided with opportunities to increase their knowledge of emerging mental health issues and how to intervene to mitigate possible escalation of symptoms.

The Navigators will be peer positions, and will provide the following services:

- Facilitate linkages to resources with warm hand-offs
- Case management for students needing long-term services
- Assist with community and on-campus mental health and wellness presentations

The Clinicians will provide services including:

- Crisis intervention support
- Coordinate integration of PBIS/MTSS with mental health services
- Supervise navigators with case management and assist with access to services
- Support student re-entry after crisis intervention

Yolo	Total Funds Received: $4 million	Partnership Entities: • Yolo County Health and Human Services Agency • Yolo County Office of Education • Five school districts including Esparto, Davis Joint, Washington, Winters, and Woodland

Summary of Services:
The Yolo County-School Partnership will provide school-based mental health prevention and intervention services and supports to students, and will use a team approach for an integrated, multi-tiered mental health service delivery model. The partnership includes every kindergarten through high school public school in Yolo County. Working alongside school personnel, project staff will increase access to the continuum of mental health services by providing prevention and intervention services in locations that are easily accessible to students and their families. The partnership will contract with community-based organizations (CBO) for culturally/linguistically matched direct service personnel and will provide evidence-based training for all direct care staff.

Grant funds will be used to employ a Project Manager, and an Administrative Analyst, and will fund regional contracts with CBOs. The CBOs will provide a continuum of preventive and interventive mental health services in each of Yolo County's five school districts and County Office of Education schools using the following staff:

- School Based Supervising Clinicians to supervise and support school-based team members
- School Based Clinicians to provide direct care, training, and local coordination
- Navigators/Outreach Workers to provide direct mental health supports and services, trainings, and coaching

Specifically, the team will:

- Improve school climate on individual school campuses
- Identify individual students in need of additional support
- Establish and provide appropriate, limited duration intervention(s) on the school campus or appropriate locations chosen by the youth and families
- Determine if the intervention(s) was successful
- Assist with navigation and transition to informal community/cultural services and supports when appropriate for individual students and/or family
- Assist the student and family in accessing more intensive, longer term services and supports

San Mateo	Total Funds Received: $6 million	Partnership Entities: • San Mateo County Behavioral Health and Recovery Services • San Mateo County Office of Education • 12 school districts

Summary of Services:

Formed in early 2020, San Mateo County's SYSTEM Support (Success for Youth and Schools through Trauma-Informed & Equitable Modules) is a new partnership between San Mateo County Health, Behavioral Health and Recovery Services (BHRS) and the San Mateo County Office of Education (SMCOE). This project will operate in two phases:

- Phase 1 for all 12 participating districts focuses on Tier 1 supports, i.e., training and coaching to implement one of three selected evidence-based Social Emotional Learning (SEL) curricula that will be delivered universally in schools to prevent, and provide for early identification of, mental health challenges.
- Phase 2 of the project is specifically designed to close identified equity gaps, and an investment will be made in hiring school- based Wellness Counselors for three districts that have over 20 schools, as well as one isolated continuation high school. These school sites will also receive training and support to implement additional promising SEL supports, and a universal screening tool to identify students at high risk of behavioral health challenges, including trauma. Upon early identification, students can be referred to Wellness Counselors for intervention. Students and families whose needs cannot be met at the school site level will be guided to CareSolace, an online mental health care matching resource, which will provide tailored assistance in locating follow-up care and treatment for more complex needs from a provider in the community.

Grant funds will be used to hire staff, including 6.75 Wellness Counselors, a Program Manager, and an Administrative Assistant. Wellness Counselors will:

- Work closely with teachers at school sites to identify students with various challenges (e.g., homelessness, experiences in the foster system, depression due to sexual identity issues, etc.)
- Perform crisis intervention and/or brief intervention therapy (individual and/or group) on a scheduled or drop-in basis
- Provide guidance regarding use of the universal screening tool
- Assist with the delivery of supplemental SEL curricula, including *Kit Grit* and *Wayfinder*

Grant funds will also be used to engage CareSolace, hire training vendors, and purchase SEL curricula.

Santa Clara	Total Funds Received: $6 million	Partnership Entities: • County of Santa Clara Behavioral Health Services • Santa Clara County Office of Education • 31 school districts

Summary of Services:
This collaborative partnership will utilize MHSSA funds to fill the gaps in existing prevention and early intervention mental health services in schools and provide strategies to support students during the Covid 19 crisis. Primary objectives are to create Wellness Centers on school sites, increase the number of mental health professionals at school sites, and provide relevant professional learning to educators.

The Wellness Centers will fill existing service gaps and will work collaboratively with existing services, utilizing the three Tiers of support:

- *Tier 1* activities are prevention based and focus on all students, including homeless and foster youth, youth who identify as LGBTQ, and underserved youth. Included are Social Emotional Learning activities and Restorative Justice practices, age appropriate resources and information about mental health issues, parenting classes and support groups, and referrals for needed services.
- *Tier 2* activities are early intervention and focus on students struggling with specific behavioral, emotional, or social functioning needs and will include groups or one on one check-ins.
- *Tier 3* activities are intervention for youth with the highest needs, and include short-term individual therapy, crisis assessment and triage and re-entry to school following suspension or expulsion.

Grant funds will be used to facilitate linkages and access to sustained services through the personnel hired. The personnel include eight Wellness Center Coordinators, four Wellness Center Liaisons, six Counseling Associates, eight Trainees/Interns, a MHSSA Coordinator, and a Data Technician.

Wellness Center Coordinators are responsible for running the Wellness Center including program implementation, day-today operations, coordinating direct services, and partnering to provide school-wide prevention and early intervention efforts.

Counseling Associates will provide individual, group, or family counseling in the school setting, perform assessments and create treatment plans, provide social-emotional classroom lessons, and accurately assess and provide crisis intervention.

California Student Mental Health Implementation Guide

Purpose: This guide is intended to support local education agencies (LEAs) and county behavioral health departments (BHDs) as they seek to partner to deliver comprehensive, high-quality school mental health services. These are challenging collaborative efforts with helpful information and tools to address barriers spread out in many different places. The goal of this resource is to create a library of helpful resources and organize tools around critical topics and challenges. Through this project, we aim to generate applicable resources specific to the needs of partners to further the growth of school mental health partnerships. Each section includes an overview of the topic and a collection of related resources. You may find that you revisit certain resources in multiple sections. A glossary is included for your convenience at the end of the table, beginning on page 23.

Click on a section to get started!

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Section 1: Overview of School Mental Health

This document is not going to outline the case for school mental health here since there are many resources that help school systems, health care systems, and mental health systems understand the importance of comprehensive school mental health. School mental health is heavily aligned with school and health care initiatives happening across the state of California, including:

- Multi-Tiered Systems of Support (MTSS)
- Positive Behavior Interventions and Supports (PBIS)
- Social and Emotional Learning
- Community Schools
- Trauma-informed classrooms and practices
- Suicide prevention policies in schools
- Restorative Justice

While this guide curates tools for building school mental health services and programs, none of this should happen in isolation from other school and county initiatives.

Implementing School Mental Health includes addressing the school environment and policies that dictate staff and students' daily experiences. School mental health initiatives are not just about increasing access to specific interventions or services but also about addressing the whole school community and climate. All of the above mentioned initiatives work to create more positive school climates and cultures with supportive student and staff relationships. This work, alongside more targeted services for students that need more intensive support, create a comprehensive approach to increasing student mental health.

A note about language: we try to use the terminology, "mental health," consistently throughout this guide to cover the continuum of school-based services, from prevention to treatment, that address a student's sense of wellbeing. However, some linked resources use the terminology, "behavioral health." The Substance Abuse and Mental Health Services Administration (SAMHSA) defines behavioral health as "the promotion of mental health, resilience, and wellbeing; and the treatment of mental and substance use disorders."

Resources (some resources appear in multiple sections)	
School-Based Mental Health: Improving School Climate and Students' Lives (California School-Based Health Alliance) – a brief two-page factsheet that summarizes the impact of mental health on students, why school-based mental health is important, and some guiding best practices.	Overview: School Mental Health Programs (California School-Based Health Alliance) – a brief two-page factsheet describing various school mental health programs and interventions, including an overview of the multi-tiered approach to school mental health.

Why Student Mental Health Matters, Student Supports: Getting the Most Out of Your LCFF Investment (California Community Schools Network) – a brief guide that presents the case to school administrators and partners for the importance of addressing student mental health in school settings. Summaries of County-School Partnerships to Advance School Mental Health (California School-Based Health Alliance) - descriptions of how local entities in seven counties are partnering to advance school-based mental health services. Information is provided about what services are included in the initiatives, who the lead partners are and how the partnerships evolved, how coordination is supported, and what funding is leveraged.	Cheat Sheet for School Mental Health Initiatives (California School-Based Health Alliance) – A short list of definitions and additional resources to help understand other school-based initiatives that intersect with school mental health. Every Young Heart and Mind: Schools as Centers of Wellness, Draft Report (Mental Health Services Oversight and Accountability Commission) - a report from the Subcommittee on Schools and Mental Health that reviews the need for school-based mental health services and provides state recommendations to improve mental health access and outcomes and increase academic success. Tulare County Office of Education Acronyms List - List of common acronyms to support cross communication between education and mental health agencies.

Section 2: Equity and Anti-Racist School Mental Health

It is critical to address the systemic racism that students, families, and communities experience. School mental health sits between two structures and systems - education and health care, particularly mental health care - that have deep histories in racist practices and structural biases. Many of which still exist today and because of this, each action or decision made must be **actively anti-racist** in order for our initiative to achieve equity.

While this is a separate section to highlight the importance, using an anti-racist and equity lens is integral and needs to be woven into every aspect of implementing school mental health.

Addressing equity and creating anti-racist schools and school-based services is deep, challenging, ongoing work. This is not one step or one section in the process of building school mental health programs and services. These are values, practices, critical conversations, and lifelong learning and humility that must be knitted throughout our school mental health partnerships, planning, and implementation. Most importantly, consideration must be given to integrate this hard work from the beginning *and* on an ongoing basis.

In this guide, there are a number of resources that explore anti-racist and structural biases in mental health delivery, organizations broadly, and school mental health systems specifically. As leaders in regional, county, or local organizations and agencies interested in building school mental health systems and programs, please consider these questions as you explore the ongoing work of dismantling biases, racism, and white supremacy in the initiatives you create:

- Reimbursement and sustainability for school mental health services (for example, through Medi-Cal funding) is currently inextricably connected to determinations of eligibility. How does this structure based on eligibility and classifying students for care create barriers to care through a deficit model, often deeply connected to structural biases?
- Are school mental health services structured (i.e. referral protocols, coordination) to be in-service to or as an alternative to punitive discipline practices (i.e. suspensions, expulsions, and interactions with police)? Research shows that school discipline practices have a disproportionately negative impact on students of color.
- What is the racial make-up of your leadership team, decision-makers, school staff, and mental health providers? What is the racial make-up of the student body and the students receiving mental health services? Oftentimes our decision-makers, teachers, and school support staff do not reflect the student populations served which can contribute to bias in the services provided to students. Do educators, staff, and providers receive on-going training in providing culturally-responsive care?
- Explore current racial disparities in your education and mental health systems. Are students of color more likely to be suspended? Are youth of color more likely to receive a formal mental health diagnoses? Are youth of color disproportionately represented in special education? Why do these disparities exist? Everyone's thoughts and actions have been affected by living in a systemically and

structurally racist society – it is important that team members are familiar with implicit bias, how it impacts others, and recognize that even well-intentioned individuals often have room to learn.

- How are school mental health programs and interventions built on resilience, collective care, and empowerment rather than ideas of saviorism or paternalism?

Resources	
Webinar Recordings & Training Materials: Youth Perspectives on COVID-19, Racism and Returning to School (National Center for School Mental Health) Supporting School Mental Health in the Context of Racial Violence (Mental Health Technology Transfer Center Network) • Session 1: Learning From and With Students, Caregivers, Advocates and Systems Leaders • Session 2: Learning from and With the School Mental Health Workforce (School Counselors, Psychologists, and Teacher Educators) Eliminating Inequities in Behavioral Health Care Webinar Series (California Institute for Behavioral Health Solutions) - Recorded webinars from a series created to increase knowledge about the interplay between structural racism, behavioral health institutional racism, implicit bias, and behavioral health disparities. The target audience for the series includes behavioral health care leadership, administrators and managers, ethnic service managers, peer professionals, clinical supervisors, clinicians/direct care providers, and care managers. Rising Practices for Telehealth Series: Partnering and Listening to Youth/Students Who We Marginalize, Specifically in Their Telehealth (Pacific Southwest Mental Health Technology Transfer Center) – A two-part webinar series exploring telehealth approaches, practices, and policies to meet the mental health needs of youth we marginalize.	Culturally Sensitive Trauma-Informed Care of Students presentation (Tulare County Office of Education) - presentation slides for a training provided to school mental health providers. **Articles & Reading Materials:** The Future of Healing: Shifting from Trauma Informed Care to Healing Centered Engagement (by Shawn Ginwright Ph.D., on Medium.com) Trauma, Racism, Chronic Stress and the Health of Black Americans (SAMHSA's Office of Behavioral Health Equity) - addresses the impacts of racism and suggests Evidence Based Interventions. Critical-Multiculturalism, Whiteness and Social Work: Towards a More Radical View of Cultural Competence (Fix School Discipline) - addresses anti-racism in social work and mental health. HEARTS: A Whole School, Multi-Level, Prevention and Intervention Program for Creating Trauma-Informed Safe and Supportive Schools (Fix School Discipline) - one example of how to use trauma-informed mental health systems in schools to reduce exclusionary discipline

Resources for Schools and Educators	Web Pages with More Resources:
Ways 2 Equity Playbook (Santa Clara County Office of Education) – a guide for education leaders designed to facilitate the overhaul of deeply embedded inequities in the current educational system. Equity Resources (San Diego County Office of Education) – a website for educators with resources to address equity in schools and education.	Cultural Responsiveness and Equity (National Center for School Mental Health) Cultural Humility and Equity (UCSF HEARTS) Implicit Bias Test (Harvard) Fix School Discipline website

Section 3: Needs Assessment

The needs assessment process (and it is a process, not a single activity) will help partners decide where to start. Whether you and your partners work in large or small counties, whether you start from scratch or think about how to expand an existing initiative, whether you consider where to start in a whole county or one school district; creating a definition of need and goals will help you identify where to start, assess your impact, and decide what to do next once there is some momentum.

Some considerations when starting the assessment process:

- Who should you recruit as part of a **small leadership team** to guide the assessment process? Is there an existing team that can be tasked with the activity? What existing relationships can you build upon?

- How are you incorporating, including, and prioritizing **community input** throughout the needs assessment and decision-making process? How are you engaging students and parents/caregivers? Are there existing or new student and/or parent advisory boards you can include to help guide this process?

- What is your **scope**? What resources are available that will help you determine your scope? For example, consider where and how many you should start (the whole county or one school district or one school site)? If you have determined that your scope is a whole county, are you considering how to create services and programs countywide or are you identifying school district(s) and/or site(s) where to start?

- If you are identifying a portion of the county to start in, how might you consider **student "needs"**? Some possible data points include: student enrollment numbers, percentage of students eligible for free & reduced-price meals (which is based on poverty and correlates with Medi-Cal eligibility), percentage or number of students with disabilities, percentage of high needs students as defined by the Local Control Funding Formula (LCFF), school climate surveys, and student/parent surveys.

- If you are identifying a portion of the county to start in, how might you consider **"readiness"**? Some existing school and/or district initiatives that you can build on for success can include: MTSS and/or PBIS, school wellness policies, student suicide prevention policies, trauma-informed classroom and school practices.

Resources	
How to Start and Sustain a School Health Initiative (Alameda County Center for Healthy Schools and Communities) – A step-by-step guide through the stages it takes to implement an initiative, specifically, gathering a team of champions and understanding assets and needs. Chapter 2: Community Planning, Vision to Reality (California School-Based Health Alliance) – A guide for collecting needs assessment data including sample surveys and focus group questions, and a process for creating and maintaining youth engagement within the planning process. School Based Behavioral Health Assessment (Alameda County Center for Healthy Schools and Communities) - A guide on types of data to gather and how to conduct an assessment on mental health needs in order to develop a plan for increasing mental health services. Active Implementation Hub (National Implementation Research Network) - an online learning environment for use by any stakeholder involved in active implementation and scaling up of programs and innovation. Some specific tools: • Root Cause Analysis Resources • Stakeholder Engagement Guide • The Hexagon Analysis and Discussion Tool	Youth Engaged in Leadership and Learning: A Handbook for Program Staff , Teachers, and Community Leaders (John W. Gardner Center for Youth and Their Communities, Stanford University) - a comprehensive handbook for guiding youth advocates and the adults who work with them on engaging young people in participatory research, analysis, and planning. Improving Performance of Students with Disabilities (California County Superintendents Educational Services Association) – A resource for conducting a root cause analysis, building an improvement team, and using data in planning. School-Based Behavioral Health: Conditions for Success (Alameda County School-Based Behavioral Health Initiative) - A checklist of school site and district level conditions for success, specifically when integrating a community-based mental health provider within the school campus. **Assessment Tools:** SHAPE System (National Center for School Mental Health) – An online tool to assess the existing structure and operations of school mental health systems. ISF District/Community Leadership Team Installation Guide – A guide to be used by facilitators and coaches to support District/Community Leadership Teams on installing infrastructures for an Interconnected System Framework.

Section 4: Planning and Partnerships

This section covers many of the formal processes and components of creating partnerships and plans to implement school mental health initiatives. But planning and partnerships happen at multiple different levels in a school, district, region and/or county. Alameda County's guide, "How to Start and Sustain a School Health Initiative," provides helpful high-level strategies for partnerships that may be coming together at a regional or county level. Comparatively, the "School Mental Health Quality Guide on Teaming" provides helpful context for school district or school site teams. The section pulls together resources that may be helpful for both levels of partnerships and planning.

This section and resources will help teams begin to identify the goals, outcomes, key activities, and resources for a school mental health initiative - both at a regional level or site level, depending on the scope of your school mental health initiative.

Some considerations for this process:

- **Create a leadership team.** Develop a core group of leaders that align around a shared vision and have the credibility and relationships to engage others. The leaders should represent key sectors, be passionate about the work, and be truly committed to a collaborative process. This group may likely have come together prior to launching a needs assessment and may be critical in guiding that process. This core team of leaders may become a more formal body to lead the school health initiative.

- **Identify community and school partners to engage**. If not already part of your leadership team, some key partners to engage early are: County Offices of Education, School District Leadership, County Behavioral Health Department

  Depending on your needs assessment and information about resources available in the community to support the school mental health initiative, other partners you may want to engage are: Special Education Local Plan Areas (SELPAs), First 5 programs, community health centers, private and Medi-Cal health plans, community mental health providers, hospitals, local philanthropies, business groups, parent groups, and community representatives.

- **Develop a shared mission and vision, scope of work, and timeline for implementation.** An implementation timeline should take into consideration the school calendar including when schools typically hire staff (i.e. March-June) and capitalize on existing time (i.e. in-service training for school staff) to prepare school and community partners for collaborative work.

- **Clarify language use and terminology.** Schools, County Behavioral Health Departments, and community partners use different language to describe services provided and student/youth needs. Creating common lists of terms, acronyms, and definitions will help support how your team communicates with each other.

- **Create memorandum of understanding (MOUs) or working agreements.** MOUs and/or contracts may be helpful at both the school site and service level (i.e. between school site providers and schools) *and* between leadership entities (i.e. between COEs and county behavioral health departments).

Resources	
For regional or county teams: How to Start and Sustain a School Health Initiative (Alameda County Center for Healthy Schools and Communities) – A step-by-step guide through the stages it takes to implement an initiative. Specifically, this includes creating a plan, formalizing agreements through contracts, and creating high level strategies. **For school district or school site teams**: School Mental Health Quality Guide: Teaming (National Center for School Mental Health) – A guide with background information on teaming, best practices, possible action steps, examples from the field, and resources. Summaries of County-School Partnerships to Advance School Mental Health (California School-Based Health Alliance) - descriptions of how local entities in seven counties are partnering to advance school-based mental health services. Information is provided about what services are included in the initiatives, who the lead partners are and how the partnerships evolved, how coordination is supported, and what funding is leveraged. Mental Health Student Services Act (MHSSA) Summaries (Mental Health Oversight and Accountability Commission) - summaries of grants awarded to establish mental health partnerships between County Mental Health or Behavioral Health Departments and educational entities.	Possible Partners in Delivering School Mental Health (California Scope of School Mental Health Initiatives (California School-Based Health Alliance) - Where should your team start? Do you provide services to schools throughout the county, district, and/or SELPA? Or should you focus on a subset first? How do you decide where to start? This resource highlights examples of scope from a couple counties and identifies some key questions to consider when planning where to start. Advancing Education Effectiveness: Interconnecting School Mental Health and School-Wide Positive Behavior Support (Center on PBIS) - this guide provides a framework to connect school mental health services with PBIS. It includes many resources and tools for developing the systems, collaborations, and practices to do this work. Some helpful tools for partnerships include: • Appendix B, Building an Inclusive Community of Practice - Four Simple Questions (page 144) • Appendix E, Implementation Guide: District and Community Cross Systems Team (page 150) Active Implementation Hub (National Implementation Research Network) - an online learning environment for use by any stakeholder involved in active implementation and scaling up of programs and innovation. Some specific tools: • Module 3: Implementation Teams

MOUs: Anatomy of an MOU (National Center for School Mental Health) – A template illustrating the components of an MOU that school-community partnerships may include. You will also need to consider relevant state law in any contract development in California. **Sample MOUs/Other agreements:** School District Letter of Agreement (LOA) (Alameda County) - An LOA between an LEA and school-based mental health provider. ISF Collaborative Partner Working Agreement (Monterey County) - A working agreement between a participating school district, county office of education, and county behavioral health department. MOU Template (Monterey County) - boilerplate contract between county behavioral health department and school district for the provision of therapeutic services for students in the district. Systems Management, Advocacy and Resource Team MOU (Placer County) - an MOU for a county-level partnership across various youth-serving agencies and entities.	**Example of Team Agendas:** Monterey County's ISF Leadership Team Calendar - An example of the discussion topics and content covered at monthly leadership team meetings. This is a helpful resource for considering how to onboard members and build a monthly calendar of coordination meetings.

Section 5: Staffing and Facilities

There are many strategies a district and/or county can take to staff school mental health services. In this section, you will find a breakdown of what types of providers can be employed to provide different services and the requirements for different types of credentials, as well as sample job descriptions and training calendars.

Some considerations to take into account when considering what type of **staffing** structure would be the best fit include:

- What types of services are to be provided across the three tiers of the MTSS framework? How are clinical and treatment services staffed? Are staff located on campus? By providing clinical services on school campuses, students are more likely to receive care.
- What services did the needs assessment and input from stakeholders demonstrate to be most necessary?
- What type of staff are necessary to deliver and coordinate the different services? Will the agency utilize mental health interns as well as paid staff? What infrastructure is the school district creating to coordinate these interventions?
- How will mental health providers be integrated into the larger school community? What opportunities are there for cross-training, for attending standing meetings, etc.?
- Who will employ the school mental health staff: county behavioral health, school district, county office of education, community agencies?
- How will the staff be supervised, taking into account both administrative and clinical supervision?
- What credentials and/or licenses will the staff and supervisors need? Are positions created to tap into community member strengths and knowledge who may not have credentials or clinical licenses?

The agency taking the role of hiring the school mental health staff will need to develop a training plan that considers how to train the staff in ways that encompass services across the three tiers of intervention as well as how school mental health staff integrate into the school culture and climate. Training considerations should also include how the school mental health staff can support education staff wellness, social and emotional literacy, and healing centered practices.

There also needs to be considerations for where the services will take place and what type of **facilities and space** are needed. Some Tier 2 and 3 mental health interventions that take place in the school need confidential spaces for services and record keeping. The type of agency providing the service will help shape factors to consider. For Medi-Cal reimbursement, you many need to consider licensing and certification requirements for sites or facilities. In this section there is a link to a guide on facility and certification requirements in order to provide Medi-Cal eligible services.

Resources	
Types of Providers and Personnel for School Mental Health (California School-Based Health Alliance) - An explanation of the roles and responsibilities for school-based providers with pupil personnel services credential (PPSC) and non-credentialed providers that may provide mental health services in schools. K-12 School Mental Health Services & Staff (California Behavioral Health Directors Association) - provides information about various mental health services to help guide and support local collaboration across the county behavioral health and education systems. Includes types of services provided by county mental health plans and LEAs, summarizes the types of licensed and credentialed professionals that can provide support, and includes examples of models to deliver services to students. **Sample job descriptions:** Coordinator Regional Mental Health Services (Orange County Office of Education) Unconditional Education Coach (Seneca Family of Agencies) Family and Youth Community Liaison, Educational Services (Placer County Office of Education) Family Partner (Fresno County Office of Education) Mental Health Specialist, Prevention Supports and Services (Placer County Office of Education) School Based Behavioral Health Clinician (Alameda County Behavioral Health Care)	Facility/Site Licensing Requirements for Medi-Cal (California School-Based Health Alliance) - In order to get reimbursement through Medi-Cal, either as a community health center or specialty mental health provider (through the county behavioral health department), facility requirements are necessary to certify the site where services are delivered. **Sample Training Plans:** Menu of Trainings (Tulare County Office of Education) - a sample of training topics available to school mental health staff Training Calendar for School Based Interns (RAMS: Richmond Area Multi Services)- a sample training/orientation calendar for school based mental health interns

Section 6: Coordination

Collaboration and coordination among stakeholders in the education and mental health field are necessary to increase student mental health. In order for efforts to be sustainable, there needs to be collaboration and buy-in at every level of leadership. The leadership between education and mental health entities need to coordinate efforts and work together from the State leadership, to the county and district leadership, to the school site and local mental health providers.

This coordination is challenging work for many reasons as leadership, staff, and providers can often have different points of view, different priorities and even the language used can be different. This makes commitment to working together and across the systems so important and requires patience, flexibility and creativity.

In efforts to support student mental health, collaboration between student supports, including partner agencies, and school administration and staff is vital. Included in this section are resources to support efforts of coordination at different levels of leadership.

School site level:
Building a team to coordinate supports and referrals is a significant component of successful school mental health partnerships. Coordination teams come in many different shapes, sizes, and names. One example of how to coordinate and work together is called **Coordination of Services Team (COST)** (see guide and resources included). There are also multiple "layers" of coordination to consider: at the school site level responding directly to student needs to regional or county levels where systemic issues and collective responses can be addressed and discussed.

Regardless of what you call the coordination team(s), there are several important components: Based on your needs assessment, an overall **understanding of the entire continuum of services** available in the system of care. It is important that various coordination teams, to the best of their ability, understand who provides what services in the system of care, how students are referred to services, and eligibility determinations. A **universal referral form** that allows students, parents, and all staff to refer students when there is indication support could be beneficial. Examples of COST referral forms are also included. The referral form ensures that students have access to available services.

Regular meetings among support staff and school staff to discuss student referrals and create plans of support at the school site level. Regular meetings ensure that staff have the opportunity to share data (while ensuring confidentiality) and report back on student outcomes, reflect on trends and needs that are coming up across the school and ways to increase school wide efforts. For example, a high number of referrals for freshman girls experiencing anxiety during the first six months of school could lead to creating support groups and curriculum implemented across a class that all freshmen are taking.

Tracking **student data and outcomes** of referrals and services ensures that the needs of the students are being met as well as identifying early warning indicators that will help provide early intervention for often overlooked students. Some school sites have been able to implement the COST referral form and services to students' educational accounts through the school so that teachers and all staff can access real time updates on what is working to help the student.

Screening students school wide for mental health risks enables students to access early intervention and allows schools to notice trends and create supports tailored to their communities. Coordination between mental health agencies and the school personnel is required for quality and effective screening and planning for meeting students' needs.

One of the biggest challenges in coordinating student mental health programs and services arises around issues of **confidentiality, protected health and student information, and data sharing**. Simply put, there are federal and state laws that protect student and patient information. We have included a comprehensive guide to help partners understand these laws and identify practices to facilitate coordination and protect student information.

Resources	
For county, regional and district efforts: Collaboration Multiplier (Prevention Institute) - an interactive framework and tool for analyzing collaborative efforts across fields and can help lay the foundation for shared understanding and common goals across all partners. Cascading Logic Model (National Implementation Research Network) - a logic model informed by implementation science to promote and support education systems to create meaningful and impactful organizational and systems change to achieve better outcomes for students. Initiative Inventory (National Implementation Research Network) - a tool to support your team's review of past and current strategies to determine what has been successful and what more is needed to achieve desired outcomes.	Creating Alliance for Change (Now Is The Time- TA Center) - Designed to increase dialogue and foster relationships between schools, families and community mental health resources and partners. Collaboration Framework (National Network for Collaboration) - a tool to support people and organizations in starting and improving existing collaborations. Tulare County Office of Education Acronyms List - List of common acronyms to support cross communication between education and mental health agencies. **For district and local school site and mental health agency efforts:** Coordination of Services Team Guide (COST) (Alameda County Center for Healthy Schools and Communities) – A comprehensive guide, with editable resources, that provides an overview and road map for schools and partners interested in launching or improving COST or similar service coordination teams.

Sample COST Forms Confidential Referral Form (Alameda County Center for Healthy Schools and Communities) COST Referral Form (Hayward Unified School District) COST Tracking Sample (Oakland Unified School District) COST Forms (zip file of referral and example tracking student outcomes files from Alameda County Center for Healthy Schools and Communities) **Screening student mental health needs** SAMHSA Ready, Set, Go, Review: Screening for Behavioral Health Risk in Schools (Substance Abuse and Mental Health Services Administration) - A tool with examples of how to prepare for and conduct school wide screenings for behavioral health risk to allow for targeted early intervention. School Mental Health Quality Guide: Screening (National Center for School Mental Health Guide) - A comprehensive resource on determining a plan for school wide screenings for behavioral health risk.	**Confidentiality and data sharing** A California Guide for Sharing Student Health and Education Information (California School-Based Health Alliance) – An online guide that provides an overview of the laws that relate to sharing student/patient information (HIPAA, FERPA and California State Law), as well as best practices and resource materials for schools and health providers. HIPAA or FERPA? A Primer on School Health Information Sharing in California (National Center for Youth Law) - A printable guide, similar to the web resource above, that helps navigate the complex interactions of HIPAA and FERPA in school health programs including SBHCs, school-based mental health programs, school nursing services, and other types of health services delivered on school campuses.

Section 7: Legal and Liability

Nothing in this section should be interpreted as legal advice for partners and agencies. The resources and information presented here are meant to highlight the legal concerns that are often raised in creating comprehensive school mental health services. Partners are strongly encouraged to engage their own legal counsels early on in the planning and implementation processes.

Contracts and MOUs will help create a structure and legal document to address many of the complex legal challenges to consider in creating these partnerships and services for students. Some areas to address and consider:

- Develop **uniform policies and procedures for referring** students to services. How will they enter services? How will they exit? What forms will be used for entrance? What process will be used for exit?

- Ensure **data and information sharing** within the LEA(s) and with third party providers (this includes both community-based agencies and county behavioral health departments) is understood and in compliance with federal and state law. This includes:
    - Determination whether services are governed by HIPAA or FERPA
    - What information can and will be shared with who?
    - Release of information forms under HIPAA or FERPA
    - Consent to treatment forms under HIPAA or FERPA

- Discuss issues associated with **treatment of minors (and minor consent for services)** and develop clear protocols and procedures for such treatment.

- **Train all staff in the continuum of care**, including obligations and entitlements under the IDEA, ADA, Section 504 of the Rehabilitation Act, Child Find, and Medi-Cal EPSDT so children are referred for entitlements that they may qualify for. How will special education interface with the rest of the system to ensure eligibility and entitlements are provided and protected?

Relatedly, once a student is referred to services, **consider issues around access to those services**. What happens if a coordination team cannot come to consensus on the responsible agency for services? How are roles between partners defined and how is the obligation to provide services determined between partners and responsible agencies?

Resources	
Anatomy of an MOU (National Center for School Mental Health) – A template illustrating the components of an MOU that school-community partnerships may include. You will also need to consider relevant state law in any contract development in California. Minor Consent (California School-Based Health Alliance) - Minor consent laws in California allow young people aged 12 and over to consent to certain services without parent or guardian involvement, including some mental health services. This webpage provides an overview of the laws and resources for school-based health providers. Commonly Overlooked School Behavioral Health Contract Terms and Protocols (Atkinson, Andelson, Loya, Ruud & Romo) – a list of commonly overlooked MOU terms and protocols for school-based mental health partnerships.	A California Guide for Sharing Student Health and Education Information (California School-Based Health Alliance) – An online guide that provides an overview of the laws that relate to sharing student/patient information (HIPAA, FERPA and California State Law), as well as best practices and resource materials for schools and health providers. HIPAA or FERPA? A Primer on School Health Information Sharing in California (National Center for Youth Law) - A printable guide, similar to web resource above, that helps navigate the complex interactions of HIPAA and FERPA in school health programs, including SBHCs, school-based mental health programs, school nursing services, and other types of health services delivered on school campuses.

Section 8: Funding and Sustainability

One of the chief barriers to creating comprehensive systems of school-based mental health services is identifying funding streams that support interventions throughout the three tiers of intervention - from school-wide support to intensive treatment services. After time-limited grants help build out a system, what resources are available to sustain the services and initiative?

Schools and community providers do not have the resources to sustain school mental health services on their own. No single entity (school, or community, or county) can provide the whole range of comprehensive services, for all students. Trust, partnerships, coordination, and community buy-in will help entities bring together resources to build out a comprehensive system of services.

Also, there is not a national or state model for how to fund these services. While available funding is largely federal and state, many decisions about how to use funding and what services to prioritize happen at the local level. So, there may be examples of how different counties and school districts across California sustain mental health services, however there is not one "best" way to sustain these services.

The resources in this section will help you **(1) learn about the funding streams that are available to sustain school mental health services.** While they will not tell you exactly how you should use these them, the resources will help you develop a general understanding of what funding streams are available and what partnerships are necessary to leverage that funding for school-based services. And **(2) learn about what others have done to sustain school mental health programs.** County demographics, strengths, and challenges vary considerably. What works in one place may not work in another (i.e. heavily leveraging Medi-Cal reimbursement). However, there are innovative and varying sustainability strategies to garner inspiration from.

Other overall recommendations to consider while identifying your sustainability plan:

- **Investing funding and resources in school and district coordination creates critical infrastructure to leverage outside resources.** This can sometimes run counter to the immense need we see in schools for direct services for students - why spend critical resources on staff that are not providing direct services to students? However, when schools invest in this infrastructure, they can be better positioned to navigate various community providers who may be able to draw down additional, and often more restrictive, funding.

- **Utilize flexible funding streams to fill in the gaps between services that are sustained by more restrictive funding sources.** There are funding streams that are more restrictive (i.e. they can only be used for specific services provided by select providers for a certain group of students) but, there are also funding streams that are more flexible. For example, you can utilize flexible funding for services for non-Medi-Cal students, staff training and prevention services that are critical to the success of a school mental health initiative, *and* to support coordination across providers and teams.

- **Investing in tier 1 (schoolwide prevention) and tier 2 (targeted interventions) are just as important as investing in traditional, one-on-one mental health inventions (tier 3).** Tier 1 investments lay the foundation for a comprehensive school mental health system and Tier 2 services provide important prevention and early intervention services that can mitigate the need for more intensive mental health supports that we see in Tier 3.

If you are benefiting from a grant to build out your school mental health initiative, **use that time-limited grant to create a "runway" to sustainability.** Use grant funding to support your services and staff as you identify and address billing and reimbursement challenges and build outcomes of interest that may bring in new partners and/or additional funding.

Resources	
Public Funding for School-Based Mental Health Programs (California School-Based Health Alliance) – A resource that outlines and explains the public mental health funding streams (on the education side and health care side) in California that can support the full continuum of school-based mental health services. Practical Guide for Financing Social, Emotional, and Mental Health in Schools (California Children's Trust and Breaking Barriers) - A guide for school district leaders interested in exploring partnerships and accessing Medi-Cal to meet the social, emotional, and mental health needs of students in schools.	Smart Financing Practices for School-Based Behavioral Health (Alameda County Center for Healthy Schools and Communities) – This resource highlights Alameda County's efforts to leverage multiple funding streams to invest in school-based behavioral health.

Section 9: Data Collection and Outcomes

Evaluations come in many forms, ranging from those run by a team of external evaluators to researchers who collect and analyze data over a period of several years to simple data collection efforts by school mental health staff and partners. The scope of your evaluation will depend on the resources you have available, the questions you want to answer, the demands of your funders, and competing priorities.

Because resources are limited, schools implementing school mental health programs will eventually want to know that the school mental health investment is a good value.

Some outcomes that are likely to be important to track from the school's perspective include:

- Improved academic performance
- Improved student behavior
- Improved school climate
- Increased teacher satisfaction and reduced turnover
- Increased parent participation in school activities
- Increased parent and student satisfaction
- Increased attendance
- Graduation rates
- Decreased suspensions and expulsions

Some outcomes that will be important to track from the county mental health agency perspective include:

- Improved student mental health outcomes such as reduced rates of students reporting depression and anxiety
- Increased student report of knowing how to access services if they have a mental health need
- Increased teacher report of knowing how to access services and supports for their students
- Increased rates of students identifying a supportive relationship with an adult on campus
- Decreased student report of loneliness
- Decreased rates of students experiencing suicidal ideation

The most important thing to remember as you develop your evaluation plan is that you need to create a plan that is realistic for your team. You don't have to measure everything! In fact, without a sufficient budget and staff capacity you are likely to get overwhelmed if you try to document everything. Instead, it is best to check in with your stakeholders and prioritize what matters most to them and make sure that staff are properly trained in order to effectively capture the data identified. In addition, these questions may help start conversations amongst you and your team:

- What is going to be the most compelling evidence for them that you are being effective?
- What are you required to track for your funders?
- What data are already being gathered (e.g., service delivery) that can tell your story?
- How can you collect other evidence in a way that is the least burdensome but the most likely to capture your outcomes?

Chapter 9: Evaluation and Data Collection, Vision to Reality (California School-Based Health Alliance) - This resource provides an overview of evaluation for school health center services, with an emphasis on what you should consider in the early stages of planning and start-up. Although specific to health centers, it includes helpful information about data sources and different strategies for evaluating impact of school health services. Evaluation and Quality in School Health Centers (Alameda County Center for Healthy Schools and Communities) - An example of one county's evaluation efforts. UCSF Project Cal-Well Mental Health Program (UCSF Institute for Health Policy Studies) – This includes templates and examples of ways to report outcomes for student wellness data. A district or school can input their unique data into the report card to use for reporting and information sharing. The template includes outcomes of interest to both schools and mental health agencies. • Report card template blank • Report card high school example	**Survey Tools** California Healthy Kids Survey – This is the largest statewide student survey of resiliency, protective factors, risk behaviors, and school climate in the nation. There is a "Learning From Home Survey" to assess remote learning impact on students and families. Project Cal-Well School Staff Survey - These data collection instruments were created to assess the social emotional wellness and mental health needs and perceptions among students and school staff.

Definitions of common terms and acronyms

AB 114, Special Education Transition	Signed in 2011, this law ended the state mandate on county mental health agencies to provide mental health services to students with disabilities. After the passage of AB 114, school districts are solely responsible for ensuring that students with disabilities receive special education and related services, including some services previously arranged for or provided by county mental health agencies. In some cases, school districts still contract with counties, or county-contracted providers, to provide mental health services to special education students.
CMAA = County Medicaid Administrative Activities	Participating local governmental agencies are eligible to receive Federal reimbursement for the cost of performing administrative activities that directly support efforts to identify and enroll potentially eligible individuals into Medi-Cal, and to remove barriers to Medi-Cal services. Eligible activities include outreach to the general population and high-risk populations, facilitating Medi-Cal applications, contracting for Medi-Cal services, and program planning and policy development.
EPSDT = Early Periodic Screening Diagnosis and Treatment	An enhanced Medicaid benefit that requires states to screen for and provide services necessary to ameliorate physical and mental health conditions for all persons under age 21 who are eligible. Under EPSDT, young people who qualify for full scope Medi-Cal (or Medicaid) with mental health conditions that meet medical necessity are entitled to services including, but not limited to, the following: mental health assessment, collateral contacts, therapy, rehabilitation, mental health services, medication support services, day rehabilitation, day treatment intensive, crisis intervention/stabilization, targeted case management, and therapeutic behavioral services.
EPSDT specialty mental health	Refers to the “moderate to severe” Medi-Cal mental health benefits that county behavioral health agencies are responsible. Medi-Cal Managed Care Organizations (MCOs, i.e. health plans) are largely responsible for the rest of the EPSDT benefit for beneficiaries under age 21.
ERMHS = Educationally Related Mental Health Services	These services are provided when special education students have significant social, emotional and/or behavioral needs that impede their ability to benefit from their special education services, supports, and placement. Services must be included in the Individualized Educational Plan (IEP) and can include individual counseling, parent counseling, social work services, psychological services, and residential treatment.
IEP = Individualized Education Plan	This is a plan or program developed to ensure that a child with an identified disability who is attending an elementary or secondary educational institution receives specialized instruction and related services.
ISF = Interconnected Systems Framework	A structure and process to integrate Positive Behavioral Interventions and Supports (PBIS) and School Mental Health within school systems. The goal is to blend resources, training, systems, data, and practices in order to improve outcomes for all children and youth.

Return to Menu

LCAP = Local Control Accountability Plan	A tool for local educational agencies (LEAs) to set goals, plan actions, and leverage resources to meet those goals to improve student outcomes. The plan is aligned with state funding that LEAs receive to achieve those goals and support the overall functioning of the LEA.
MHSA = Mental Health Services Act	Created in 2004 with the passage of Proposition 63, which levied a 1 percent tax on personal income above $1 million. MHSA provides the state's second largest public funding stream for mental health services, after Medi-Cal. MHSA programs and services are intended to enhance, rather than replace, existing programs. A majority of MHSA funding goes to counties and counties are required to submit three-year program and expenditure plans and annual updates.
MOU = Memorandum of Understanding	An agreement between two parties that is not legally binding, but which outlines the responsibilities of each of the parties to the agreement. These agreements may describe the relationship between counties, LEAs, and community provider(s) and outline the responsibilities and expectations of partnerships between the various entities.
MTSS = Multi-Tiered System of Support	An integrated, comprehensive framework that focuses on Common Core State Standards, core instruction, differentiated learning, student-centered learning, individualized student needs, and the alignment of systems necessary for all students' academic, behavioral, and social success.
PEI = Prevention and Early Intervention	One of five categories of expenditures in MHSA. This category is intended to fund programs and services that intervene early prior to the development of serious mental health issues and catch mental health issues in their earliest stages to prevent long-term suffering. PEI programs emphasize strategies to reduce negative outcomes that may result from untreated mental illness: suicide, incarcerations, school failure or dropout, unemployment, prolonged suffering, homelessness, and removal of children from their homes.
PBIS = Positive Behavioral Interventions and Supports	A framework for enhancing the adoption and implementation of a continuum of evidence-based interventions to achieve academically and behaviorally important outcomes for all students. As a "framework," the emphasis is on a process or approach, rather than a curriculum, intervention, or practice. The "continuum" notion emphasizes how evidence- or research-based behavioral practices are organized within a multi-tiered system of support.
SELPA = Special Education Local Plan Area	Consortiums in geographical regions with sufficient size and scope to provide for all special education service needs of children residing within the region boundaries. Each region develops a local plan describing how it would provide special education services. SELPAs vary in size: some serve just one school district, some serve multiple school districts, some serve an entire county.

Summary of Updates

Contracts

New Contract: None

Total Contracts: **3**

Funds Spent Since the November Commission Meeting

Contract Number	Amount
17MHSOAC073	$0
17MHSOAC074	$0
18MHSOAC040	$145,126
Total	**$145,126**

Contracts with Deliverable Changes

17MHSOAC073
17MHSOAC074
18MHSOAC040

Regents of the University of California, Davis: Triage Evaluation (17MHSOAC073)

MHSOAC Staff: Kai Le Masson

Active Dates: 01/16/19 - 12/31/23

Total Contract Amount: **$2,453,736.50**

Total Spent: $1,312,350

This project will result in an evaluation of both the processes and strategies county triage grant program projects have employed and the outcomes obtained in those projects, funded separately to serve Adult, Transition Age Youth and child clients under the Investment in Mental Health Wellness Act in contracts issued by the Mental Health Services Oversight and Accountability Commission. This evaluation is intended to assess the feasibility, effectiveness and generalizability of pilot approaches for local responses to mental health crises in order to promote the implementation of best practices across the State.

Deliverable	Status	Due Date	Change
Workplan	Complete	4/15/19	No
Background Review	Complete	7/15/19	No
Draft Summative Evaluation Plan	Complete	2/12/20	No
Formative/Process Evaluation Plan **Updated Formative/Process Evaluation Plan**	Complete **In Progress**	1/24/20 **1/15/21**	No **Yes**
Data Collection and Management Report	Complete	6/15/20	No

MHSOAC Evaluation Dashboard February 2021
(Updated February 3rd, 2021)

Deliverable	Status	Due Date	Change
Final Summative Evaluation Plan	Complete	7/15/20	No
Data Collection for Formative/Process Evaluation Plan Progress Reports **(10 quarterly reports)**	In Progress	**1/15/21-** 3/15/23	Yes
Formative/Process Evaluation Plan Implementation and Preliminary Findings **(11 quarterly reports)**	In Progress	**1/15/21-6/15/23**	Yes
Co-host Statewide Conference and Workplan **(a and b)**	Not Started	**9/15/21** Fall 2022	Yes
Midpoint Progress Report for Formative/Process Evaluation Plan	Not Started	7/15/21	Yes
~~Revised Final Summative Evaluation Plan~~	~~Not Started~~	~~4/15/21~~	~~Yes~~
~~Data Quality Report and Summative Evaluation Progress~~	~~Not Started~~	~~4/15/22~~	~~Yes~~
Draft**s** Formative/Process Evaluation Final Report **(a and b)**	Not Started	**3/30/23** 7/15/23	Yes
Final Report and Recommendations	Not Started	11/30/23	Yes

The Regents of the University of California, Los Angeles: Triage Evaluation (17MHSOAC074)

MHSOAC Staff: Kai Le Masson

Active Dates: 01/16/19 - 12/31/23

Total Contract Amount: **$2,453,736.50**

Total Spent: $850,850

This project will result in an evaluation of both the processes and strategies county triage grant program projects have employed and the outcomes obtained in those projects, funded separately to serve Adult, Transition Age Youth and child clients under the Investment in Mental Health Wellness Act in contracts issued by the Mental Health Services Oversight and Accountability Commission. This evaluation is intended to assess the feasibility, effectiveness and generalizability of pilot approaches for local responses to mental health crises in order to promote the implementation of best practices across the State.

Deliverable	Status	Due Date	Change
Workplan	Complete	4/15/19	No
Background Review	Complete	7/15/19	No
Draft Summative Evaluation Plan	Complete	2/12/20	No
Formative/Process Evaluation Plan **Updated Formative/Process Evaluation Plan**	Complete **In Progress**	1/24/20 **1/15/21**	No **Yes**
Data Collection and Management Report	Complete	6/15/20	No
Final Summative Evaluation Plan	Complete	7/15/20	No
Data Collection for Formative/Process Evaluation Plan Progress Reports **(10 quarterly reports)**	In Progress	**1/15/21-** 3/15/23	Yes

MHSOAC Evaluation Dashboard February 2021
(Updated February 3rd, 2021)

Deliverable	Status	Due Date	Change
Formative/Process Evaluation Plan Implementation and Preliminary Findings **(11 quarterly reports)**	In Progress	**1/15/21-6/15/23**	Yes
Co-host Statewide Conference and Workplan **(a and b)**	Not Started	**9/15/21** Fall 2022	Yes
Midpoint Progress Report for Formative/Process Evaluation Plan	Not Started	7/15/21	Yes
~~Revised Final Summative Evaluation Plan~~	~~Not Started~~	~~4/15/21~~	~~Yes~~
~~Data Quality Report and Summative Evaluation Progress~~	~~Not Started~~	~~4/15/22~~	~~Yes~~
Draft**s** Formative/Process Evaluation Final Report **(a and b)**	Not Started	**3/30/23** 7/15/23	Yes
Final Report and Recommendations	Not Started	11/30/23	Yes

The Regents of the University of California, San Francisco: Partnering to Build Success in Mental Health Research and Policy (18MHSOAC040)

MHSOAC Staff: Dawnte Early

Active Dates: 07/01/19 - 06/30/21

Total Contract Amount: **$1,257,008**

Total Spent: $590,504

UCSF is providing onsite staff and technical assistance to the MHSOAC to support project planning, data linkages, and policy analysis activities.

Deliverable	Status	Due Date	Change
Quarterly Progress Report	Complete	09/30/19	No
Quarterly Progress Report	Complete	12/31/19	No
Quarterly Progress Report	Complete	03/31/2020	No
Quarterly Progress Report	Complete	06/30/2020	No
Quarterly Progress Report	Complete	09/30/2020	No
Quarterly Progress Report	Complete	12/31/2020	Yes
Quarterly Progress Report	Not Started	03/31/2021	No
Quarterly Progress Report	Not Started	06/30/2021	No

Mental Health Services
Oversight & Accountability Commission

INNOVATION DASHBOARD
FEBRUARY 2021

UNDER REVIEW	Final Proposals Received	Draft Proposals Received	TOTALS
Number of Projects	1	14	**15**
Participating Counties (unduplicated)	1	7	**8**
Dollars Requested	$1,753,140	$14,549,187	**$16,302,327**

PREVIOUS PROJECTS	Reviewed	Approved	Total INN Dollars Approved	Participating Counties
FY 2015-2016	N/A	23	$52,534,133	15 (25%)
FY 2016-2017	33	30	$68,634,435	18 (31%)
FY 2017-2018	34	33	$149,548,570	19 (32%)
FY 2018-2019	53	53	$304,098,391	32 (54%)
FY 2019-2020	28	28	$62,258,683	19 (32%)

TO DATE	Reviewed	Approved	Total INN Dollars Approved	Participating Counties
FY 2020-2021	5	4	$$4,566,224	2

Total number of counties that have presented an INN Project since 2013:	Average Time from Final Proposal Submission to Commission Deliberation†:
57 (97%)	52 days

† This excludes extensions of previously approved projects, Tech Suite additions, and government holidays.

FY: Fiscal Year (July 1st – June 30th)

INNOVATION PROJECT DETAILS

DRAFT PROPOSALS						
Status	County	Project Name	Funding Amount Requested	Project Duration	Draft Proposal Submitted to OAC	Final Project Submitted to OAC
Under Review	San Francisco	Culturally Congruent Practices for Black African Americans	$5,400,000	5 Years	10/13/2020	Pending
Under Review	Colusa	Social Determinants of Rural Mental Health	$495,568	3 Years	12/10/2020	Pending
Under Review	Sonoma	New Parent TLC	$394,586	3 Years	10/6/2020	Pending
Under Review	Sonoma	Instructions Not Needed	$689,860	3 Years	10/6/2020	Pending
Under Review	Sonoma	Nuestra Cultura Cura Social INN Lab (aka On the Move)	$736,584	3 Years	10/6/2020	Pending
Under Review	Sonoma	Using Cognitive Technologies to Create Client Care Plans	$992,428	2 Years	11/13/2019	Pending
Under Review	San Francisco	Help@Hand Extension	$340,950	5 Years	1/8/2021	Pending
Under Review	San Francisco	Wellness In The Streets Extension	$262,500	5 Years	1/8/2021	Pending
Under Review	Humboldt	Resident Engagement & Support Team (REST)	$1,612,342	5 Years	12/17/2020	Pending
Under Review	Madera	Project DAD (Dads, Anxiety & Depression)	$930,401.56	5 Years	3/3/2020	Pending
Under Review	San Luis Obispo	BH Education & Engagement Team (BHEET)	$963,197.00	4 Years	6/4/2020	Pending
Under Review	San Luis Obispo	SoulWomb Project	$733,640.00	4 Years	6/4/2020	Pending
Under Review	Santa Clara	Independent Living Facilities Project	$990,000	3 Years	6/29/2020	Pending
Under Review	Santa Clara	Community Mobile Response Program (Phase I-Planning Funding)	TBD	TBD	11/20/2020	Pending

FINAL PROPOSALS						
Status	County	Project Name	Funding Amount Requested	Project Duration	Draft Proposal Submitted to OAC	Final Project Submitted to OAC
Under Final Review	Santa Clara	Addressing Stigma and Trauma in the Vietnamese and African American/African Ancestry Communities	$1,753,140	3 Years	11/20/2020	12/15/2020

APPROVED PROJECTS (FY 20-21)			
County	Project Name	Funding Amount	Approval Date
San Mateo	Cultural Arts and Wellness Social Enterprise Café for Filipino/a/x Youth	$2,625,000	8/27/2020
Modoc	INN and Improvement through Data (IITD)-Extension	$91,224	10/12/2020
San Mateo	Co-location of Prevention Early Intervention Services in Low Income Housing	$925,000	11/16/2020
San Mateo	PIONEERS (Pacific Islanders Organizing, Nurturing, and Empowering Everyone to Rise and Serve)	$925,000	12/9/2020

Calendar of Tentative Commission Meeting Agenda Items

Proposed 2/8/2021

Agenda items and meeting locations are subject to change

February 25, 2021: Sacramento, CA (Teleconference)

Prevention and Early Intervention Panel Presentation
The Commission will hear a panel of subject matter experts on key concepts and opportunities for population-based prevention and early intervention, particularly mental health awareness and identifying and removing barriers to access to appropriate services.

Santa Clara County Innovation Plan
The Commission will consider approval of $1,753,140 in Innovation funding to support the Addressing Stigma and Trauma in the Vietnamese and African American/African Ancestry Communities Innovation Project.

March 25, 2021: Sacramento, CA (Teleconference)

Innovation Plan Approval
San Francisco County seeks approval of $5,400,000 in Innovation funding for their Culturally Congruent Practices for Black African Americans innovation project.

Legislative Priorities for 2021
The Commission will consider legislative and budget priorities for the current legislative session.

Triage Grants – Next Round
Staff will provide an update on the current Triage grants and evaluation activities and the Commission will consider opportunities for the next round of Triage grants.

Public Hearing and Update on the Mental Health in the Workplace Project
The Commission will hear an update on the Commission's Mental Health in the Workplace project and a panel presentation on the challenges and opportunities related to workplace mental health.

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

April 22, 2021: Sacramento, CA (Teleconference)

Potential Innovation Plan Approval
The Commission reserves time on each month's agenda to consider approval of Innovation projects for counties. At this time, it is unknown if an innovative project will be calendared.

Legislative Priorities for 2021
The Commission will consider legislative and budget priorities for the current legislative session.

Award Early Psychosis Intervention Plus (EPI Plus) Phase 2 Grants
The Commission will consider awarding EPI Plus grants to the highest scoring applications received in response to the Request for Applications for the Early Psychosis Intervention Plus Phase 2 grants.

Outline for Triage Request for Applications
The Commission will be presented with an outline for the next round of Triage grants.

Public Hearing on Prevention and Early Intervention
The Commission will hold a hearing to explore key concepts and opportunities for prevention and early intervention across the lifespan and place-based approaches to prevention and early intervention to meet people where they learn, work, connect with social networks and cultural practices, and receive care and support.

Mental Health Student Service Act Update
The Commission will be presented with an update on the implementation of the Mental Health Student Service Act.

Innovation Systems Change Project Recommendations

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

May 27, 2021: Sacramento, CA (Teleconference)

Potential Innovation Plan Approval
The Commission reserves time on each month's agenda to consider approval of Innovation projects for counties. At this time, it is unknown if an innovative project will be calendared.

June – No Commission meeting

July 22, 2021: Sacramento, CA (Teleconference)

Potential Innovation Plan Approval
The Commission reserves time on each month's agenda to consider approval of Innovation projects for counties. At this time, it is unknown if an innovative project will be calendared.

Prevention and Early Intervention Report Presentation
The Commission will consider the final report of the PEI project subcommittee for adoption.

DHCS Status Chart of County RERs Received
February 17, 2021 Commission Meeting

Attached below is a Status Report from the Department of Health Care Services regarding County MHSA Annual Revenue and Expenditure Reports received and processed by Department staff, dated January 29th, 2021. This Status Report covers the FY 2016-17 through FY 2019-20 County RERs.

For each reporting period, the Status Report provides a date received by the Department of the County's RER and a date on which Department staff completed their "Final Review."

The Department provides MHSOAC staff with weekly status updates of County RERs received, processed, and forwarded to the MHSOAC. MHSOAC staff process data from County RERs for inclusion in the Fiscal Reporting Tool only after the Department determines that it has completed its Final Review. FY 2017-18 RER data has not yet been incorporated into the Fiscal Reporting Tool due to format changes.

The Department also publishes on its website a web page providing access to County RERs. This page includes links to individual County RERs for reporting years FY 2006-07 through FY 2015-16. This page can be accessed at: http://www.dhcs.ca.gov/services/MH/Pages/Annual-Revenue-and-Expenditure-Reports-by-County.aspx. Additionally, County RERs for reporting years FY 2016-17 through FY 2017-18 can be accessed at the following webpage: http://www.dhcs.ca.gov/services/MH/Pages/Annual_MHSA_Revenue_and_Expenditure_Reports_by_County_FY_16-17.aspx.

Counties also are required to submit RERs directly to the MHSOAC. The Commission provides access to these reports through its Fiscal Reporting Tool at http://mhsoac.ca.gov/fiscal-reporting for Reporting Years FY 2012-13 through FY 2016-17 and a data reporting page at https://mhsoac.ca.gov/resources/documents-and-reports/documents?field_county_value=All&field_component_target_id=46&year=all

On October 1, 2019, DHCS published a report detailing MHSA funds subject to reversion as of July 1, 2018, covering allocation year FY 2015-16 for large counties and 2008-09 for WET and CFTN funds, updating a July 1, 2018 report detailing funds subject to reversion for allocation years FY 2005-06 through FY 2014-15 to satisfy Welfare and Institutions Code (W&I), Section 5892.1 (b). Both reports can be accessed at the following webpage:

https://www.dhcs.ca.gov/services/MH/Pages/MHSAFiscalRef.aspx

DHCS Status Chart of County RERs Received
February 17th, 2021 Commission Meeting

DCHS MHSA Annual Revenue and Expenditure Report Status Update

FY 2005-06 through FY 2018-19, all Counties are current

County	FY 19-20 Electronic Copy Submission Date	FY 19-20 Return to County Date	FY 19-20 Final Review Completion Date
Alameda			
Alpine			
Amador	1/15/2021	1/15/2021	
Berkeley City	1/13/2021	1/13/2021	1/13/2021
Butte			
Calaveras			
Colusa			
Contra Costa			
Del Norte			
El Dorado	1/29/2021		
Fresno	12/29/2020	12/29/2021	1/26/2021
Glenn			
Humboldt			
Imperial			
Inyo			
Kern			
Kings	1/4/2021	1/4/2021	
Lake			
Lassen	1/25/2021	1/25/2021	1/28/2021
Los Angeles			
Madera			
Marin			

DHCS Status Chart of County RERs Received
February 17th, 2021 Commission Meeting

County	FY 19-20 Electronic Copy Submission Date	FY 19-20 Return to County Date	FY 19-20 Final Review Completion Date
Mariposa	1/29/2021	1/29/2021	
Mendocino	12/30/2020	1/4/2021	1/20/2021
Merced	1/11/2021	1/12/2021	1/15/2021
Modoc			
Mono	1/29/2021		
Monterey			
Napa	12/23/2020	12/24/2020	12/28/2020
Nevada			
Orange	12/31/2020	1/20/2021	
Placer			
Plumas			
Riverside			
Sacramento			
San Benito			
San Bernardino			
San Diego			
San Francisco			
San Joaquin			
San Luis Obispo	12/31/2020	1/20/2021	1/20/2021
San Mateo			
Santa Barbara	12/29/2020	12/30/2020	1/5/2021
Santa Clara	1/28/2021	1/28/2021	
Santa Cruz			
Shasta	1/14/2021	1/15/2021	1/19/2021
Sierra	12/31/2020	1/25/2021	
Siskiyou			

DHCS Status Chart of County RERs Received
February 17th, 2021 Commission Meeting

County	FY 19-20 Electronic Copy Submission Date	FY 19-20 Return to County Date	FY 19-20 Final Review Completion Date
Solano			
Sonoma			
Stanislaus	12/31/2020	1/5/2021	1/5/2021
Sutter-Yuba			
Tehama			
Tri-City	1/27/2021	1/28/2021	
Trinity			
Tulare	1/26/2021	1/27/2021	
Tuolumne			
Ventura	1/29/2021		
Yolo	1/28/2021		
Total	22	18	10